South Wales and South West CHD Network Morbidity and Adverse Incident Reporting

This document sets out the process by which morbidity and network incidents in the South Wales and South West Congenital Heart Disease Network should be reported and how learning from investigations is shared with the wider network. It should be read in conjunction with the Network Risk Management documents.

Context:

The new Congenital Heart Disease Standards require that the Network operates within a governance framework that includes:

- *Regular meetings of the wider network clinical team, held at least every six months, whose role extends to reflecting on mortality, morbidity and adverse incidents and resultant action plans from all units.*
  Standard F3, Congenital Heart Disease Standards & Specifications, NHS England, May 2016

Network Responsibility

- ***These requirement do not replace individual provider's responsibilities to report and act upon incidents within their own institution***
- The reporting to the Network should be seen as additional to, not replacement of, local reporting and action
- Incidents should therefore be reported to the network where they affect cross-provider care or pathways, are significant in nature, or where there may be wider learning for other network partners. See trigger list, appendix 2.

Investigation

- Incidents should be investigated locally, following local Trust / Health Board procedures. The network management team may identify particular opportunities for wider learning within the network and therefore ask that the local investigation considers and reports back on these.
- Learning from investigations should be shared with the network management team
- Where required, the network team may inform external stakeholders (e.g. commissioners and regulators), but this should not supersede or replace the individual provider's responsibilities in this regard
- Investigation of an incident may identify a network risk. This should be logged in accordance with the network Risk Management document

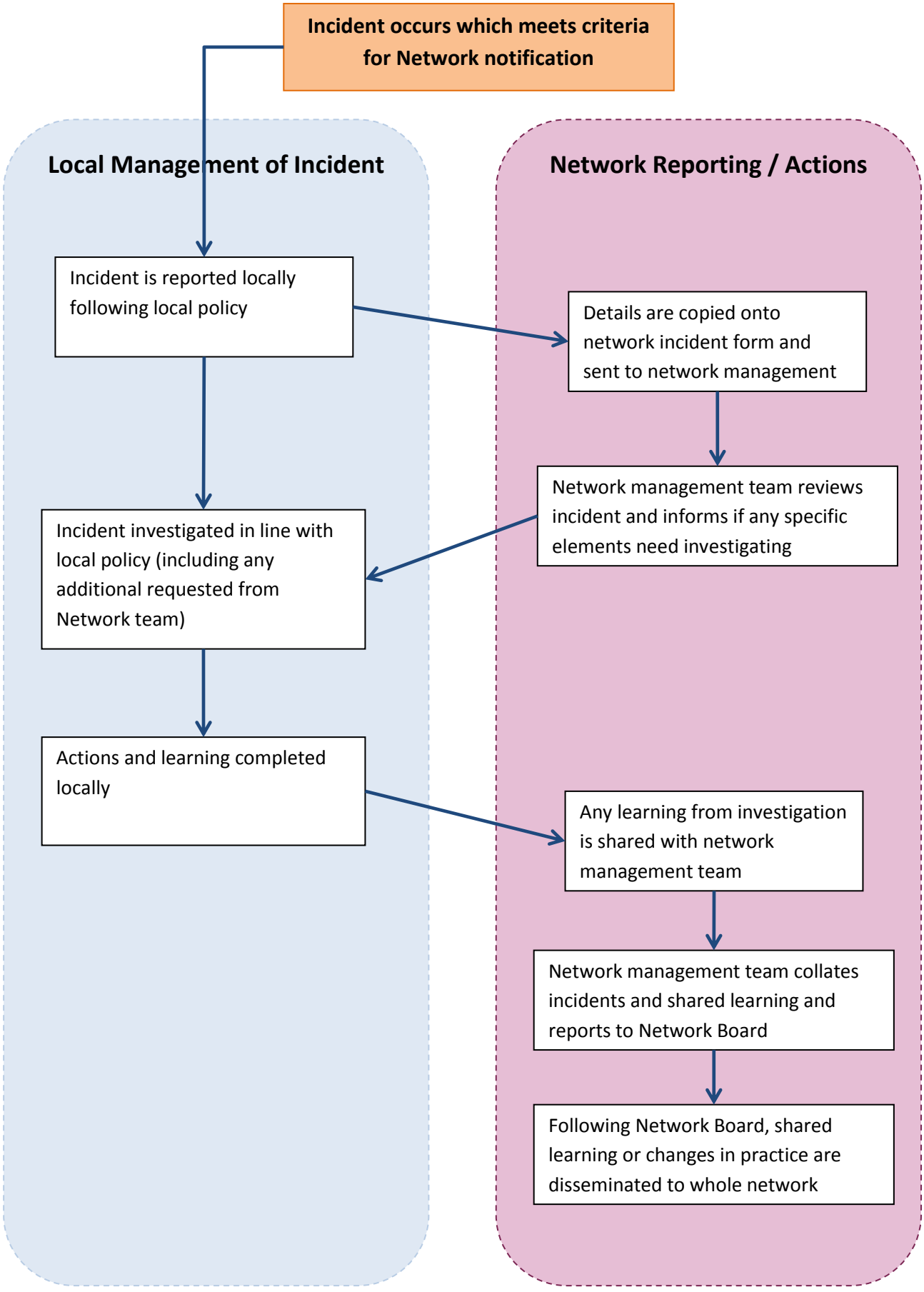
Investigation and broader learning

- On notification of an incident, the network management team will log this and capture any learning from the incident
- On a quarterly basis, a summary of incidents and learning will be collated and presented to the Network Board Meeting
- Analysis of any themes, common learning will be used to inform changes in practice and approach in the network. This will be communicated to all providers following the Network Board meeting.
- Responsibility for taking forward local action remains with the individual provider Trusts. The network management team will be responsible for coordinating actions across and between providers, or for those actions that need commissioner input

Document Control

Author:		
Name:	Position:	Date:
Sheena Vernon	Network Lead Nurse	03.03.17
Amendments:		
Name:	Details:	Date:
Approved By:		
Name:	Position:	Date:
David Mabin	Network Chair	15/03/17

Appendix 1: Reporting and Learning Flow Chart



Appendix 2: Trigger List for CHD Network Risks and Incidents

This list is not exhaustive, but serves as a prompt for staff to consider how to identify network incident.

Impact on safety of patients, staff and public

- Excessive wait for outpatient review, leading to delays to patient's treatment / diagnosis, resulting in an impact on the clinical condition / outcome
- Excessive wait for JCC / MDT review, leading to delay to patient's discussion and treatment planning, resulting in an impact on the clinical condition / outcome
- Excess wait for surgery or procedure leading to delay to patient's treatment, resulting in an impact on the clinical condition / outcome
- Inability to admit patient to appropriate level of care (e.g. NICU / PICU / children's cardiac ward / CICU / CCU / adult cardiac ward) bed within network, resulting in transfer out of area, or patient being held in inappropriate bed
- Re-presentation of a patient with concerning symptoms after missed diagnosis
- Inability to access timely clinical advice from specialist centre in accordance with network standards
- Identification of clinical decision making not having been in line with current guidelines and protocols
- Any Serious Untoward Incident or Never Event relating to a CHD patient

Quality / complaints / audit

- Formal patient complaint relating to the provision of care or communication across or between centres (level 1, 2 or 3)
- Where a centre or network is an outlier against national quality or outcome measures e.g. PRAiS mediated VLAD outcomes and unplanned re-interventions, mortality, morbidity, NICOR.
- Poor quality or limited communication of clinical information between centres (e.g. delayed clinic letters, failure to receive test results)
- Lack of local management engagement, impacting on ability to deliver service
- Lack of facilities (e.g. outpatient, ward, family accommodation, diagnostic) to deliver service

Workforce

- Loss of key staff, resulting in inability to maintain service
- Centre unable to release staff for training / professional development
- Inability to identify appropriate staff with an interest / expertise in CHD

Statutory

- Service / unit fails a national inspection or is put into special measures (e.g. CQC or Monitor)
- Significant outlier against CHD Standards, with inability to address concerns

Reputational

- Incident relating to CHD patient resulting in adverse publicity / media interest

Business Objectives

- Inability to secure funding, putting key objectives (e.g. network) at risk

Finance

Service Interruption / Environmental

- Loss of service, impacting on ability to meet service needs (e.g. building damage resulting in temporary closure of service)

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Notable morbidity: heart failures, rhythm issues, airway issues, endocarditis, process / operational issues (e.g. delayed access to clinic / diagnostic), preventable prolonged inpatient stay, lack of PICU/NICU bed, delayed repatriation between centres,

Appendix 3: Incident Reporting Form

Congenital Heart Disease Network South Wales and South West
Morbidity or Adverse Incident Reporting Form

Clinical Incident type *(please see Trigger List for CHD Network Risks and Incidents)*	*Tick*
Impact on safety of patients, staff and public	
Quality / complaints / audit	
Workforce	
Statutory	
Reputational	
Business Objectives	
Finance	
Service Interruption / Environmental	
Notable morbidity: (please highlight / circle) heart failures, rhythm issues, airway issues, endocarditis, process / operational issues (e.g. delayed access to clinic / diagnostic), preventable prolonged inpatient stay, lack of PICU/NICU bed, delayed repatriation between centres, **other – please specify: ……**	

Incident being investigated locally Yes / No	**Incident reported for information only** Yes / No
Incident reported by (name & title):	**Date:**
Organisation:	**NHS number of patient involved**:
Brief outline of incident / morbidity and outcome:	
Learning to be shared with wider Network (for completion after investigation has taken place):	
Contacts: Consultant: Nurse: Manager:	**Telephone/Bleep**
Has this Incident been referred for clinical governance procedures in another Trust? Yes / No **If yes, please specify which**:	
Date received by Network Clinical Lead / Governance Lead	

Completed form to be emailed to: Rachel.Benefield@uhbristol.nhs.uk