South Wales and South West CHD Network

Morbidity, Patient Safety Event, Learning and Risk Reporting

This document sets out how patient safety events, morbidity and adverse outcomes across the South Wales and South West Congenital Heart Disease (CHD) Network are identified, shared and responded to, and how learning is used to support system-wide improvement, in line with the NHS Patient Safety Incident Response Framework (PSIRF).

1. Context:

- The NHS England 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).

- The Operational Delivery Network provides system-level oversight by monitoring cross-provider themes in patient safety events, morbidity, mortality and pathway risks, supporting shared learning and escalation in line with NHS England Patient Safety Incident Response Framework (PSIRF) oversight principles. Provider organisations retain responsibility for incident reporting, investigation and risk management
  (NHS England Patient Safety Incident Response Framework and supporting guidance, 2022;
  NHS England PSIRF Oversight Roles and Responsibilities Specification 2022).

2. Purpose

The aim of this process is to:

- Promote shared learning across the CHD Network
- Support early identification of pathway risks
- Strengthen system-wide quality improvement
- Ensure incidents with cross-provider impact are visible at Network level

Provider organisations remain responsible for incident reporting, investigation and risk management under their local PSIRF plans.

3. Roles and Responsibilities

Provider Organisations

Provider Trusts and Health Boards retain responsibility for the management of patient safety events in line with their local Patient Safety Incident Response Framework (PSIRF) plans.

This includes:

- Identifying and reporting events through local governance systems
- Determining and delivering the appropriate **PSIRF learning response**
- Engaging with patients, families and staff
- Implementing and monitoring local improvement actions
- Managing organisational risk and statutory reporting requirements

Where events meet Network notification criteria, providers should share relevant information to support system learning.
Network notification does **not** replace local reporting, investigation or risk management processes.

CHD Network Role (Operational Delivery Network)

The South Wales and South West CHD Network provides **system-level oversight, coordination and shared learning** across the Congenital Heart Disease pathway.

The Network role is to:

- Receive notifications of events, risks or concerns with potential cross-provider impact
- Identify emerging themes, pathway risks or opportunities for shared improvement
- Support dissemination of learning across the Network
- Facilitate collaborative discussion through Network governance forums
- Escalate system risks to the Network Board where appropriate

The Network does **not**:

- Undertake or direct investigations
- Replace provider governance processes
- Hold individual organisations to account for incident management

Where appropriate, the Network may highlight system questions or learning themes for providers to consider within their local PSIRF learning responses.

Network Clinical Governance Group / Network Board

The Network Clinical Governance Group (reporting to the Network Board) provides oversight of:

- Themes and trends identified across the Network
- Shared learning and improvement priorities
- Escalation of significant pathway or system risks

The focus of reviewing incidents is system learning and coordination rather than performance management or investigation.

4. Learning, Oversight and Information Flow

The reporting pathway is summarised **in Appendix 2.**

The CHD Network supports system-wide learning by bringing together information about patient safety events, risks and pathway concerns that may have cross-provider relevance.

All patient safety events continue to be managed within provider organisations in line with their local PSIRF plans.

How the Process Works

1. **Event or Risk Identified Locally**
   A patient safety event, pathway issue or emerging risk is identified and managed through local governance processes.

2. **Local PSIRF Learning Response**
   The provider organisation determines and undertakes the appropriate learning response in line with PSIRF.
   This may include reviews, improvement work, thematic learning or other proportionate approaches.

3. **Notification to the Network**
   Where an event meets Network criteria (see Appendix 2), a summary is shared using the Network Patient Safety Event, Risk and Learning Reporting Form.
   Notification should take place as early as possible — organisations do not need to wait for learning responses to be completed, though they may wish to do so if further information is likely to come to light from local investigations/reflections on the incident.

4. **Network Review for System Learning**
   The Network Management Team reviews submissions to identify:

   - Cross-provider themes
   - Pathway risks
   - Opportunities for shared learning or coordination

   The purpose of review is system oversight and learning.
   The Network does not investigate events or direct provider learning responses.

5. **Shared Learning and Escalation**
   Themes and learning are collated and discussed through the Network Clinical Governance Group and Network Board, as appropriate.

   Outcomes may include:

   - Dissemination of shared learning
   - Identification of system improvement priorities
   - Coordination of pathway discussions across providers

Principles Underpinning the Process

This approach reflects the NHS Patient Safety Incident Response Framework (PSIRF) by:

- focusing on learning and improvement rather than incident management
- supporting proportional, locally led responses
- enabling early sharing of risks and themes across the Network
- strengthening system oversight while maintaining clear organisational accountability

5. Completing the Network Patient Safety Event, Risk and Learning Reporting Form (Appendix 3)

Use this form to share patient safety events, risks, pathway issues or learning themes which may have cross network learning implications.

Important:

- This form does note replace local incident reporting or PSIRF processes.
- Submit early – you do not need to wait for an investigation to finish.

What to include:

- A brief factual description of the issue
- Where in the CHD pathway the incident occurred
- Why Network awareness or learning may help
- Local reference number (if already reported locally)

What NOT to include:

- Detailed investigation reports
- Extensive clinical history
- Unnecessary patient identifiers

Document Control		
Author:		
Name:	Position:	Date:
Becky Lambert	Network Lead Nurse	
Approved By:		
Name:	Position:	Date:

Appendix 1:

When to Notify the CHD Network

This list is a guide only. Professional judgement should be used.

Notify the Network when an event, risk or concern may have **cross-provider impact, pathway risk or shared learning value**, particularly where it relates to:

1. Patient Safety or Clinical Pathway Risks

- Delays in review, MDT decision-making, surgery or intervention that affect clinical outcome
- Inability to access appropriate beds or specialist care within the network
- Missed or delayed diagnosis with potential pathway learning
- Difficulty accessing specialist advice in line with network standards
- Recurrent morbidity themes or unexpected clinical deterioration

2. System or Pathway Issues Affecting More Than One Organisation

- Communication failures between centres (e.g. clinic letters, results, referrals)
- Delayed transfers, repatriation issues or unclear pathway ownership
- Operational pressures affecting patient flow across the network
- Gaps in guideline use or variation in practice with potential system impact

3. Workforce, Capacity or Service Sustainability Concerns

- Loss of key staff impacting service delivery
- Inability to maintain parts of the CHD pathway safely
- Training or workforce issues affecting network standards

4. Quality, Statutory or Reputational Concerns

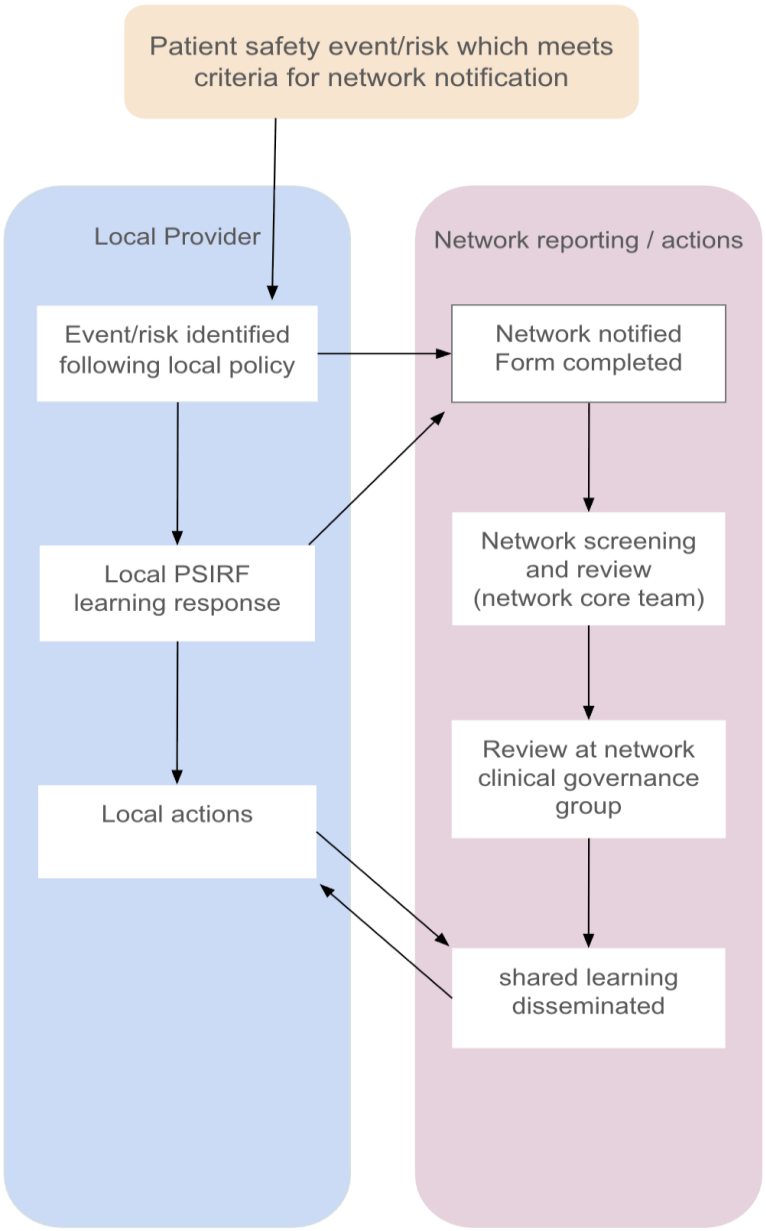
- Serious incidents or nationally defined never events involving CHD patients
- Outlier outcomes, national audit concerns or regulatory action
- Significant complaints involving care across more than one provider
- Media or reputational issues affecting the network

5. Emerging Risks or Themes

- Repeated minor issues suggesting wider system risk
- Concerns that may benefit from early shared learning or coordination

Important:
This process supports shared learning and system oversight.
Local PSIRF reporting and learning responses must continue within each provider organisation.

Appendix 2:


Patient safety event/risk which meets criteria for network notification
Local Provider
Network reporting / actions
Event/risk identified following local policy
Network notified Form completed
Local PSIRF learning response
Network screening and review (network core team)
Review at network clinical governance group
Local actions
shared learning disseminated

Appendix 3:

South Wales and South West Congenital Heart Disease Network
Patient Safety Event, Risk and Learning Reporting Form

This form is used to share patient safety events, risks or concerns that require Network oversight, coordination, or shared learning. It does not replace local incident reporting or PSIRF processes

Section 1 – Reporter Details	
Name:	
Role:	
Organisation (Trust / Health Board):	
Contact email / phone:	
Date of submission:	
Section 2 – Patient Details (if applicable)	
NHS Number (if applicable):	
Date of Birth:	
CHD service area:	☐ Neonate ☐ Child ☐ Adult
CHD service area:	☐ Paediatric ☐ Transition ☐ Adult

Section 3 – Type of Submission	
Please indicate the primary reason for reporting (tick all that apply): ☐ Patient safety event ☐ Risk or emerging concern ☐ Pathway or system issue ☐ Workforce or capacity issue ☐ Quality, audit or outcome concern ☐ Reputational or statutory concern	☐ Other (please specify):

Section 4 – Brief Description	
Briefly describe the event, risk or concern, including what happened (or may have happened), and the part of the CHD pathway involved:	

Section 5 – Local Status	
Has this been reported and managed locally? ☐ Yes – local PSIRF learning response underway ☐ Yes – risk logged locally ☐ No – shared for information and learning only	If yes, please provide local reference number (if available) & update on progress:

Section 6 – Network Learning and Oversight Considerations	
Why is Network oversight or shared learning helpful? (e.g. cross-provider pathway issue, repeated theme, system risk, learning for others):	

Section 7 – Immediate Actions / Risks	
Are there any immediate safety concerns or actions required at Network level?	☐ Yes (please describe) ☐ No

Section 8 – Learning to Share (if known)	
Any initial learning, insights or questions for the Network to consider:	

Section 9 – Key Contacts	
Clinical Lead contact	
Nursing / AHP contact:	

Operational / governance contact:	
Section 10 – Network Use Only	
Date received:	
Reference no:	
Reviewed by:	
Theme / category:	
Actions agreed:	
Escalation required: Yes / No	
Date reviewed by Network Clinical Governance Group	
Any further action following review:	
Action implemented (if appropriate) and date:	