



South Wales and South West
**Congenital Heart
Disease Network**

Deep delve into incidents

Dr Andy Tometzki

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Network Morbidity and Adverse Incident Reporting

The document sets out the process by which morbidity and network incidents in the network should be reported and how learning from investigations is shared with the wider network.

18 network incidents on Datix (as of February 2019)



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 requirements 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.

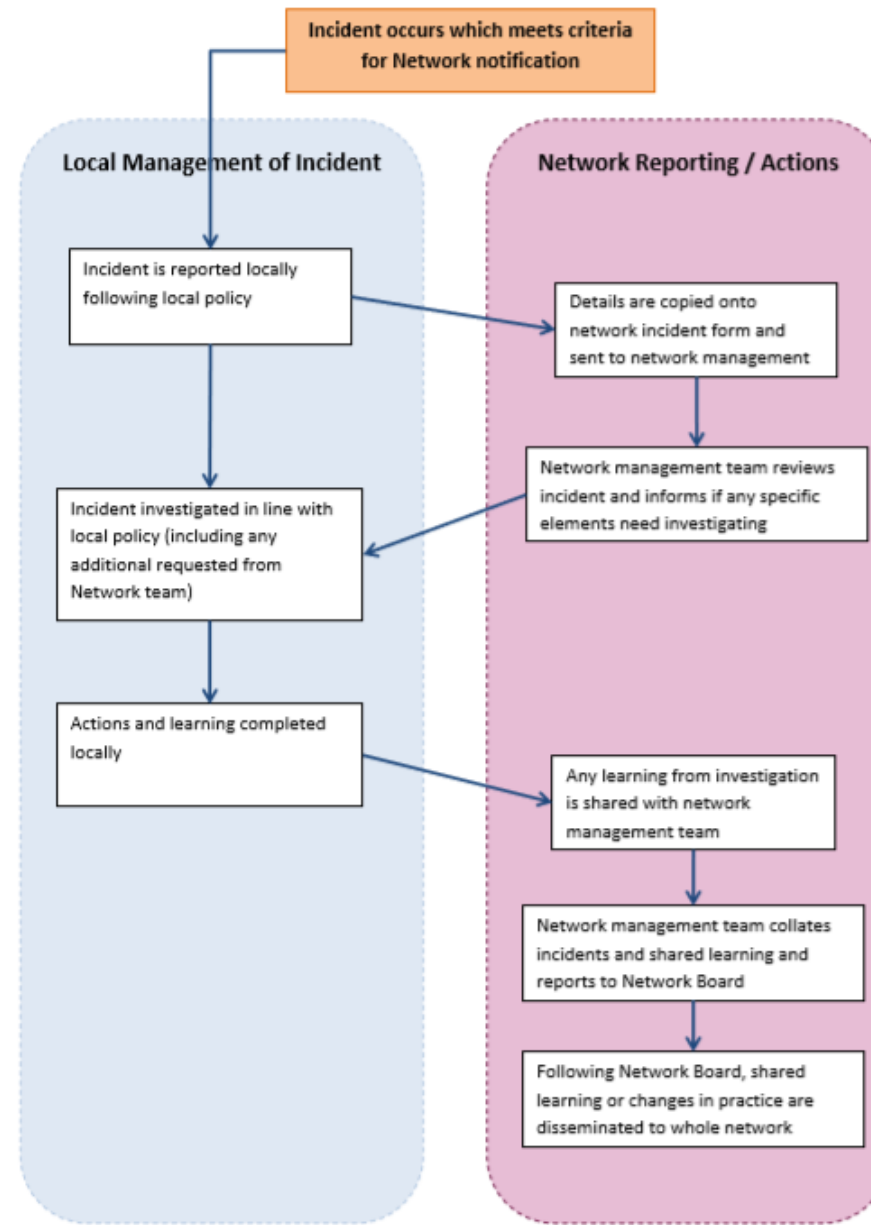
Investigation

- 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

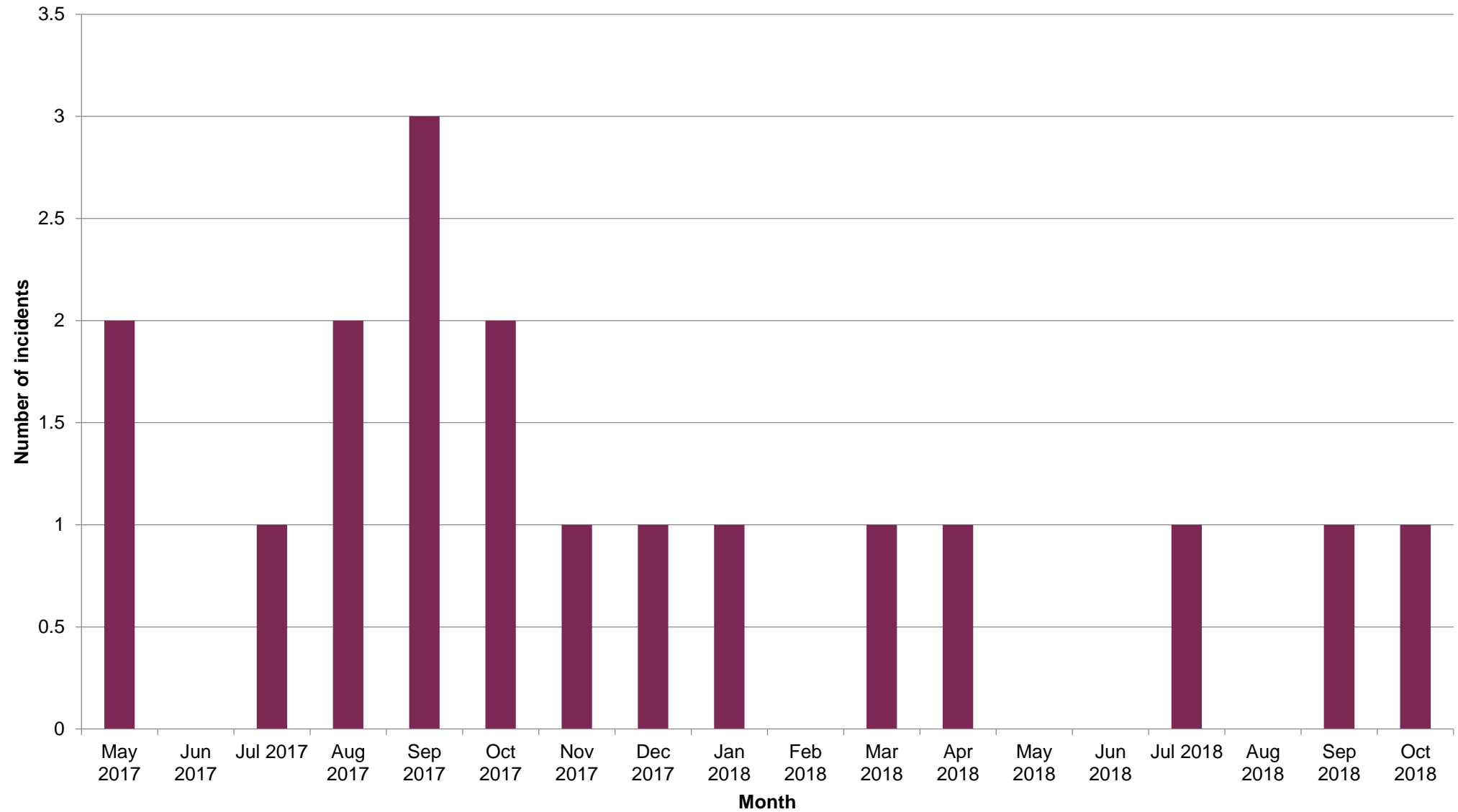
Investigation and broader learning

- 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

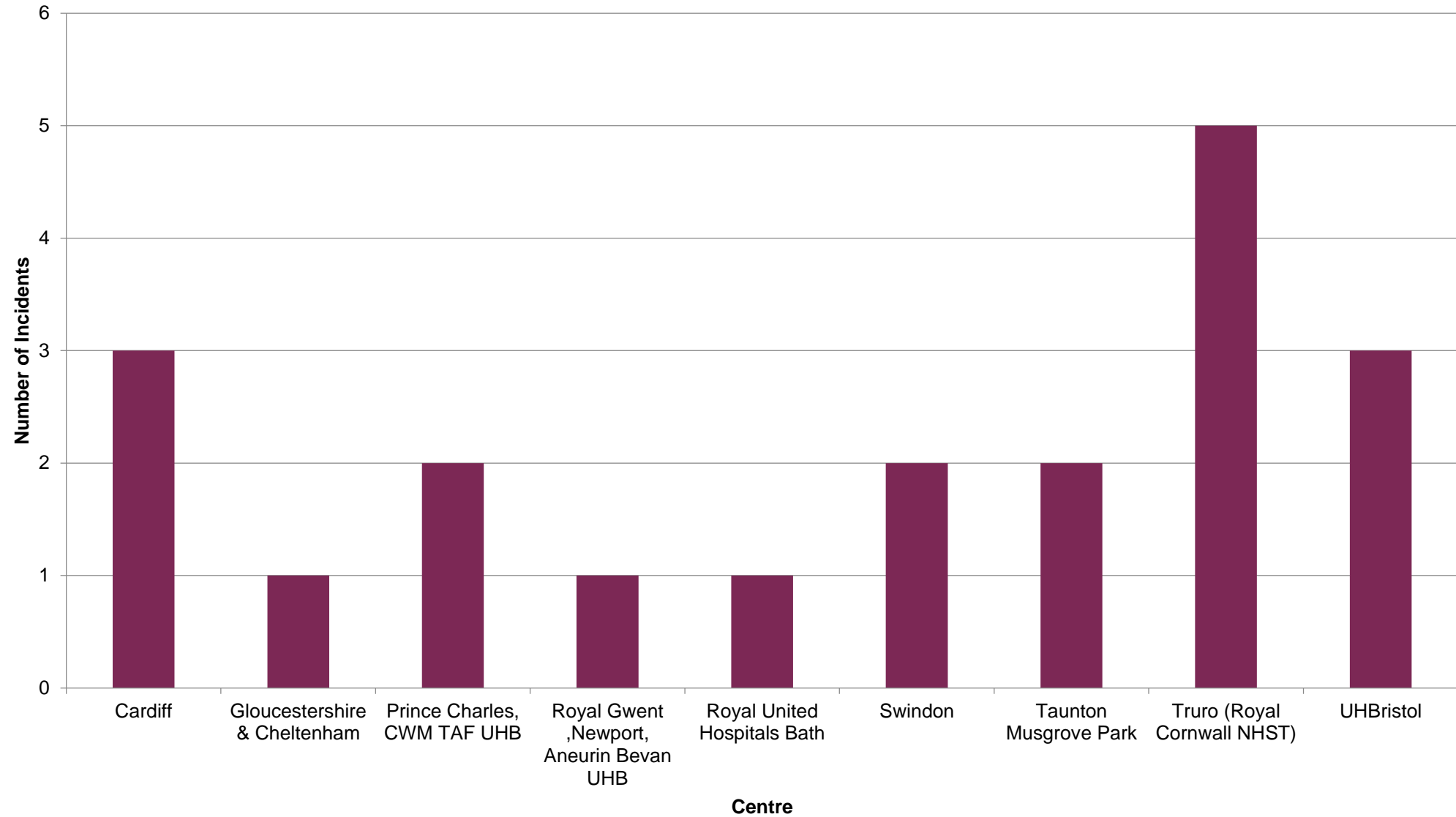
Reporting and learning flow chart



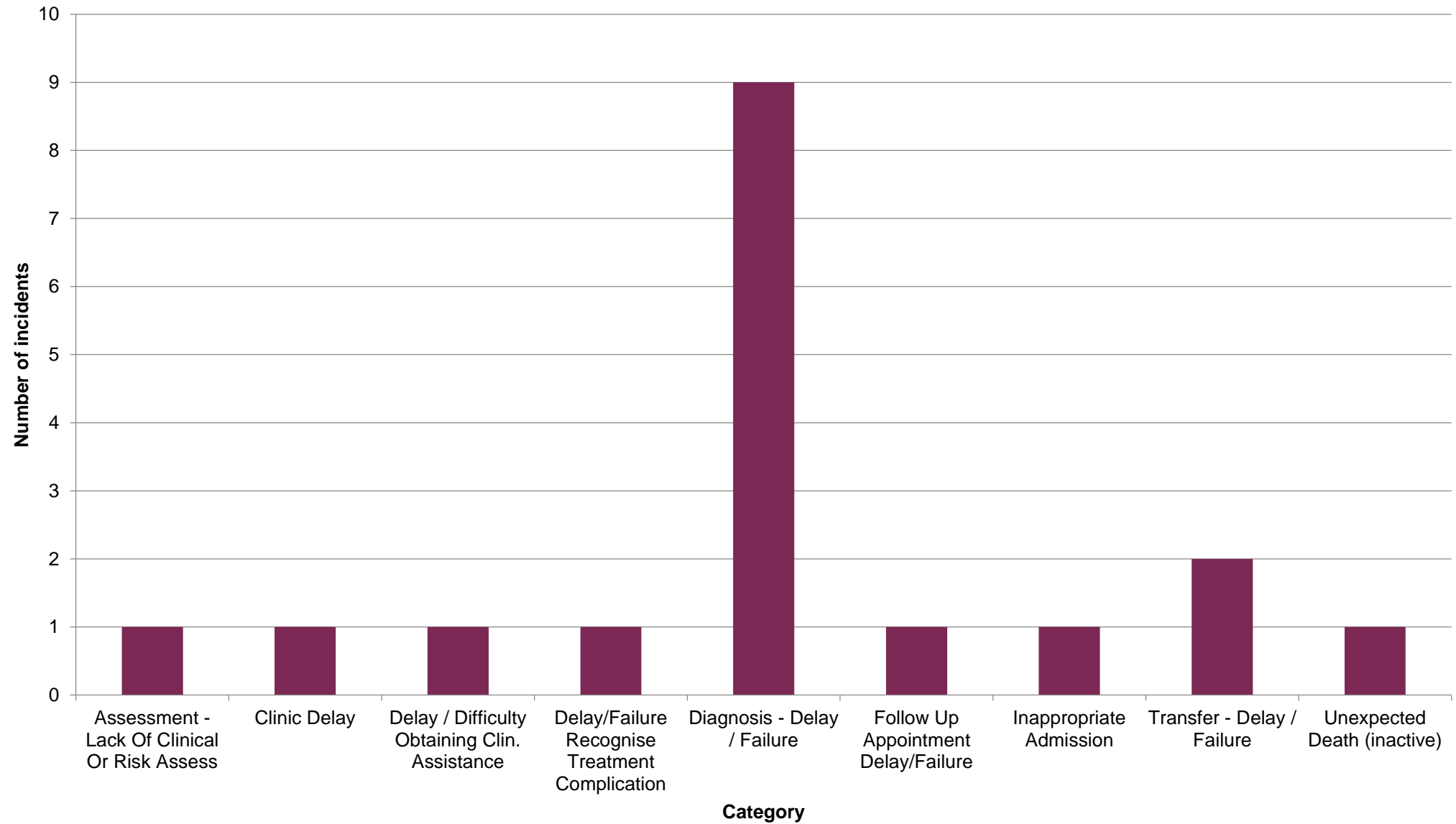
Number of network incidents by date of incident (Up to February 2019)



Number of network incidents by centre (up to February 2019)



Number of CHD Network incidents by category (up to February 2019)



Incidents

SVT 15 day old baby death – later metapneumonovirus

Capacity issues:

to transfer post Fontan patient from L2 to L1,

post PA IVS transferred to Southampton

Antenatal diagnosis – 4 x TGA, 1 x CoA, 1 x TAPVC, 1 x DORV, 1 x PA VSD

Damage to echo machine – 2 clinics cancelled – discuss resilience issues

Communication issue with ACHD L1 to L2

New patients >16 not able to be seen in adult clinic because not >18

Lost to FU – 22 yo with AS, treated as a SUI currently under investigation.

Group work

Issues

Patchy reporting – how to improve reporting

Watch should we be informed about?

What are purely network events - ? Transport (helicopter from Cardiff)

How do we interface with themed CDOPs

Learning from events and sharing solutions

Annual report

Conclusions

Do we have some work to do?

Equity
of access

Seamless
care

Meeting
national
standards

Continual
improvement

Patient
voice