

# Learning Lessons

## Final Internal Audit Report

2024/25

Hywel Dda University Health Board



Reasonable Assurance

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### Review Reference

HDU-2425-09

### Fieldwork

January - February 2025

### Executive Sign Off

1 April 2025

### Audit Committee

April 2025

### Executive Lead

Sharon Daniel, Interim Executive Director of Nursing, Quality & Patient Experience

### Audit Team

James Johns, Head of Internal Audit

Sophie Corbett, Deputy Head of Internal Audit

# Executive Summary

## Purpose

This review sought to provide the Health Board with assurance that following incidents and complaints, lessons are identified and learned to avoid similar instances, where possible, in the future. Learning from incidents and complaints is important to help improve services for patients.

## Overview

We have concluded **Reasonable** assurance on this area. Matters requiring management attention include:

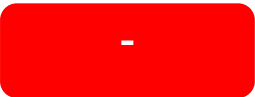
- The Listening & Learning Framework is yet to be finalised and launched. This will reinforce responsibilities and mechanisms for sharing learning.
- Learning is not always captured clearly and consistently in Datix
- Greater clarity is required over the circumstances where an action plan should be completed following investigation of a concern (incident or complaint).
- Our sample testing identified some instances where there was a lack of evidence to demonstrate sharing of learning

Full details of matters arising are detailed within the Findings & Agreed Action Plan.

## Scope & Assurance Summary

Objectives	Related Findings	Assurance
1 Processes are in place to capture and share learning from incidents and complaints	1, 2, 3	<b>Reasonable</b>
2 Implementation of associated actions is monitored and effectiveness assessed, with assurance reported through the appropriate governance structures	4	<b>Reasonable</b>

### Management Actions



High Priority



Medium Priority

### Themes



■ Lessons Learnt

### Risk Types

Quality or Safety Issues  
Public Perception & Reputational Risk

# Findings & Agreed Action Plan

**Objective 1:** Processes are in place to capture and share learning from incidents and complaints Reasonable

**Overview / Summary of Observations**

A Listening & Learning Framework is being developed to reinforce the Health Board’s commitment to learning, clarify roles and responsibilities and set out the sources and routes for learning. **[Finding 1]**

The Health Board utilises a single point of entry for raising and recording incidents and complaints (‘concerns’) via the Datix system. Responsibility for recording lessons learned within Datix lies with the designated directorate or service area (for incidents) or the Complaints Team (for complaints).

Cursory review of Datix reports of closed incidents and complaints noted that the quality of the narrative in the “Lessons Learned” field varied, often not concisely documenting the learning from the event where appropriate. **[Finding 2]** Detailed sample testing of 29 concerns identified that even where this field had not been adequately completed, learning identified was recorded elsewhere within the Datix file.

Directorates are responsible for the dissemination and escalation of lessons learned from concerns. For the 15 incidents sampled, it was stated on the Datix record that learning had been discussed with the staff members involved, and there was evidence of wider sharing of learning via Directorate quality governance structures where appropriate. For the 14 complaints sampled, in some cases there was no evidence of learning shared at Directorate level. **[Finding 3]**

Governance arrangements are in place for sharing learning more widely within the Health Board (covered in Objective 2). We noted that there is opportunity to improve the timeliness of sharing learning outside of formal governance structures. A Learning Library is being established, for staff to submit learning to the Quality, Assurance & Safety Team (QAST) for sharing via appropriate mechanisms such as the *7-minute briefings*. The Learning Library is in its infancy and dependent on Directorates and services proactively sharing learning. The Listening & Learning Framework will reinforce responsibilities and mechanisms for doing so. **[Finding 1]**

Key Findings	Risk & Impact	Agreed Management Action
<p>1 <b>Learning &amp; Learning Framework</b></p> <p>Whilst development of the Listening &amp; Learning Framework is ongoing, it has been discussed at Listening &amp; Learning Sub Committee and Quality Safety &amp; Experience Committee in November / December 2024.</p> <p>The framework will be key to raising awareness of sources of learning, and the responsibilities and mechanisms for sharing and escalating learning.</p>	<p>Staff are not aware of their responsibilities or processes in place for sharing learning.</p>	<p><b>Agreed Action:</b></p> <p>The Learning Framework will be finalised and made available to all staff through the Health Board’s SharePoint site. The Framework will include responsibilities and routes / mechanisms for sharing learning.</p> <p>The SharePoint page will be presented at the Listening and Learning Sub-Committee for support in May 2025.</p> <hr/> <p><b>Expected Evidence of Implementation:</b></p> <p>Finalised Learning Framework available on SharePoint</p> <hr/> <p><b>Officer:</b> Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding</p>
	<b>Medium Priority</b>	
<b>Theme:</b> Lessons Learnt	Control Design	<b>Date:</b> 31/05/2025

2	<p><b>Capturing Learning in Datix</b></p> <p>The 'Lessons Learned' field in Datix is not consistently used as intended, to concisely record the learning from the event. Common examples identified include:</p> <ul style="list-style-type: none"> <li>• "new processes implemented"</li> <li>• "appropriate actions taken / in place"</li> <li>• "will discuss with staff"</li> </ul>	<p>Learning identified captured is not or</p>	<p><b>Agreed Action:</b></p> <p>Guidance on what is meant by "lessons learned" is being written by the Quality Assurance and Safety Team.</p> <p>The guidance will be sent to all investigation managers and made available on the Concerns Investigation and Management SharePoint page.</p> <hr/> <p><b>Expected Evidence of Implementation:</b></p> <p>Evidence of guidance being shared via email</p> <p>Availability of guidance on SharePoint</p> <hr/> <p><b>Medium Priority</b></p> <p><b>Officer:</b> Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding</p>
	<p><b>Theme:</b> Lessons Learnt</p>	<p>Control Operation</p>	<p><b>Date:</b> 31/05/2025</p>
3	<p><b>Learning is Shared</b></p> <p>There was no evidence of shared learning, either within or outside of the Directorate, for six complaints.</p>	<p>Learning is not shared</p>	<p><b>Agreed Action:</b></p> <p>The new template for Clinical Care Groups (CCG) to report to the Quality, Safety and Experience Sub-Committee (QSESC) includes lessons learned.</p> <p>A workshop will be held to discuss the governance and reporting expectations from Service Groups to the CCG and from the CCG to the Integrated Quality Performance and Finance Delivery Group and QSESC.</p> <hr/> <p><b>Expected Evidence of Implementation:</b></p> <p>Workshop held</p> <p>Reporting template circulated</p> <hr/> <p><b>Medium Priority</b></p> <p><b>Officer:</b> Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding</p>
	<p><b>Theme:</b> Lessons Learnt</p>	<p>Control Operation</p>	<p><b>Date:</b> 31/05/2025</p>

**Overview / Summary of Observations**

The Concerns Investigation & Management SharePoint page states that an improvement action plan should be developed and implemented in a timely manner following completion of the investigation. Only six of the 29 concerns reviewed had action plans in Datix, and there was evidence of monitoring arrangements in each case. For those that didn't have an action plan, in some cases details of action taken was identified elsewhere within the Datix record (e.g. within a Learning From Events report, for Redress cases). The Quality Assurance and Safety Team (QAST) advised that the necessity for an action plan depends on the nature and extent of learning identified, although it is encouraged for all concerns. **[Finding 4]**

A review of the Quality Governance meetings for three directorates (Scheduled Care, Unscheduled Care and Women and Children's) confirmed that improvement and learning for concerns and serious incidents are a standing agenda item. Reports/snapshots of incidents (via the Patient and Safety dashboards), complaints, Public Services Ombudsman Wales and claims are submitted with the detail being scrutinised for the identification of themes, trends, and learning. Review of the meeting notes confirmed that concerns data, including scrutiny meeting notes are presented.

Directorate Quality Governance meetings feed into the Quality, Safety & Experience Sub-Committee (QSESC), with Directorates responsible for escalating learning from events as appropriate via the update reports. Learning from serious incidents and concerns progressing to redress are also reported to the Listening & Learning Sub Committee (LLSC). QSESC and the LLSC report to the Health Board's Quality, Safety & Experience Committee (QSEC). The Quality, Assurance & Safety Team (QAST) also report learning via the Quality Assurance report.

**Key Findings**

**Risk & Impact**

**Agreed Management Action**

**4 Action Plans**  
Greater clarity is required over the circumstances where an action plan should be completed following investigation of a concern (incident or complaint).

Action plans are not developed or implemented

**Agreed Action:**  
The Learning Framework will be finalised and made available to all staff through the Health Board's SharePoint site. The Framework will include responsibilities for development of an improvement action plan and the arrangements for monitoring of the plan.  
The SharePoint page will be presented at the Listening and Learning Sub-Committee for support in May 2025.  
The new template for Clinical Care Groups (CCG) to report to the Quality, Safety and Experience Sub-Committee (QSESC) includes monitoring of improvement action plans for nationally reportable incidents and serious concerns.  
A workshop will be held to discuss the governance and reporting expectations from Service Groups to the CCG and from the CCG to the Integrated Quality Performance and Finance Delivery Group and QSESC.

		<p><b>Expected Evidence of Implementation:</b>          Finalised Learning Framework made available on SharePoint          Workshop held          Reporting template circulated</p>
<p><b>Theme:</b> Lessons Learnt</p>	<p><b>Medium Priority</b>           Control Design</p>	<p><b>Officer:</b> Cathie Steele, Interim Assistant Director of Nursing Assurance and Safeguarding   <b>Date:</b> 31/05/2025</p>

# Appendix A

## Assurance Opinion

	<b>Substantial</b>	Few matters require attention and are compliance or advisory in nature. <b>Low impact</b> on residual risk exposure.
	<b>Reasonable</b>	Some matters require management attention in control design or compliance. <b>Low to moderate impact</b> on residual risk exposure until resolved.
	<b>Limited</b>	More significant matters require management attention. <b>Moderate impact</b> on residual risk exposure until resolved.
	<b>Unsatisfactory</b>	Action is required to address the whole control framework in this area. <b>High impact</b> on residual risk exposure until resolved.
	<b>Advisory</b>	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

## Prioritisation of Findings

Priority	Explanation
<b>High</b>	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
<b>Medium</b>	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

Website: [Audit & Assurance Services - NHS Wales Shared Services Partnership](#)

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## Public Sector Internal Audit Standards

Audit work undertaken by NHS Wales Audit and Assurance Services conforms with the International Standards for the Professional Practice of Internal Auditing and associated Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Chartered Institute of Public Finance & Accountancy in April 2023.

