Lessons Learned
Final Internal Audit Report

June 2023

Hywel Dda University Health Board

Partneriaeth Cydwasanaethau
Gwasanaethau Archwilio a Sicrwydd
Shared Services Partnership
Audit and Assurance Services

Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

Contents

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Committee:	Audit & Risk Assurance Committee

Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement
NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Executive Summary

Purpose

The purpose of the audit was to review arrangements across the Health Board for the implementation of lessons learned and actions resulting from incidents, claims and complaints and in accordance with the Putting Things Right process.

Overview

The organisation has an established governance structure with clear lines of reporting for identified lessons learned from directorate and services to the Health Board and an agreed *Putting Things Right Policy* in place.

Two medium priority matters arising were identified relating to:

- the lack of evidence for the sharing of lessons learned with directorate colleagues; and
- the consistent and accurate recording of lessons learned and their sharing within case files recorded on the Datix system.

We have concluded **Reasonable** assurance overall. Full detail are provided in Appendix A.

Report Opinion

		Trend
Reasonable 	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.	N/A

Assurance summary[1]

Objectives		Assurance
1	Documentation is in place to capture learning from incidents, claims and complaints.	Reasonable
2	Lessons learned are shared with the relevant parties and action taken throughout the Health Board	Reasonable
3	Reporting within the Health Board to provide assurance on the impact of implementing actions following lessons learned	Substantial

[1]The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising

		Objective	Control Design or Operation	Recommendation Priority
1	Sharing of Lessons Learned	2	Operation	Medium
2	Accurate Recording of Lessons Learned	2	Operation	Medium

1. Introduction

1.1 The NHS Wales Putting Things Right (PTR) guidance came into force on 1st April 2011 to enable responsible bodies to effectively handle concerns according to the requirements of the *NHS (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011*. Section 9 of this guidance refers to 'Learning from Serious Incidents'.

> *"The outcome of any investigation must be used to maximise opportunities for learning, quality improvement and improving patient safety. This should be a key element in our overall attempts to reduce adverse events and avoidable harm to patients/service users in line with the aims set out in 1000 Lives Plus programme and organisations' local priorities."*

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

1.3 The associated potential risks are:

- continued harm to patients; and
- financial and reputational damage to the Health Board.

2. Detailed Audit Findings

Objective 1: Documentation in place to capture learning from incidents, claims and complaints from across the Health Board

2.1 The Health Board has in place the *'Putting Things Right' Management and Resolution of Concerns Policy* that sets out the Health Board's responsibilities for fostering a culture of learning from experience and the sharing of lessons learned to colleagues. The policy is written in line with the *NHS (Concerns, Complaints and Redress) (Wales) Regulations 2011* and *Public Services Ombudsman (Wales) Act 2019.*

2.2 The *'Putting Things Right' Policy* is supported by other documents and procedures. Whilst we confirmed that all policies and procedures are accessible to staff via the Health Board's intranet, the *Claims Management Policy* and *Being Open/Duty of Candour Guideline* had expired and were being reviewed at the time of fieldwork.

2.3 The Health Board utilises a single point of entry for raising and recording concerns via the Datix system. A dedicated intranet page enables staff access to Datix along with a suite of documents, forms and flowcharts to ensure the consistent reporting of incident management and the lessons learned.

Conclusion:

2.4 Whilst some policies and procedures had expired and required review and approval, actions were in place to address these items. Recognising the work ongoing, no further recommendations are raised. We have therefore concluded **Reasonable** assurance for this objective.

Objective 2: Lessons Learned from the Putting Thigs Right process are shared with relevant parties and action undertaken throughout the Health Board

2.5 The identification of lessons learned should be recorded on the Datix system. The responsibility for inputting the incident/complaint details, including lessons learned, lies with the designated directorate or service officer. The '*Putting Things Right*' *Policy* states that directorate managers, heads of service and triumvirate teams are responsible for the dissemination of any lessons learned to colleagues within their own and other directorates where appropriate.

2.6 A sample of 30 incidents, claims, complaints and Public Services Ombudsman for Wales (PSOW) cases recorded on Datix for the period January – October 2022 was tested to establish whether the action taken in response to the incident/complaint had resulted in lessons learned being adequately captured and shared.

2.7 Six instances were identified where lessons learned had not been recorded on the Datix record by the responsible directorate/service officer.

2.8 Where lessons learned had been input in the Datix record, a quality review of the content identified three instances where the narrative was not deemed as 'lessons learned' but rather steps to mitigate the identified risks only.

2.9 The Datix system also allows for the uploading of documents to support any actions and/or evidence of the incident/complaint. Of the 30 cases reviewed, 11 instances were identified where evidence to support the sharing of lessons learned within the organisation was not evident.

2.10 Of the 11 instances where the sharing of lessons learned was not evident, the responsible directorate/service officers were contacted to establish and evidence how the sharing of lessons learned was communicated to staff. Concluding testing, evidence was provided of lessons learned being shared with employees in four instances. **[Matter Arising 1]**

2.11 A complaints toolkit and associated key performance indicators are currently being developed to facilitate the investigation and recording of complaints in the Datix system. Progress updates of the toolkit have been reported to Quality, Safety and Experience Committee (QSEC) via the Listening and Learning Sub-Committee (LLSC).

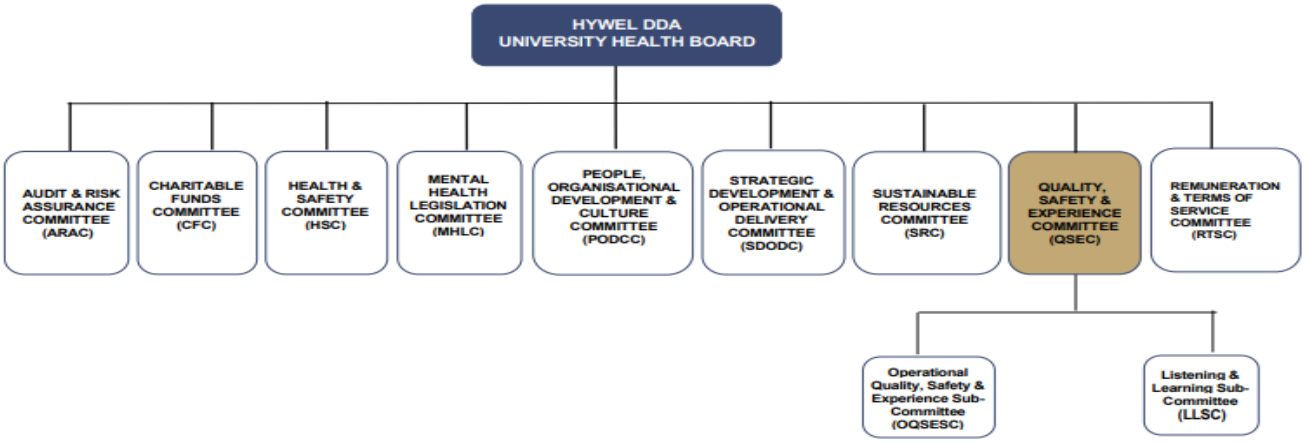
Conclusion:

2.12 Instances of non-compliance with policy were identified where lessons learned had not been fully recorded or shared. We have concluded **Reasonable** assurance for this objective.

Objective 3: Reporting within the Health Board to provide assurance on the impact of implementing actions following lessons learned

2.9 The organisation has an established governance framework for the scrutiny and review of lessons learned from directorates and services up to the Health Board – see the structural hierarchy below. The reporting arrangements of all concerns with significant learning is also outlined in the *'Putting Things Right' Policy*.

Figure 1: Health Board Reporting Structure



2.10 A review of three directorate Quality, Safety & Experience meetings confirmed that improvement and learning action plans for concerns and serious incidents were a standing agenda item. Reports on incidents, complaints, PSOW and claims were submitted with the detail being scrutinised for the identification of themes, trends, and learning.

2.11 The LLSC has an agreed terms of reference with the primary aim of providing a platform to share and scrutinise learning from incidents and complaints, and to triangulate emerging data and identify emerging trends, themes and learning outcomes.

2.12 Review of minutes and papers for the October and December 2022 meetings highlighted the reporting of lessons learned from incidents, complaints claims and PSOW cases scrutiny of cases as a standing agenda item.

2.13 The LLSC provide assurance to the Health Board via the QSEC through regular submission of exception reports.

Conclusion:

2.14 We have therefore concluded **Substantial** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Sharing of Lessons Learned (Operation)	**Impact**
Of the 30 cases of incidents, complaints, claims and PSOW reviewed, seven instances where the sharing of lessons learned amongst the originating directorate and any other teams (where appropriate) was not evident.	Potential risk of: • continued harm to patients; and • financial and reputational damage to the Health Board.

Recommendations		**Priority**
1.1	Case officers should confirm with directorate management the dissemination of lessons learned to relevant colleagues and where applicable to other directorates.	**Medium**
1.2	To ensure a complete and clear audit trail, evidence of sharing lessons learned should be uploaded on Datix by the responsible directorate/service officer.	

Agreed Management Action		**Target Date**	**Responsible Officer**
1.1	The individual directorate/teams are responsible for lessons learned and disseminating to all relevant staff where relevant. The responsibility for documenting the dissemination and sharing of lessons learnt on Datix, will be clearly set out in the concerns investigation procedures and relevant paperwork.	**31/7/23**	**Louise O'Connor/Cathie Steele**
1.2	The team is currently trialling AMAT for incident action plans as this provides better control and is easier for evidence linking.	**31/7/23**	**Louise O'Connor/Cathie Steele**

Matter Arising 2: Accurate Recording of Lessons Learned (Operation)	**Impact**
Of the 30 cases of incidents, complaints, claims and PSOW reviewed, we identified: • six instances where lessons learned had not been accurately recorded in Datix; and • where lessons learned had been input in the Datix record, a quality review of the content identified three instances where the narrative was not deemed as 'lessons learned' but rather steps to mitigate the identified risks only. A complaints toolkit and associated key performance indicators are currently being developed to facilitate staff in the investigation and recording of complaints onto the Datix system. Progress updates of this toolkit has been reported to the QSEC via the LLSC.	Potential risk of: • continued harm to patients; and • financial and reputational damage to the Health Board.

Recommendations		**Priority**
2.1	The Health Board should reinforce the full and accurate completion of the lessons learned section for incidents and complaints recorded in Datix by the responsible directorate/service officers.	**Medium**
2.2	Consideration should be taken to include incident investigation and reporting into the toolkit currently being developed to aid staff in ensure a consistent approach is taken for the recording of cases in Datix.	**Low**

Agreed Management Action		**Target Date**	**Responsible Officer**
2.1	A small task and finish group will be established including the corporate concerns team, legal services and operational colleagues to devise a lessons learned procedure, including the use of datix. The aim will be to devise directorate wide learning plans, rather than individual action plans to strengthen the governance	30th September 2023	**Louise O'Connor / Cathie Steele**

	and monitoring around actions. This will enable easier identification of repeated themes/trends and dissemination.		
2.2	An incident reporting process and tools to aid investigation are already in place and contained within the SharePoint site for all staff access. The concerns investigation training is ongoing and well attended which provides support to staff on investigation methodologies and practical skills. The Health Board will engage with the all Wales work to develop an incident investigation framework which will provide the investigation procedural requirements for all NHS bodies. Alongside this will be the implementation of a separate investigation module on Datix which will be utilised for all concerns investigations.	31st December 2023	**Louise O'Connor/ Cathie Steele**

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	**Substantial assurance**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable assurance**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited assurance**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**No assurance**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Assurance not applicable**	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 Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.

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