Learning from Incidents and Concerns

Final Internal Audit Report

2024/25

Swansea Bay University Health Board

Reasonable Assurance

Contents

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Executive Summary

Purpose

Review arrangements for learning and taking actions as a result of incidents, claims, complaints and other indicators. To consider findings raised in the recent Welsh Risk Pool report.

Overview

We have concluded reasonable assurance on this area. The significant matters requiring management attention include:

- Policy does not clearly set out responsibilities and mechanisms for documenting and 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 the investigation of incidents and concerns.
- Our sample testing identified some instances where there was a lack of evidence to demonstrate sharing of learning.
- Strengthening reporting arrangements to provide more focus on learning from incidents and concerns.

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

Scope & Assurance Summary

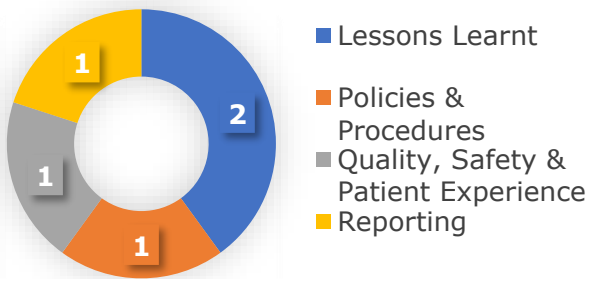
Objectives (The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.)		Related Findings	Assurance
1	Clear processes are in place to identify and capture learning from incidents, claims, complaints and concerns, with action plans developed as appropriate;	1-3	**Reasonable**
2	Lessons learned are shared with relevant parties and action undertaken throughout the health board.	4	**Reasonable**
3	Reporting within the health board to provide assurance on the impact of implementing actions following lessons learned, including to limit future occurrence.	5	**Reasonable**

Management Actions

0 High Priority

5 Medium Priority

Themes



Risk Types

Quality or Safety Issues

Public Perception & Reputational Risk

Findings & Agreed Action Plan

Objective 1: Clear processes are in place to identify and capture learning from incidents, claims, complaints and concerns, with action plans developed as appropriate.	**Reasonable**

Policies and Guidance

The health board's Concerns Management Policy and Claims Management Policy set out the expectation in relation to post-incident learning. This includes:

- *incidents and complaints are managed, together or individually, within a timely manner, ensuring that a full investigation has is undertaken and shared learning identified;*
- *learn lessons and improve services from these incidents;*
- *Ensure learning from concerns and errors drives quality improvement and reduces adverse events, and avoidable harm to patients/users.*

While these policies commit to the need for and importance of learning following the raising of a concern, the Policy does not set out nor define what learning should look like, how it should be shared, or the extent and expectation of learning and its documentation based on its harm rating or seriousness. We understand that an 'All Wales Learning From Events Framework' model document has been developed on a national basis by the Welsh Risk Pool (WRP), and a local version has been developed within the health board, which will be revised to incorporate the findings of this review. There is also the opportunity to learn from frameworks being developed elsewhere across NHS Wales to reinforce the commitment to learning, clarify roles and responsibilities, set out the sources and routes for learning, and mechanisms for sharing and escalating learning (**see Key Finding 1**).

The health board utilises a single point of entry for raising and recording incidents and complaints ('concerns') via the Datix incident reporting system. The Patient Experience, Risk and Legal section on the Health Board's SharePoint intranet site includes a page specifically for Datix. The site includes user guides and training videos which provide ongoing support to users, and there are also scheduled drop-in sessions available for staff. However, our review of the lessons learned field within Datix has shown that it is not always completed with sufficient detail, information is inconsistently captured and often not concisely documenting the learning from the event where appropriate (**see Key Finding 2**).

Learning

We selected a sample of 20 patient safety incidents and WRP claims and redress incidents in order to assess the learning undertaken in response:

- Detailed sample testing of patient safety incidents identified that where the 'lessons learned' field had not been adequately completed, learning was recorded elsewhere within the Datix file. There were instances where the health board identified no learning as investigations had determined that the correct processes had been followed and liability settlements defended (**see Key Finding 2**).
- Nine WRP incidents were tested, and we were provided with a Learning From Events Report (LFER) for all. There was one instance where no learning was identified, however the submission to WRP indicated that learning had been shared internally. There was also an instance where a safety notice to share learning had not been issued at the time of audit fieldwork (**see Key Finding 2**).

Action Plans

In relation to learning, the health board's 'Concerns Management Policy' sets out that '*The Health Board will ensure that it has arrangements in place to review the outcome of any Concern that has been subject to an investigation under the Regulations, in order to ensure that any deficiencies in its actions or its provision of services, identified during the investigation, are:*

a) *Acted upon - where immediate action cannot be taken an action plan will be developed using the template action plan in Datix. All action plans will be recorded in Datix Action Plan module;*
b) *Monitored - by the Service Delivery Service Group to ensure the actions are implemented timely and the action(s) taken are minimising the risk of reoccurrence.*

We were advised that action plans are generally only developed following an incident investigation, where the post investigation harm outcome is graded as moderate or above. The results of these incidents subsequently meet the requirements of Redress (Under the 'Putting Things Right Regulations 2011) which would require the creation of a LFER for WRP.

Of the 11 patient safety incidents tested, we were provided with only two action plans. 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, within the focused review section). The Patient Safety Incident Investigation Team (PSIIT) advised that the necessity for an action plan depends on the nature and extent of learning identified (**see Key Findings 3 and 5**). We note that for the WRP claims tested, each LFER requires the inclusion of evidence to support incident outcomes, which include learning and actions.

Key Findings		Risk & Impact	Agreed Management Action
1	**Learning Framework** The health board's Claims Management Policy and Concerns Management Policy set out the need for and importance of learning following the investigation of a concern or complaint to reduce the risk of recurrence. Our review of the policies has shown that there is limited guidance as to what learning should look like, how it should be shared, or the extent and expectation of the learning and its documentation based on the individual incident severity rating. We understand that an 'All Wales Learning From Events Framework' model document has been developed on a national basis by Welsh Risk Pool, and a local version has been developed within the health board. There is also an opportunity to learn from frameworks being developed elsewhere across NHS Wales to reinforce their commitment to learning, clarify roles and responsibilities, set out the sources and routes for learning, and mechanisms for sharing and escalating learning.	Staff are not aware of their responsibilities or processes in place for sharing learning.	**Agreed Action:** 1. We will link in with other health board's nationally to learn their learning structures and to review and revise our existing Learning Framework in light of other models. 2. We will review and revise Claims Management and Concerns Management Policy to include specific management of learning and reference to the Listening and Learning Framework 3. The revised Claims Management and Concerns Management policies will be issued through Quality and Safety Group with direction for service group triumvirates to ensure implementation within their areas. **Expected Evidence of Implementation:** 1. Review and revise Listening and Learning framework and present to Management Board 2. Revised policies presented to Quality and Safety Group 3. Confirmation of dissemination and implementation arrangements received within Quality and Safety Group.
		Medium Priority	**Officer:** (1 & 2) Head of Quality and Safety; (3) Quality and Safety Group Chair **Target Implementation Date:** (1) 30 November 2025; (2) 31 January 2026; (3) 1 March 2026

Key Findings		Risk & Impact	Agreed Management Action
	Theme: Policies & Procedures	Control Design	
2	**Capturing and Evidencing Learning** Our review of the 'Lessons Learned' field within Datix identified that it is not always completed with sufficient detail, information is inconsistently captured and often did not always clearly and concisely document the learning from the event where appropriate. We also note that there were instances where learning was captured elsewhere within the incident record, which provides a challenge for the health board to manage and analyse learning themes and trends across incident categories (see **key finding 5**). In addition, the absence of clear guidance that sets out requirements and expectation to document learning (see **key finding 1**) has contributed in making it difficult to confirm what learning has been identified, and whether it has been successfully implemented and sustained. However, we have been provided with some very good examples of learning and how it has been implemented which suggests an inconsistent approach being applied across the health board.	Learning is not identified, captured or implemented.	**Agreed Action:** 1. Develop training resource for investigators in how to complete investigations on DATIX and action planning and disseminate this resource 2. Executive Director of Nursing (EDON) and Executive Medical Director (EMD) to write to Service Group Nurse Directors to remind service groups of the importance of completion of investigations and action planning 3. Quality and Safety Group to receive confirmation of arrangements for sharing learning from service groups **Expected Evidence of Implementation:** 1. Training resource available 2. Letter sent to service group medical and nurse directors 3. Service groups to present to QSG on systems for learning
		Medium Priority	**Officer:** (1) Assistant Head of Concerns Assurance; (2) Executive Director of Nursing & Executive Medical Director; (3) Chair of Quality and Safety Group **Target Implementation Date:** (1) 31 October 2025; (2) 30 November 2025; (3) 31 January 2026
	Theme: Lessons Learnt	Control Operation	
3	**Action Plans** The Concerns Management Policy establishes that *'where immediate action cannot be taken, an action plan will be developed using the template action plan in Datix'*. There is no determination to differentiate between 'immediate action only required' or 'action plan required' and therefore it was difficult to determine whether the actions completed (and subsequent learning and outcomes) were appropriate/sufficient or in line with expectation set out in policy. Of the 11 incidents tested, only 2 action plans were provided to us which were not supported by evidence of monitoring or scrutiny at Service Group level. We have not had sight of the Datix template action plan as part of this review and so we are unable to determine its appropriateness, however discussion with key officers at Service	Lack of clarity in policy to support when an action plan is required. Action plans are not developed, implemented nor monitored at an appropriate level.	**Agreed Action:** 1. Develop training resource for investigators in how to complete investigations on DATIX and action planning and disseminate this resource 2. Discussion with service group quality leads regarding functionality of DATIX action plan and feedback provided to All –Wales user group 3. Guidance to be developed on the criteria for developing an action plan and local template to be developed, if DATIX tool agreed as unsuitable 4. EDON and EMD to write to service group nurse directors to remind service groups of the importance of completion of investigations and action planning 5. Quality and Safety Group to receive confirmation of arrangements for ensuring completion of action plans from service groups

Key Findings	Risk & Impact	Agreed Management Action
Groups implied that the function to produce action plans directly from Datix was not fit for purpose. Greater clarity is therefore required over the circumstances where an action plan should be completed following investigation of incidents and concerns and in what format.		**Expected Evidence of Implementation:** 1. Training resource available 2. Feedback provided to DATIX user group 3. Criteria for action planning and local template developed and made available to service groups 4. Letter sent to service group medical and nurse directors from EMD and EDON with instruction regarding use of action plans and to share the action plan template 5. Quality and Safety Group minutes
	Medium Priority	**Officer:** (1 & 2) Assistant Head of Concerns Assurance; (3) Executive Director of Nursing (4) Executive Medical Director & Executive Director of Nursing; (5)Quality and Safety Group Chair. **Target Implementation Date:** (1) 31 October 2025; (2) 30 November 2025; (3) 31 January 2026; (4) 1 March 2026; (5) 1 April 2026
Theme: Quality, Safety & Patient Experience	Control Design	

Objective 2: Lessons learned are shared with relevant parties and action undertaken throughout the health board.	**Reasonable**

Our testing of a sample of 20 patient safety incidents and Welsh Risk Pool (WRP) claims and redress incidents also considered how learning is shared, both more widely across the health board and externally.

Patient Safety Incidents

We were only provided with evidence to support the sharing of learning for two incidents. Regarding the other incidents sampled, it was confirmed via Datix review or discussion with key officers, that learning had been discussed with the staff members involved, and there was evidence of wider sharing of learning via local quality governance structures where appropriate. However, in some cases there was a lack of evidence of learning shared (**see Key Finding 4**).

As part of the wider sharing of incident learning, a learning summit was held within the health board following a serious patient safety incident. A learning forum was established to discuss and cascade learning, and the action plans developed in response to the coroner's Regulation 28 Report. This was subsequently extended to *'a) target additional learning / opportunities for service improvement and b) pilot a format that could be used to foster interagency learning and service improvement through future summits and related events'*. The summary report was presented within the Mental Health and Learning Disabilities (MH&LD) Service Group and subsequently presented to the MH&LD's Quality and Safety Group. This summit received positive feedback and was well received. We were advised by Head of Quality and Safety (Corporate) that the Health Board would look to promote the undertaking of these summits more widely and more regularly across the health board.

Welsh Risk Pool Reporting

Reporting to WRP in relation to claims requires the completion and submission of a 'Learning From Events Report' (LFER), and the inclusion of evidence to support post-incident learning and actions undertaken. These are reviewed by the WRP, and approval of the claim can be deferred if they are not satisfied with the quality of learning. Fortnightly meetings are subsequently held between the health board's Claims Managers and the Service Group Quality Leads to manage and progress the learning, in readiness for resubmission to the WRP. We were provided with LFERs for each of the claims selected in our testing sample, including evidence embedded within to support the actions taken and lessons learned.

A review of the WRP '*Learning From Events Scoping Project*' report presented to Quality & Safety Committee in May 2024 indicated that the '*health board is currently consistently fulfilling many of the expectations set out in the All Wales Framework to provide guidance for the preparation of LFERs; particularly those around the identification of learning, culture, scrutiny, discussion, benchmarking, and subsequent development of Action Plans and LFERs.* However, the report also sets out that *'The processes around the storage and sharing of learning with relevant parties is less consistent across the health board and would benefit from further review and development by Service Groups.'*

Discussion with the Head of Quality and Safety (Corporate) and the Assistant Head of Patient Experience indicated, due to the impact of staff absences/ resources within the Patient Safety Incident and Investigation Team (PSIIT), a lack of progress has been made to develop a new repository of learning briefs on SharePoint for Nationally Reportable incidents that would contribute towards addressing this issue. We are aware that similar initiatives, i.e. learning libraries, are being established elsewhere in NHS Wales, for staff to submit learning for sharing more widely via appropriate mechanisms. The health board has proactively sought to engage with other organisations to learn from their processes for sharing learning. It is recognised that the success of these is dependent on Service Groups and Divisions proactively sharing learning (**see Key Finding 4**).

Key Findings		Risk & Impact	Agreed Management Action
4	**Sharing of Learning** We were only provided with evidence to support the sharing of learning for two incidents. Regarding the other 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 local quality governance structures where appropriate. However, in some cases there was a lack of evidence of learning shared. The WRP report issued to the health board in May 2024 identified the need to improve processes around the storage and sharing of learning between the Service Groups. A repository for storing and sharing learning brief for NRIs is under development by the PSIIT for staff to submit learning for sharing more widely, but the progress against this has been impacted by absence/ resources within the Team. It is recognised that the success of this initiative will be dependent on Service Groups and Divisions proactively sharing learning.	Learning from incidents and concerns across SGs is inhibited due to the absence of centralised storage for sharing.	**Agreed Action:** 1. Development of learning brief repository for National Reportable Incidents (NRIs) via SharePoint. 2. Review function of Patient Safety Congress events, to include sharing learning from Never Events and creation of learning briefs. 3. Service groups to present to QSG on systems for learning 4. Development of learning briefs following Patient Safety Congress events **Expected Evidence of Implementation:** 1. Development of SharePoint resources 2. Evaluation paper to QSG to include terms of reference for Patient Safety Congress 3. QSG agendas 4. Learning briefs
		Medium Priority	**Officer:** (1) Assistant Head of Concerns Assurance; (2&4) Head of Quality and Safety (3) Quality and Safety Group Chair. **Target Implementation Date:** (1) 31 December 2025; 30 November 2025; (3) 31 January 2026; (4) 1 March 2026
	Theme: Lessons Learnt	Control Operation	

Objective 3: Reporting within the health board to provide assurance on the impact of implementing actions following lessons learned, including to limit future occurrence.	**Reasonable**

Service Group Reporting

The overarching management and oversight of incidents is undertaken at the respective Service Group Patient Safety / Quality and Safety Groups (noting that governance structures and group titles vary between them). Incidents are also managed at divisional and at more specific forums, including Safeguarding and Clinical Outcomes and Effectiveness Groups. Divisional/Service level reports are presented at these meetings to provide local updates on incident management.

Our review of Service Group Quality meetings identified that the level of detail captured within the report templates vary between them, but the format of divisional reports being received internally within both Morriston and Neath Port Talbot & Singleton (NPTS) Service Groups are consistent. We also note that the NPTS template includes a specific section on lessons learned across incident types (**see Key Finding 5**).

Corporate Groups

The Patient Safety & Compliance Group (PSCG) receives updates from each Service Group at each bi-monthly meeting. These reports are standardised using the same template to ensure consistency in the information presented. This includes data on general incidents, Duty of Candour incidents, Nationally Reportable incidents, Never Events and Complaints. There is also a section that enables Service Groups to include comments and actions being undertaken, which are generally well populated with a summary position of progress in terms of the management of incidents. While there is existence of learning being captured within some of these reports, they tend to be data driven with a focus on incident management. Learning themes and how learning is being addressed and/or shared is not currently consistently included (**see Key Finding 5**).

The PSCG is a sub-group that reports into the Quality and Safety Group (QSG) which, in turn, reports into Management Board and the Quality and Safety Committee (QSC). The QSG Terms of Reference states that it will *'Demonstrate that learning from incidents events and best practice is systematised*'. Learning from incidents has been observed within the following reports:

- Never Events Report - details the steps taken following the occurrence of a never event and any learning;
- Safeguarding Report - includes discussion around peer reviews to ensure learning is both embedded and sustained;
- PSCG Highlight Reports - sets out Service Group incident management and progress against incident reduction.

The health board's Quality Priorities are partially informed by its incident profile, and highlight reports on these are presented to QSC and Management Board monthly. These provide an overview on data trends (including incident related), key achievements, progress in month and upcoming actions. While it is not necessarily clearly set out, learning is generally reflected here.

While reporting routes for the management of incidents and concerns exist across the health board, improvements could be made to strengthen the reporting on learning. This would include the identification, analysis and scrutiny of wider learning, and to highlight key themes and trends in order to drive quality improvement and reduce adverse events (**see Key Finding 5**). We note that another NHS Wales organisation has established a Listening and Learning forum to identify, share and scrutinise learning from incidents, concerns and good practice. This forum reports through to their equivalent of the QSC.

Key Findings		Risk & Impact	Agreed Management Action
5	**Report on Learning From Incidents and Concerns** Our review has identified variation in the reporting of learning from incidents and concerns, at both Service Group and Corporate level. We have seen some good examples where learning is identified by incident type, for instance within reporting to the NPTS Quality and Safety Group. While reporting routes for the management of incidents and concerns exist across the health board, improvements could be made to strengthen the focus on learning. This would include the identification, analysis and scrutiny of wider learning, and to highlight key themes and trends. We note that there is a link to the inconsistent documentation and capturing of learning within Datix (see key finding 2), lack of clarity on roles, responsibilities and mechanisms for documenting, sharing and escalating learning within policy and guidance, and the absence of a centralised learning repository to better coordinate this activity.	Learning from incidents and concerns is not effectively reported to reduce further recurrence of incidents.	**Agreed Action:** 1. NPTS to present in Quality and Safety Group on their systems for learning and assurance 2. Review of learning systems from other health boards presented to Quality and Safety Group with recommendations 3. Learning to be included in Duty of Candour annual report **Expected Evidence of Implementation:** 1. Quality and Safety Group minutes 2. Paper to Quality and Safety Group 3. Duty of Candour annual report
		Medium Priority	**Officer:** (1) Quality and Safety Group Chair; (2) Head of Quality and Safety; (3) Assistant Head of Concerns Assurance **Target Implementation Date:** (1) 30 November 2025; (2) 31 January 2026; (3) 30 November 2025
	Theme: Reporting	Control Design	

Appendix A Assurance Opinion & Prioritisation of Findings

Assurance Opinion

	**Substantial**	Few matters require attention and are compliance or advisory in nature. **Low impact** on residual risk exposure.
	**Reasonable**	Some matters require management attention in control design or compliance. **Low to moderate impact** on residual risk exposure until resolved.
	**Limited**	More significant matters require management attention. **Moderate impact** on residual risk exposure until resolved.
	**Unsatisfactory**	Action is required to address the whole control framework in this area. **High impact** on residual risk exposure until resolved.
	**Advisory**	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
High	Significant risk to achievement of a system objective OR evidence present of material loss, error, or misstatement. Poor system design OR widespread non-compliance.
Medium	Some risk to achievement of a system objective. Minor weakness in system design OR limited non-compliance.

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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.

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