Lessons Learned 1 – July 2026

Lessons Learned are an important part of our Clinical and Care Governance process so that our services can learn from areas of good practice or quality improvement.

The following demonstrates example(s) where we have implemented changes following feedback from team members or from members of the public.

Learning from adverse events and complaints in Specialist Inpatient and Tertiary Mental Health and Learning Disability Services at Royal Cornhill Hospital

The data from adverse events and complaints is used actively to identify themes, understand areas of risk, and direct improvement activity across Mental Health and Learning Disability Services. Adverse event reporting remains high within mental health services, which reflects both the scale and complexity of the service and an established positive reporting culture. The highest recorded category continues to relate to abusive behaviour, with two particular subsets, relating to violence and aggression, and also to self-harm and suicide-related incidents.

In response to this intelligence, two focused working groups have been commissioned within Mental Health Services. One group is reviewing suicide and self-harm across inpatient settings, and the second is focused on the prevention and management of violence and aggression. These groups will consider local data, good practice, national evidence, training needs, and opportunities to strengthen safety, quality of care, and support for both patients and staff.