NHS GOLDEN JUBILEE

ANNUAL LEARNING SUMMARY 2025/26

Report summary

The purpose of this document is to provide an Annual Learning Summary of adverse events and complaints across NHS Golden Jubilee. This will support identification of trends/ themes for learning and considering this in the context of our improvement work, next steps and adverse events.

Adverse events

Chart 1

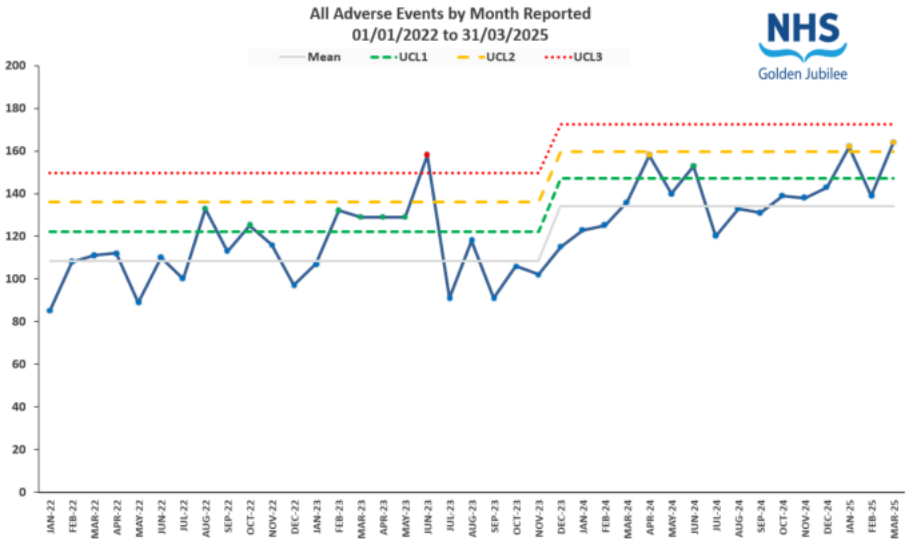


Chart 2

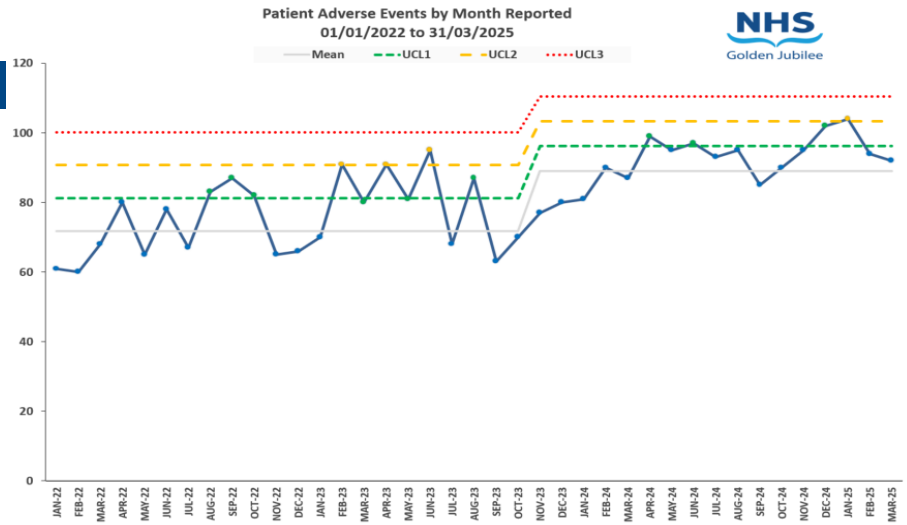
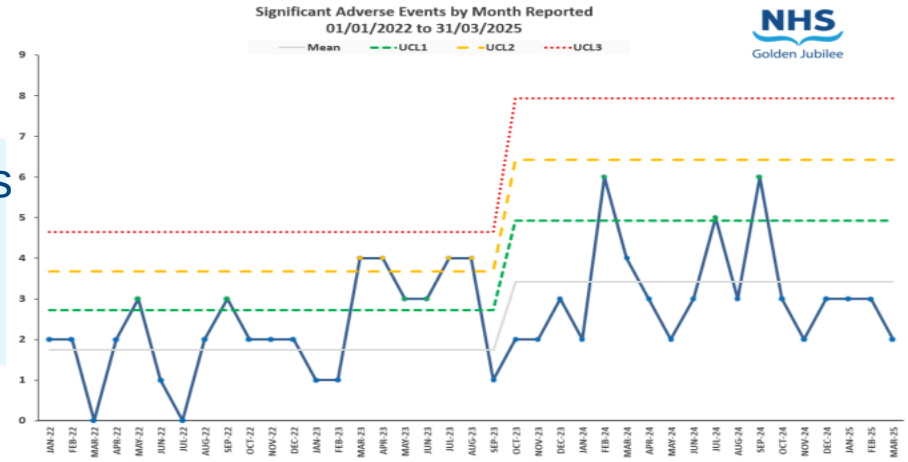
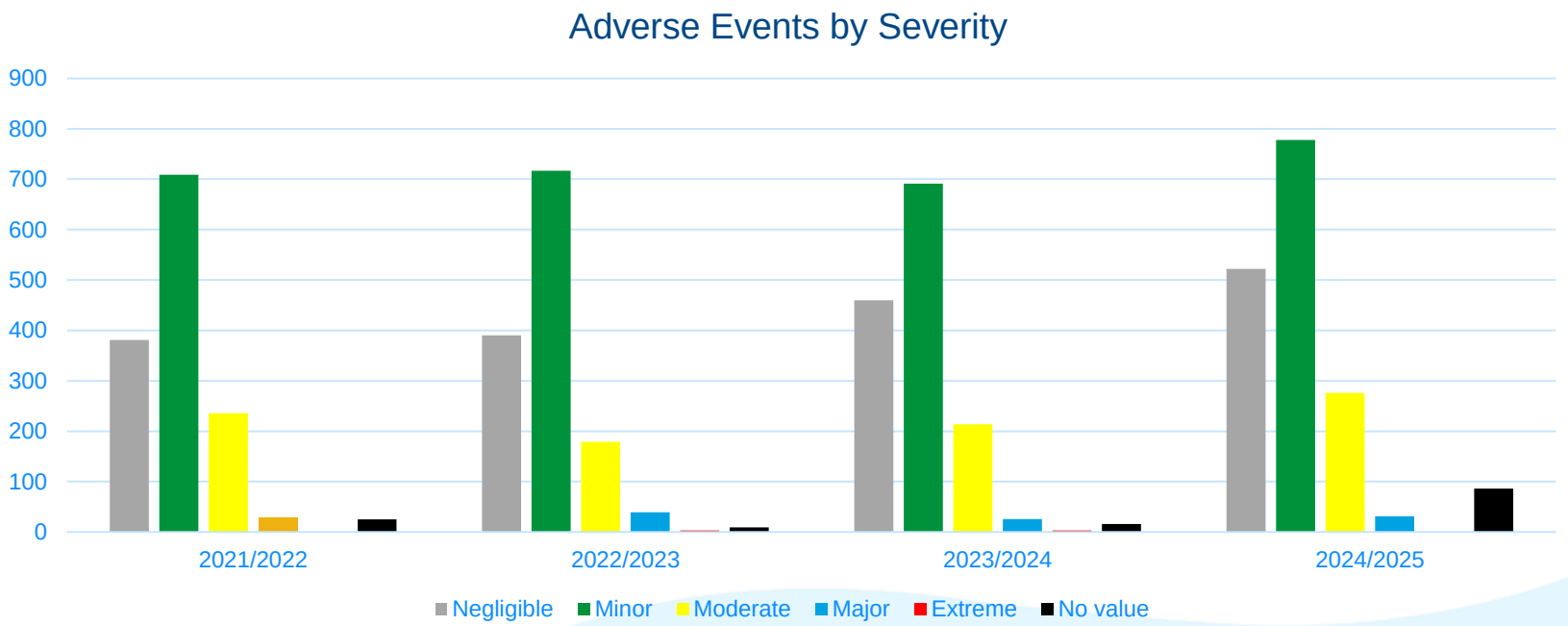


Chart 3



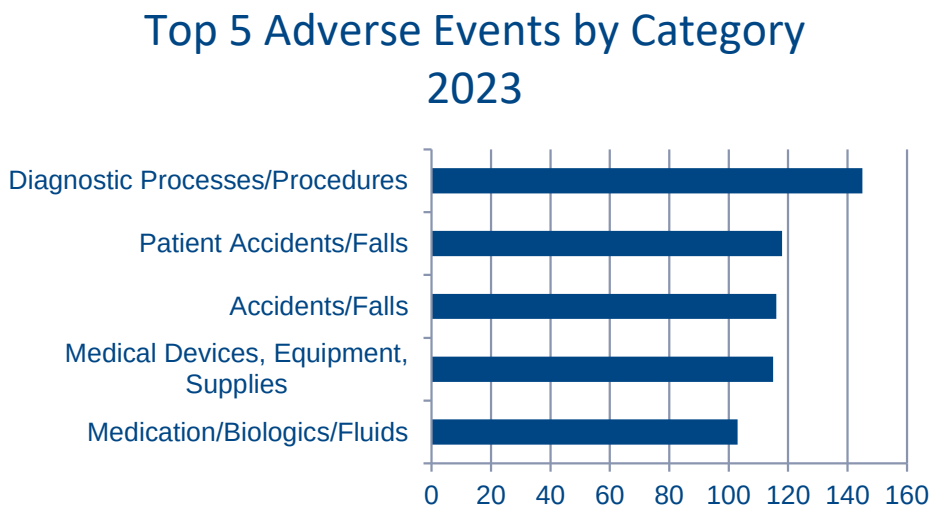
- The charts demonstrate that adverse events have increased throughout the reporting period.
- Significant Adverse Events have decreased throughout this period as a result of an increase in Initial Assessment Tool reviews for timely learning.

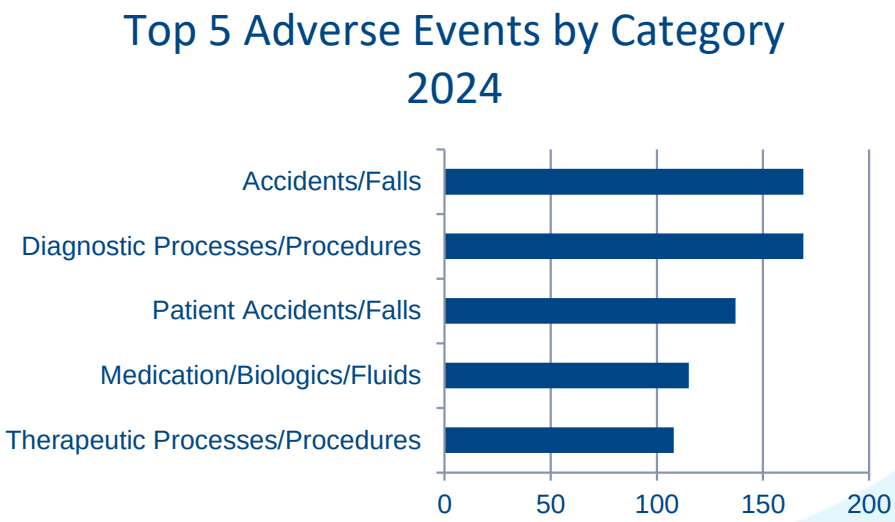
Adverse Events by Severity



- On review, an event is assessed and given a severity grading score. The figures in the chart above show a comparison over the previous four years of incidents by severity.
- The volume of incidents has increased in 2024-25, though the biggest increase in severity is in the negligible minor moderate ratings with an increase in 211 on 2023-224 for those 3 ratings.
- There were no events marked as extreme in 2024-2025.

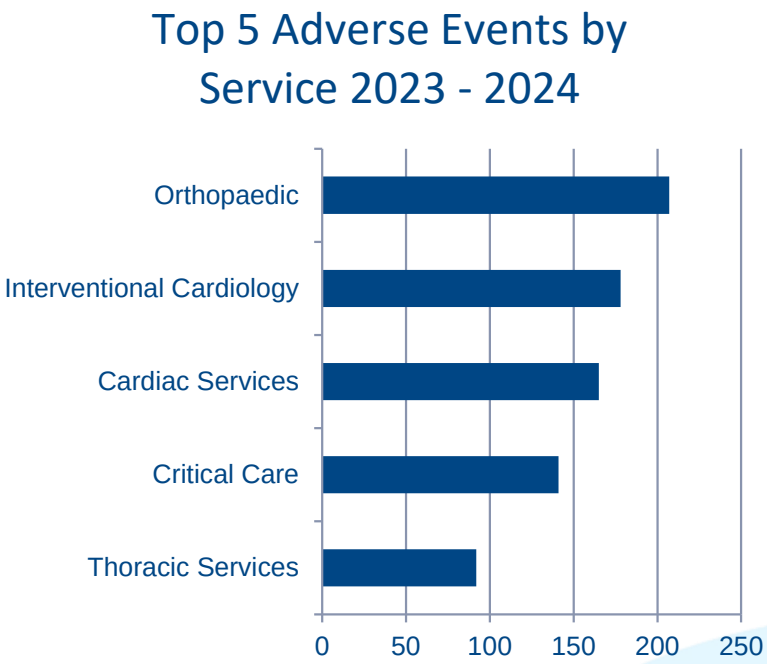
Top 5 Adverse Events Categories

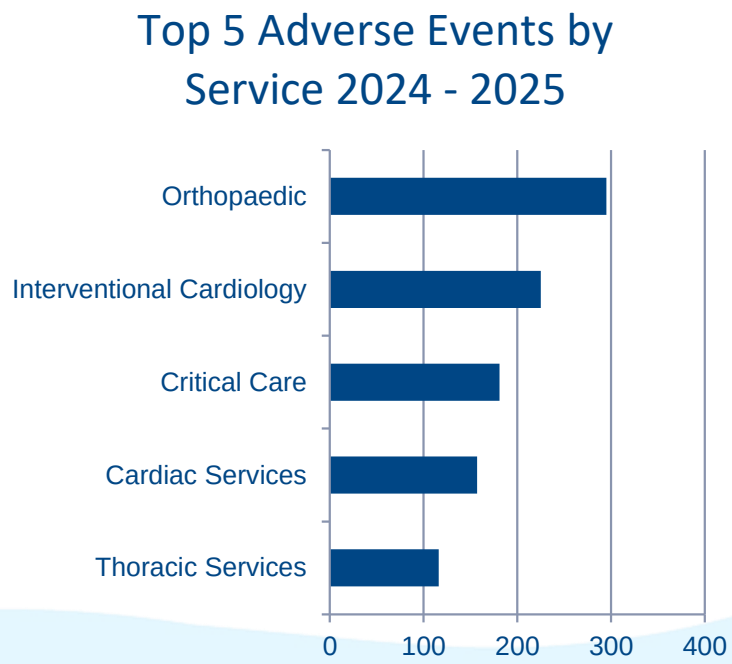




- The top categories remain consistent, diagnostic processes, accidents/falls and patient accident and falls remain within the top 3 categories of most reported incidents.
- Medication incidents have increased from 103 to 115. This may be reflective of the general increase in reported incidents and an increase in hospital activity.

Adverse Events by Service

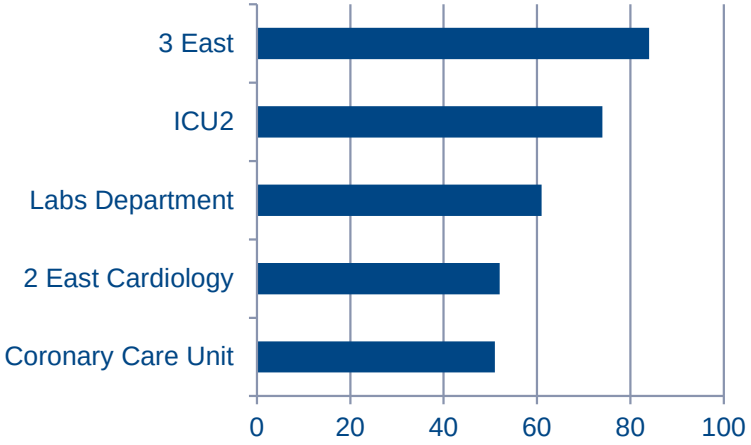




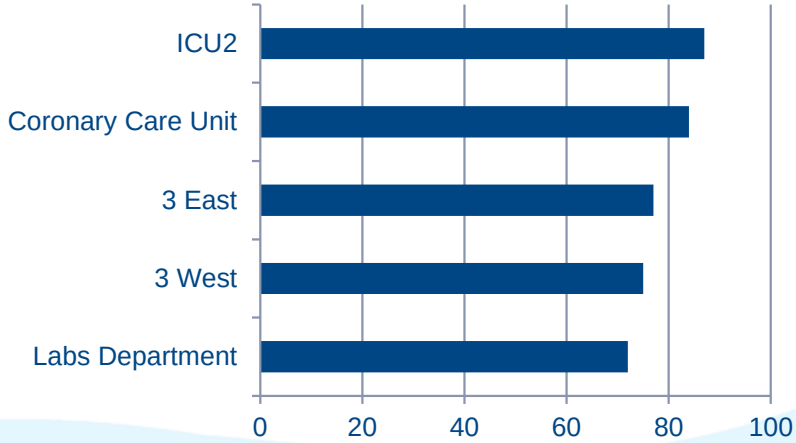
- The services with the most incidents remains consistent.

Adverse Events by Location

Top 5 Adverse Events by Location 2023- 2024



Top 5 Adverse Events by Location 2024-2025



- The top 5 locations are similar to the previous year with 3 West included with 75 incidents.
- Coronary care unit number has increased from 51 to 84. On further investigation in 2024-25 there were an additional 25 adverse events that resulted in no injury, harm or adverse outcome, compared to 14 in 2023-24. 28 deaths were reported within this service on datix compared to 2023-24 there was 21 deaths reported.

Patient Falls

Chart 1

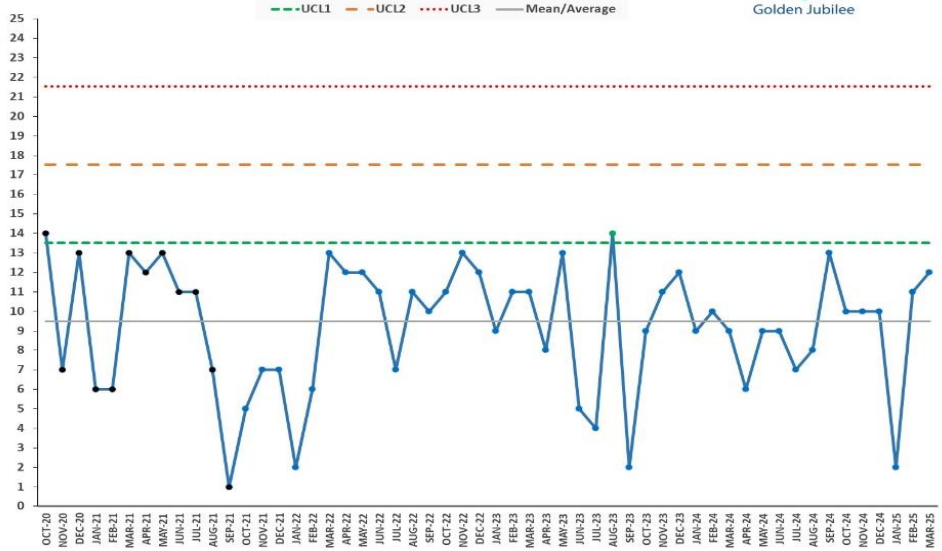
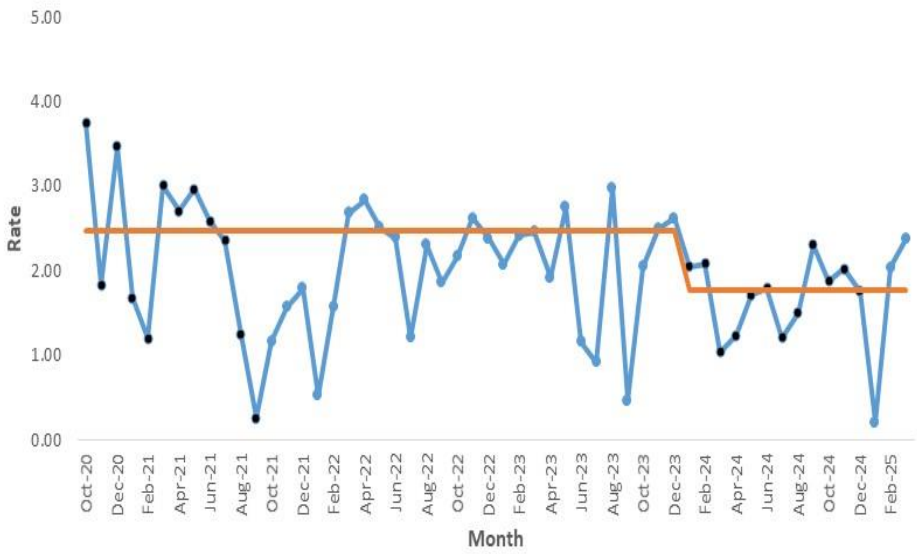


Chart 2



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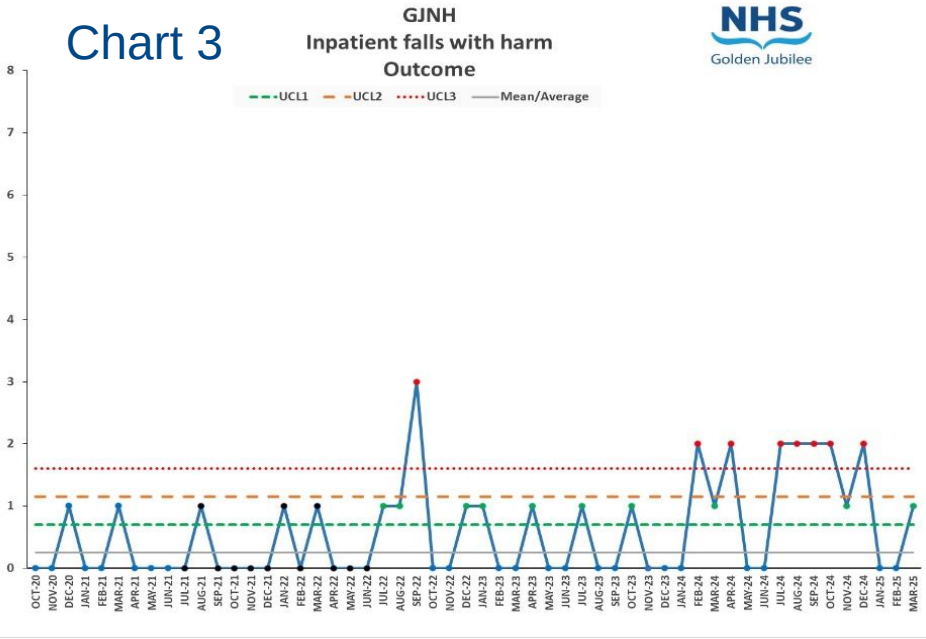
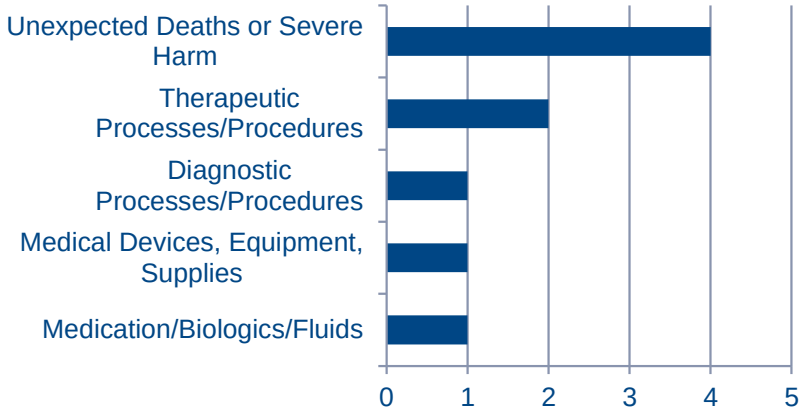


- Significant focus on patient falls has continued to demonstrate consistency within patient falls reporting.
- The inpatient falls with harm chart demonstrates the low numbers of patient falls the result in harm. The Safe Mobilisation Group (SMG) scrutinise falls outcome data monthly and report this to Clinical Governance Risk Management Group through the CG Dashboard.
- Datix triggers further information gathering when Slips/Trips/Falls are selected as sub-categories. It will then be mandatory to complete questions on Post Fall Review.

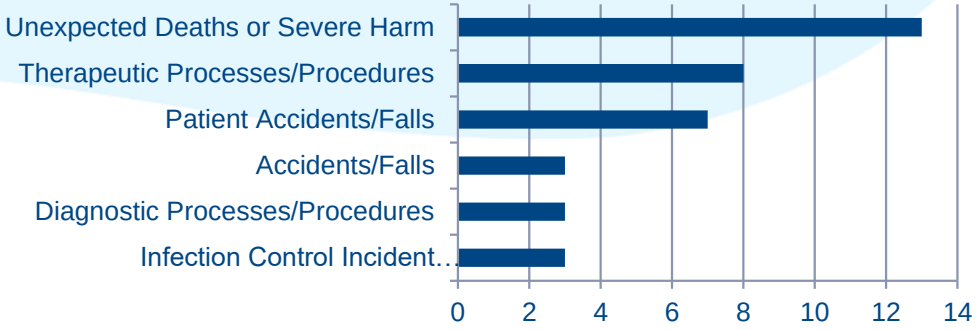
Significant Adverse Events

- There were 10 Significant Adverse Event Reports (SAER) and 28 Initial Assessment Tool Reports (IAT's) undertaken in 2024-25. In comparison to 18 Significant Adverse Event Reviews (SAER), 32 IAT's. The learning is monitored through the Clinical Governance Risk Management Group
- All events with severity major or extreme will trigger an Initial Assessment to consider if an SAER is required however the severity of the event is not the only indicator.
- In March 2025, HIS National Framework for Reviewing and Learning from Adverse Events has reflected that challenge of completing an SAER within the 90 day timeframe by amending the national guidance to 140 days for completion and sign off.
- The Clinical governance team created a Gantt chart this year to track the progress, alongside the functionality of datix, and detect where there may be issues, so that we can improve our procedures, where appropriate. This is monitored through the CGRM group.

Significant Adverse Event Reviews by Category

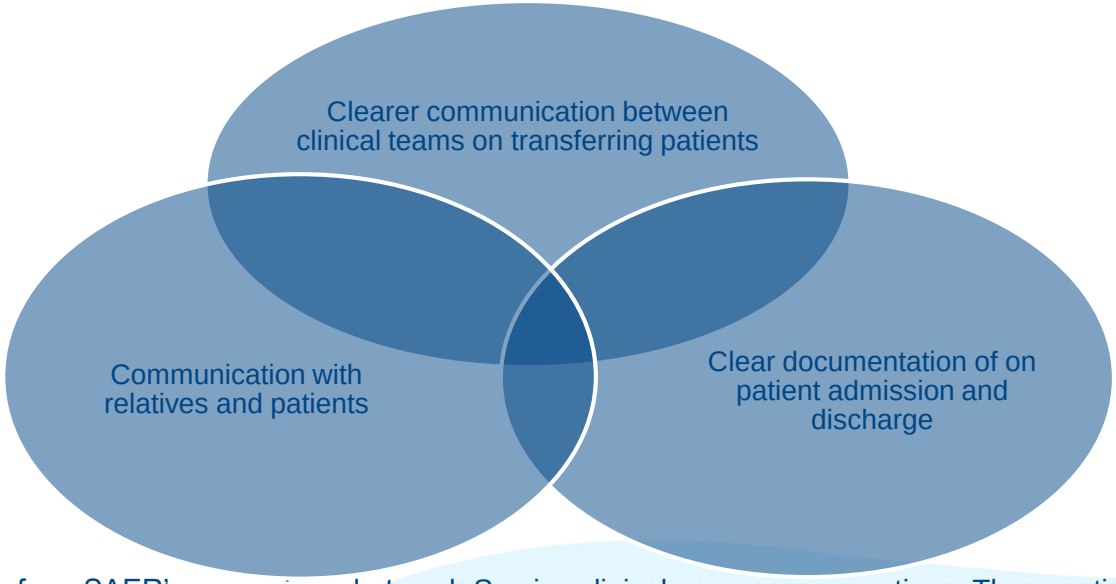


Top 6 Initial Assessment Tools by Category (not commissioned to SAER)



SAER Learning

- There has been a variety of learning points generated from SAER's during the year, the main themes remain as communication and documentation. There are a number of different aspects of communication improvements including:

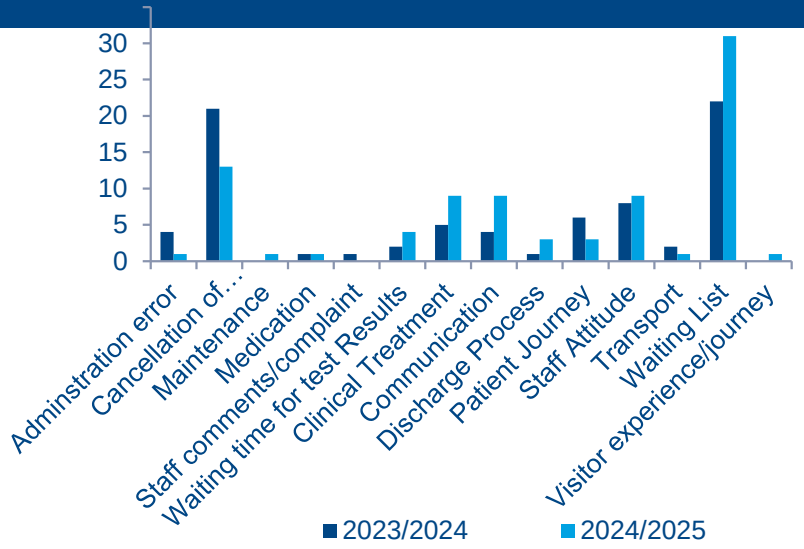


- All open actions from SAER's are reviewed at each Service clinical governance meetings. Those actions that are cross divisional are monitored via the Clinical Governance Risk Management Group (CGRMG).
- There has also been an emphasis placed on open SAER actions, Divisional Management Teams have established an oversight group. Work is ongoing to ensure recommendations and actions from SAER's are
- On completion of a SAER investigation, each case is given an outcome code based on the following descriptors:
  - 1. Appropriate care, well planned and delivered.
  - 2. Issues identified but they did not contribute to the event.
  - 3. Issues identified which may have caused or contributed to the event.
  - 4. Issues identified which directly related to the cause of the event.
- NHS GJ had 7 SAERs of outcome 3 Issues identified which may have caused or contributed to the event. The remaining 3 SAER's were 1 from each outcome.

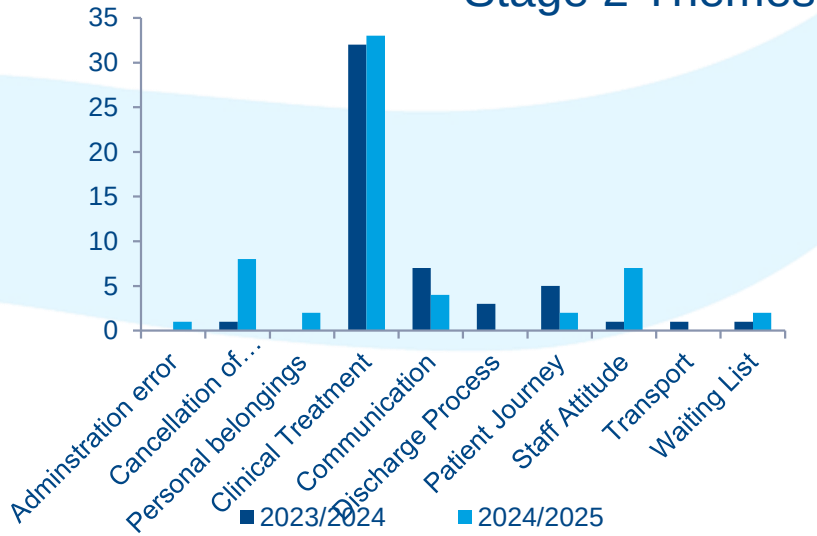
Feedback Learning

- The full overview for feedback can found in the Annual Feedback Report. NHS GJ appreciates all feedback to the hospital as this helps us improves our services for our patients and visitors. Where complaints are upheld, a full apology is given and learning is identified and learning is shared widely within the teams and where required via the Clinical Governance Service meetings. During the year NHS GJ received and logged a total of 647 items of formal feedback.
- Compliments continue to be the highest category of overall feedback received with 330 formal compliments recorded in the year; 51% of all feedback received.
- The following is a summary of some of the improvements to the service from feedback received during 2024/2025:
  - Remind the team of the importance of informing patients how long the MRI scan will take to allow patients to be fully aware of what to expect during their scan.
  - Review the provision of information that patients receive, to ensure it is accessible for all patients, as not all patients will have access to be able to view information that is generated via a QR code.
  - Review the information on the website to ensure patients are fully informed about access to the hospital and provide information requesting that patients with mobility difficulties present themselves at the main hospital reception where assistance can be arranged.
  - A discharge checklist to include discussions with family, estimated discharge date, social circumstances.
  - Review consent form to explore whether trainees carrying out procedures should be included to make patient's aware that it may not always be the named consultant who is carrying out procedure.

Stage 1 Themes



Stage 2 Themes



Conclusions and Next Steps

- Clinical Governance and NHS GJ services continue to identify and learn from adverse events and patient feedback.
- The IAT process is working well to identify learning in a timely manner.
- Our frameworks and processes are continually reviewed for opportunities for improvement.
- A review of our current clinical governance framework will be undertaken in 2025/26, with a focus on training and education resources, communication of system wide learning points, and using data to support decision making.
- Enhancements to our complaints handling processes will be implemented and monitored by CGRM in 2025/26.