Royal United Hospitals Bath
NHS Foundation Trust

Report to:	**Public Board of Directors meeting**	**Agenda item:**	**12**
Date of Meeting:	**22nd July 2024**		
Title of Report:	**Quarterly Learning from Deaths Report**		
Status:	**For Discussion**		
Board Sponsor:	**Andy Hollowood, Chief Medical Officer**		
Author:	**Heather Boyes, Head of Legal Services**		
Appendices	**Appendix 1: Learning from Deaths Report Q3 &Q4**		

1. Executive Summary of the Report

77% of SJRs completed in Q3 and Q4 rated care as either good or very good and 0% of SJRs completed rated overall care as very poor but there were four findings (5% of SJRs) of poor care in Q4. The themes identified where care was deemed poor align with our patient safety priorities and learning has been fed into our improvement workstreams. Where concerns regarding poor care have been identified divisional teams have taken action to provide insight and where necessary guide improvement.

Over the last two quarters the number of outstanding SJRs remains static. The number of SJRs completed has risen quarter on quarter. The number of requested SJRs aligns with the number completed every month.

Eighteen inquests were opened and 20 were concluded during Q3 and Q4, seven following in-person hearings. In two instances, the Trust was on the periphery of the issues explored by the Coroner.

The two inquests that involved a greater analysis of the care provided focussed on antibiotic choice and the care of elderly trauma patients. This final issue requires continuing attention as there is a further inquest, which raises similar issues, occurring in March 2024.

The Trust did not receive any Regulation 28 Reports and the Coroner did not express any concerns about the care provided. However, there were some families who were disappointed with the outcome or remained concerned. The Trust are considering how those involved in the inquest process can be better supported.

2. Recommendations (Note, Approve, Discuss)

The Board of Directors is asked to note the report.

3. Legal / Regulatory Implications

The Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England* found that learning from deaths was not being given sufficient priority in some

organisations and consequently valuable opportunities for improvements/learning were being missed.

4.	Risk (Threats or opportunities, link to a risk on the Risk Register, Board Assurance Framework etc)
If we are unable to consistently perform a structured judgement review within 2 months of a person's death due to a mismatch in the demand and capacity for SJR completion, then we will not generate timely insight into patient safety issues to guide improvement.	

5.	Resources Implications (Financial / staffing)
n/a	

6.	Equality and Diversity
n/a	

7.	References to previous reports/Next steps
Q2 Learning From Deaths Report	

8.	Freedom of Information
Public	

9.	Sustainability
N/A	

10.	Digital
N/A	