

Emma Serrano

Stoke-on-Trent and North Staffordshire Coroner's Chambers 547 Hartshill Road Hartshill Stoke-on-Trent ST4 6HF **National Medical Director**

NHS England Wellington House 133-155 Waterloo Road London SE1 8UG

11 December 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Myra Maxfield who died on 12 March 2022

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 25 October 2023 concerning the death of Myra Maxfield on 12 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Myra's family and loved ones. NHS England are keen to assure the family and the coroner that the concerns raised about Myra's care have been listened to and reflected upon.

NHS England sets out our response to each of your concerns below.

1. Evidence emerged during the inquest that it was crucial that patients who were at risk of developing pressure ulcers, had ulcers already, or had developed them whilst in hospital, saw the Tissue Viability Team as soon as possible, and usually within 6 hours.

People who are bedbound are at increased risk of pressure ulcers. Healthcare professionals play a crucial role in identifying individuals who are at risk of developing pressure ulcers (using a valid and reliable risk assessment tool, as per the National Institute of Clinical Excellence (NICE) guidance below) to identify their level of risk and inform the development of an individualised plan of care.

People admitted to hospital, or a care home should have their risk of developing a pressure ulcer assessed by a healthcare professional within six hours of being admitted.

The National Institute of Clinical Excellence (NICE) guidance CG179 <u>Pressure Ulcers</u>: Prevention and Management, published April 2014, recommends that adults who have been assessed as being at high risk of developing a pressure ulcer are encouraged to change their position frequently and at least every four hours.

If they are unable to reposition themselves, assistance should be offered to enable them to do so, using appropriate equipment if required, documenting the frequency of repositioning required. In cases where a patient develops a pressure ulcer, healthcare professionals should regularly measure and assess its depth and severity to determine the appropriate level of care and treatment.

The recently published <u>National Wound Care Strategy Programme (NWCSP)</u> Clinical Recommendations, align with the Quality Standard from NICE and emphasise the need for assessing patient risk of pressure ulcers within six hours of hospital admission. The NWCSP was launched with the purpose to improve the quality of chronic wound care by developing recommendations for preventing, assessing and treating people with wounds to optimise healing and minimise the burden of wounds for patients, carers and health care providers.

There are no specific guidelines for when patients should be referred to a Tissue Viability Specialist (TVS) within the NICE guidance or in the international best practice guidelines. You may wish to engage with NICE or the NWCSP regarding this issue.

2. It was said that delays in doing so, could be causative in the death of patients.

Every organisation has a policy for preventing and managing pressure ulcers, which staff should adhere to, and should align with NICE guidance and best evidence-based practice.

In the case of a patient showing signs of a severe infection that could potentially lead to death, it is expected that the patient would be promptly referred to the medical team for urgent review, treatment and appropriate intervention and management.

Even if the patient was seen by the TVS (Tissue Viability Specialist) urgently, it is likely that their first course of action would be to refer the patient to the medical team for review and appropriate management and treatment.

3. Evidence emerged that at the Royal Stoke University Hospital, Tissue Viability is not available over the weekend, and this leads to substantial delay in patients being seen.

Tissue Viability Teams across England differ in size, aligned to provider requirements with only a few providing a service seven days a week. Typically, most TVS services prioritise their referrals on Monday mornings to ensure prompt attention to urgent cases to enable them to be seen. Management and care plans are documented for the ongoing treatment and management of the patient by ward / clinical staff caring directly for the patient.

NHS England is not able to provide comment on the provision of the service specifically within Royal Stoke University Hospital and would refer you to the Trust on this issue.

I would like to assure you that further work has been progressed nationally to further improve pressure ulcer care and reduce the risk of harm to patients. In addition to the NWCSP, further work is also underway as part of the <u>National Patient Safety Strategy</u> and further work is underway to progress a diagnostic phase of improvement work in relation to pressure ulcer prevention and management.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director