Royal Devon
University Healthcare
NHS Foundation Trust

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15 January 2025

Dear Mr Spinney

I am writing further to the Regulation 28 Report issued on 28 November 2024 following the inquest touching the death of Mr Raymond Reid.

Mr Reid died of sepsis on a background of severe frailty. The sepsis had multiple causes but one of those was thought to be an infected pressure sore that developed while he was an inpatient in North Devon District Hospital. During the inquest, you heard evidence about the significant work that was done with the staff on Capener Ward to reduce pressure damage and that this had been successful in reducing hospital acquired pressure damage.

However, you remained concerned that further work may be needed and work around pressure damage reduction may warrant further consideration and dissemination across the Trust.

I am pleased to be able to write and provide you with real assurance that the Trust is doing significant work to reduce pressure damage in patients and I hope you will be reassured that this has been a priority of the Trust for some time now and substantial work is being done to ensure improvements.

The RDUH Trust-wide Improvement Plan

The Trust has an annually refreshed plan (the Trust-wide Improvement Plan) which is informed by scrutiny of events over the preceding year. This enables us to target our efforts on key areas of work that require ongoing quality improvement. The prevention of pressure damage has been recognised as one of these areas and continues to be one of our five main priority areas as per our Improvement plan. This issue has been on the Plan for some time, and this was refreshed in December 2024 and it remained on the plan as a top priority.

This means that we have an agreed data set of identified issues and that a regular working group reviews the improvement work that has taken place to ensure we are implementing and sustaining the improvements that we have identified. Progress is reported to a Trustwide Committee (the Patient Safety Committee) with executive oversight.

Further, pressure damage prevention has always been a key metric in the Trust's integration performance framework. Data is reviewed by site and then aligned and reported and so parity of care and service delivery across both areas of the Trust has been scrutinised at Board level and the Quality Committee.

Tissue Viability Steering Group

In order to deliver this priority in patient care, a Trust wide Steering Group (so covering both sites in the North and East) was established in January 2024. I am attaching the minutes from the group meeting in November 2024 which also includes the Terms of Reference for the group.

From this, you can see that there is a huge amount of work covered by the Group. All Care Groups attend the quarterly meeting and it is jointly led by the two Trust Tissue Viability Leads. All reported incidents of tissue damage are reviewed by the TV team in collaboration with the Care Group Senior Nurses. Immediate local learning/actions will be taken following this initial review. All incidents will also be reviewed to determine any implications for the Trust wide TV improvement plan. Trends and discrepancies in care can be identified centrally and early work can then be done to improve patient care.

I am also attaching the Tissue Viability Improvement Work Plan 2024-2025. This Plan is developed, implemented and overseen by the Tissue Steering Group and is updated on a quarterly basis at the meeting. It is a comprehensive work plan setting out specific actions for improvement with accountability for completion.

This Steering Group reports in to the Patient Safety Committee which includes the Directors of Nursing and Medicine as well as the Executive Chief Nursing Officer and Chief medical Officer with joint accountability for patient safety and so there is high level scrutiny of this plan and its implementation.

Delivering patient care at the front line

There is a huge amount of good work being done at a higher level to ensure that best practice is recommended in reducing pressure damage for patients.

In order to ensure that this is actually being delivered on the front line, the Chief Nursing Officer has commissioned a significant leadership piece of work from the Director of Nursing on the Northern site. She has been asked to ensure we have right systems and processes for care in Northern services and specifically looking to “foster leadership in best practice in front line nursing staff who have ward based responsibilities regarding the day to day prevention and management of pressure ulcers”. This Group is being set up and delivery against the agreed actions will be report to the Tissue Viability Group and the Patient Safety Committee so again there will be high level and senior oversight of this piece of work.

This will ensure that front line nursing leadership is able to implement the good practice and recommendations made by the Steering Group and to advance the Trust- wide Improvement Plan.

I hope that the above, along with the attached documents, has given you an overview of the importance in pressure damage reduction to the Trust and how this is being delivered.

Please do let me know if you have any further questions and I will be very happy to assist

Yours sincerely

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Chief Executive Officer