Blackpool Teaching Hospitals
NHS Foundation Trust
Trust Headquarters
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12th September 2024

FAO Mr Alan Wilson
Coroner for Blackpool and Fylde
PO Box 1066
Corporation Street
Blackpool
Lancs, FY1 1GB
Via email: [redacted]

Dear Mr Wilson

Re: Regulation 28: Report to Prevent Future Deaths – Sandra Philpott

Firstly, on behalf of Blackpool Teaching Hospitals NHS Foundation Trust, I should like to offer my sincere condolences to the family of Ms Philpott.

Thank you for raising your concerns regarding sepsis with the Trust, please find below the Trust responses to the issues raised in the report to prevent future deaths.

Concerns Raised

- **The concern I raise relates to the recognition of suspected sepsis, and the need for timely provision of treatment for suspected sepsis.**
- **Notwithstanding that I determined that from the available evidence timely treatment would not have altered the fatal outcome, I remain firmly of the view this report is necessary.**
- **I was informed at the inquest that there have been significant improvements in the management of sepsis within the Emergency Department.**
- **This court has raised concerns with the hospital Trust about this issue previously, and I know it is an issue which the Trust is very aware of and I do not doubt that efforts have been made to make improvements, but having conducted this inquest into Sandra's death, in my view there remains a risk that sepsis will go unrecognized, and urgent treatment will be delayed, putting patients attending Blackpool Victoria Hospital at risk. My duty to write this report is therefore met. It is not for me to be prescriptive about what action ought to be taken, but to raise this concern should I feel this is necessary.**

Trust response

For context, I provide detail regarding the Trust's improvement journey relating to the recognition and management of sepsis, and the ongoing actions which remain in focus to ensure the safety of our patients.

In April 2022 following an unannounced inspection at Blackpool Teaching Hospital (BTH), the Care Quality Commission (CQC) issued a Regulation enforcement action Section 31, under the Health and Social Care Act 2008. The CQC deemed that there was a lack of quality assurance in relation to the care and treatment of patients with suspected or confirmed sepsis. In response, the organisation committed to an improvement programme, with the following key areas of focus:

- To overcome barriers surrounding underperformance within the sepsis pathway,
- To improve the care of patients with suspected or confirmed sepsis,
- To ensure that the Trust had robust governance arrangements in place to demonstrate compliance and alert any concerns.

Once these areas of focus had been addressed it was expected that this would support an application for the CQC Section 31 notice and associated licence conditions to be lifted and improvements transacted into business as usual processes, where they would be monitored and sustained.

Two sepsis leads were nominated for the organisation and put into place. The Associate Medical Director, and the Associate Director of Nursing/Harm Free Care led the response, ensuring system wide action, governance, and oversight.

To support staff knowledge, briefings for all staff were developed and shared through safety huddles, team meetings and training. This was supported by ward/ unit level 'teach/learn' audits whereby the ward managers/ leaders ask staff questions related to sepsis each month and use the results to improve practice. For sustainability sepsis was included in the mandated recognise and act training for all clinical staff and inductions.

A new sepsis proforma was developed for clinical practice and the policy updated. Historically, the Trust had contributed to the AQUA audit for peer review and had a composite process score of around 30% and ranked below 12th position in the league tables within our area. The AQUA audit is of a small percentage of patients each quarter. This process was improved by increasing the number of audits to 40 patients per week, through the clinical audit team, with validation being completed weekly by the Associate Directors. This more detailed audit provided the team with richer data which enabled the identification of learning themes and areas of targeted focus. The learning themes were used to design a quality improvement collaborative which began in May 22 for the management of patients with sepsis. A change package was developed and initially 10 teams from across the trust took place in the collaborative to improve the management of patients. This work was then shared across the organisation through the clinical teams. At the time of Ms Philpott's sad death, the Trust's AQUA pathway compliance performance was on an improving trajectory, which has been sustained for over 6 months with the Trust's current compliance reported at 90% against the Composite Process Score (CPS).

For areas with high numbers of sepsis patients, such as the Emergency Department (ED), a weekly review meeting was put in place and has continued to ensure focus on data and improvements. Overall compliance to the actions from the organisation are reviewed through a monthly subject matter expert group for sepsis, where the data, training, new ways of working are monitored.

Current position

The Trust has in place an updated sepsis policy, which includes the sepsis six, and is in line with national guidance and requirements. The Trust has identified sepsis leads and a comprehensive sepsis training package. The Trust has in place a Sepsis Quality Improvement (QI) Collaborative to support the work being undertaken regarding sepsis and to drive improvement. The Trust also undertakes monthly audits of sepsis performance and has demonstrated significant improvement across the sepsis six.

For transparency and oversight sepsis compliance is reported to the wider organisation through both Clinical Governance Committee and Quality Assurance Committee. Divisions include sepsis pathway compliance, training data and clinical concerns in divisional governance meetings. For sustainability, the sepsis CPS score is now included in the organisational integrated performance report which is overseen at the Quality Assurance Committee and is reviewed at the Trust's performance forum, the Performance, Improvement, Delivery and Assurance (PIDA) Meeting and at Trust Board to ensure continuing compliance with the pathway.

Across the region the AQUA data reflects the improvements and work undertaken, with the Trust ranking 5th regionally, out of 15, for sepsis compliance and performance. The Associate Directors have also contributed to the regional AQUA expert sepsis group to improve standards. Mersey Internal Audit Agency (MIAA) were requested to 'test' the Trust's evidence of improvement to support the application for the removal of the Trust's Section 31 licence conditions. The review returned an opinion of high assurance.

The application for the removal of the Trust's Section 31 licence conditions was submitted in May 2024. The CQC reviewed the evidence and improvement data submitted and informed the Trust in July 2024 that the licence conditions had been removed.

The Trust continues to keep sepsis in focus with monthly updates provided to the Trust's Clinical Governance Committee, and Quality Assurance Committee regarding sepsis pathway compliance. The current area of focus for improvement are:

- Time to recognition for suspicion and diagnosis of sepsis to initiate time critical pathway
- Early Escalation of The Acutely Unwell Patient.

In the next 12 months, The Quality Improvement team are focusing on all Escalation Pathway work with expert forums and trust wide events.

I would like to assure you that if our records show that a patient's sepsis has not been identified within the appropriate timescale, incidents are submitted on the Trust's incident management system. Where harm is suspected the Trust undertakes a Rapid Review which is presented to the twice weekly Rapid Review Panel. This process ensures that appropriate learning is identified and a proportionate learning response deployed. Where learning is identified, this is fed into the Trust's sepsis pathway group to enable further improvements to be initiated.

I hope that my response has provided you with the assurance you require that the Trust continues to place significant improvement focus on the identification and management of sepsis with well embedded systems for oversight and improvement where harm is identified. Should you require any further information or evidence, this can be provided.

Yours sincerely

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Chief Executive