HQIP Healthcare Quality Improvement Partnership

Clinical Audit Awareness Week 2025

Webinar and Q&A: Data-driven improvements in maternity care

A Regional Medical Director's perspective

Thursday 5 June 2025, 2.15pm - 3.00pm

This event will start at 2.15pm

Dr Edward Morris CBE FRCOG
Regional Medical Director & Chief Clinical Information Officer
NHS England (East of England Region)

Tina Strack
Associate Director, National Clinical Audit and Patient Outcomes Programme (NCAPOP), HQIP

Welcome & introduction

- Welcome to Clinical Audit Awareness Week 2025 (2-6 June 2025)
- More info: www.hqip.org.uk/clinical-audit-awareness-week
- Introduction to today's topic

A Brief History from my CV

- NHS O&G Consultant from 2001 Norwich (Trained in London)
- RCOG President (2019-2022)
- RCOG Vice President (Clinical Quality) (2016-2019)
- Chair Clinical Quality Board (2016-2019), Member (2009-2016)
- Chair National Maternity and Perinatal Audit Project Board (2016-19)
- Co-Investigator, Each Baby Counts (2016-2019)
- Guideline Committee (2016-2019)
- Nice Guideline Alliance Consortium Board (2016-2019)
- Chair, RCOG Safety and Quality Committee (2009-2013)
- NCEPOD Steering Group 2010-2016
- NHSE HQIP Independent Advisory Group (Women & Children) (2014-2025)
- Vice Chair, Clinical Standards, Academy of Medical Royal Colleges (2020-2022)

My Current Role

- The Regional Medical Director (RMD) in NHS England is a key leadership role responsible for providing clinical leadership, advice, and support within a specific region, focusing on improving quality and safety of patient care, and driving transformation. They play a vital role in overseeing clinical commissioning, ensuring workforce resilience, and supporting trusts facing challenges.

Current Maternity Leaders in NHSE

- National
- National Chief Midwife – Kate Brintworth
- National Clinical Director – Donald Peebles

- Regional (NHSE East of England)
- Regional Chief Midwife – Wendy Matthews
- Regional Lead Obstetrician – Tejinder Kumar

Current Maternity Support System in NHSE

- National
- Maternity and Neonatal Board
- Maternity Quality, Performance and Surveillance committee

- Direct Support
- Maternity Service Support Programme via Regional teams
- Early Warning System (In Development)

Why the Interest in Maternity Safety?

- Numerous maternity investigations
  - Morecambe Bay
  - Cwm Taf
  - Shrewsbury and Telford
  - East Kent
  - Nottingham

THE TIMES

Thursday March 31 2022 | thetimes.co.uk | No 73745

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Why Bruce Willis is quitting acting

News, page 3

Deborah Ross

Who's the real Elena Ferrante?

Me, Honestly

Times2

Childbirth 'is not safe for women in England'

Mothers and babies died avoidably in NHS scandal

Eleanor Hayward
Health Correspondent

Women in England are not safe in childbirth until the recommendations of a report on the NHS's worst maternity scandal are implemented in full, its author has said.

Donna Ockenden said that many of the failures at Shrewsbury and Telford Hospital NHS Trust were "not unique".

Her five-year investigation, which reported yesterday, concluded that 201 babies and nine mothers had died avoidably because of "repeated failures in care over two decades".

Calling for "systemic change" across the NHS, Ockenden said that "safe maternity care for all" must be the legacy of the babies who had died.

Her report into care at the trust between 2000 and 2019 identified 1,592 incidents in which women and babies were left dead, disabled or traumatised. Instead of investigating or learning from mistakes, the Shropshire trust had tended "to blame mothers ... in some cases even for their own deaths".

Rhiannon Davies and Richard Stanton, whose daughter Kate died hours after her birth in March 2009, led calls for an inquiry. "All we ever wanted was to understand why Kate died," Davies said. "I began to ask questions but we were met with such hostility and bold lies that really forced us to question what was going on, so it became a fight."

Kayleigh and Colin Griffiths, whose daughter Pippa died in 2016, also fought to expose the scandal. Kayleigh Griffiths said: "It's really important that maternity services up and down the country read this and listen to what families have gone through."

Ockenden said it was "astounding" that the trust's poor care was allowed to continue for so long and that families were consistently "brushed aside and ignored". She criticised eight external bodies that had "inspected, visited and checked on" the trust but failed to raise the alarm. These included the Care Quality Commission, responsible for regulating the NHS in England, which rated maternity services at Shrewsbury as "good" in 2015.

Ockenden's report highlighted many themes that have arisen in other NHS maternity scandals, including at Morecambe Bay where 11 babies died avoidably. Inquiries are also being made into deaths at the Nottingham and East Kent hospital trusts.

Four in ten NHS maternity units in England are rated as inadequate or requiring improvement, meaning they do not meet safety standards. There is now a shortage of 2,000 midwives.

Ockenden called for 15 "immediate and essential" actions across all NHS maternity units in a "blueprint" for safe care. They focused on staff numbers, training, listening to families and improving how hospitals investigate and learn from serious incidents. "Without this, maternity services cannot provide safe and effective care," the report said.

Alicia Kearns, a Tory MP, told the Commons yesterday that she had had an emergency caesarean after initially being denied one, saying that the NHS had "a systemic problem of sexism".

Sajid Javid, the health secretary, said

Continued on page 4, col 4

STATE MEMORIAL SERVICE

Mr Shane Warne

13 September 1969 – 4 March 2022

King of spin Shane Warne's son, Jackson, 23, told 55,000 people of his father's "passion" in a memorial at Melbourne Cricket Ground. Page 27; Sport, pages 68-69

Putin faces revolt over blunders in Ukraine

Larisa Brown Defence Editor

President Putin faces a growing military insurrection over his "personal war" in Ukraine as his advisers lie to him about the campaign's failures, a British spy chief will say today.

Sir Jeremy Fleming, the director of GCHQ, will outline how the Russian leader has "massively misjudged" the capabilities of his military, the resolve of the Ukrainian people and the strength of the West's response to his invasion.

Putin's errors amount to a "strategic miscalculation", Fleming will say in a speech at the Australian National University in Canberra. Putin "overestimated" his military's capacity to win a rapid victory and Russian soldiers are "short of weapons and morale".

Intelligence shared with British spy agencies has pointed to Russian troops refusing to carry out orders, sabotaging their equipment and accidentally shooting down their own aircraft.

Officials in Washington said that Putin "didn't even know his military was using and losing conscripts ... showing a clear breakdown in the flow of accurate information".

One told CNN: "We have information that Putin felt misled by the Russian military. There is now persistent tension between Putin and the [Russian Ministry of Defence]."

John Kirby, the Pentagon spokesman, said last night: "If [Putin] is not fully informed of how poorly he's doing, then how are his negotiators going to come up with an agreement?

"The other thing is, you don't know how a leader like that is going to react to getting bad news ... it's disconcerting."

Russian forces have been regrouping in Belarus after the Kremlin said it would limit its invasion to focus on the "liberation" of Donbas in the east. About 15,000 Russian troops are now thought to have been killed in the month-long war.

Defectors have joined the Ukrainian army in a "legion" of volunteers. Images of Russian soldiers learning how to use anti-tank weapons were shared on the Telegram messaging app yesterday.

Fleming will outline in his speech the

Continued on page 2, col 3

IN THE NEWS

Trans cyclist banned
The transgender cyclist Emily Bridges has been barred by the sport's global governing body from the female category in the National Omnium Championships. Page 74

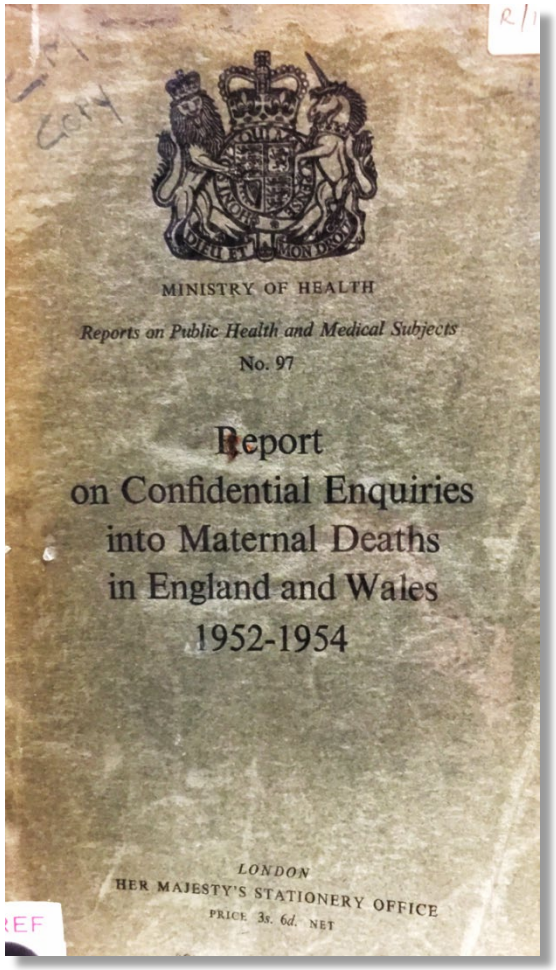
Andrew at Jubilee
The Duke of York may make an appearance at the Queen's Platinum Jubilee only weeks after settling a civil sex abuse case in the US for an estimated £7 million. Page 17

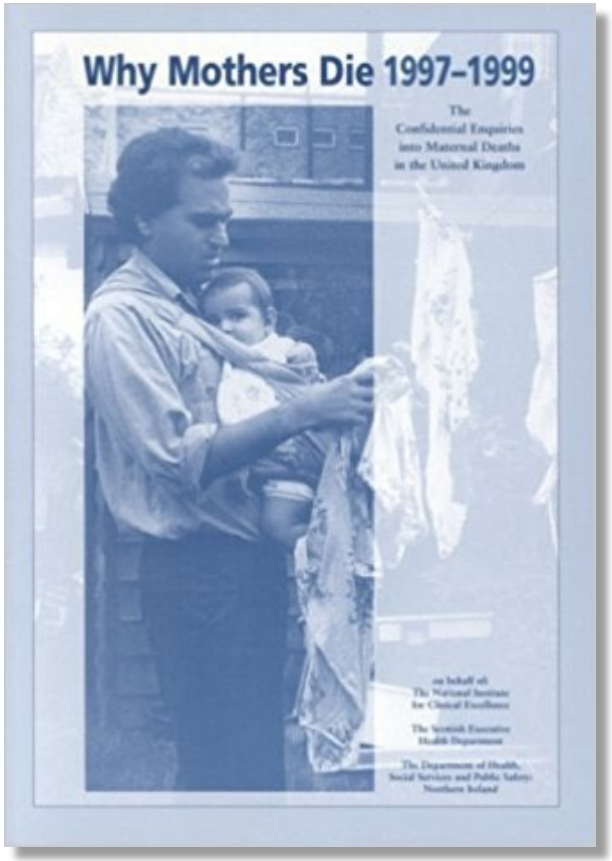
'Isis Beatle' on trial
El Shafee Elsheikh said at the start of his trial in the US that he was a "simple Isis fighter" and not one of the "Beatles" gang who tortured and murdered hostages. Page 36

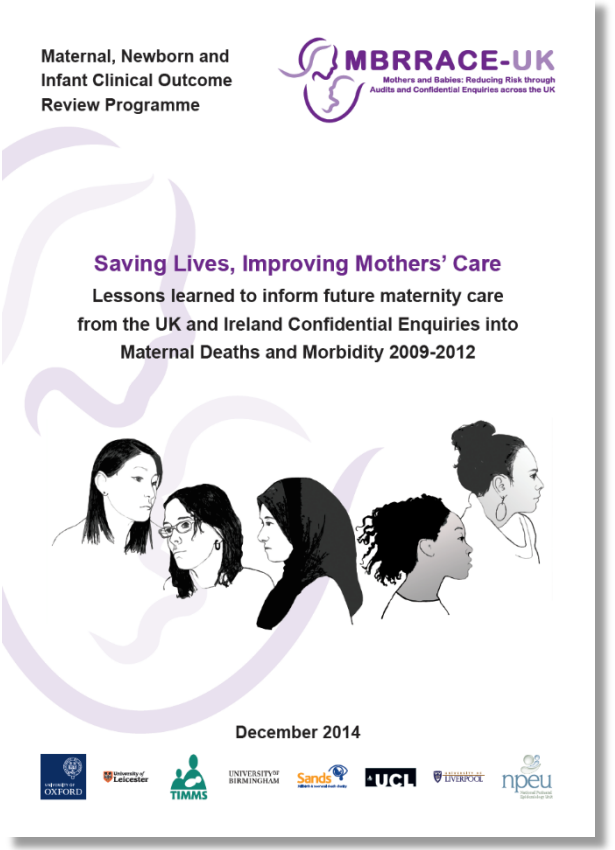
Oldest star spotted
Astronomers have used the Hubble telescope and a wrinkle in the fabric of space to look further back in time than ever at a star as it looked 12.9 billion years ago. Page 21

S4 Capital audit delay
Almost £1 billion was wiped from the value of S4 Capital, Sir Martin Sorrell's advertising company, after it suddenly pulled the publication of its annual results. Page 39

“Big data” in Maternity







each baby COUNTS

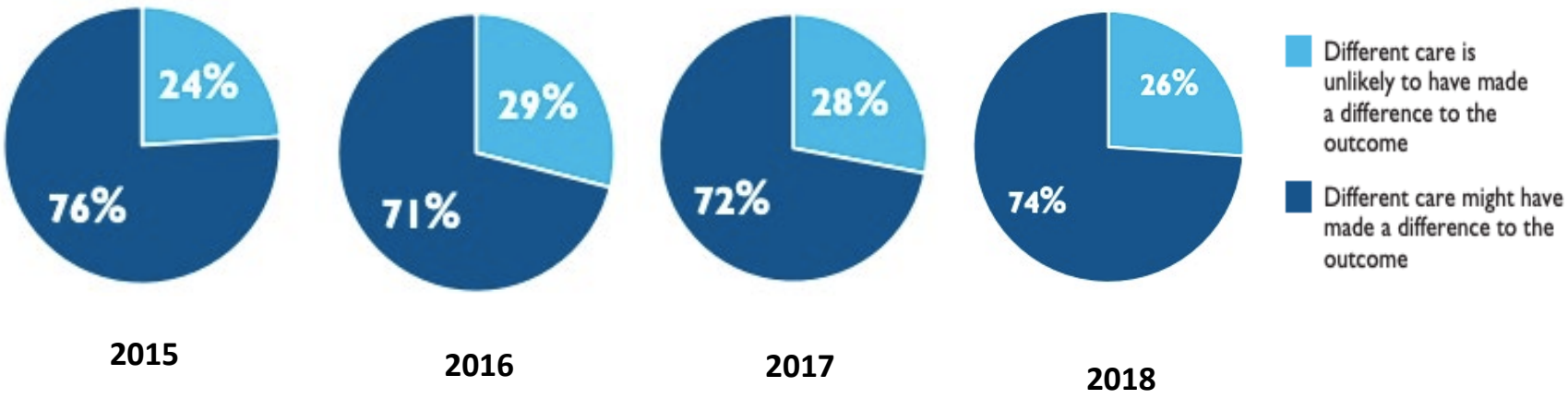
Each Baby Counts is the RCOG's national quality improvement programme with the aim:

"To reduce the number of babies who die or are left severely disabled as a result of incidents occurring during term labour by 50% by 2020"

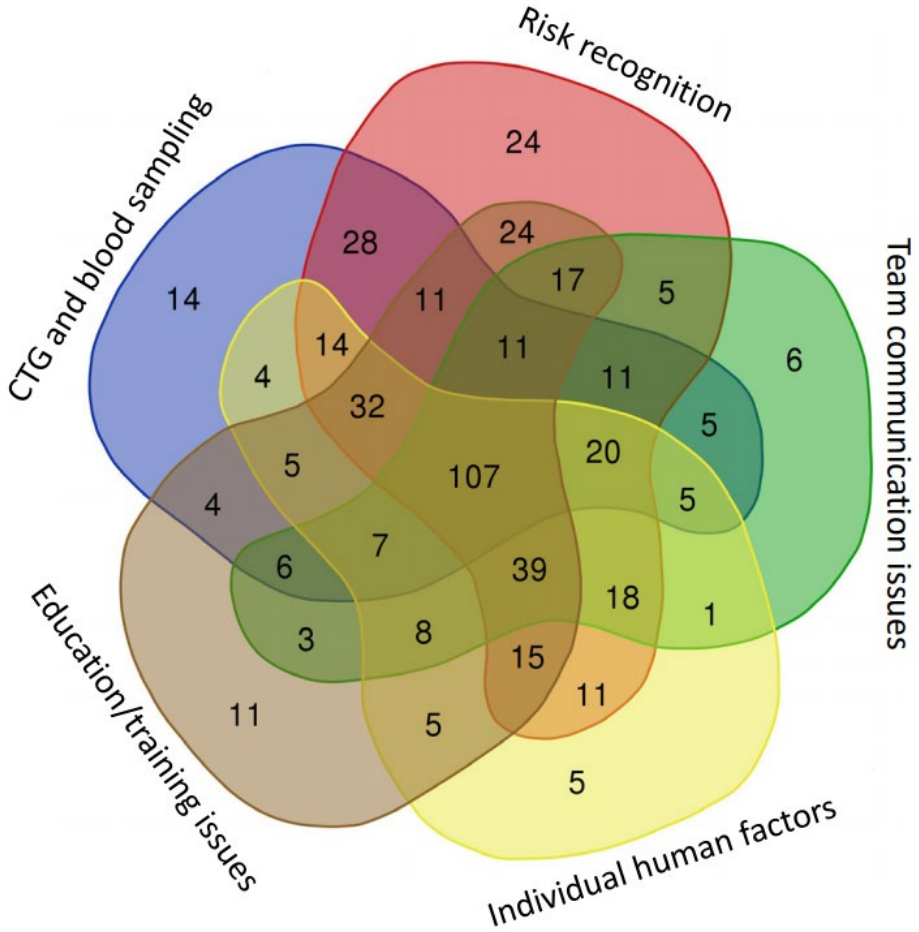
@eachbabycounts

Each Baby Counts

Would different care have changed the outcome?



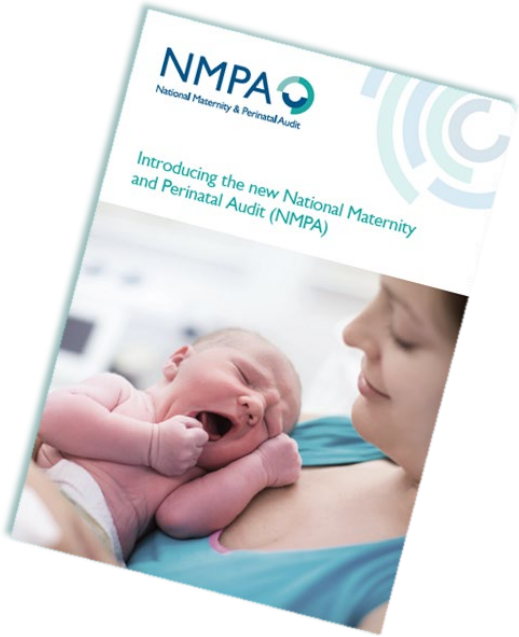
Each Baby Counts
Key Themes

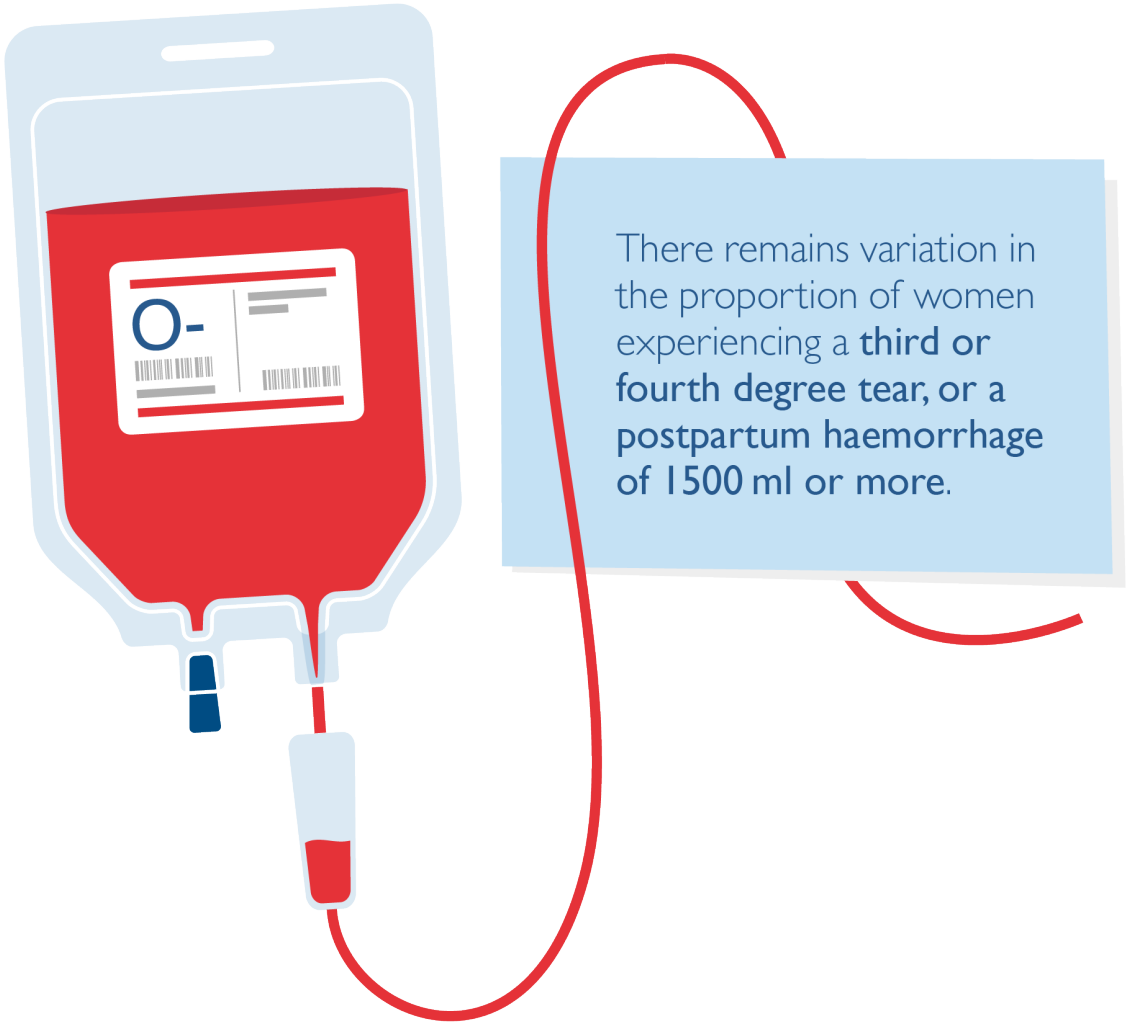


National Maternity & Perinatal Audit

- A large scale audit of the **NHS maternity services** across England, Scotland and Wales

- Using timely, high quality data, the audit **evaluates** a range of **care processes** and **outcomes** in order to identify **good practice** and **areas for improvement** in the **care** of women and babies looked after by **NHS maternity services**



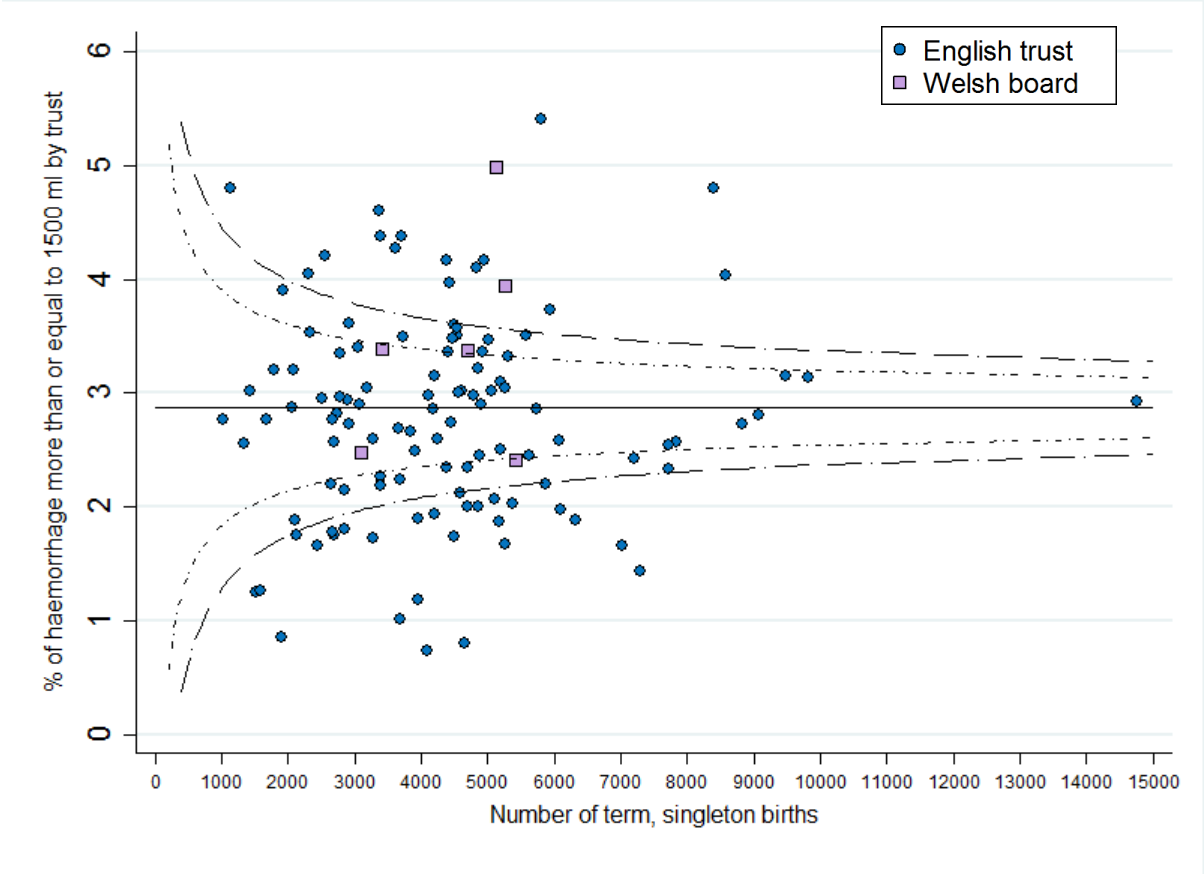


There remains variation in the proportion of women experiencing a **third or fourth degree tear, or a postpartum haemorrhage of 1500 ml or more.**

NMPA
National Maternity & Perinatal Audit

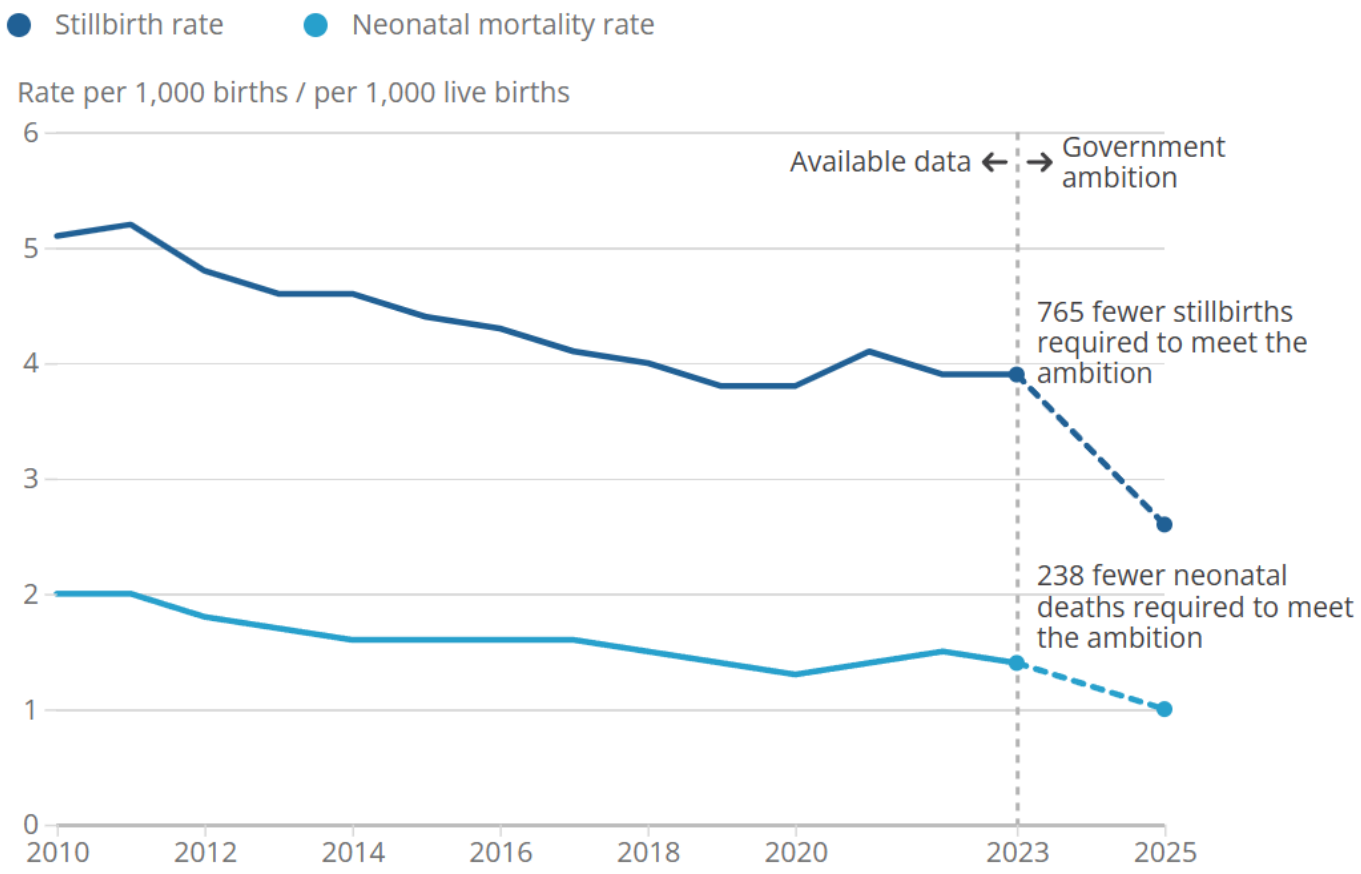
Haemorrhage of 1500 ml or more

NMPA
National Maternity & Perinatal Audit



Stillbirth & Neonatal Mortality – the National Ambition

Stillbirths and neonatal mortality rates, England, 2010 to 2023



Source: Child and Infant Mortality in England and Wales, 2023 from the Office for National Statistics

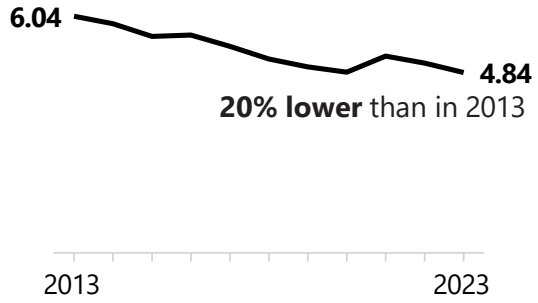
MBRRACE - 2025

Rates of baby death continued to decrease in 2023, mostly because of a reduction in stillbirths

Compared to 2022, stillbirth rates were lower in every nation of the UK, and fewer newborns died in England, Wales, and Northern Ireland. However, changes over a single year don't always tell the whole story, so it's important to look at trends over a longer period of time.

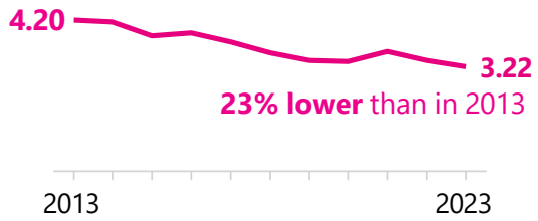
Since MBRRACE-UK started in 2013, the number of babies who died shortly before, during, or soon after birth has been falling. In 2023, the rate was 4.84 baby deaths for every 1,000 births. This is 20% lower than in 2013, mostly because there were fewer stillbirths.

Extended perinatal deaths
per 1,000 total births



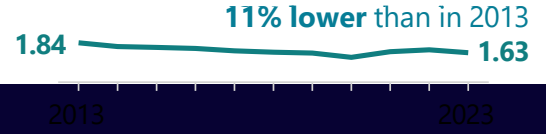
Country	2022	2023
UK & Crown Dependencies	**5.04**	**4.84** ▼
England	5.00	4.88 ▼
Scotland	4.90	4.56 ▼
Wales	5.54	5.10 ▼
Northern Ireland	5.78	4.16 ▼

Stillbirths
per 1,000 total births



Country	2022	2023
UK & Crown Dependencies	**3.35**	**3.22** ▼
England	3.33	3.27 ▼
Scotland	3.31	2.95 ▼
Wales	3.63	3.32 ▼
Northern Ireland	3.49	2.51 ▼

Neonatal deaths
per 1,000 live births



Country	2022	2023
UK & Crown Dependencies	**1.69**	**1.63** ▼
England	1.67	1.62 ▼
Scotland	1.59	1.61 ▲
Wales	1.91	1.79 ▼
Northern Ireland	2.29	1.66 ▼

MBRRACE - 2025

Stillbirths
per 1,000 total births

Gestational age	2022	2023
22 to 23 weeks	405.5	403.0 ▼
24 to 27 weeks	216.0	207.8 ▼
28 to 31 weeks	74.4	69.9 ▼
32 to 36 weeks	12.7	12.5 ▼
37 to 41 weeks	1.09	0.99 ▼

Neonatal deaths
per 1,000 live births

Gestational age	2022	2023
22 to 23 weeks	625.2	641.1 ▲
24 to 27 weeks	139.6	146.1 ▲
28 to 31 weeks	29.5	31.1 ▲
32 to 36 weeks	6.58	5.05 ▼
37 to 41 weeks	0.62	0.60 ▼

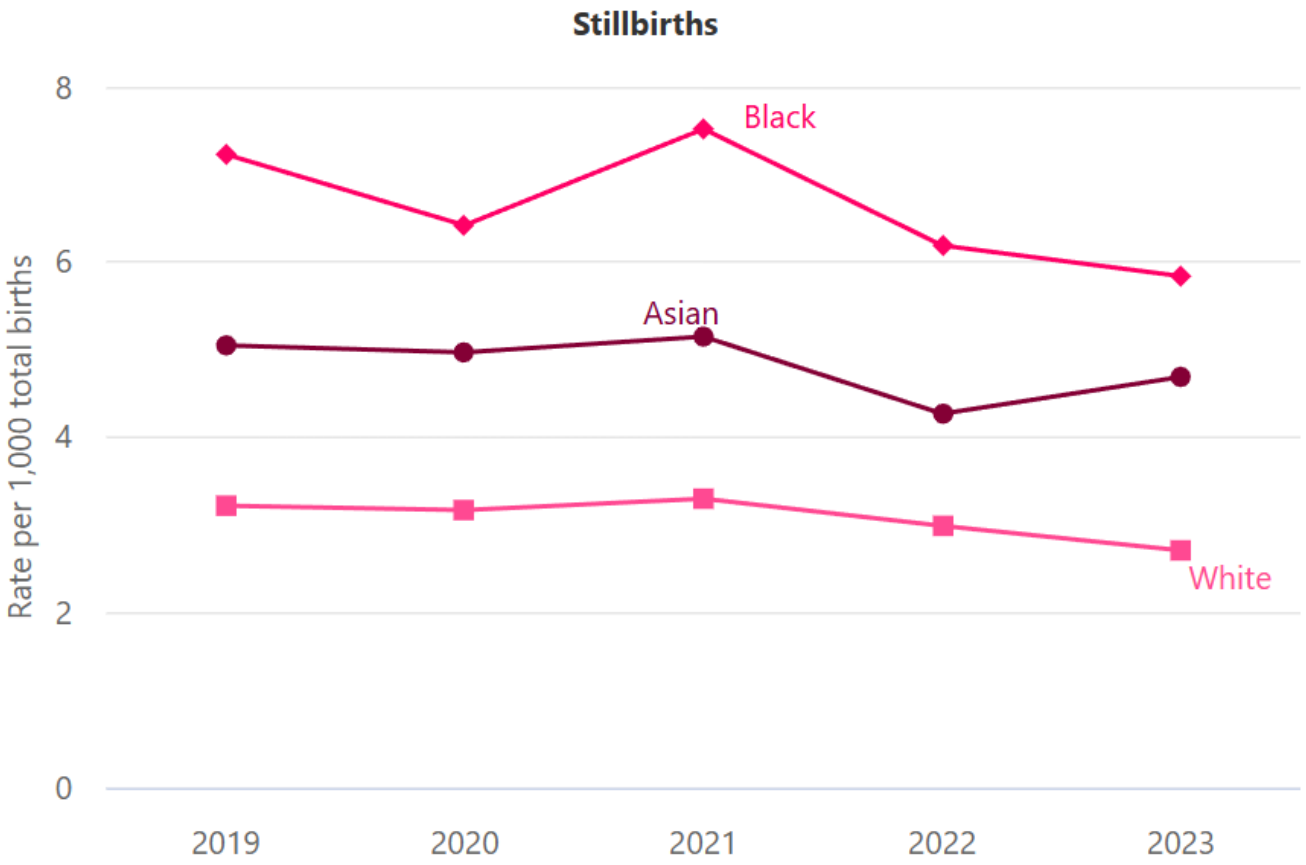
Stillbirth rates decreased, but neonatal mortality rates increased for the most preterm babies

Stillbirth rates dropped across all stages of pregnancy, with the biggest decrease seen in babies born at term (37 to 41 weeks). However, neonatal deaths increased for babies born very prematurely, between 24 and 31 weeks, but decreased for those born at 32 weeks or later.

Babies born at 22 to 23 weeks made up a growing share (25%) of all neonatal deaths.

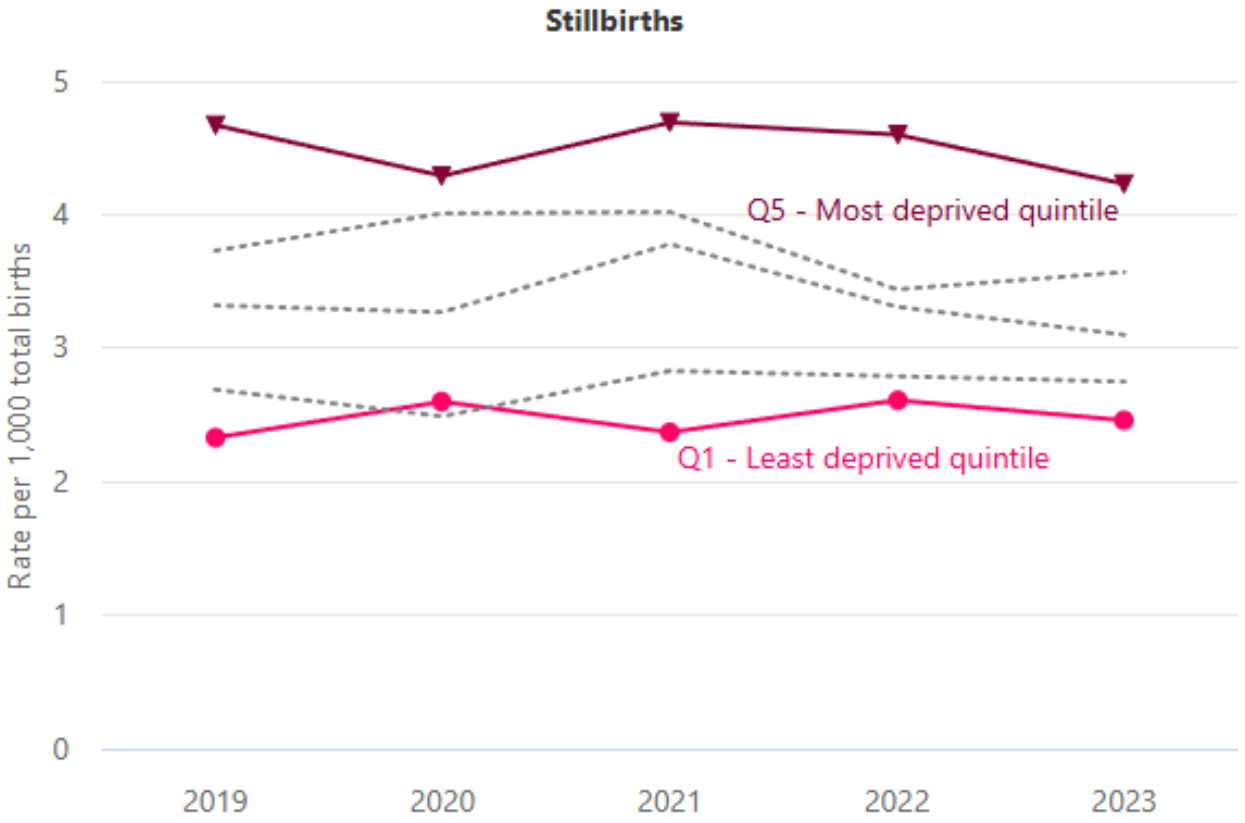
Preterm births remained a major factor in baby deaths, with 76% of stillbirths and 75% of neonatal deaths happening in babies born before 37 weeks.

Ethnicity



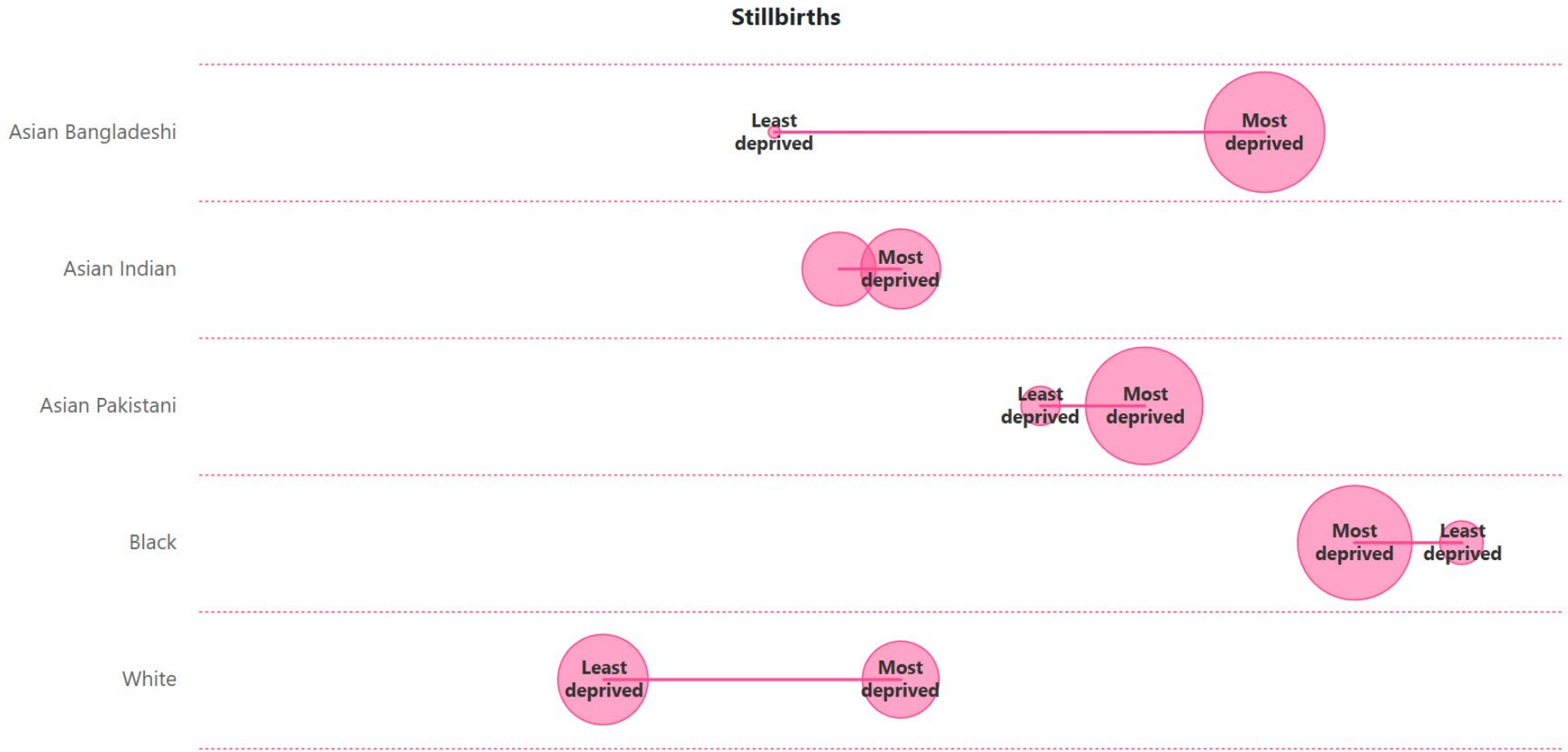
Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

Deprivation



Data sources: MBRRACE-UK, PDS, ONS, NRS, PHS, NIMATS, States of Guernsey, States of Jersey.

Combined Deprivation and Ethnicity



Turning Data Into Actions

What do we need to do?

These findings show that progress is being made in reducing baby deaths, but there is still important work to do—especially to
tackle the gaps linked to deprivation, ethnicity, and how early in pregnancy a baby is born.

MBRRACE-UK has previously made national recommendations to help with this, but local services, networks, and commissioners may need to take a closer look at their own areas to understand what's happening and take action that works for their communities.

1. **Make sure services are planned and funded to meet the growing need for intensive care for extremely premature babies**

   Care commissioners should ensure that neonatal intensive care services have the capacity and resources to support the increasing number of babies born before 24 weeks who are receiving active care focused on survival.

2. **Support thorough reviews of baby deaths to help improve care**

   All stillbirths and neonatal deaths across the UK should be reviewed with the Perinatal Mortality Review Tool (PMRT), with input from experienced external clinicians, so services can learn from them and improve how care is delivered.

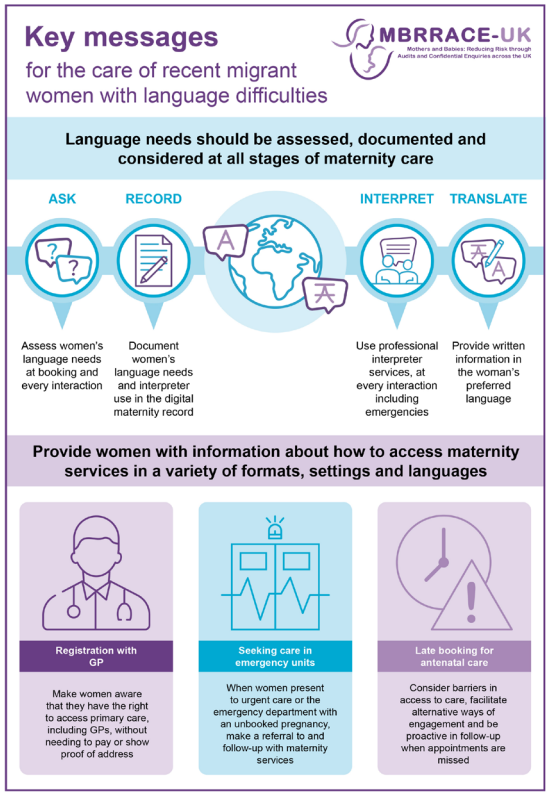
3. **Help healthcare providers use national guidance to improve care for premature babies**

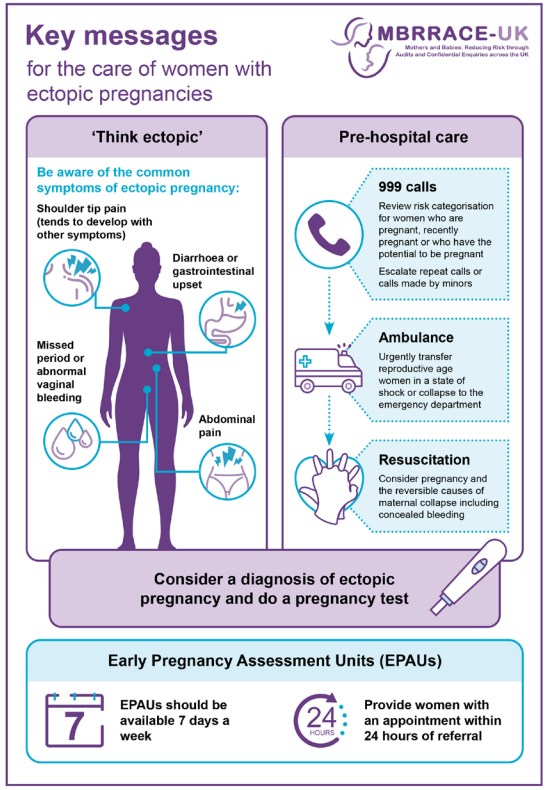
   Royal Colleges and care commissioners should support healthcare providers to adopt and implement the BAPM Perinatal Optimisation Pathway, which aims to improve outcomes for preterm babies.

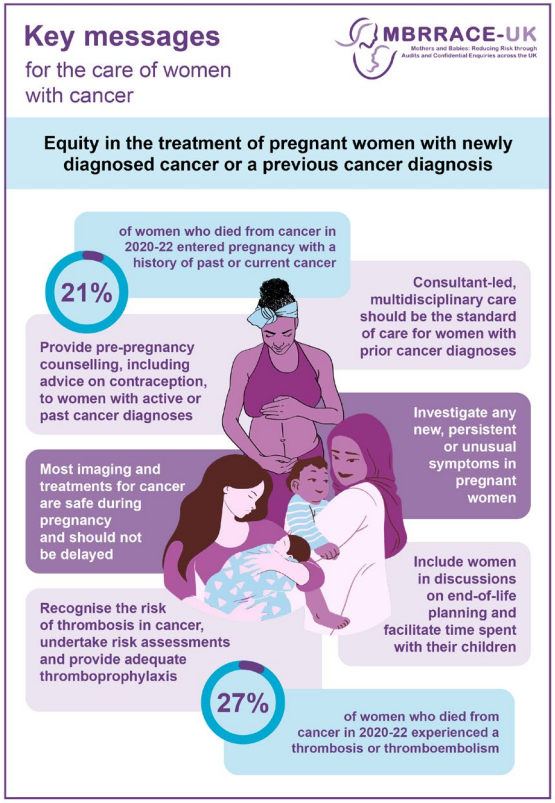
4. **Keep taking targeted action to reduce health inequalities**

   Work should continue at both national and local levels to reduce the unfair differences in outcomes linked to factors like poverty, ethnicity, and where families live.

MBRRACE Maternal Deaths





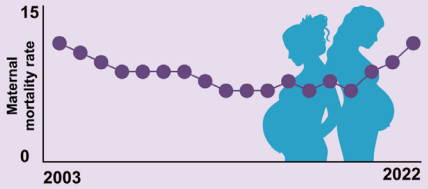


Key messages
from the report 2024

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

275 women died during pregnancy or up to six weeks after pregnancy in 2020-2022

13.56 women per 100,000 died during pregnancy or up to six weeks after pregnancy



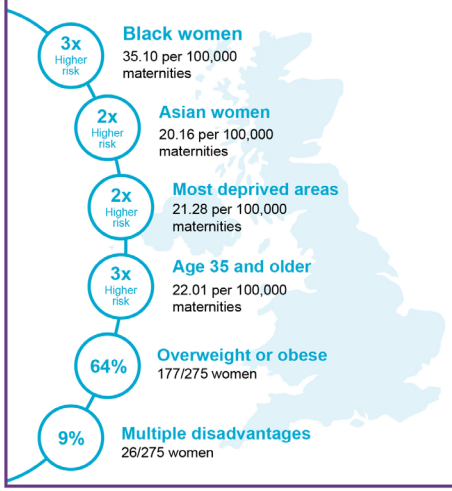
Causes of women's deaths

The **national risk assessment tool** must be evidence-based, clear and accurate

Consider the effects of vomiting, dehydration, immobility and other **symptoms** that can increase risk

Risk happens early - define pathways so women who need medication to prevent blood clots can access it when they need it, including in the first trimester

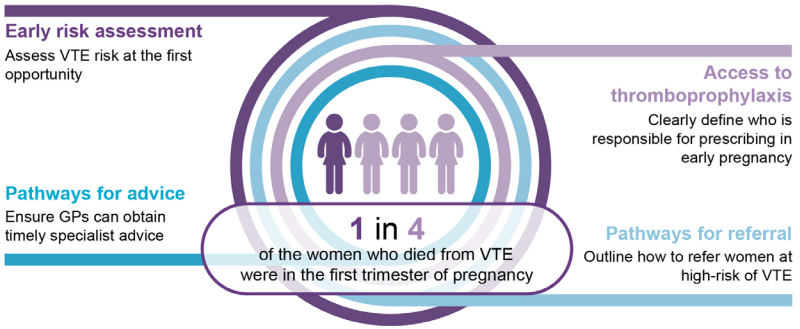
Inequalities in maternal mortality



Key messages
for the care of women with thrombosis and thromboembolism

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Ensure women at high-risk of venous thromboembolism (VTE) receive pre-pregnancy counselling and are appropriately managed in the first trimester



Research evidence is needed to restructure the existing national VTE risk assessment tool

The national assessment tool should:

- Be easy to use, clear and accurate
- Take into account factors that may arise during pregnancy or in the postnatal period
- Be based on research evidence

Women should be assessed:

- At booking or as early in pregnancy as possible
- After pregnancy, regardless of how the pregnancy ends
- If they are admitted to the hospital or develop other problems

Evidence-based

A Real World Example…….

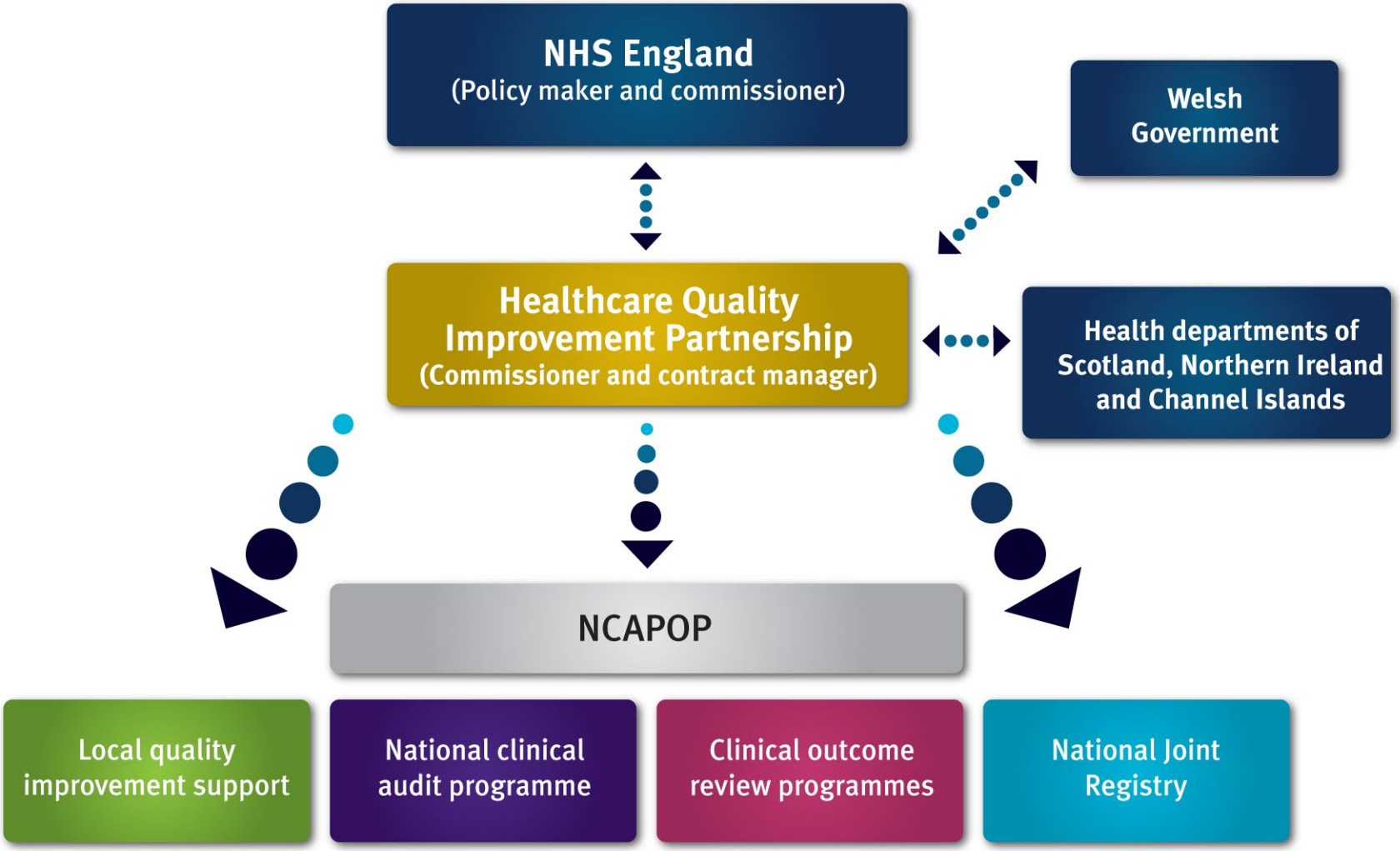
- I was contacted by a medical director concerned by a run of adverse events within their hospital. He was concerned that perhaps a local intervention with clinical teams might be necessary but didn't want to without knowing if this would be the right thing to do.
- I obtained details of the cases, agreed that they were of concern and suggested some early things to do and promised to see if there was data to support an intervention or otherwise
- For this particular problem with this patient group I could not get reassurance from published papers or other leaders
- I remembered an HQIP database from which I could get the detail that suggested to me that the number of adverse events was above that normally expected and then worked with the MD on service improvements

So What Does This Data Add?

- Central collection of data:
  - Unbiased
  - Authoritative
  - Trusted
  - Influential
  - Less demand on the clinical front line
- Driver of improvements in:
  - Safety
  - Quality
  - Choice
  - Performance?

Thank you and over to Tina Strack

About HQIP


NHS England
(Policy maker and commissioner)
Welsh Government
Healthcare Quality Improvement Partnership
(Commissioner and contract manager)
Health departments of Scotland, Northern Ireland and Channel Islands
NCAPOP
Local quality improvement support
National clinical audit programme
Clinical outcome review programmes
National Joint Registry

Maternal Newborn and Infant CORP

- 5 streams of work, split into:
  - Maternal mortality
  - Perinatal mortality
  - Surveillance
  - Confidential enquiries

MBRRACE – Impact and influencing change

External reviews ordered over trust's baby death rates

By Alison Moore | 29 May 2025

5 Comments

- National audit shows high mortality – Leeds says it reflects very high risk and sick babies
- CQC reports expected soon
- Trust and NHSE commission external reviews

Two external reviews are being commissioned into maternity and neonatal care at the trust with the highest perinatal mortality rates.

Leeds Teaching Hospitals Trust has claimed its extended perinatal mortality rate – which measures stillbirths and neonatal deaths – is within the expected range, considering it takes many high-risk pregnancies, including some where babies are not expected to survive, as a specialist centre.

However, a report to its board meeting today reveals its chief medical officer, Magnus Harrison, is commissioning an external review of the issue.

The trust, one of the biggest in England, told *HSJ* the work was in the "very early stages". The review

Most popular | Most commented

New CEO named at trust facing calls for public inquiry
3

NHSE director: 50% cut to ICB costs 'may well not be right number'
39

Up to a third of ICBs to remain independent despite budget cut

Influencing change - Sepsis

- 2014 Report

Sepsis – case studies

A woman went to her GP in the first trimester with a sore throat. She had lymphadenopathy but no other assessment was made. She presented to the gynaecology department 24 hours later with diarrhoea and vomiting and feeling unwell. She was hypotensive and tachycardic. She was reviewed by a junior doctor almost three hours after admission who did not recognise the seriousness of her condition. The obstetric registrar reviewed her 6 hours following admission and prescribed antibiotics, which were not given for over an hour. When the seriousness of her condition was recognised she was transferred to another hospital for intensive care. Despite emergency surgery she died from overwhelming Group A Streptococcal sepsis.

A woman who was seven days post spontaneous vaginal delivery became unwell at home with a fever. She was advised to attend the maternity unit immediately. On admission she was noted to be tachycardic, tachypnoeic and febrile. She was prioritised for urgent medical review. A diagnosis of acute sepsis from retained products was made and fluid resuscitation started immediately. Intravenous antibiotics were started within one hour of the diagnosis and she was transferred to the high dependency unit. The retained products of conception were removed promptly and she made a full recovery. Blood culture subsequently grew Klebsiella. Early recognition, clear advice and prompt treatment led to a good outcome without any further complications.

Sepsis

Think Sepsis

Almost a quarter of women who died had **Sepsis** (severe infection).

Women with sepsis need:

- Early diagnosis
- Rapid antibiotics
- Review by senior doctors and midwives

Prompt treatment and action can make the difference between life and death

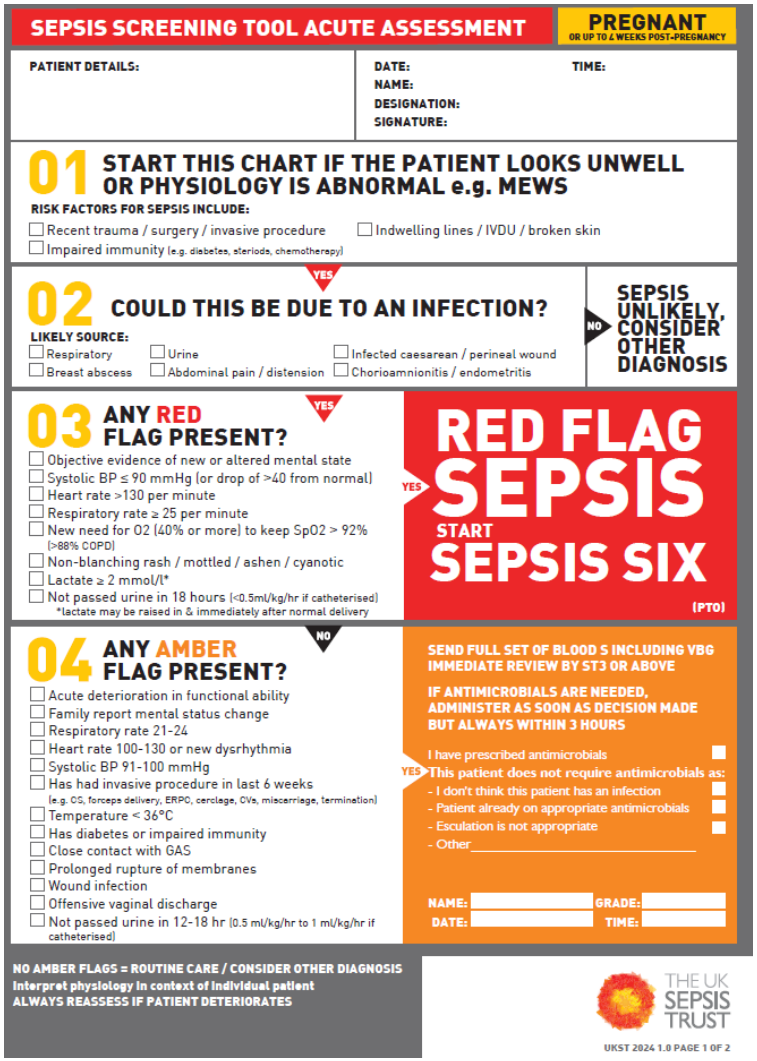
Sepsis - Impacts

- **NHS Education Scotland Maternal Sepsis e-Learning Package**
- 60 minute e-learning package, featuring scenarios based on the vignettes included in the MBRRACE-UK 2014 report, to help improve identification and early management of maternal sepsis

Sepsis - Impacts

- **NHS Education Scotland Maternal Sepsis e-Learning Package**
- 60 minute e-learning package, featuring scenarios based on the vignettes included in the MBRRACE-UK 2014 report, to help improve identification and early management of maternal sepsis
- **UK Sepsis Trust Clinical Toolkits**

Sepsis



SEPSIS SCREENING TOOL ACUTE ASSESSMENT

PREGNANT OR UP TO 6 WEEKS POST-PREGNANCY

PATIENT DETAILS:

DATE: TIME:
NAME:
DESIGNATION:
SIGNATURE:

01 START THIS CHART IF THE PATIENT LOOKS UNWELL OR PHYSIOLOGY IS ABNORMAL e.g. MEWS

RISK FACTORS FOR SEPSIS INCLUDE:

- ☐ Recent trauma / surgery / invasive procedure
- ☐ Indwelling lines / IVDU / broken skin
- ☐ Impaired immunity (e.g. diabetes, steriods, chemotherapy)

02 COULD THIS BE DUE TO AN INFECTION?

YES

LIKELY SOURCE:

- ☐ Respiratory
- ☐ Urine
- ☐ Infected caesarean / perineal wound
- ☐ Breast abscess
- ☐ Abdominal pain / distension
- ☐ Chorioamnionitis / endometritis

NO → SEPSIS UNLIKELY, CONSIDER OTHER DIAGNOSIS

03 ANY RED FLAG PRESENT?

YES

- ☐ Objective evidence of new or altered mental state
- ☐ Systolic BP ≤ 90 mmHg (or drop of >40 from normal)
- ☐ Heart rate >130 per minute
- ☐ Respiratory rate ≥ 25 per minute
- ☐ New need for O2 (40% or more) to keep SpO2 > 92% (>88% COPD)
- ☐ Non-blanching rash / mottled / ashen / cyanotic
- ☐ Lactate ≥ 2 mmol/l*
- ☐ Not passed urine in 18 hours (<0.5ml/kg/hr if catheterised)

*lactate may be raised in & immediately after normal delivery

YES → **RED FLAG SEPSIS**

START **SEPSIS SIX**

(PTO)

04 ANY AMBER FLAG PRESENT?

NO

- ☐ Acute deterioration in functional ability
- ☐ Family report mental status change
- ☐ Respiratory rate 21-24
- ☐ Heart rate 100-130 or new dysrhythmia
- ☐ Systolic BP 91-100 mmHg
- ☐ Has had invasive procedure in last 6 weeks (e.g. CS, forceps delivery, ERPC, cerclage, CVs, miscarriage, termination)
- ☐ Temperature < 36°C
- ☐ Has diabetes or impaired immunity
- ☐ Close contact with GAS
- ☐ Prolonged rupture of membranes
- ☐ Wound infection
- ☐ Offensive vaginal discharge
- ☐ Not passed urine in 12-18 hr (0.5 ml/kg/hr to 1 ml/kg/hr if catheterised)

YES → **SEND FULL SET OF BLOOD S INCLUDING VBG IMMEDIATE REVIEW BY ST3 OR ABOVE**

IF ANTIMICROBIALS ARE NEEDED, ADMINISTER AS SOON AS DECISION MADE BUT ALWAYS WITHIN 3 HOURS

- ☐ I have prescribed antimicrobials

YES → This patient does not require antimicrobials as:

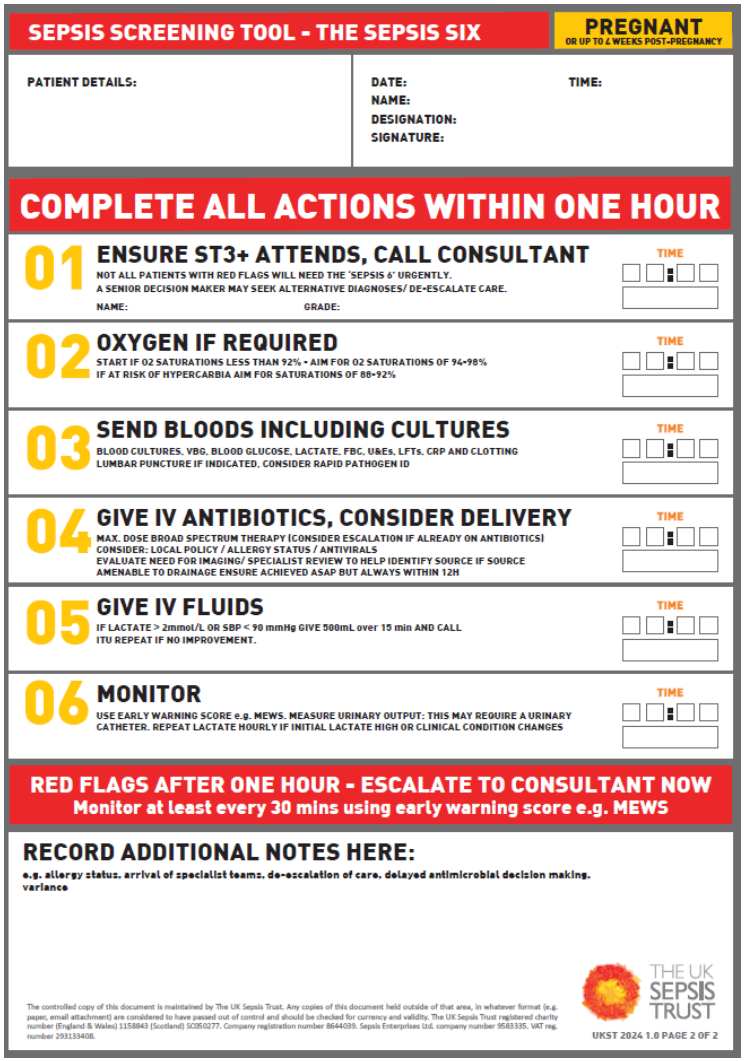
- ☐ I don't think this patient has an infection
- ☐ Patient already on appropriate antimicrobials
- ☐ Esculation is not appropriate
- ☐ Other _____

NAME: GRADE:
DATE: TIME:

NO AMBER FLAGS = ROUTINE CARE / CONSIDER OTHER DIAGNOSIS
Interpret physiology in context of individual patient
ALWAYS REASSESS IF PATIENT DETERIORATES

THE UK SEPSIS TRUST

UKST 2024 1.0 PAGE 1 OF 2



SEPSIS SCREENING TOOL - THE SEPSIS SIX

PREGNANT OR UP TO 6 WEEKS POST-PREGNANCY

PATIENT DETAILS:

DATE: TIME:
NAME:
DESIGNATION:
SIGNATURE:

COMPLETE ALL ACTIONS WITHIN ONE HOUR

01 ENSURE ST3+ ATTENDS, CALL CONSULTANT — TIME

NOT ALL PATIENTS WITH RED FLAGS WILL NEED THE 'SEPSIS 6' URGENTLY.
A SENIOR DECISION MAKER MAY SEEK ALTERNATIVE DIAGNOSES/ DE-ESCALATE CARE.

NAME: GRADE:

02 OXYGEN IF REQUIRED — TIME

START IF O2 SATURATIONS LESS THAN 92% - AIM FOR O2 SATURATIONS OF 94-98%
IF AT RISK OF HYPERCARBIA AIM FOR SATURATIONS OF 88-92%

03 SEND BLOODS INCLUDING CULTURES — TIME

BLOOD CULTURES, VBG, BLOOD GLUCOSE, LACTATE, FBC, U&Es, LFTs, CRP AND CLOTTING
LUMBAR PUNCTURE IF INDICATED, CONSIDER RAPID PATHOGEN ID

04 GIVE IV ANTIBIOTICS, CONSIDER DELIVERY — TIME

MAX. DOSE BROAD SPECTRUM THERAPY (CONSIDER ESCALATION IF ALREADY ON ANTIBIOTICS)
CONSIDER: LOCAL POLICY / ALLERGY STATUS / ANTIVIRALS
EVALUATE NEED FOR IMAGING/ SPECIALIST REVIEW TO HELP IDENTIFY SOURCE IF SOURCE AMENABLE TO DRAINAGE ENSURE ACHIEVED ASAP BUT ALWAYS WITHIN 12H

05 GIVE IV FLUIDS — TIME

IF LACTATE > 2mmol/L OR SBP < 90 mmHg GIVE 500mL over 15 min AND CALL ITU REPEAT IF NO IMPROVEMENT.

06 MONITOR — TIME

USE EARLY WARNING SCORE e.g. MEWS. MEASURE URINARY OUTPUT: THIS MAY REQUIRE A URINARY CATHETER. REPEAT LACTATE HOURLY IF INITIAL LACTATE HIGH OR CLINICAL CONDITION CHANGES

RED FLAGS AFTER ONE HOUR - ESCALATE TO CONSULTANT NOW
Monitor at least every 30 mins using early warning score e.g. MEWS

RECORD ADDITIONAL NOTES HERE:

e.g. allergy status, arrival of specialist teams, de-escalation of care, delayed antimicrobial decision making, variance

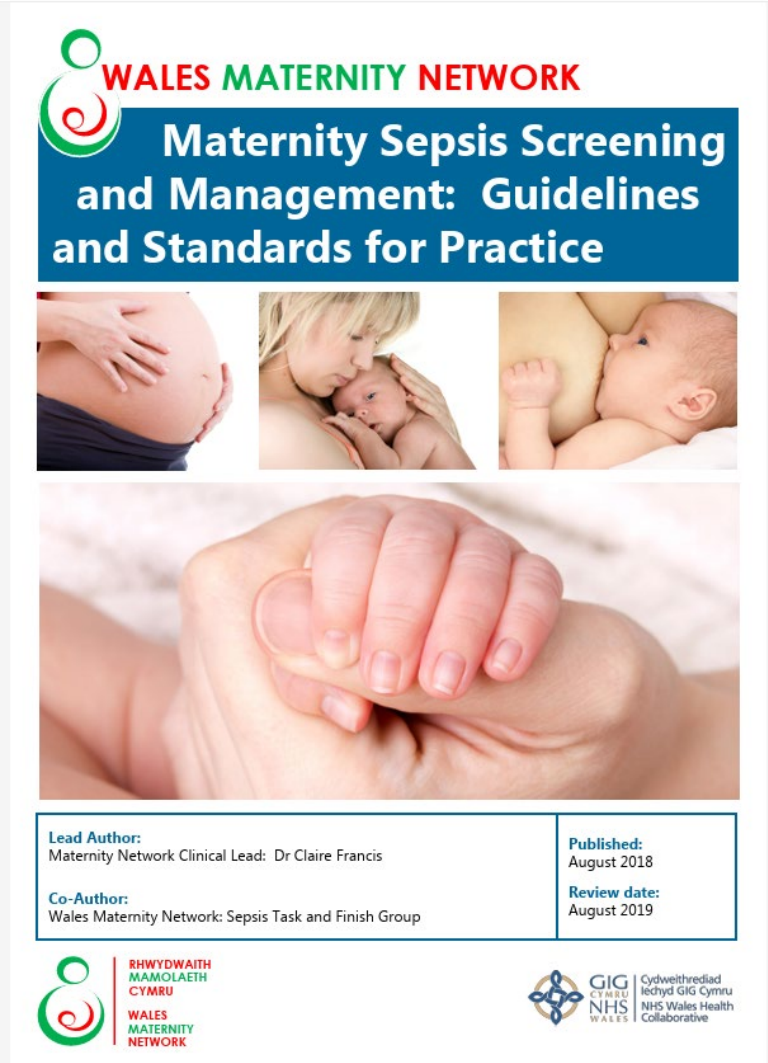
THE UK SEPSIS TRUST

UKST 2024 1.0 PAGE 2 OF 2

Sepsis - Impacts

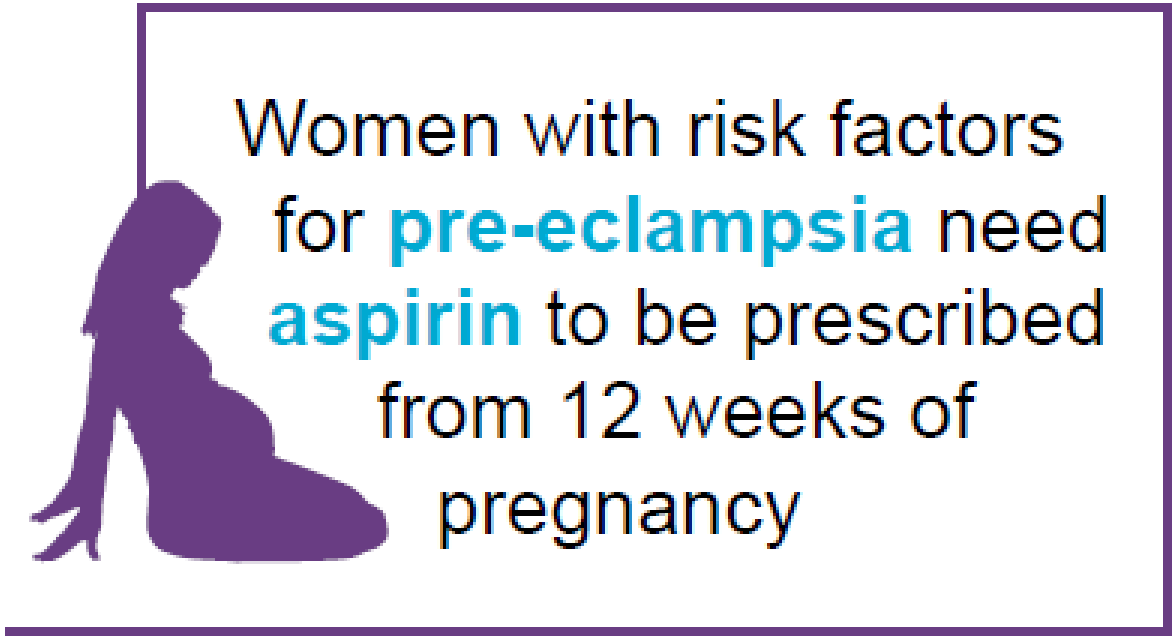
- **NHS Education Scotland Maternal Sepsis e-Learning Package**
- 60 minute e-learning package, featuring scenarios based on the vignettes included in the MBRRACE-UK 2014 report, to help improve identification and early management of maternal sepsis
- **UK Sepsis Trust Clinical Toolkits**
- **Wales Guidelines and Standards**

Sepsis


WALES MATERNITY NETWORK
Maternity Sepsis Screening and Management: Guidelines and Standards for Practice
Lead Author:
Maternity Network Clinical Lead: Dr Claire Francis
Co-Author:
Wales Maternity Network: Sepsis Task and Finish Group
Published:
August 2018
Review date:
August 2019
RHWYDWAITH MAMOLAETH CYMRU
WALES MATERNITY NETWORK
GIG CYMRU NHS WALES
Cydweithrediad Iechyd GIG Cymru
NHS Wales Health Collaborative

Pre-eclampsia and Aspirin Use

- 2019 Report identified pre-eclampsia as an issue



Pre-eclampsia and Aspirin Use

- Recommendation:
- A national Patient Group Direction, including advice relating to safe, timely and cost-effective local implementation, as a solution should be explored to ensure consistent high quality care by allowing midwives to supply aspirin to eligible women in line with NICE Guidance (MPG2, NG133).

Pre-eclampsia and Aspirin Use

Aspirin tablets for use within antenatal and maternity services

Published 9 February 2022 · Last updated 3 February 2025 · **See all updates**

Topics: Aspirin · Patient Group Directions · Safety in Pregnancy · Templates

SPS PGD template for the supply of aspirin tablets to individuals at risk of pre-eclampsia during pregnancy.

Provenance

Developed by SPS and NHS England, reviewed by the Royal College of Obstetrics and Gynaecology (RCOG), with the support of specialists working within clinical practice for medicines commonly supplied for the prevention of complications in pregnancy.

PGD template attachment

The template PGD is attached below to download and use in conjunction with our implementation advice.

PMP Aspirin National PGD template V2.0 FINAL October 2024 · Word · 59 KB

More pregnancy and supportive medicines PGD templates

- **Omeprazole for use within antenatal and maternity services**
- **Terbutaline injection for use in labour within maternity services**
- **Benzylpenicillin for Group B Streptococcus for use in neonates**
- **Folic acid 5mg tablets for use during pregnancy**

All PGD templates

National PGD templates

National PGD templates are developed with experts for clinical specialties. They reduce duplication and variation, and improve consistency of care.

Pre-eclampsia and Aspirin

Insert logo of authorising body

This Patient Group Direction (PGD) must only be used by registered healthcare professionals who have been named and authorised by their organisation to practice under it. The most recent and in date final signed version of the PGD should be used.

PATIENT GROUP DIRECTION (PGD)

Supply of aspirin tablets for individuals at high risk of pre-eclampsia in location/service/organisation

Version Number 2.0

Change History	
Version and Date	**Change details**
Version 1 February 2022	New template
Version 2 October 2024	Planned review. Updated SLWG membership. Minor formatting changes. Watermark removed.

Each organisation using this PGD must ensure that it is formally signed by a senior pharmacist, a senior doctor and any other professional group representatives involved in its review and that it is reviewed in line with the organisations' PGD governance system. The organisation's governance lead must sign to authorise the PGD on behalf of the authorising organisation to ensure that this document meets legal requirements for a PGD.

practise under it (See Appendix A). The most recent and in date final signed version of the PGD must be used.

PGD DEVELOPMENT GROUP	
Date PGD template comes into effect:	1st February 2025
Review date	August 2027
Expiry date:	31st January 2028

This PGD template has been peer reviewed by the Preventative Medicines in Pregnancy PGDs Short Life Working Group in accordance with their Terms of Reference. It has been reviewed by the Royal College of Obstetrics and Gynaecology (RCOG) and has been endorsed by Professor Donald Peebles, National Clinical Director for Maternity NHS England.

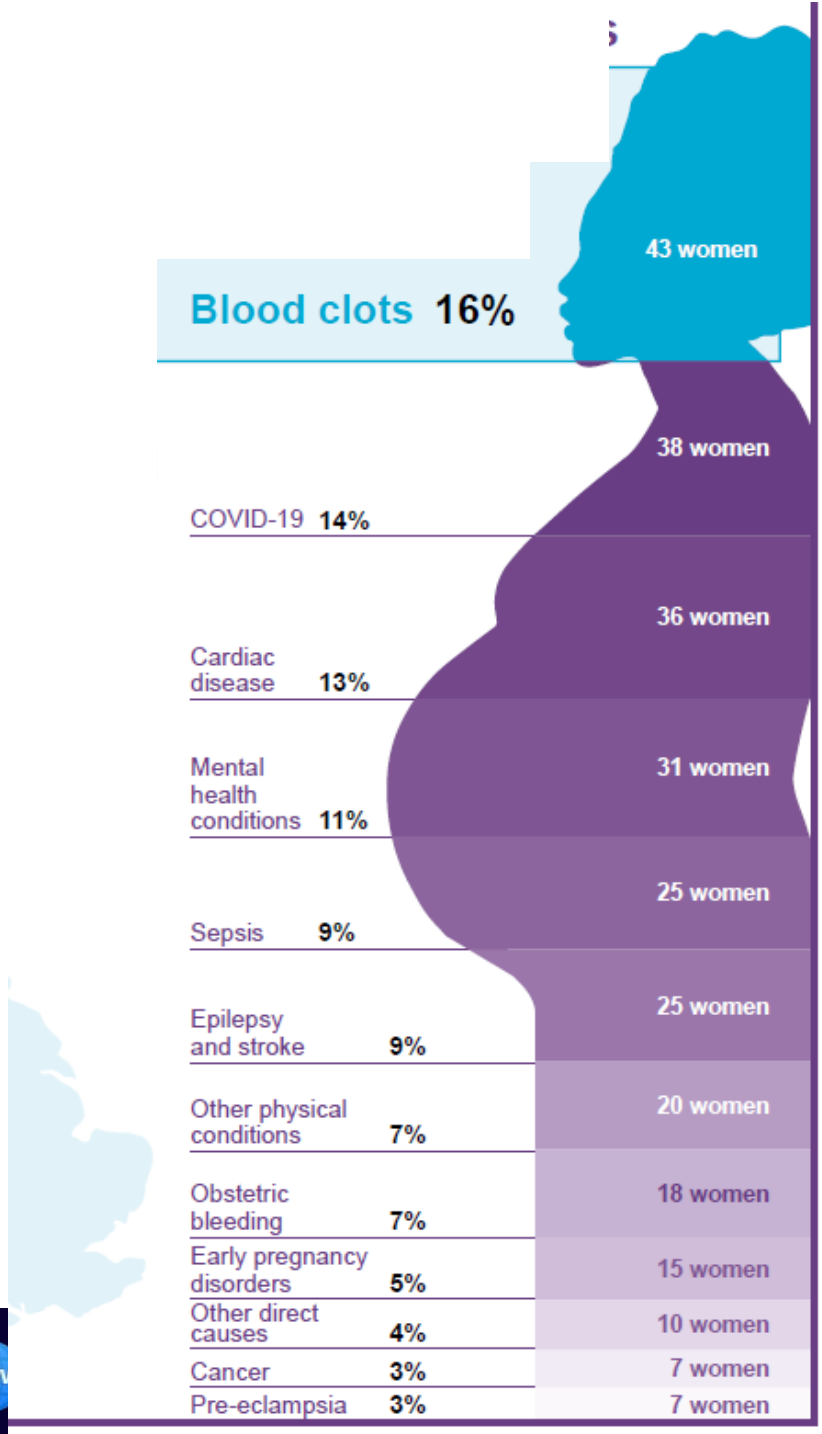
This section MUST REMAIN when a PGD is adopted by an organisation.

Name	Designation	DATE
Amy Moore	Pharmacist HIV, Sexual and Reproductive Health Kingston Hospital NHS Foundation Trust	October 2024
Christina Nurmahi	Women & Newborn Care Group Lead Pharmacist, University Hospital Southampton NHS Foundation Trust	
Emma Luhr	Director of Midwifery, Frimley Health NHS Foundation Trust	
Felipe Castro Cardona	Head of Midwifery Clinical Workforce Chief Midwifery Office, NHS England	
George Attilakos	Consultant in Fetal Medicine and Obstetrics in UCLH, Clinical Lead for Obstetrics and RCOG Council member	
Hannah Putley	Policy Manager - Maternity and Neonatal, NHS Quality, Safety and Investigations, Department of Health and Social Care	
Jo Jenkins	Associate Director Medicines Governance Specialist Pharmacy Service	
Rosie Furner (Working Group Co-ordinator)	Advanced Specialist Pharmacist - Patient Group Directions and Medicines Mechanisms, Specialist Pharmacy Service	
Sandy Richards	BSW LMNS Midwife NHS Bath and North East Somerset, Swindon and Wiltshire Integrated Care Board (ICB)	

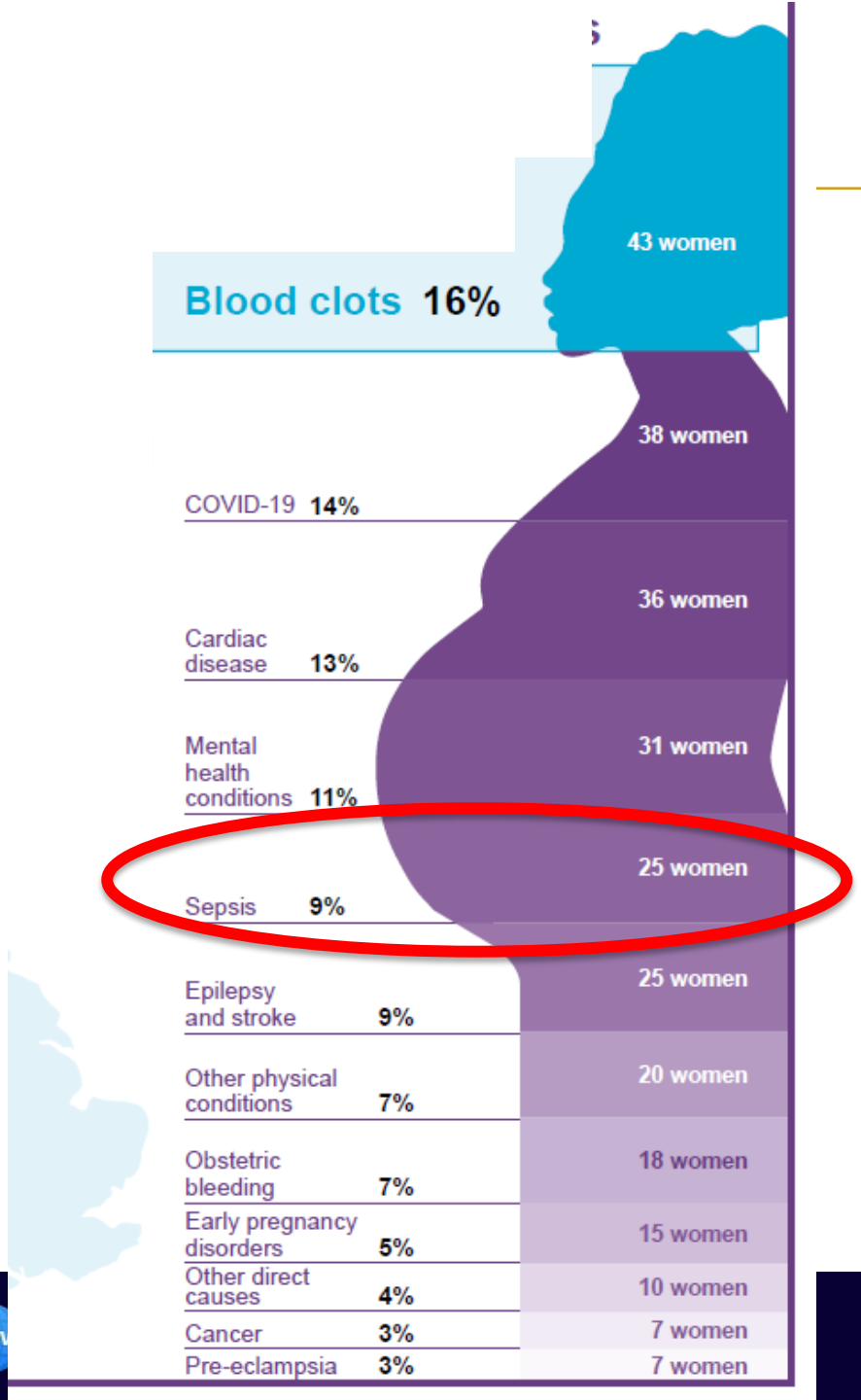
So what?

Has any of this made a difference?

2024 report


Blood clots 16%
43 women
COVID-19 14%
38 women
Cardiac disease 13%
36 women
Mental health conditions 11%
31 women
Sepsis 9%
25 women
Epilepsy and stroke 9%
25 women
Other physical conditions 7%
20 women
Obstetric bleeding 7%
18 women
Early pregnancy disorders 5%
15 women
Other direct causes 4%
10 women
Cancer 3%
7 women
Pre-eclampsia 3%
7 women

2024 report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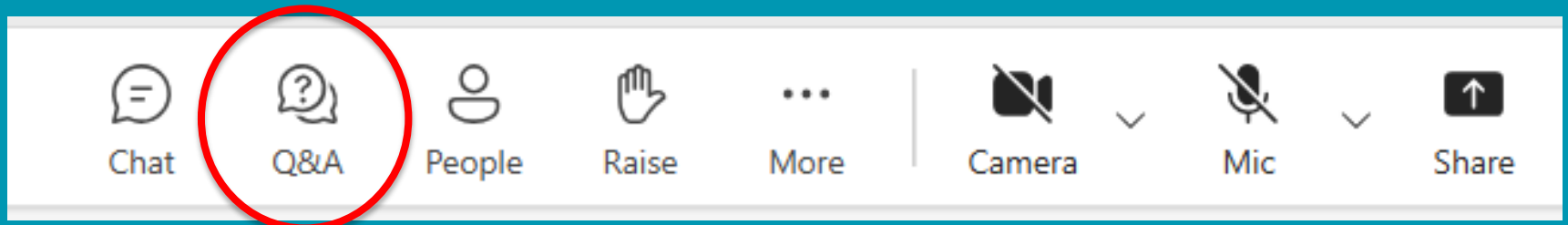
Q&A



Submit a written question via Q&A

Upcoming Clinical Audit Awareness Week activities

- **SIGN UP for tomorrow's Clinical Audit Heroes Awards COMMENDATIONS webinar on Fri 6 June, 10am – 11am**
  Find out who won the brand-new NCAPOP and Communicating for Impact Commendations
  With HQIP's NCAPOP Associate Director, Rachael Sample

- **SIGN UP for tomorrow's Lunch & Learn on Fri 6 June, 12.30pm – 1.45pm**
  Efficiencies
  With RCP's Dr Theresa Barnes, N-QI-CAN, and HQIP's CEO, Chris Gush

- **Find out more about all #CAAW25 activities and releases (event recordings, resources, case studies etc)**
  Scan the QR code or go to: www.hqip.org.uk/clinical-audit-awareness-week

- For those on social media, please share your **#CAAW25** updates!

Tell us what you think…

Complete the short form to share your feedback about this #CAAW25 event

www.bit.ly/3S6D7LS

HQIP Healthcare Quality Improvement Partnership

In collaboration with

N-QI-CAN National Quality Improvement (inc. Clinical Audit) Network

Clinical Audit Awareness Week 2025 (#CAAW25)

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