CONVENZIS

Welcome to the NHS Neonatal & Midwifery Transformation Conference

Maternity

11th November 2026
etc venues Manchester, 8th Floor, 11 Portland Street, Greater Manchester, M1 3HU

Maternity

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Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.



SCAN ME

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Stay Connected Beyond Today

Join the **HES Integrated Care, Patient Flow & Workforce WhatsApp Community** to stay connected with the people, ideas and conversations shaping this space. Receive relevant updates, access focused peer discussion groups, share practical insight and be first to hear about future events, resources and opportunities.

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Scan the QR code to join the Community

Chair Morning Address



Dawn Johnston
Trustee
British Pregnancy Advisory Service (BPAS)

MATERNITY 2026

NHS Neonatal & Midwifery Transformation Conference

Dawn Johnston

Event Chair | BPAS Board of Trustees

BPAS: leading women's health provider

100,000+

Patients cared for each year

44 clinics, online and telemedical care

Across England and Wales

NHS-commissioned

Nearly all patients' self refer, their care paid for by the NHS

Comprehensive reproductive healthcare

Abortion advice and treatment • Pregnancy testing • Counselling • STI screening

Contraception • Vasectomy • NHS central booking services

Advocacy for informed choice, modernised laws and reproductive autonomy

BPAS' own transformation journey

From regulatory scrutiny to stronger, more resilient care

01

Quality & assurance

Almost all clinics rated Good by the CQC; some with elements of Outstanding.

02

Safety & governance

Relentless focus on patient safety, consistent quality and robust clinical governance.

03

Sustainable future

Investing in people, estates and services, underpinned by stronger NHS commissioning.

A women's healthcare system under pressure

Recurring themes across the Ockenden, Thirlwall and Amos reviews

Women's voices

Concerns not always heard or acted upon

Workforce

Shortages and service pressures

Speaking up

Barriers to escalation and challenge

Accountability

Inconsistent leadership and governance

Inequalities

Persistent differences in outcomes

Learning

Missed opportunities after incidents

Safe care = listening to women + supporting staff + open, accountable cultures

What this means for all women's health services

Shared principles across maternity, reproductive and sexual healthcare

01 **Listen to women and families**

02 **Value experience alongside clinical outcomes**

03 **Make services accessible and equitable**

04 **Encourage openness, challenge and learning**

05 **Design care around individual needs and choices**

ONE LEARNING. ONE ACTION.

What is the one learning you will take away today and apply in your practice?

Thank you

Interview Session



Manesha Kaur Hayer
Founder
Baby Loss Hub

Maternity



BABY LOSS HUB

Forever Loved, Never Forgotten

Skill Clinic



Dr Peter Yeh
Consultant Obstetrician & Fetal Maternal Medicine
East Kent Hospitals University NHSFT



Dr Amitava Sur
Neonatal Consultant, Lancashire Women& Newborn Centre
East Lancashire Hospital NHS Trust

Maternity

Point-of-Care Testing in Maternity Services

Peter Yeh

Consultant Obstetrician

East Kent Hospitals University NHS Foundation Trust

10:00, Wednesday 11th November 2026

Saving Babies Lives Care Bundle

- Element 1: Reducing smoking in pregnancy
- Element 2: Fetal growth: risk assessment, surveillance and management
- Element 3: Raising awareness of reduced fetal movement
- Element 4: Effective fetal monitoring during labour
- **Element 5: Reducing preterm births and optimising perinatal care**
- Element 6: Management of pre-existing diabetes in pregnancy

Point of Care Testing – Biomarkers in preterm labour assessment

Predict

- Assess the risk of preterm birth
- Cervical length ultrasound scanning
- Biomarkers

Prevent

- Smoking cessation
- low dose aspirin
- cervical cerclage
- progesterone
- continuity of care
- arabin pessary

Perinatal optimisation

- Antenatal steroids
- Antenatal magnesium
- Intrapartum antibiotics
- Cord management

Predict

- Assess the risk of preterm birth
- Cervical length ultrasound scanning
- **Biomarkers – rapid diagnostics**

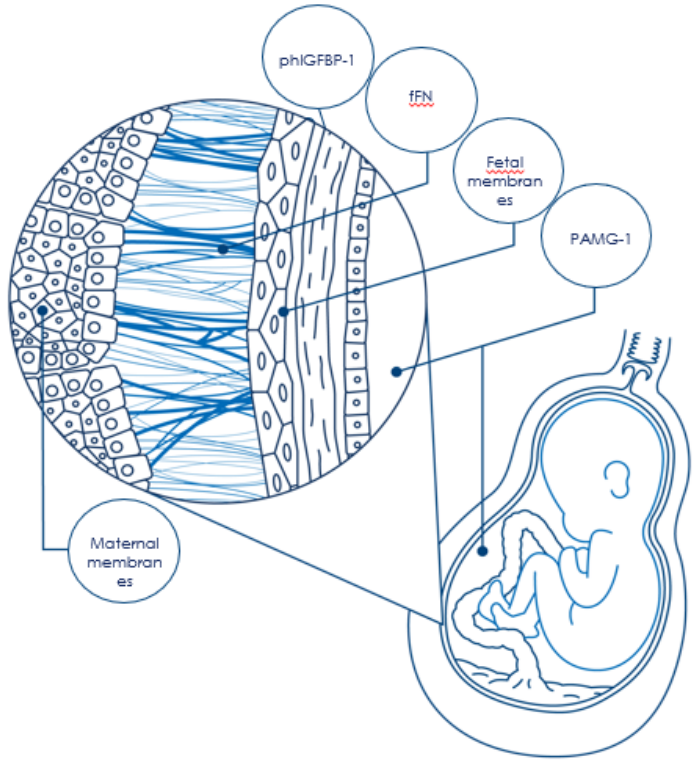
Case

- 30wk pregnant woman in her pregnancy comes to Triage with some intermittent abdominal pain, not requiring analgesia but visibly showing some distress with each episode
- All vital functions normal and Urine NAD
- Abdominal exam: NAD, except some intermittent tightenings
- VE and Speculum: NAD but cannot see cervix clearly.

Biomarkers

fFN	Partosure	Actim Partus
fetal Fibronectin (Hologic)	PAMG-1 = placental alpha microglobulin 1 (AG Health)	phlGFBP = phosphorylated form of insulin-like growth factor binding protein (Abbott)

What is the difference between fFN, phIGFBP-1, and PAMG-1?



fFN is found in the ECM and is a glue-like protein that holds the developing baby in the womb and may be released into the vaginal cavity after digital examination or manipulation of the cervix (1)

phIGFBP-1 is found in the ECM and released into cervical vaginal fluid after tissue damage (2)

PAMG-1 is a small protein, formed by decidual cells, and released into the amniotic cavity throughout pregnancy (3)

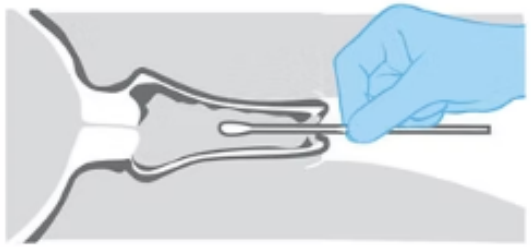
As PAMG-1 is not found in the ECM around the amniotic cavity, this can reduce the opportunity for unnecessary release into the vaginal cavity due to cervical disturbances (3)

PartoSure can be used shortly after vaginal examination without impacting results

Sample to Insight

PartoSure 4-Step Testing Procedure

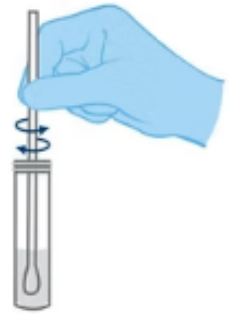
1



Collect sample

Collect sample of vaginal discharge with sterile collection swab for 30 secs (no active rotation or speculum required).

2



Transfer to solvent

Rinse specimen swab in solvent vial for 30 seconds. Discard swab.

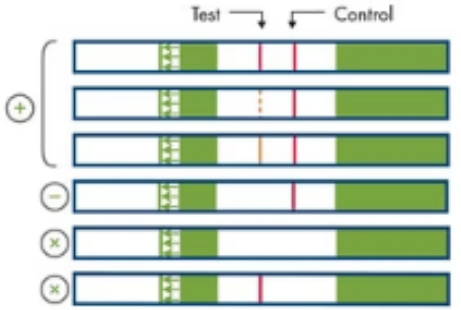
3



Insert test strip

Insert test strip into vial. Positive as soon as two lines are visible on strip. 5 minutes to call negative result.

4



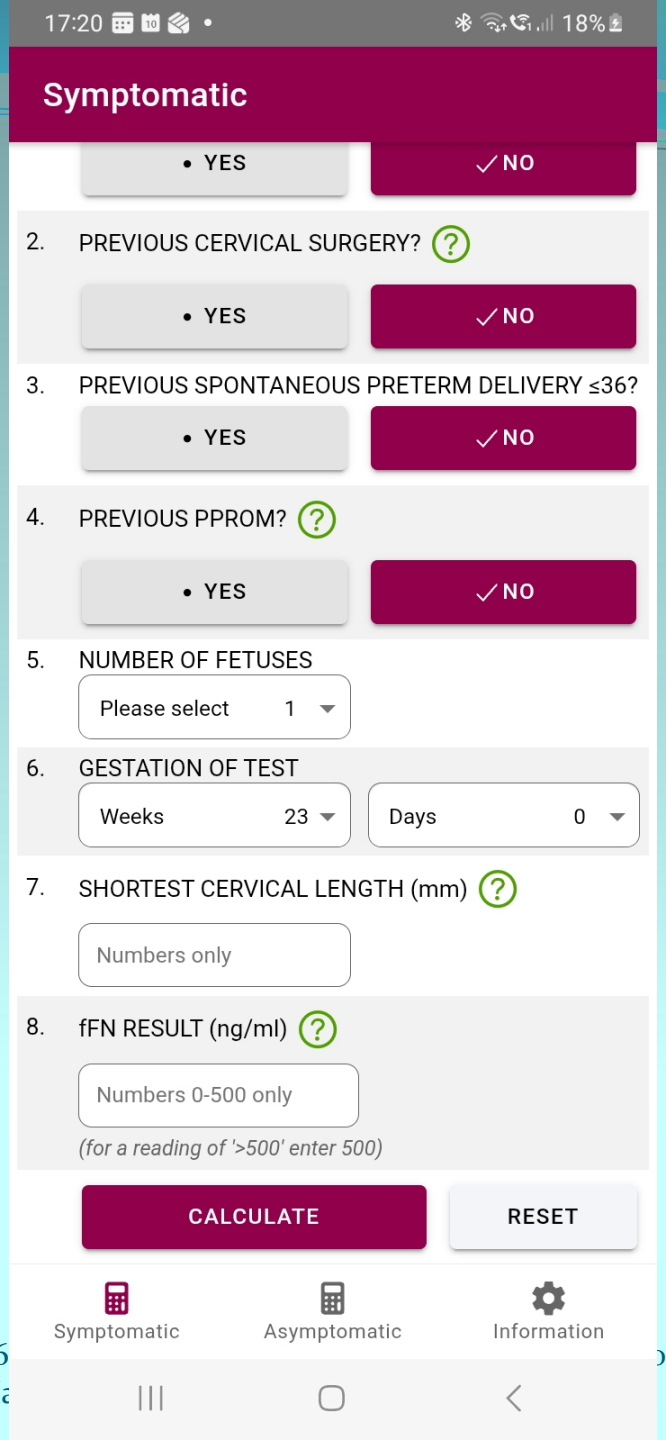
Read result

A positive result is indicated by two lines in the test region, while a negative result is indicated by a single control line in the test region. Do not read or interpret the result after 10 minutes have passed since inserting the test strip into the vial.


1
10-15 sec
*If Actim Partus is combin

Positive & Negatie Predictive Values

	PartoSure test [4]	Actim Partus [5]	Rapid fFN [6]
Notes	PAMG-1 biomarker	phIGFBP-1 biomarker	fFN biomarker
PPV	76	50	13
NPV	96	96	99


17:20
18%
Symptomatic
• YES
✓NO
2. PREVIOUS CERVICAL SURGERY?
• YES
✓NO
3. PREVIOUS SPONTANEOUS PRETERM DELIVERY ≤36?
• YES
✓NO
4. PREVIOUS PPROM?
• YES
✓NO
5. NUMBER OF FETUSES
Please select 1
6. GESTATION OF TEST
Weeks 23
Days 0
7. SHORTEST CERVICAL LENGTH (mm)
Numbers only
8. fFN RESULT (ng/ml)
Numbers 0-500 only
(for a reading of '>500' enter 500)
CALCULATE
RESET
Symptomatic
Asymptomatic
Information

Another case for

? Premature rupture of membranes PROM

Detection of ruptures of membranes

	AmniSure ROM Test [1]	ROM Plus Test [8]	Actim PROM [9]
Biomarker	PAMG-1	IGFBP-1 (PP12) & AFP	IGFBP-1
Specificity	100% (no speculum)	75% (no speculum)	91.0% (no speculum) 86.4% (speculum)
Sensitivity	98.9% (no speculum)	99.1% (no speculum)	90.1% (no speculum) 95.5% (speculum)

Medical Devices Committee

- Oversight of medical devices
- Maintenance and clinical user training
- Asset management, maintenance and replacement
- Procurement and budget
- Reviewing requests for trials
- Membership of stake holders

Thank you

Point-of-care testing in neonatal care

A discussion on utility, challenges and governance

Dr Amitava Sur
Neonatal Consultant , Lancashire Women and Newborn Centre
Neonatal clinical lead- Lancashire & South Cumbria

POCT across the NICU journey

- Point-of-care tests support assessment from admission through the infant's stay.
- Rapid results can inform decision making on cardio- respiratory, metabolic, sepsis, and electrolyte management
- Results must be interpreted alongside clinical assessment and formal laboratory testing.



Blood gas analysis: fast, useful, limited loss

- Blood gas analysis is the most common and useful neonatal POCT.
- A “full blood gas” can also report haemoglobin and electrolytes.
- Results arrive within minutes from **less than 0.3 ml of blood.**



Blood gases: benefits and cautions

Benefits

- Quick to obtain by staff without venepuncture training.
- Results are available within minutes.
- Useful for trend analysis.

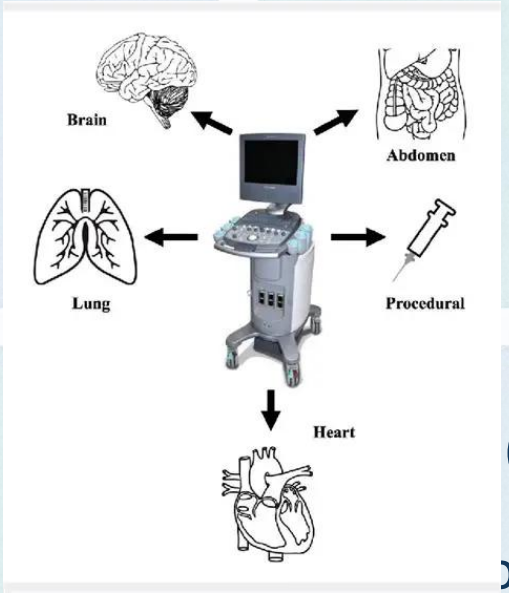
Cautions

- Results for electrolytes may be insufficiently accurate for decisions without laboratory trends.
- Repeated daily sampling can contribute to effective blood-volume loss.

Point-of-care ultrasound: decisions at the bedside

Cranial ultrasound

Assess for Intraventricular hemorrhage (IVH)



Lung scan

Support surfactant and ventilation decisions.

Point-of-care echo

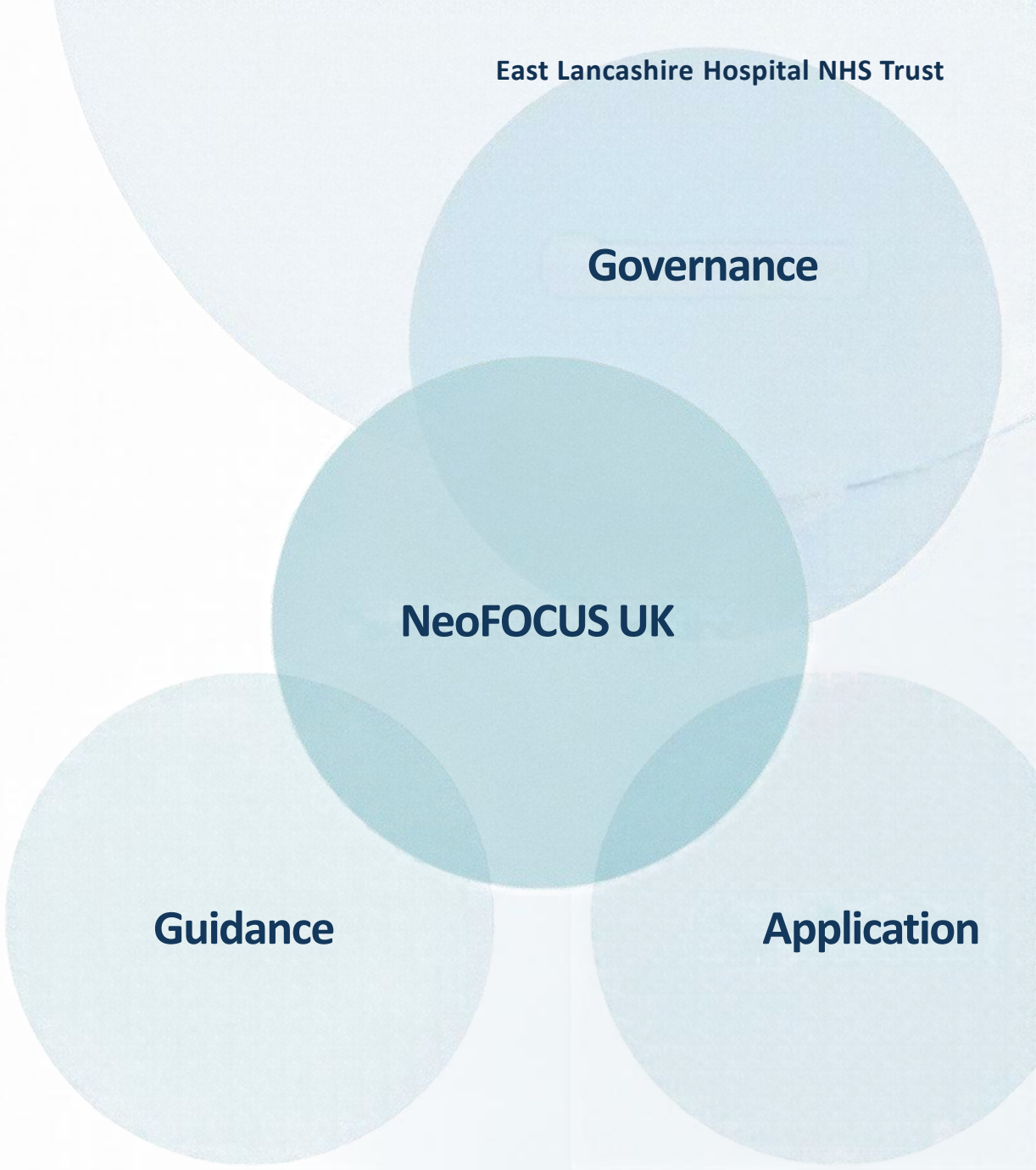
Assess cardiac function, PDA management, and fluid support.

Central-line tips

ore accurate for positioning assessment than X-ray.

Ultrasound needs clear governance

- NeoFOCUS UK oversees governance, guidance, and application nationally.
- Training oversight and competence accreditation remain challenges.
- Interpretation is individualized
- Clear governance structures and radiology support are still needed.



Rapid genetic testing and gentamicin safety (PALOH study)

- A cheek or mouth swab identifies the m.1555A>G mitochondrial variant.
- The variant can cause permanent hearing loss after gentamicin exposure.
- A rapid result can support switching to an alternative antibiotic within the admission golden hour.

25-30

Reported test time

Evidence and adoption of rapid genetic testing

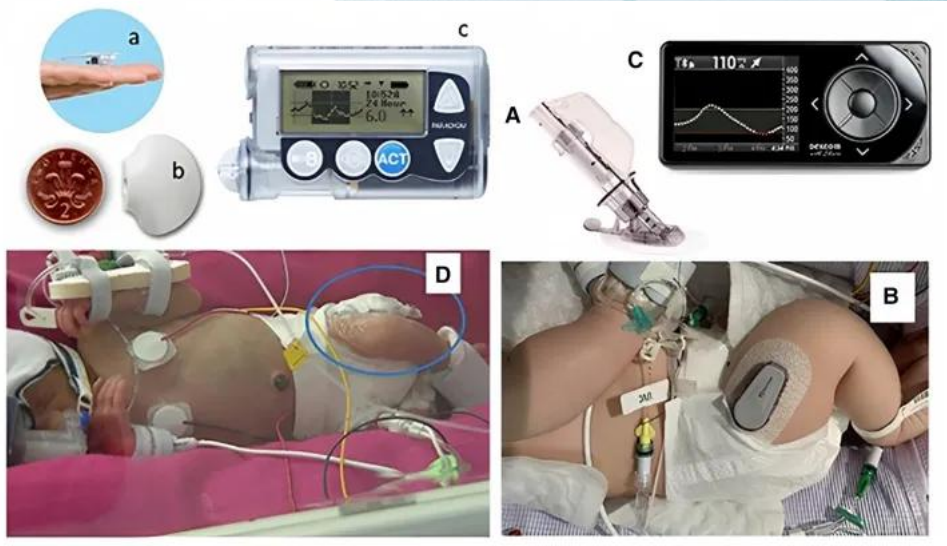
- About 1 in 500 babies carry the m.1555A>G variant.
- PALOH and PALOH-UK studies support rapid bedside testing.
- NICE guidance backs adoption, with trial networks expanded across multiple UK sites.

Adoption is not yet universal.

Glucose monitoring: promise and access

- Randomized trials and feasibility studies provide evidence across term and preterm infants.
- Continuous monitoring can detect silent hypo- and hyperglycaemia.
- Better glycaemic control is a potential benefit.

Routine use remains limited: no licensed devices are available for term and preterm infants.



Transcutaneous monitoring

Bilirubin



Supports community midwives in referring infants for formal bilirubin assessment.

CO2



Routinely used in ventilated NICU infants across gestational ages.

Can reduce the need for blood gas sampling.

Emerging infection and biomarker assays

- UK research explores rapid bedside tests for suspected sepsis and Ureaplasma lung infections.
- Studies include NeoQUACK and specialized device trials at Singleton Hospital, Swansea.
- Samples under study include blood, urine, stool, and respiratory secretions.

Potential decisions:

Targeted antibiotics

Beyond testing- POC algorithms support clinical decision making

Kaiser Permanente score for sepsis

Respiratory severity scores

AI for POC decision making

Types- Rule based machine support, Predictive machine learning, Generative AI and LLM

Core Bedside Applications:

- ❑ Early Sepsis Detection
- ❑ Respiratory Support Optimization
- ❑ Necrotizing Enterocolitis (NEC) Risk
- ❑ Neuromonitoring and Seizure Detection
- ❑ Imaging and Screening



To Summarise

- POCT is evolving rapidly and already routinely used in many forms in the neonatal settings
- Integration of AI can make it more intuitive
- All forms of POC/POCT require central governance , standardization and compliance audit checks

Thank you…

Refreshments & Networking



Chair Morning Reflection



Dawn Johnston
Trustee
British Pregnancy Advisory Service (BPAS)

Keynote Presentation



Caterina Raniolo
Senior Midwifery Leader, Specialising in Quality Improvement | Visiting Professor
Speaking in a personal capacity

Maternity

Building a Culture of Continuous Improvement in Maternity and Neonatal Care

Caterina Raniolo
Senior Midwifery Leader specialising in Quality Improvement | Visiting Professor



The challenges in the real world

Leadership

Instability and turnover • vacancies • loss of continuity • lack of experience

Governance

Ward-to-board visibility • fragmented plans •competing priorities

Workforce

Capacity • skill mix • protected time

Finance, estates & digital

Constraints • restructures and mergers • infrastructure not fit for purpose• digital limitations

Culture

Psychological safety • hierarchy • change fatigue • loss of trust • fear

Equity

Variation • access • whose voice is heard?

The temptation under pressure



Acknowledging constraints is not the same as accepting that nothing can change.

Beware the illusion of improvement

Action completion is not improvement

ACTION COMPLETED

SOP updated
Training delivered
Action turned green

ASSURANCE

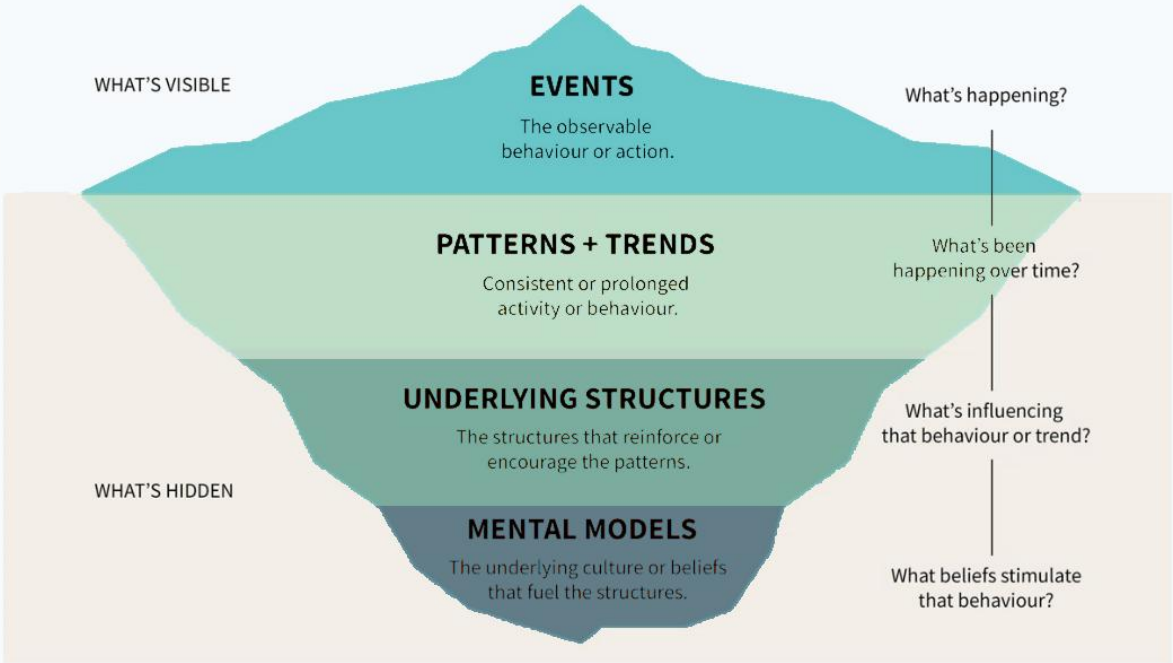
Is the process happening reliably in practice?

IMPROVEMENT

Is care safer, better and more equitable?

Evidence of impact: data over time, women's and families' experiences, and observation of work as done.

Look beneath the event



Events are visible. Patterns, structures and mental models shape what happens.

Systems thinking: look beneath the visible problem

A pathway flows through visible events and deeper system conditions.



Six conditions of system change

EXPLICIT

Policies • Practices • Resources

Visible structures and resource flows

SEMI-EXPLICIT

Relationships & connections • Power dynamics

Trust, influence and whose voice is heard

TRANSFORMATIONAL

Mental models

Beliefs and assumptions shaping behaviour

Reference: Kania J, Kramer M, Senge P. The Water of Systems Change. FSG; 2018.

Making Improvement Everyone's Business

NOT another project owned by a small team → **A shared way of working, built into daily management**

1 LISTEN

Women, families and frontline teams define what matters.

Ask what is working, what is not and what support is needed.

2 ALIGN

Translate national expectations and local evidence into a small number of shared, measurable aims

See the pathway in practice before agreeing the aim.

3 EQUIP

Build practical improvement capability at every level.

Use observation, measures, run charts and SPC to learn.

4 EMPOWER

Give multidisciplinary teams permission, time and support to test.

Remove barriers and close the feedback loop.

5 LEARN & SPREAD

Use data, experience and PDSA learning before wider adoption and continue to monitor afterwards.

Track equity, variation and unintended consequences.

Practical synthesis informed by NHS IMPACT and IHI improvement principles.

Distribute improvement capability, while aligning everyone around a small number of shared priorities.

IHI Psychology of Change: the human side of improvement

Improvement science helps us understand what and how to change. Psychology helps us understand who and why.

1 UNLEASH MOTIVATION

Connect improvement to purpose, values and what matters.

2 CO-DESIGN

Design change with staff, women, families and communities.

PEOPLE CHANGE SYSTEMS

3 AUTHENTIC RELATIONSHIP

Build trust, empathy and collaboration with people closest to the problem.

4 DISTRIBUTE POWER

Give people agency, permission and influence regardless of hierarchy.

5 ADAPT IN ACTION

Act → observe → learn → adapt → test again.

Behave like an improver. Create the conditions for others.

QI is not only a methodology. Leadership behaviour determines whether curiosity, learning and accountability can thrive.

MY BEHAVIOUR

CURIOUS
not certain

GO AND SEE
not only read reports

ASK WHY
rather than assign blame

TEST & LEARN
before implementing at scale

USE DATA
to learn, not simply judge

NOTICE INEQUITY
and share power

THE CONDITIONS I CREATE

FRAME
Connect work to women, babies, families and staff

INVITE
“Consider who is missing in the conversation. “I may be missing something. What are you seeing?”

PROTECT
Make speaking up, testing and failing safe

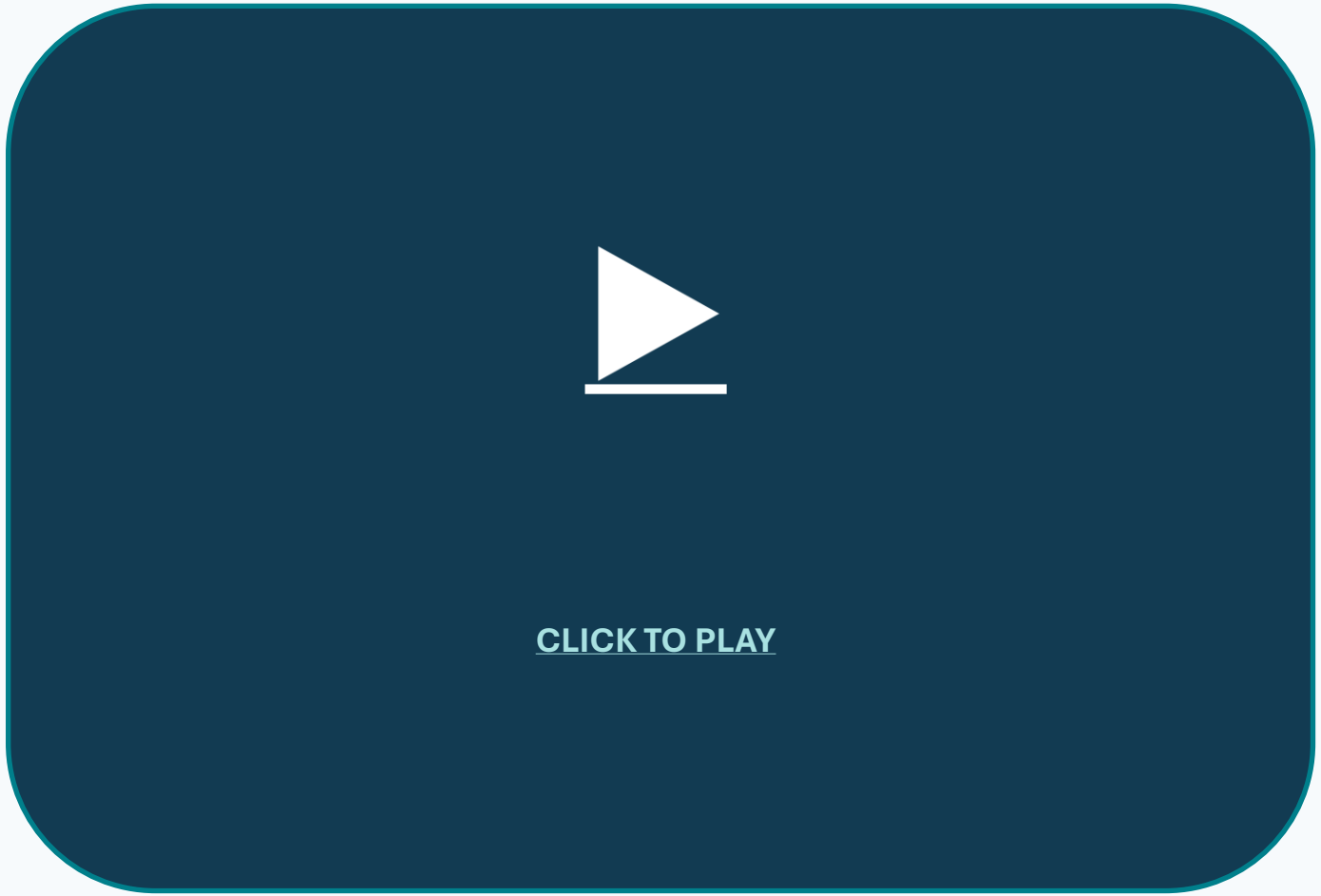
ENABLE
Provide time, data, coaching and escalation

DISTRIBUTE
Move decisions closer to the work

RECOGNISE
Credit contributors and celebrate both learning and successes.

Adapted synthesis informed by Edmondson (2019), Nembhard and Edmondson (2006), and Swensen et al. (2013), with testing principles from the Model for Improvement.

What if nobody said it was impossible?



What becomes possible when people have permission to try?

What will you do differently from now on?

Continuous improvement is not another programme to deliver.

It is a way of working where:

leaders create the conditions

people have capability and permission

women and families are partners

teams test, measure and learn every day

When people are not thriving, ask not only what they need to do differently, but whether we have created the conditions in which they can thrive and improve.

NHS Deep Dive



Nazia Fitzpatrick
Co-Founder and Business Psychologist
Mind Strong Hub

Maternity

NHS DEEP DIVE · 11 NOVEMBER 2026

MIND STRONG HUB

Beyond Process: Building a Culture of Safe Escalation in Maternity Services

Nazia Fitzpatrick

Chartered Psychologist · Co-founder, Mind Strong Hub

We make good work possible when it's hard

Nazia@mindstronghub.co.uk

Who we are

OUR PURPOSE

We make good work possible when it's hard

Most leadership assumes a steadier world than the one leaders are actually in.

1

Psychologist-led

A healthcare leadership and OD consultancy, co-founded by Nazia Fitzpatrick and Carley Brown.

2

Maternity safety

Culture, teamwork and safe escalation in fast-changing, multidisciplinary teams.

3

Who we've worked with

Including NHS England, BOB ICB (three trusts) and Isle of Wight NHS Trust.

Hands up if you've...

01
walked into work with a plan for your day, and within 10 minutes that plan has completely disappeared

02
left a meeting thinking, “We have talked about this before. Why are we still here?”

03
avoided a difficult conversation because you simply haven't had the energy for it

04
become frustrated because someone hasn't done something you asked, despite feeling you'd been perfectly clear

05
seen different professional groups interpret the same situation completely differently

06
realised afterwards that someone had been trying to raise a concern, but it didn't quite register in the moment

Our brains are primed for quick answers

Listen more openly, question, challenge assumptions, consider others' perspectives. We know it. But under pressure, our thinking takes the shortcut.

95%

System 1 · fast

Automatic, intuitive, low energy. Most of our decisions are made here.

5%

System 2 · slow

Deliberate, effortful, high energy. Where we question our first read.

Tired, short of time? System 1 kicks in. We need to be intentional about System 2.

TRY THIS · 1 OF 2

MIND STRONG HUB

FOLK

TRY THIS · 2 OF 2

MIND STRONG HUB

SHOP

MIND STRONG HUB

TURN TO YOUR PARTNER

When was the last time your first interpretation of a situation turned out to be wrong?

Two minutes. What made the first read feel right at the time?

A way to access System 2, for shift teams

1

Not another human factors model

We have plenty of those. Most rely on stability, and we know patients are anything but.

2

Built for patients and healthcare settings

Developed with the realities of clinical work in mind: changing teams, shifting priorities, the unexpected.

3

Not about slowing every decision down

It's about noticing when our automatic thinking needs to be interpreted. The more we do it, the more natural it becomes.

> **We don't need to think faster. Sometimes we need to know how we think.**

CART: why did it make sense at the time?

MIND STRONG HUB

C — Context

Staffing, hierarchy, workload and environment: the conditions around the decision.

A — Adaptability

Non-technical skills: communication, teamwork and situational awareness.

R — Randomness

Unpredictable events: chance, variation and unforeseen complexity. Not an excuse; something to design for.

T — Technical

Clinical knowledge, procedural skill and decision-making.

Nazia@mindstronghub.co.uk

A shift you may recognise: every policy was in place

MIND STRONG HUB

02:10

A triage midwife is uneasy about a woman's observations. The guideline says escalate.

02:25

The registrar is in theatre. The last night-time call to the consultant was met with a sigh.

02:40

She re-checks, documents carefully, and decides to give it another half hour.

03:15

When the concern reaches a senior decision-maker, the window has narrowed.

Your first read: why didn't she escalate at 02:10?

Illustrative composite, not a real case

C Context

Staffing, hierarchy, workload and environment: the conditions around the decision.

C

ASK THE ROOM

Who felt able to challenge whom?

What assumptions did she make?

What else got in the way?

WHAT COULD BE HAPPENING

Hierarchy: who feels 'allowed' to wake the consultant at night?

Environment: the last night-time call was met with a sigh

Staffing and workload: registrar in theatre, triage busy, little slack at 02:00

A Adaptability

Non-technical skills: communication, teamwork and situational awareness.

A

ASK THE ROOM

Was the risk clear to all?

How did we work together as the landscape changed?

Is there clear shared language to land that concern?

WHAT COULD BE HAPPENING

Situational awareness: did anyone else share her picture of the risk?

Teamwork: was there a shared Plan B, or was she deciding alone?

Communication: could she voice the concern in a way that would land?

R Randomness

Unpredictable events: chance, variation and unforeseen complexity. Not an excuse; something to design for.

R

ASK THE ROOM

What couldn't we have predicted?

Was this chance, or a familiar pattern?

What would help us absorb it next time?

WHAT COULD BE HAPPENING

Chance: a theatre case and a triage concern collided at the same moment

Variation: every woman presents differently, were there any early deterioration signs?

Unforeseen complexity: what other information was needed at 02:10?

T Technical

Clinical knowledge, procedural skill and decision-making.

T

ASK THE ROOM

Did we have the knowledge to spot it early?

Were the steps clear and practiced?

What shaped the decision? What was missing?

WHAT COULD BE HAPPENING

Clinical knowledge: how experienced was she in recognising this deterioration?

Procedural skill: did she know the escalation steps with the registrar unavailable?

Decision-making: why did 'another half hour' feel like the right call?

Questions for your team

C Context

- Who felt able to challenge whom?
- What assumptions did she make?
- What else got in the way?

A Adaptability

- Was the risk clear to all?
- How did we work together as the landscape changed?
- Is there clear shared language to land that concern?

R Randomness

- What couldn't we have predicted?
- Was this chance, or a familiar pattern?
- What would help us absorb it next time?

T Technical

- Did we have the knowledge to spot it early?
- Were the steps clear and practised?
- What shaped the decision? What was missing?

Nazia@mindstronghub.co.uk

Take a CART card with you

Pick one up on your way out, to use at your next huddle, handover or debrief.

FRONT

The CART model, with a reflective question for each element and a ten-minute Reveal, Rethink, Reinforce debrief.

BACK

Details of the free Maternity Leadership Roundtable on Friday 20 November.



Nazia@mindstronghub.co.uk

CONTINUE THE CONVERSATION

Maternity Leadership Roundtable

A small, free, facilitated conversation for maternity leaders: what is really stopping safe escalation becoming everyday behaviour, and where to start.

Friday 20 November · 12:30–14:00 · Online

No more than 10 · Up to two places per trust

nazia@mindstronghub.co.uk



Scan to register interest

We make good work possible when it's hard

Nazia@mindstronghub.co.uk

Keynote Presentation



Marianne Quinn
Lead Midwife, SE Genomic Medicine Service
Guys and St Thomas's



Nicky Scott
Communication and Involvement Lead, SE Genomic Medicine Service
Guys and St Thomas's

Maternity

Service Improvement: Improving the equitable access to genetic testing after recurrent miscarriage?

NHS
South East
Genomic Medicine Service

Why are we doing this?

The background

- 1 in 4 pregnancies will end in miscarriage
- Predicted that over 250,000 pregnancies will end in miscarriage each year in the UK (Tommy's baby charity), accounting for over 50,000 hospital admissions (NICE, 2023)
- Approximately 1% of women will suffer 3 or more miscarriages- known as recurrent miscarriage
- Several reports have highlighted significant gaps in the care pathway



Genetics behind recurrent miscarriage

- 60% of miscarriages are associated with an underlying genetic cause in the baby
- Women who experience three or more miscarriages are eligible for genetic testing of pregnancy-loss tissue, which can provide valuable information about the cause of miscarriage and inform future care
- The South East Genomic Medicine Service continuously reviews genetic testing data to ensure that genetic tests are being offered equitably
- Our partners in Clinical Genetics raised concerns with us because they felt they were receiving lower than expected referrals following recurrent miscarriage. We wanted to understand if that was the case, and if so, what was causing it

What were we aiming to achieve?



Understand the barriers to genetic testing following multiple miscarriages

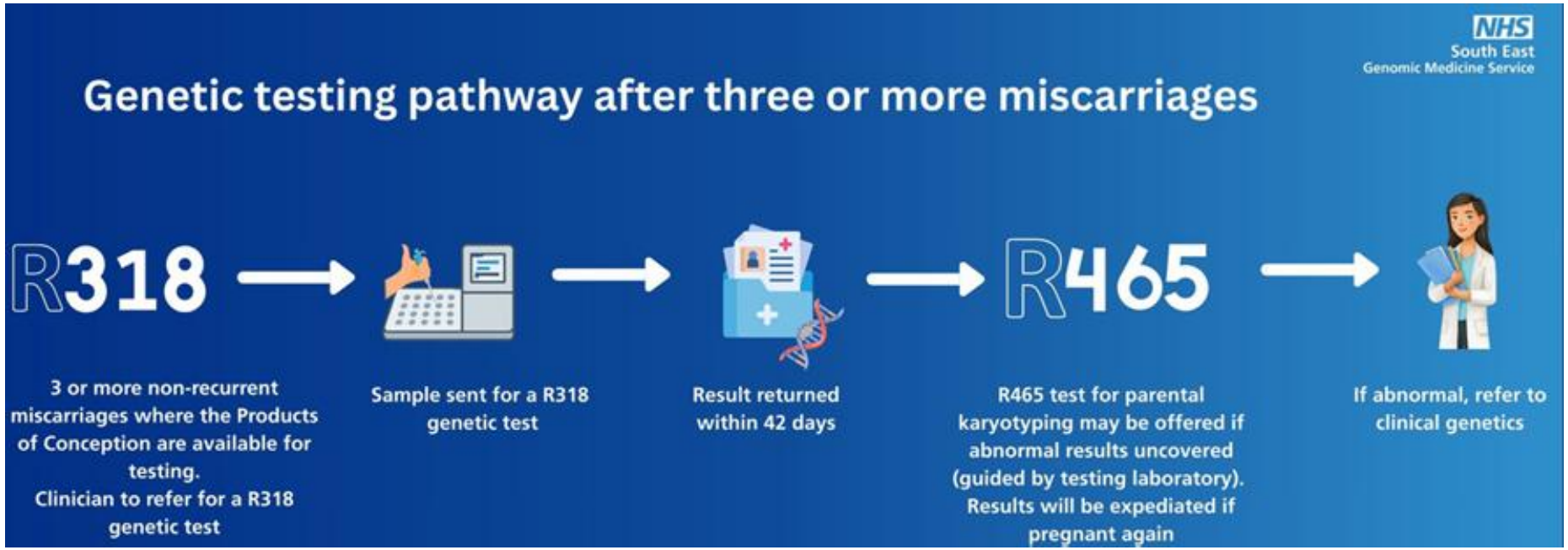


Understand what information & support is available to people and professionals

Defining the issue

Mapping the pathway

Visualise end to end clinical pathway for genetic testing of pregnancy loss tissue, and identify key stakeholders



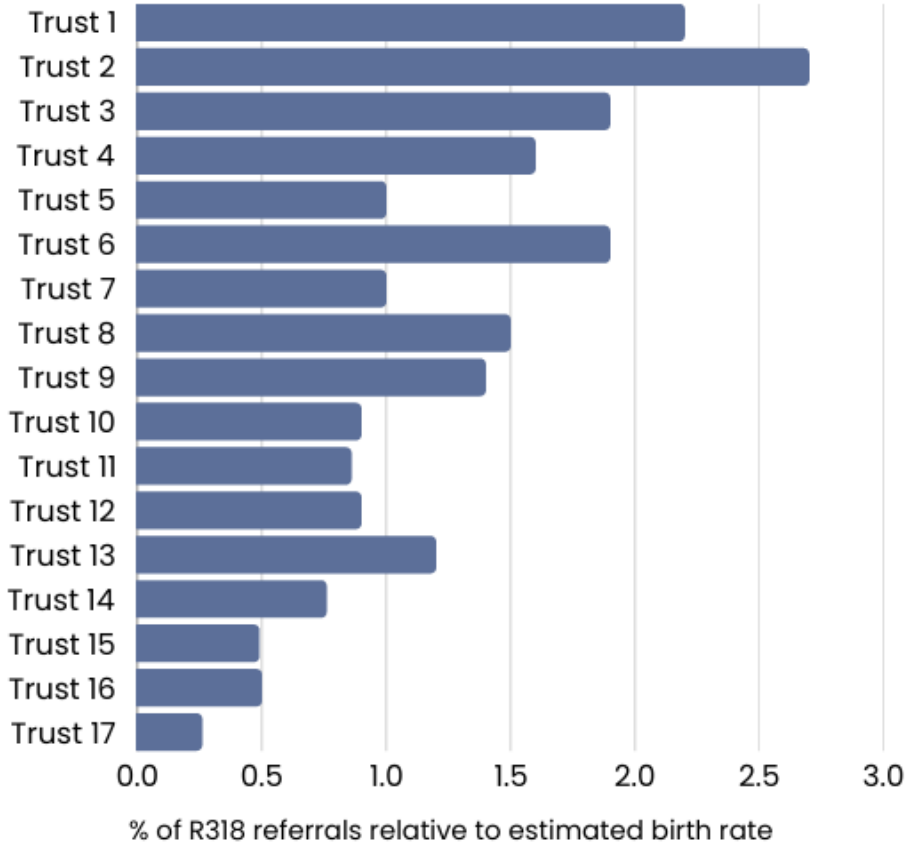
Scoping the issues

- 10 women
- 10 healthcare professionals
- Laboratory colleagues
- National charities
- Data review



What did the data tell us?

- Lack of national data set a barrier
- Referral data from each trust across the SE evidences **inequity**
- Laboratory is **rejecting** 16% of pregnancy tissue samples because they are unsuitable samples.
- Causing **poor patient and professional experience**



What did healthcare professionals tell us?

We interviewed 10 healthcare professionals. Their honest feedback was reviewed and thematically analysed.

THE HEADLINES were



Better education for professionals needed



Lack of information about how to identify suitable samples



Support needed to understand genetic reports



Patient information needed to explain genetic testing and miscarriage

“I have seen clinicians shy away from having conversations about recurrent miscarriage and genetic testing. It is such a sensitive topic, so without training on how to have these conversations and why we are offering this testing, I can understand why clinicians avoid it”.- EPU nurse

“We have so many families who are desperate and angry they are not eligible for genetic testing. As clinicians we need to be able to signpost them to why this is the case, but we have nothing.”

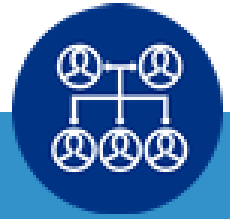
What did women tell us?

We listened to 10 women who shared their personal experiences.

THE HEADLINES were



Women are not routinely offered genetic testing



Women forced to advocate for themselves to get genetic testing



Better education for professionals needed



Lack of suitable information for women

"I was given no information, no support. I have had to find the answers for myself."

"After three miscarriages, I expected my care to become more proactive and to get help to find some answers. It didn't."

"I wish someone had told me what to expect and then I might not have felt so alone."

"Information would have given me back some control."

The power of partnerships

The Association of Early Pregnancy Units

Miscarriage UK

Because every loss matters

NHS South East Genomic Medicine Service

Creating the solutions

We want to see change

- Patient friendly information is needed for women who are facing multiple miscarriages to explain the options available to them

- There is an urgent need to educate and support healthcare professionals who see and care for women after, or during, miscarriage

Driving that change

Work with us to improve equitable access to genetic testing after recurrent miscarriage

- REPORT LAUNCH detailing clinical perspective & lived experiences of women
- Hear from clinical experts, testing laboratory & patients
- Be part of the discussion about how we can improve

Be Part of the Solution

Thursday November 19th from 12 -1.30pm

All NHS staff in England are welcome.

Scan the QR code to sign up

NHS South East Genomic Medicine Service

NHS Genetic testing after three miscarriages

If you have had three or more miscarriages, you are eligible for genetic testing on pregnancy loss tissue. This is to understand if there is a genetic reason that might help to explain why.

What do we mean by recurrent miscarriage?

Recurrent miscarriage means the loss of three pregnancies before 24 weeks' gestation. This includes any chemical pregnancies (very early miscarriages that usually happen in the first five weeks), but does not include ectopic pregnancies.

Your losses don't all need to be with the same partner, and you may have had a successful pregnancy in between.

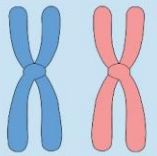
What do we mean by genetics?



We have 2 metres of DNA in almost every cell in our bodies.



Genes are small sections of DNA. We have around 23,000 genes which dictate who we are, what we look like and how our bodies work.



Genes are arranged into large structures called chromosomes. We inherit 23 chromosomes from each parent.

Research shows that up to 60% of early miscarriages are caused by a genetic change in the pregnancy.

Miscarriages caused by a genetic change in the pregnancy are usually due to a change in the number of chromosomes which means the pregnancy miscarries. The most well-known chromosomal change is Down syndrome which is caused by an additional copy of chromosome 21. Any changes to the number of chromosomes will often result in early pregnancy loss.

Although we know genetic changes are common causes of miscarriages, they are usually random events with no increased risk to future pregnancies. More information here.

A note about language

This leaflet explains what genetic testing means and how it works. We've created this leaflet in partnership with women who have had personal experience of multiple miscarriages and genetic testing. We have chosen our language very carefully but we recognise that everyone will have very personal preferences.

The art of the possible : what have we learnt?

What have we learnt?

- End to end pathway engagement to drive change at all levels
- Relationships are key & require investment of time
- Supporting a culture of positive change
- Small changes can have a big impact

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“

Thank you to you for giving us a voice and really hearing us.

Jessica, following multiple miscarriages



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Genomic Medicine Service

Get in touch. We'd love to hear your thoughts.

Nicky.scott7@nhs.net

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Lunch & Networking



Chair Afternoon Address



Dawn Johnston
Trustee
British Pregnancy Advisory Service (BPAS)

NHS Deep Dive



Dr Denise Chaffer
Health Care Leadership Consultant
Denise Chaffer Consulting

Maternity

Dr Denise Chaffer CBE

From service review to implementation

Sharing learning for Improvement


Start with the end in mind.
Stephen R. Covey
quotefancy

Sample of Inquiries /reviews 2001 – 2025

2001	Sir Ian Kennedy Bristol Inquiry reported significant failings in care and called for a change in the culture of the NHS.
2013	The Francis full public inquiry report is published. The report shows significant failings and neglect of patients.
2013	Government responds to Francis Inquiry.
2013	Don Berwick invited by the prime minister to review the Francis report. Berwick's (2013) Commitment to Learn published.
2015	The Morecambe Bay Investigation Report independent public inquiry conducted by Bill Kirkup
2020	Paterson inquiry
2022	Kirkup inquiry – East Kent Hospitals University Foundation Trust
2022	Ockenden inquiry Shrewsbury and Telford Hospital NHS Trust
2023	Ockenden inquiry Nottingham university NHS Trust
2023	Thirlwell inquiry Countess of Chester Hospital NHS Trust (Re Lucy Letby Case)

The core components of report

This report had five key components:

- **The voices of families** – Many views were presented in their raw form and there is also a section which analyses many aspects of feedback to establish themes;
- **The clinical review of cases** – This detailed review was undertaken by experienced independent clinical experts;
- **Governance and culture** – A ward to board review of systems, processes and controls.
- **Staffing and leadership** – Throughout both services.
- **Data and context** – Many contextual aspects including staffing numbers, demographic risk data, incident numbers and outcome data.

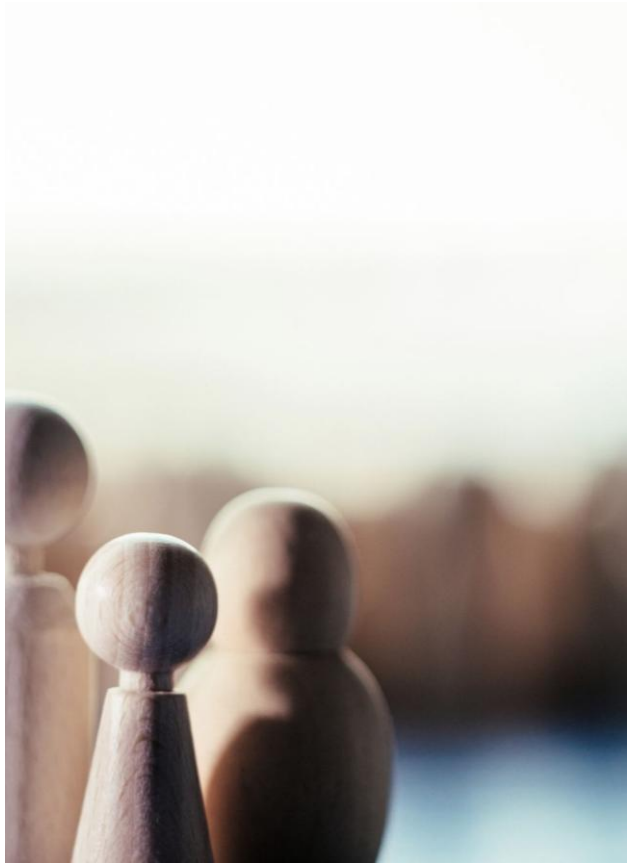


Clinical care/ safety critical factors

- Triage - research evidence
- Induction of labour prioritisation
- 2 site working , risk mitigation, Early Warning Scores , job planning
- Multi Disciplinary Training
- Investigations / learning/ actions
- Senior level supervision / oversight
- Escalation / raising concerns

Family engagement

- Response to harm
- Decision making and consent
- Investigations and learning
- Birth trauma
- Culture / behaviours , cultural and diversity awareness



Family feedback themes

- Access to care
- Feeling ignored
- Birth trauma
- Decision making
- Communication
- Compassion
- Birth partner



Birth Trauma

Birth Trauma Report - Theo Clarke 2024

“Birth trauma is not only about what happens physically during childbirth , but also how women are treated, listened to and supported before, during and after childbirth”

Workforce/ leadership / education / training

- Compassion / culture/ cultural awareness
- Behaviours
- Trauma informed care
- Education and training monitoring



Governance / systems / structures / guidelines

- Complaints/ incidents/ claims processes
- Board reporting
- Structures and processes
- External relationships and reporting

What do people expect?

What do patients and families want?

- An apology
- To prevent it happening to someone else
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Signposting to support where appropriate

What do staff want?

- Help to say sorry
- To prevent it happening to someone else
- To understand what went wrong
- To have answers and be heard
- Compassion, understanding and support
- Signposting to support where appropriate

Restorative Justice

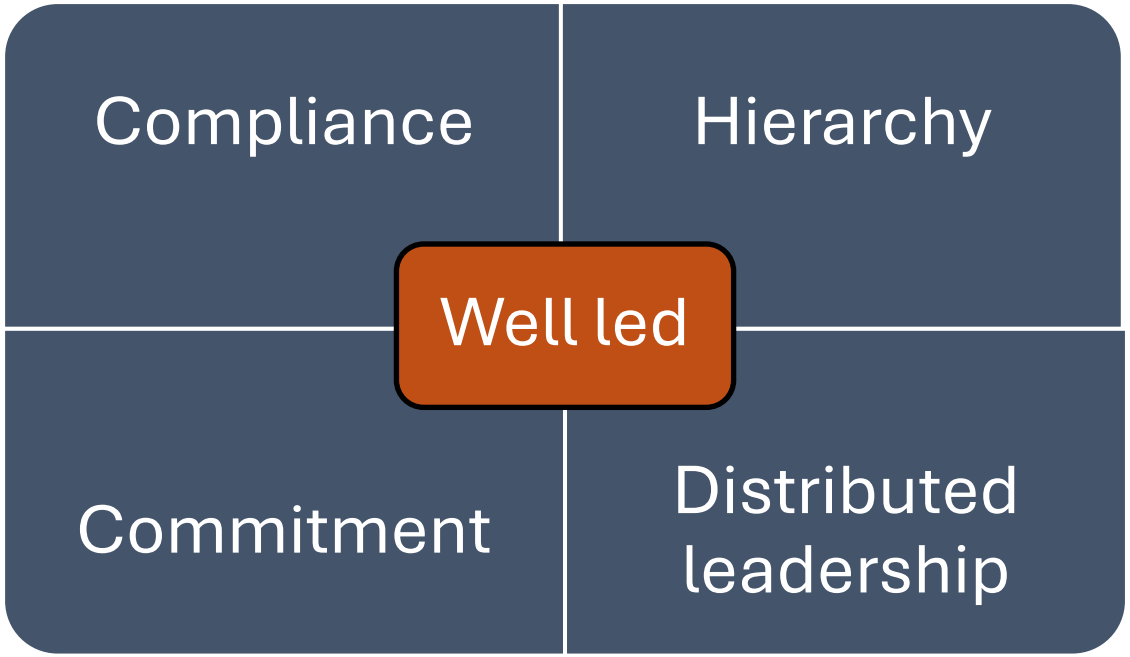
REPLACE FEAR AND BLAME WITH

ACKNOWLEDGMENT AND ACCOUNTABILITY

After Martha – Paul Laity on a preventable death (London Review of Books vol 47. No 17 25 Sept 2025)’

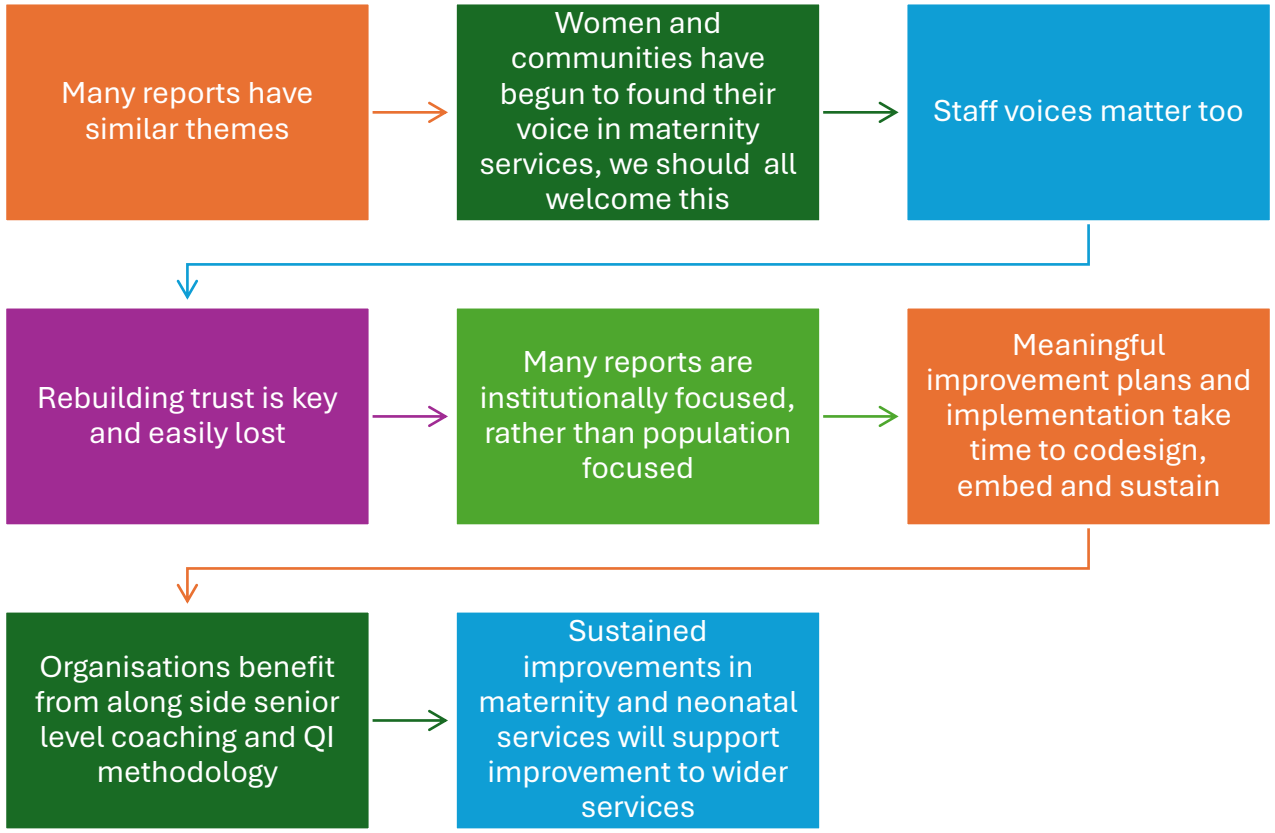
‘**All doctors get things wrong. What matters hugely to families in our position is that they have the courage and humility to admit their mistakes**’

Traditional organisation	Learning organisations
Vision imposed on organisation	Shared vision & values
Managing and organising	Staff engagement
Control and compliance	Staff commitment
Hierarchy	Distributed leadership

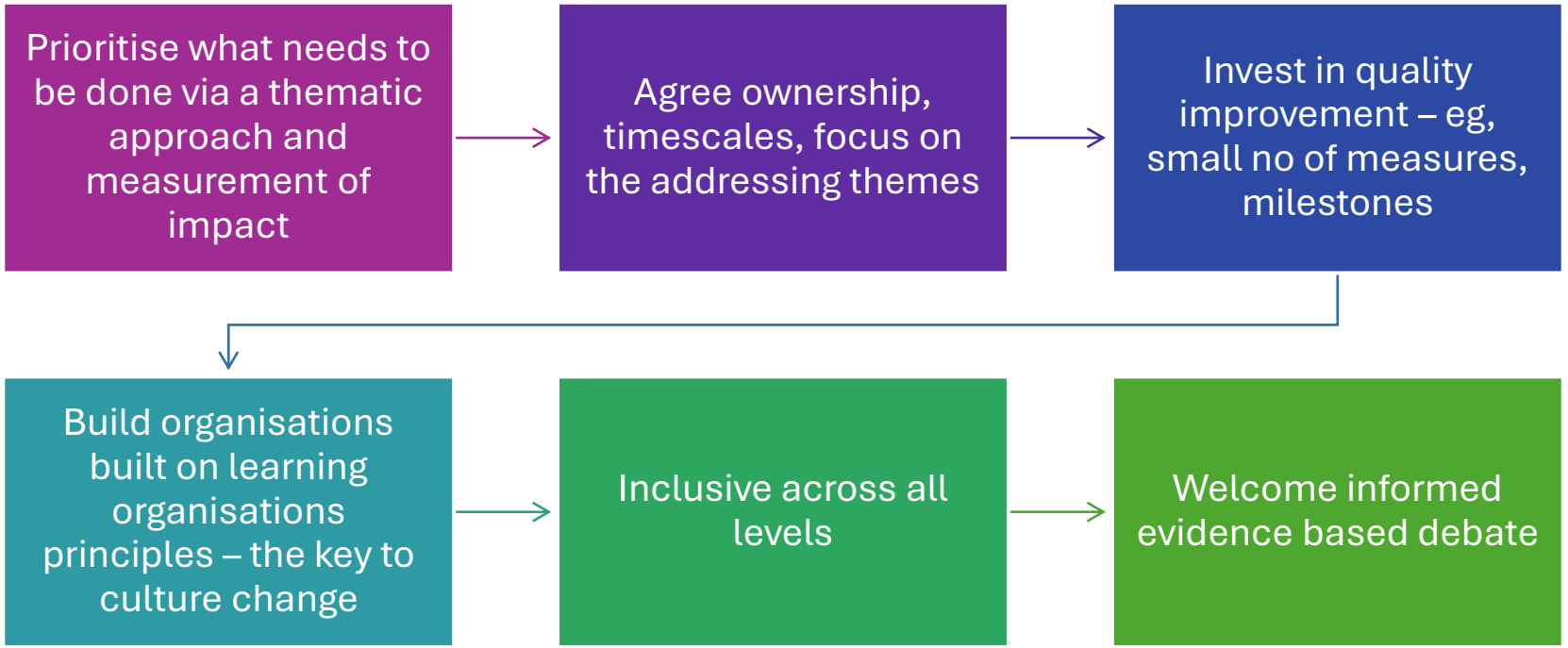


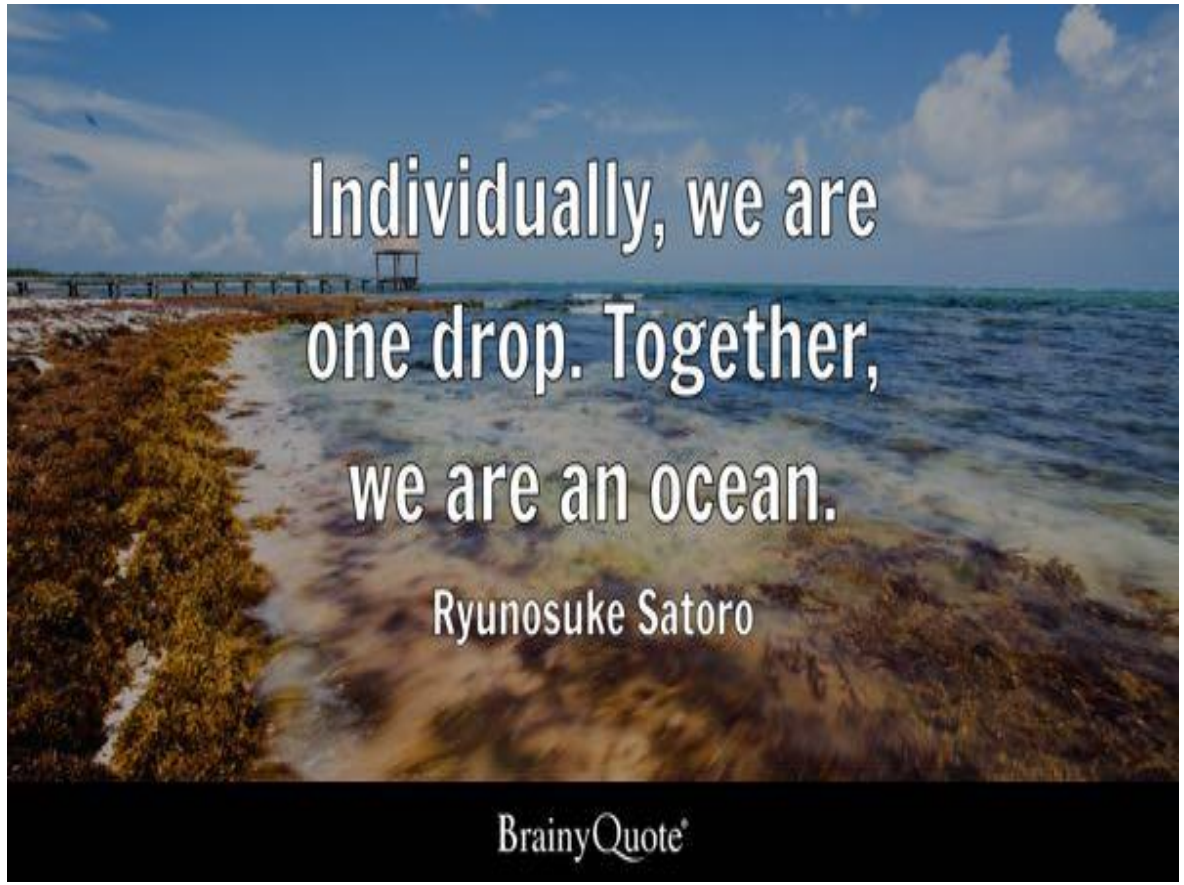
Balancing polarities for being Well led (Chaffer 2019)

Reflections a year on .....



Focusing on the ‘how’ to move recommendations to implementation and ensure sustainable change




Individually, we are
one drop. Together,
we are an ocean.
Ryunosuke Satoro
BrainyQuote

The Independent Review of Maternity and Neonatal Services at Swansea Bay University Health Board (July 2025)

- **https://sbuhb.nhs.wales/files/independent-review-maternity-and-neonatal-services/sbuhb-mns-independent-review-pdf**

Useful References – triage

https://pmc.ncbi.nlm.nih.gov/articles/PMC12399223/

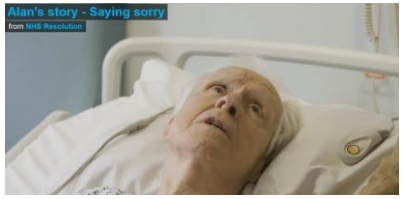
Abdalla Elsheikh NE, M Osman HM, Alfaki Ahmed SA, Elsamani Mohamed SA, Alhessen Saidahmed RO, Awad Eltalkhawy RSS, Ahmed Elbashir HM. **Effectiveness and Implementation of Obstetric Triage During Pregnancy and Childbirth**: A Systematic Review. Cureus. 2025 Aug 1;17(8):e89215. doi: 10.7759/cureus.89215. PMID: 40895699; PMCID: PMC12399223.

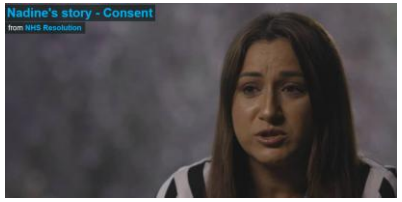
RCOG publishes Good Practice Paper on Maternity Triage -https://www.rcog.org.uk › news › rcog-publishes-good-...

NHS England New National Maternity Triage Specification set by NHS ...

Sharing learning resources: NHS Resolution



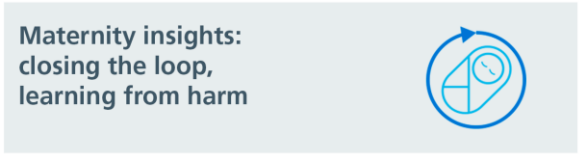






Case story
Better joint working and specialist help benefits patients, families and the NHS

elfh **Maternity insights: closing the loop, learning from harm**



Workshop



Dr Denise Chaffer
Health Care Leadership Consultant
Denise Chaffer Consulting



Elizabeth Rix
Executive Director of Nursing & Patient Experience/Deputy Chief Executive Officer
Swansea Bay University Health Board

Maternity

Chair Closing Remarks



Dawn Johnston
Trustee
British Pregnancy Advisory Service (BPAS)