Fetal Abnormality Referral UHL Obstetric Guideline

University Hospitals of Leicester NHS
NHS Trust

Trust ref: C87/2005

Contents

1. Introduction and who the guideline applies to:

This guideline is intended for the use of all medical, midwifery, Sonographers and nursing staff involved where there is an identified or suspected fetal abnormality. This guideline describes the process of how this is achieved.

Background:

It is essential that there is good communication between the team caring for a family where there are identified fetal abnormalities, both before and after the child's birth. This will ensure that all relevant obstetric, fetal and neonatal history is available.

Related documents:

- **Ultrasound UHL Obstetric Guideline**
- **Congenital Abnormalities of the Kidney and Urinary Tract UHL Neonatal Guideline**
- **Postnatal Ward Handbook UHL Neonatal Guideline**

2. Recommendations:

2.1 Any fetal anomalies suspected

Any fetal anomalies suspected at any time during pregnancy should be referred to the fetal medicine consultants. If this is a potentially life limiting or one of the 11 FASP auditable conditions this should be within 3 working days.

Normal variant: If one or more of the normal variants listed below are seen, the woman does not need referral for further assessment as part of the NHS FASP:

- choroid plexus cysts
- dilated cisterna magna
- echogenic foci in the heart
- 2 vessel cord

However, the scan findings listed below need to be reported and the woman referred for further assessment according to local guidelines:

- Nuchal fold (greater than or equal to 6.0mm) - refer to FM between 5-7 days
- Echogenic bowel (with density equivalent to bone – ensure GAIN settings correct when assessing this) – in 5-7 days
- Renal pelvic dilatation antero-posterior (AP) measurement (greater than 7.0mm) – see in FM within 7-10 days
- Estimated Fetal weight under 10th centile for gestational age - see in FM between 5-7 days
- All long bones under the fifth centile for gestational age refer to FM within 5 working days

- Head circumference under fifth centile (on viewpoint system) for gestational age – refer to FM within 5-7 days
- Ventriculomegaly – refer to training video in this link: Fetal Ventriculomegaly training and if required refer to FM within 5 working days

If several of these anomalies are seen on scan the referral to Fetal medicine should be within the standard 3 working days.

- Confirmed Fetal anomalies identified in the antenatal period should be recorded on the "Paediatric alert form". The Paediatric Alert Form should be filed in the neonatal alert folder (a central register if anticipated cases) on the Neonatal Unit according to the month of anticipated delivery or captured electronically.

- **Significant** fetal anomalies should be the subject of multidisciplinary consultation / discussion during the antenatal period.

- At the LRI appointment slots with the ADAM (antenatally detected anomalies meeting) Clinic will be available on the 1st and 3rd Thursday morning of each month for couples to meet with relevant professionals at the same time. This is open to patients from both the LRI and LGH. The lead clinician will be responsible for assessing the need for patients to attend this clinic and to organise the appointment at the appropriate gestation.

- Where it is not possible for patients from the LGH to be integrated into ADAM Clinic, alternative arrangements should be organised at the LGH using the same principles of a multidisciplinary approach.

- Cases referred from outside UHL requiring delivery at UHL will be assessed and a decision made for when it is appropriate to refer to the ADAM clinic. The lead clinician will need to decide on optimum time and mode of delivery.

- Where referral outside the UHL Trust is required, this will be the responsibility of the lead Fetal Medicine Clinician.

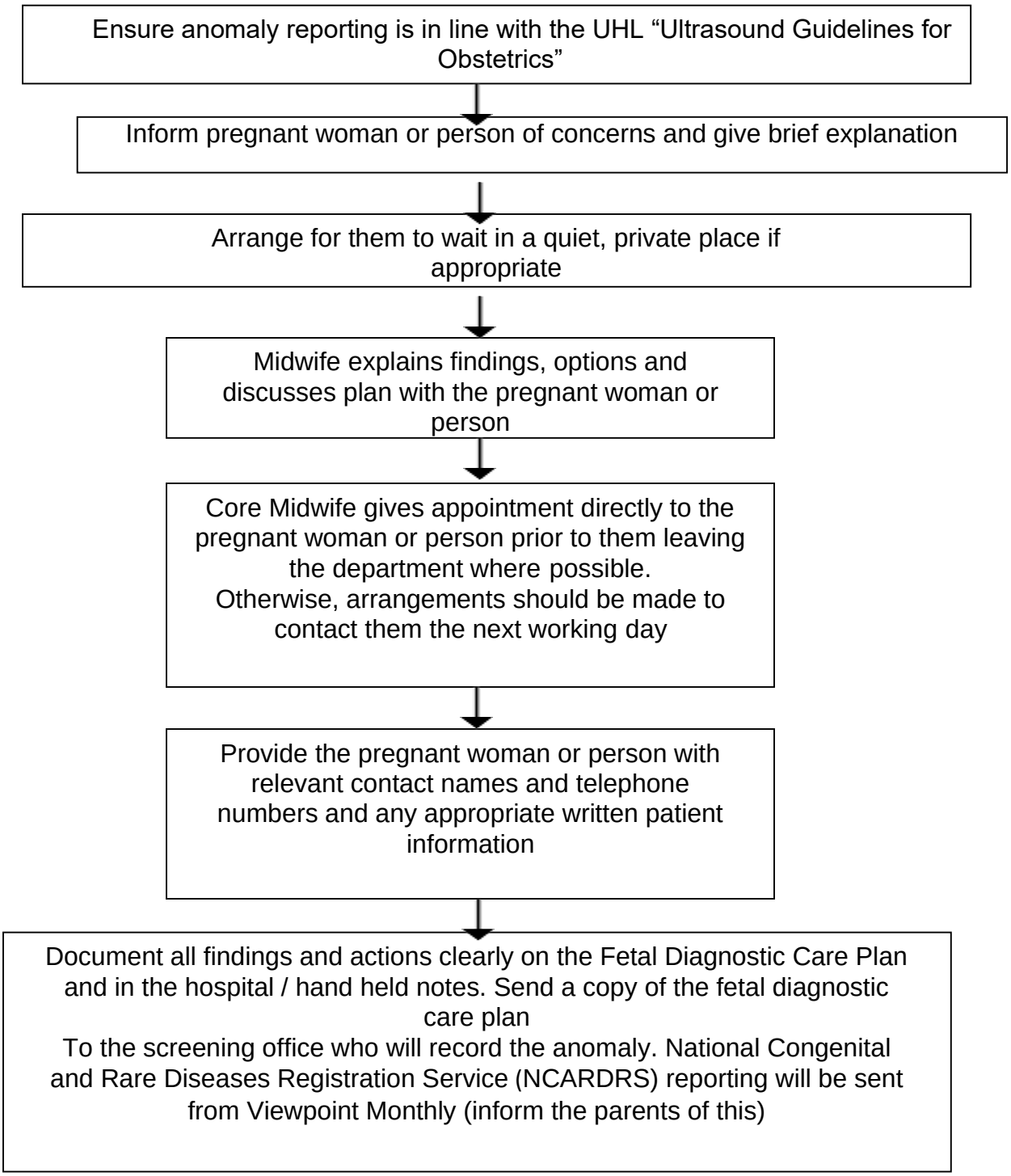
- All cases should be followed up by review from the Neonatal Clinical Team.

- All discussions with parents and management plans should be documented in the patient's notes and on the Fetal anomaly intrapartum care plan.

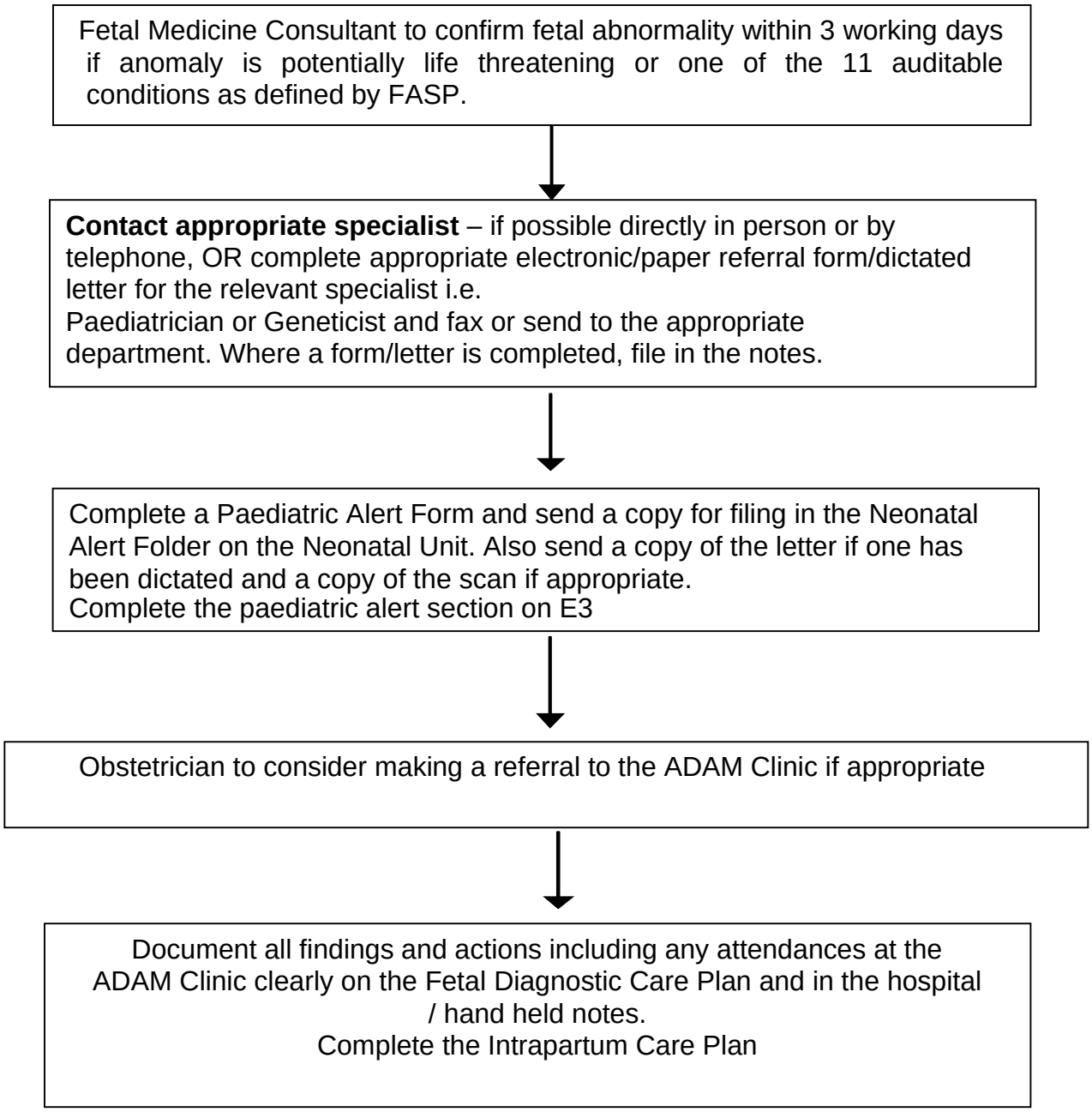
- Cases that will require palliative care should be seen by neonatal team. A clear plan is included in the notes with guidance regarding mode of delivery and fetal monitoring in labour.

Flowchart 1: for referral by sonographer

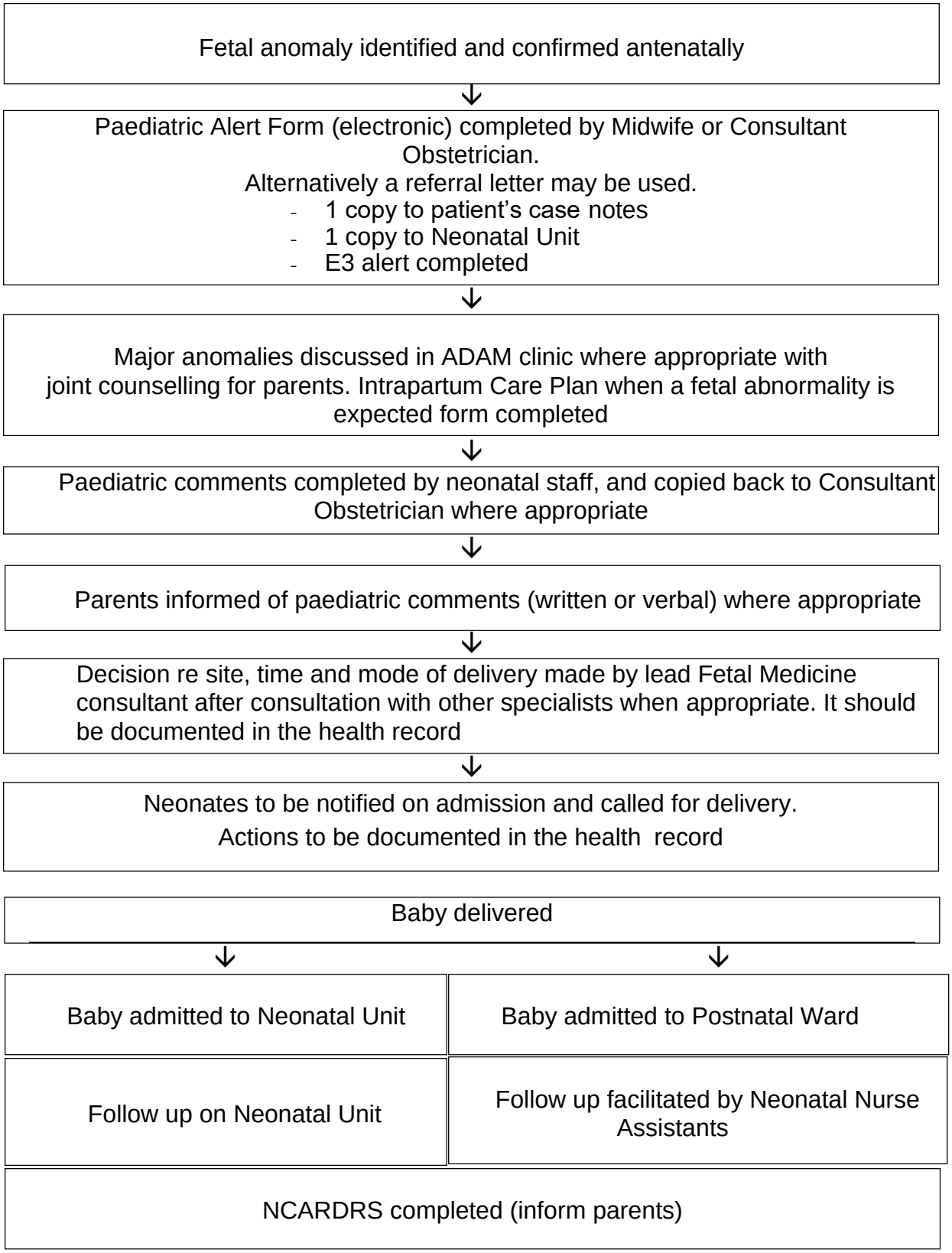
Flowchart for referral by Sonographer following detection of fetal anomaly (with the exception of women who will need to follow the **renal protocol**)



Flow chart 2: Communication pathway between obstetric staff and specialist staff within or outside UHL following diagnosis / confirmation of a fetal anomaly:



Flow chart 3: Summarising system for communicating fetal abnormalities to and from the Neonatal staff:



2.2 Confirmed anomalies

All confirmed fetal anomalies identified in the antenatal period should be recorded on the 'electronic paediatric alert form'.
All paper paediatric alert forms/referral letters should be filed on the Neonatal Unit according to the month of anticipated delivery.

- Paediatric alert form / referral letter to be completed by either the midwife or obstetrician.
  - 1 copy to be placed in patient's case notes
  - 1 copy to be sent to Neonatal Unit

- Information about the plan of care should be communicated to the parents either by a copy of the paediatric alert form, or verbally at the next antenatal appointment.

- On receipt of the paediatric alert form/referral letter by neonatology, a plan of care should be documented by the neonatal staff and then copied back to the consultant obstetrician.

- Alert forms / letters should be filed according to the expected month of delivery.

- Registers should be kept at both the LGH and the LRI Neonatal Unit.

2.3 Significant fetal anomalies

Significant fetal anomalies should be the subject of multidisciplinary consultation/ discussions during the antenatal period.

- The fetus with a significant anomaly, such as major structural problems or chromosome disorders present with multiple problems.

- It is important that management plans involve a multidisciplinary team to ensure:

  - appropriate and relevant information is given to the parents and

  - a clear management plan for the pregnancy and subsequent neonatal care of the fetus is agreed and documented.

2.4 Antenatal care

- At the LRI appointment slots for the ADAM clinic are generally available on the 1st and 3rd Thursday morning of each month for couples to meet with relevant multidisciplinary professionals at the same time. This is open to patients from both the LRI and LGH

- This will allow a comprehensive and agreed clinical management plan to be given to the parents so expectations are better informed.

- All correspondence arising from this clinic should be copied into the maternal notes.

- Correspondence to be addressed to the parents with appropriate health professionals copied into letters.

- Where it is not possible for patients from the LGH to be integrated into the ADAM clinic, alternative arrangements should be organised at the LGH using the same principles of a multidisciplinary approach.

- It is recognised that the current geography of perinatal services does not allow for easy access for patients from the LGH to the multidisciplinary clinic service at the LRI in all circumstances.

- Where it is not possible to do so arrangements should be available for parents of a fetus with a major anomaly to meet with appropriate individuals for counselling.

- Where possible this should be done as a joint multidisciplinary meeting to allow for detailed and balanced discussion as well as development of appropriate management plans for the infant.

- Special attention should be made to refer all major surgical anomalies to the LRI clinic as these infants will ultimately need care at the LRI.

2.5 Cases referred from outside UHL

- Cases referred from outside UHL Trust and require delivery at UHL will be assessed and a decision is made for appropriate referral to ADAM clinic. Lead clinician will need to decide on optimum time and mode of delivery.

- Cases with fetal cardiac or surgical anomalies who are referred from outside UHL to be assessed and delivered at UHL will need formal assessment by the team and decision of optimum time and mode of delivery.

- Neonatal alert to be completed.

- Formal referral form to be completed by the referring hospital to provide information about maternal health and past medical and surgical history.

- Team to evaluate appropriate referral to ADAM clinic.

- Where referral outside the UHL Trust is required, this will be the responsibility of the lead Fetal Medicine Clinician

- UHL is a tertiary referral centre; however, for certain conditions, advice and treatment

is currently sought outside the Trust (e.g. laser ablation in TTTS, cleft surgery, neurosurgery).

- Where this is the case, the Lead Fetal medicine Clinician is responsible for making appropriate referrals to relevant specialists. This is often initiated verbally (phone etc.), however a written referral should be made in all cases either in letter format or clear documentation in the patient's handheld notes.

- Appropriate follow up arrangements should be made to ensure that the advice from the specialist outside the Trust is implemented and acted upon.

2.6 Follow up

- All cases should be followed up by review from the neonatal clinical team

- Babies, who are considered unwell at birth or at high risk, will be admitted to the Neonatal Unit following clinical evaluation by the neonatal medical team.

- Babies who are considered well at birth will remain with their mother, and will be transferred to the postnatal ward. These infants should be seen by a medical member of the Neonatal team prior to discharge.

- The Neonatal Nurse Assistants will facilitate the review of well babies on the postnatal ward.

2.7 Documentation

- All discussions with parents and management plans should be documented in the patient's notes.
- Documentation of all actions taken discussion with the parents, referrals and antenatal, intrapartum and postnatal management plans should be made in the patient's handheld notes, or hospital folder if appropriate.

- These should include multidisciplinary advice and neonatal management plans

- The primary care team should be kept informed where appropriate

2.8 Cases requiring palliative care

- Cases that will require palliative care should be seen by neonatal team. A clear plan is included in the notes with guidance regarding mode of delivery and monitoring in labour.

- Cases that diagnosed with major multiple malformation and/or major choromosomal problem that is un-survivable anomaly will need careful counselling by neonatal team.

- The Lead Fetal Medicine consultant will need to provide clear plan regarding time and mode of delivery. Special attention should be directed towards management if admitted

with fetal distress or in labour.

- Fetal medicine consultant to document monitoring in labour and optimum approach for fetal distress.

- Neonatal team will need to provide clear plan regarding the management in the first 24 hours and when baby will be discharged out of hospital.

3. Education and Training

- Antenatal and newborn screening mandatory training for midwives and children's/neonatal nurses

- Induction training for midwives, MCA's and Obstetricians

4. Monitoring criteria

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Reporting of FASP standard 8	Audit	Fetal medicine Cons/AN services manager	Annual	National programme centre.
Copy of the Paediatric alert form or letter should be filed in the neonatal alert folder on the neonatal unit	Audit	Fetal medicine Cons/AN services manager	Annual	
Documentation; • of contact between Obstetric team and Neonatologists /other specialists as appropriate • that patient has been seen by appropriate specialist • that patient was seen in ADAM or another centre (e.g. neurosurgery, outside Trust) if appropriate. • Discussion with the woman about the abnormality should be documented	Audit	Fetal medicine Cons/AN services manager	Annual	

5. Supporting References

NHS England September 2021. FASP standards:
https://www.gov.uk/government/publications/fetal-anomaly-screening-programme-standards

6. Key Words

Pregnancy, Fetal abnormality, Anomaly, Paediatric referral, Intrapartum care plan, Cardiac

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT	
Original Author L Matthews and M Bodley **Lead Officer:** H Ulyett ANNB Screening Midwife and H Mousa Consultant in Fetal Medicine	**Executive lead;** **Chief Nurse**

REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
November 2020	1		
February 2024	3	H Ulyett and T Mousa	Cardiac referral and intrapartum care plan form added. Changes to timeline of referrals for less serious anomalies found on scan
February 2025	4	T Mousa & PcParland	Estimated Fetal weight under 10th centile (previously under 5th centile) for gestational age - see in FM between 5-7 days

Appendix I: Paediatric Alert Form

Form for paediatric referral / alert of potential paediatric problems identified during the antenatal period.

Patient Identification Label	Obstetric Consultant: Date of referral: E.D.D: **Person completing referral / alert (block letters):**

Potential problem / abnormality identified (including description of relevant history and investigation):

Advice already given to patient:

Plan for further pregnancy care:

Paediatric comment (if other advice appropriate please communicate directly with Obstetric Consultant):

Paediatrician signature:

Appendix 2: FETAL CARDIOLOGY REFERRAL FORM.
EAST MIDLANDS CONGENITAL HEART CENTRE
Email this completed form (along with the detailed scan report) to the ANNB screening team at UHL.
E-mail:fcardiac@uhl-tr.nhs.uk
Tel: 0116 258 4860/07814339627

East Midlands Congenital Heart Centre

NHS University Hospitals of Leicester NHS Trust
Caring at its best

NHS No: Surname: First Name: DOB: First Line of Address: Postcode: Primary Contact Number: E-mail address:	Name of referrer: Name of Base Hospital: Responsible Consultant: Date of referral: E-mail address of referrer: Contact number of referrer:

Please provide phone number & e-mail of the patient, as she will be contacted by us directly regarding the appointment.

Parity: **Anomaly scan date:** **EDD:** **Weight:** **BMI:**
If referral from anomaly scans please provide report.

In order to provide appropriate information for the fetal cardiac scan, please see below for the type of referral required. Once you know which one is needed, please enter the number into the box below.

Referral type required. Please enter number from list below →

1. Fetal malformation or anomaly identified or suspected. Specify anomalies in the box below.

2. Abnormal 4 or 5 chamber view / suspected structural heart defect on detailed scan. Specify anomalies in the box below.

-For these first two indications, there is evidence of a structural anomaly and a TIMELY diagnostic scan is necessary. A referral form must be sent urgently to our Fetal Cardiac Referrals team, see above for email address.
- For information regarding appointments & referrals, or if you would like confirmation that your referral has been received, you may wish to call the Antenatal and Newborn Screening team on 0116 258 4860 / 07814339627 Mon - Fri 8:30am and 4.30pm
- For information / queries about anything else, please contact one of our Fetal Cardiology Consultants or Specialist Nurses directly.

3. Previous child with structural cardiac defect. Using the box below, **indicate diagnosis, date of birth and name of child.**
NB: -If previous child has ASD or PDA - subsequent pregnancy does not need antenatal fetal cardiac scan, but should be referred for postnatal cardiac assessment.
-History of previous child with a murmur that resolved spontaneously does not require a cardiac referral investigation.

4. Pregnant woman or partner has a history of congenital heart disease. Using the box below, **indicate diagnosis, hospital of diagnosis, current status as well as name and DOB of partner if he is the affected individual.**

NB: -If pregnant woman or partner has a history of ASD, PDA, an antenatal fetal cardiac scan is not indicated, **but** the baby should be referred for postnatal cardiac assessment.
- History of cardiac murmur that resolved spontaneously in either parent does not require fetal or postnatal cardiac referral.

5. Other Indication: **Use box below to specify reason for referral.**

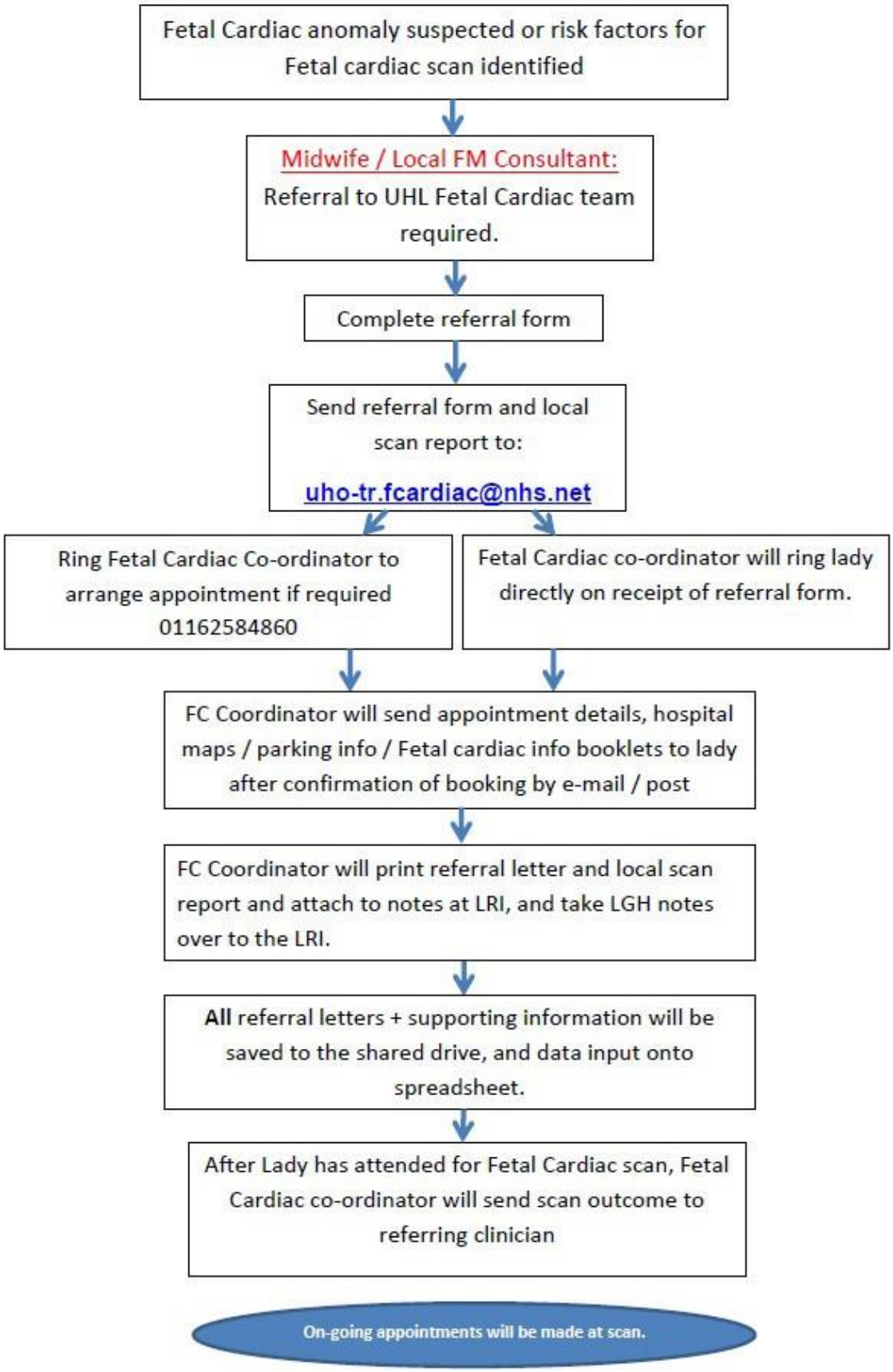
Further Information:

Will the patient require Fetal Medicine input?

SAFEGUARDING: MENTAL HEALTH: MEDICAL INFORMATION:
PLEASE PROVIDE DETAILS

Please send completed form to: fcardiac@uhl-tr.nhs.uk

Appendix 3: Suspected fetal cardiac anomaly pathway



Appendix 4: Intrapartum care plan form

Intrapartum Care Plan when a Fetal Anomaly is expected.

Fetal anomaly diagnosed/suspected:
EDD: **Planned Elective C/S or IOL date:**

Plan for Intrapartum Care/Birth.

Must include: Plan for fetal monitoring inc.actions if abnormal, Relevant Maternal history ie: antibodies, prev. uterine surgery, Placental Location, Cross matching if needed

Singleton / Twin / Multiple Pregnancy (Delete as appropriate)
Reduced dose of misoprostol if required Yes/No/Not needed

Parent's wishes.

Neonatal/Maternal Postnatal Care.

Paediatric/Cardiac plan completed? Yes/No **File Paed alert form in maternal notes**
Baby needs Paed. Check prior to discharge? Yes/No
Neonatal cot required? Yes/No *** Inform NNU on admission ***

Plan made by Senior Obstetrician/Fetal Medicine Specialist.

Date plan made:..... Plan made by:.....
Signature of delivery planner:.....
Signature of the woman:.....