NHS
Isle of Wight
NHS Trust

Standard Operational Procedure for Referral to the Fetal Medicine Unit (FMU)

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Version: 2

Status: Ratified

Effective from: 20th February 2020

Review: 20th February 2023

1. Purpose/Background:

This Standard Operating Procedure (SOP) aims to guide all staff in the appropriate referral pathways to FMU

2. Scope:

- This is for the use of all obstetricians, obstetric sonographers, screening team and midwives and
- Applies to all women cared for by St Mary's Hospital Maternity Services and identified as requiring referral to the Fetal Medicine Unit.

3. Responsibilities

It is the responsibility of all midwifery, sonography and medical staff to access read and understand this SOP.

It is the responsibility of the maternity service to

- Ensure the SOP is reviewed as required in line with trust and national recommendations
- Ensure the SOP is accessible to all relevant staff

4. Procedure:

4.1 Initial Diagnosis

- Diagnosis of a fetal abnormality may happen as a result of an ultrasound scan, screening result at consultant request due to a maternal condition affecting a pregnancy.
- Consideration should be given to how best to disclose the information to the parents.
- Information should be given in a sensitive and empathetic manner, in an appropriate setting. It should be congruent with the ability of the woman and her partner to understand the information. Where appropriate it may be necessary to use diagrams or simplified language or arrange interpreting services.

4.2 Procedure if a fetal abnormality is detected at scan in pregnancy

- The sonographer will complete a detailed report, and inform the woman that there are concerns regarding the developing pregnancy

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- The sonographer will refer the woman to the Antenatal & Newborn Screening Co-ordinator or Antenatal Clinic (ANC) midwife, who will refer to the obstetric consultant if appropriate.
- The woman is taken to the quiet room in the antenatal clinic.
- The ultrasound report findings and implications will be discussed with the woman. The plan of care should be documented in the antenatal notes to reflect the discussions undertaken.
- Referral can be made by the sonographer, Screening Co-ordinator or ANC midwife.

4.3 Procedure if referral is required following increased chance or abnormal screening result.

- The screening coordinator will offer counselling to the woman as soon as any increased chance or abnormal screening result is reported to the screening team.
- Referral to the obstetric consultant will be made if appropriate.
- The discussions, plans and reasons for referral to Fetal Medicine will be documented in the antenatal notes.
- Referral will be made by the Screening Co-ordinator

4.4 Procedure if the obstetric consultant requests referral due to maternal condition.

- The obstetric consultant will discuss reasons for referral with the screening team who will then complete the referral process.

4.5 Referral to FMU

Referral criteria

- Abnormality noted on scans (the table in Appendix B gives general guidance and the timeframe in which FMU aim to see mother's with each condition)
- Women requiring CVS or amniocentesis
- Fetal Growth Restriction(FGR) or Small for gestational age(SGA) fetus (<3rd Centile)

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4.6 Referral process

FGR or SGA <34/40

- In the first Instance, the case must be discussed by the Woman's consultant with the FMU.
- If referral has been accepted follow the procedure as detailed below

Fetal Anomaly

- Inform the woman prior to the referral and ensure she understands and agrees for the referral to be made.
- The Sonographer and or consultant obstetrician will inform the Screening Co-ordinator who will make the referral. In the event that the screening coordinator is not available the sonographer or ANC midwife can complete the referral.
- The referral to the tertiary FMU for suspected fetal abnormality should happen at the point of diagnosis.
- The woman should be given an FMU leaflet containing contact and website information before she leaves hospital. The woman must be given a leaflet with directions to FMU and a Red Funnel Travel Scheme leaflet (Red Funnel offer a two-for-one ferry ticket for those using the Red Jet service to attend an FMU appointment)
- The woman should have a full understanding of why she is being referred and should see someone proficient and able to give advice and any appropriate information leaflets. A full discussion of findings should be given from the sonographer, consultant or LCO.
- If the referring clinician (midwife, sonographer, or obstetrician) does not have enough information to answer the parent's questions, they should say so to avoid being led into answering inappropriately.
- Unless there is high confidence about the exact diagnosis the FMU would prefer that specific information about the significance of an abnormality is not given until the diagnosis is confirmed. Misleading information can be particularly frustrating for the parents especially when there are subsequent significant differences in the diagnosis and outlook.

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- Referrals should be sent via the nhs.net generic email account to suh-tr.WessexFMU@nhs.net using the electronic template (Appendix A) in the ANNB screening folder on Kdrive, in the FMU folder. It is important that all of the referral form is completed fully, giving a brief past history and detailed reason for referral.
- If the woman is Rhesus negative and there is a possibility she may be offered CVS or amniocentesis then a copy of her blood group report should be attached to the referral email.
- The referral should be marked routine, urgent or very urgent. Very urgent cases must be discussed by phone with FMU prior to sending the referral.
- The woman should be informed that FMU will contact her by telephone with an appointment.
- If referral is being made by anyone other than the Screening Co-ordinator, then the coordinator should be informed as soon as possible.
- Following the appointment at FMU a report is emailed to the St Mary's screening office on that day. If any further appointments are required these are made in Southampton following the first visit.
- The Screening Co-ordinator will ensure that any FMU reports are discussed with the obstetric consultant. A plan of care for the pregnancy will then be documented in the notes and disseminated to the multidisciplinary team. The woman's community midwife, GP and NICU will then be informed by the antenatal screening coordinator as appropriate.
- A follow up visit to St Mary's will be offered to the woman and her family if requested or required so that any questions can be discussed with the obstetrician (and the Neonatal team if required).
- Where follow up care for the baby is required in the neonatal period a paediatric alert will be completed and a copy given to NICU. A paediatric alert sticker will be attached to the maternal notes (hard copy)
- All staff should familiarise themselves with the care plan upon the woman's admission.

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4.7 Referral to neonatal specialist services

- The FMU will refer the woman to the appropriate specialist team if the pregnancy is to continue (e.g. neonatal, surgery, cardiac, genetics, neurology, orthopaedics, cleft team) as soon as it becomes apparent that input from that team will be necessary or helpful.
- Information from other professionals such as letters or scan reports or a summary of discussion should be documented in the woman's hand held notes.

4.8 Communication and documentation between obstetric, neonatal and specialist staff in the antenatal period

Communication between obstetric and neonatal specialist staff in the antenatal period occurs as follows:

- Following an appointment at FMU, a report is sent via the net account to the Screening Co-ordinator with details of the outcome of the appointment and a copy is also given to the parents. This will include a management plan which has been discussed with the parents.
- This management plan must then be discussed with the referring consultant to ensure the plan is followed accordingly
- An antenatal tracker form will be maintained and updated by the Screening Co-ordinator (Appendix A). Electronic tracker records are also maintained.
- A paediatric alert form is completed by the obstetric staff if any involvement from neonatal services is predicted.
- Relevant specialist services may be contacted, such as CLAPPA team for a suspected cleft palate/lip. Any referrals must be documented in the maternal records

4.9 Keeping the woman informed throughout the process

- The mother/parents are the focus of all communication and should be kept fully informed at all times as to the nature of the anomaly and its implications. The plan of care must be discussed with the woman and she must be kept informed throughout the process

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- Verbal communication should be backed up with written information if available
- Any verbal communication should be documented in the woman's hand held and or hospital notes.
- Consideration should be given to parents who have communication or language support needs.
- A telephone interpreting service is available for those whose understanding of English is limited.
- Please note that it is considered bad practice to use family members or other visitors to interpret, as they may willingly or accidentally pass on incorrect information.

4.10 Documentation

- Any referrals made should be documented clearly in the hand held and hospital notes and a copy of the referral form secured in the hospital notes.
- As some women have several visits, all reports and correspondence between specialist services that are received must be brought to the attention of the woman's consultant, signed by them, and filed in chronological order in the hospital copy of the notes.
- Ensure that any further appointments that are required are made and the woman and the community midwife are informed.
- All conversations regarding the outcome of the pregnancy and parents' wishes should be documented clearly by all staff involved in the woman's care

4.11 Ongoing care

- Women who plan to continue with their pregnancy should be supported in their decision making, and a management plan agreed with them.
- See Appendix D. Print and use this to plan and document actions taken.
- It may be appropriate for the planned delivery location to be changed.

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- The woman may be booked for delivery in Southampton but ongoing routine antenatal care and support should continue as planned by her midwife.
- The woman and her family should be offered the opportunity to visit specialist wards such as the neonatal unit.
- Where appropriate a plan should be made for care of the baby at delivery and documented in the paediatric alert form. A copy of this should be kept in the neonatal unit and another placed in the hand held notes.
- If the woman makes a decision not to continue with the pregnancy, she should be referred for management of termination of pregnancy. Concise and timely communication of the woman's wishes and a plan for review should be documented in the woman's hand held notes.

5. Implementation/training/awareness

- This is a review of a current document and it formalises current practice.
- Once ratified it will be available in all clinical areas within the Maternity Unit and on the intranet.
- All new, reviewed and ratified documents are notified to staff via the monthly maternity newsletter

6. Auditable Standards

What aspects of compliance with the document will be monitored	What will be reviewed to evidence this	How and how often will this be done	Detail sample size (if applicable)	Who will coordinate findings	Which group or report will receive findings
Timely referral to the fetal medicine unit (FMU)	The record of all women referred to the fetal medicine unit	Annually	All referrals	Screening Co-ordinator	The screening steering group
Outcome of pregnancies for women referred to FMU	The record of each woman referred will	Monthly	All referrals	Screening Co-ordinator	The screening steering group

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	be reviewed monthly to delivery outcome				

7. **Related Documents:**

Guidelines:

- Ultrasound SOP for Fetal Anomaly Screening Programme (FASP) V3
- Guideline for the management of fetal loss, late intrauterine fetal death and termination for fetal abnormality

Key Personnel:

- Antenatal and newborn screening coordinator
- Sonography lead for FASP

Patient Information:

- The FMU produces their own patient information sheet available online and in the ANC.

Trust Policies/Procedures:

8. References:

- **PHE FASP guidelines**

9. DISCLAIMER

It is the responsibility of staff to check the Trust intranet to ensure that the most recent version/issue of this document is being referenced.

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DOCUMENT HISTORY					
Date of Issue	**Version No.**	**Next Review Date**	**Date Approved**	**Director Responsible for Change**	**Nature of Change**
May 2019	SOP V1	May 2022	May 2019	MCEG	New SOP
March 2020	2	Feb 2023	20th Feb 2020	MCEG	Amendments to bring in line with SBL

Appendix A

Please complete or Affix Patient Label	Ward/Dept …………………………………… Name of Consultant……………………… **TRACKER FORM FOR 'HIGH RISK' SCREENING or FETAL ABNORMALITY (ANTENATAL)**

TRACKER FORM FOR HIGH CHANCE SCREENING RESULT /FETAL ABNORMALITY		**Date**	**Signature (and print name)**
HIGH RISK COMBINED/QUAD SCREENING RESULT **CHANCE 1: T**	Patient phoned		
	Outcome of phone call		
	Date of CVS/ Amniocentesis		
	Declined further tests		
	Alert sticker affixed to notes for paediatric review at birth		
	RESULT of diagnostic test :		
	Follow Up		
	Result Letter sent		
ABNORMALITY ON SCAN:	Referred to Fetal Medicine Unit		
	Seen by Consultant above		
	Date of FMU appointment		
DIAGNOSIS			
ABNORMAL CARDIAC SCAN	Referred to Fetal Cardiac Specialist		
	Date of Specialist Appointment		
DIAGNOSIS			
FOLLOW UP	Planned place of delivery		
	Paediatricians Notified		
	Consultant Notified		
	Community Midwife Notified		
FINAL OUTCOME			
Further Comments			

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Hydrops	Discuss with Fetal Medicine consultant urgently.
Polyhydramnios >30cm AFI	Confirm fetal movements and normal stomach. Manage in local unit. Discuss with Fetal Med consultant if possible therapy indicated. (e.g. amnioreduction, indomethacin)
Oligohydramnios <5cm AFI <28 weeks	Manage locally. Discuss with Fetal Medicine consultant if concerns e.g. abnormal Dopplers, renal anomalies.
Severe IUGR <28 weeks	Discuss with Fetal Medicine consultant *See UHS 'management at the extremes of viability' guideline*
?Twin To Twin Transfusion Syndrome	Discuss with Fetal Medicine consultant immediately. *See network guideline: Ultrasound management of MC twins*
Skeletal dysplasia	See within 3 days in Fetal Medicine
Echogenic bowel	Manage locally if satisfactory cardiac views. Offer CF screening, TORCH and parvo, amniocentesis, serial growth scans
Femur <5th centile with prior screening	Manage locally if satisfactory cardiac views unless concerns re skeletal dysplasia. Growth scans at 28 and 34 weeks.
Cranial anomalies: mild ventriculomegaly or worse, posterior fossa anomaly, fusion, cysts, haemorrhage, calcification	See within 3 days in Fetal Medicine.
Confirmed Down's syndrome	Cardiac scan at 20 weeks in Fetal Medicine
NT >3.5mm	Cardiac scan at 20 weeks. *(See FASP standards)*
Abnormal cardiac views	Cardiac scan list (usually Mon/Wed) ASAP
Dysrhythmias: sustained tachycardias and bradycardias	Discuss with Fetal Medicine consultant immediately.

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Ectopic beats	Manage locally unless progresses to sustained tachycardia, consider discussion with FM consultant if electronic fetal monitoring is uninterpretable.
Family history of significant CHD in mother, father, previous child, (not patent ducts, small VSDs, mild valve stenosis, secundum ASDs or conditions which did not require treatment).	Cardiac scan at 20 weeks in Fetal Medicine or by suitably trained individual locally.
Maternal history: Diabetes or PKU	Manage locally. Refer if any concerns re cardiac views.
Red cell antibodies	Discuss with Fetal Medicine if concerns and immediately if more than 15iu/l of anti-D as a new finding. Refer >4iu anti-D or 7.5iu anti-c; >1:32 titre for anti-E, Kell, JKa, Duffy etc. MCA Dopplers can be performed locally , (Fetal Medicine team happy to discuss if any concerns)
Cleft lip and palate	Manage in local unit if confident that it is isolated, or see within one week in Fetal Medicine. Consider and discuss amnio. Recommend information leaflet, cleft lip and palate support group website etc.
Gastroschisis	See within one week depending on surgical team availability
Exomphalos	See within 3 days, usually pre-surgical discussion. Offer amnio. Then require surgical review ASAP.
Duodenal atresia/bowel dilatation	See within 3 days, usually pre-surgical discussion.
Persistent small/absent stomach ?TOF/OA	See within 3 days, usually pre-surgical discussion.
Talipes	Manage in local unit if confident that it is isolated, or see within one week in Fetal Medicine. Consider and discuss amnio.
Cystic lung lesions	See within one week. For surgical review. Serial scans if risk of hydrops.

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Diaphragmatic hernia	See within 3 days. For surgical review once karyotype known or testing declined.
Abdominal cysts	Manage in local unit if happy or within one week in Fetal Medicine. Refer for surgical discussion if additional concerns e.g. large size.
Anencephaly	No need to see in Fetal medicine. (We are happy to review images for confirmation)
NTDs	See within 3 days, usually pre-surgical discussion.
Bladder exstrophy	See within 3 days to confirm. Then arrange urologist discussion @Great Ormond Street
MCDK	See within one week in Fetal Medicine if unilateral, ASAP if bilateral. Consider referral to Paediatric nephrology team. *(See UHS antentally detected uropathy pathway – attached)*
Bladder outflow obstruction or ureterocele	See within 3 days. consider referral to Paediatric nephrology team
Renal pelvis >15mm	See within one week. Consider referral to Paediatric nephrology team *(See UHS antentally detected uropathy pathway – attached)*
Unilateral renal agenesis or uncomplicated duplex kidney(s)	Manage in local unit. *(See UHS antentally detected uropathy pathway – attached)*

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Appendix C

Wessex Maternal and Fetal Medicine Unit
Electronic referral form

Please e-mail referrals to : suh-tr.WessexFMU@nhs.net

Tel: 023 81 206025

PLEASE DO NOT FAX REFERRALS

Urgent referrals can be telephoned prior to e-mail. The e-mail Account is checked regularly throughout the day during office hours

You will receive confirmation of the referral by e-mail

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Patient Name**:** DOB: BMI:	Referral date/time: Referring Unit: Consultant:
Address: Post code:	Contact Tel No:
GP & Surgery address:	Ethnic origin:
Blood Group: Virology (HIV/Hep B status):	NHS No:
EDD by scan:	Gestation:

Urgency a) Routine (at appropriate gestation) ☐

b) Urgent (within 2 working days) ☐

c) Very urgent (same or next day **MUST TELEPHONE TO DISCUSS)**
WHERE POSSIBLE PLEASE E-MAIL COPIES OF ALL SCAN REPORTS
Date/time of appointment (If known): Is an interpreter required?
Is patient aware of appointment?
Name of person completing referral form: Contact telephone number:

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Please ensure patients are given the information below

- Appropriate information leaflets given where applicable
- Check they have the correct post code **SO16 5YA** and contact details
- Website address: www.uhs.nhs.uk then search Fetal medicine
- Limited parking, allow time to park
- Parking charges apply
- Women need a comfortably full bladder before 14 weeks. After this there is no need to have a full bladder.
- Please avoid bringing small children as space is limited and it is often not appropriate

APPENDIX D

<table>
<tr><td colspan="2">Continuing pregnancy following diagnosis of:
Prompt for care and communication</td></tr>
<tr><td>Action</td><td>Comment/ action taken/ information given</td></tr>
<tr><td>Immediate care:
Consultant appointment?
Scan?
FMU?</td><td></td></tr>
<tr><td>Who needs to be informed?
Obstetric Consultant
Community midwife
GP
Health visitor
Paediatric consultant</td><td></td></tr>
<tr><td>Birth plan:
Is there a documented plan for delivery?
Where will delivery be?
Consider multidisciplinary meeting.</td><td></td></tr>
<tr><td>Care of baby at birth:
Paediatric alert completed?
Consider multidisciplinary meeting to make a plan.</td><td></td></tr>
<tr><td>Support during pregnancy:
ARC
Written information available?
Support group (Down’s syndrome association, SOFT, SPIRES).
Visit to SCBU/NICU.
Appt with paediatrician or appropriate specialist or surgeon</td><td></td></tr>
<tr><td>Contacts numbers, names or services for woman following delivery.
Local parent support groups.
Health Visitor.
Specialist services.</td><td></td></tr>
<tr><td>Other</td><td></td></tr>
</table>

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