Royal Cornwall Hospitals
NHS Trust

Fetal Medicine Referral, Multi-disciplinary Team and Communication Clinical Guideline

V4.0

September 2026

1. Aim/Purpose of this Guideline

1.1. Describes the referral process between maternity Ultrasound (USS) / main ultrasound and the screening team into the Fetal Medicine Unit (FMU) when a fetal chromosomal or structural concern is suspected or identified at Fetal Anomaly Screening Programme (FASP) screening.

1.2. Outlines the care pathway options when a fetal concern is suspected or identified.

1.3. Describes the communication pathways between the screening, fetal medicine, neonatal teams and other relevant specialist services and tertiary centres when a fetal concern is confirmed.

1.4. Describes the referral pathways between Clinical Genetics and FMU.

1.5. This guideline should be read in conjunction with the following guidelines:

- Referral and care pathways for fetal growth concern are outside of this guideline and are listed within Fetal Growth Restriction (FGR): Risk Assessment, Prevention, Surveillance and Management of Pregnancies at Risk of FGR Clinical Guideline

- FASP screening handbook Fetal anomaly screening programme handbook - GOV.UK

1.6. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women, but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

1.7. This version supersedes any previous versions of this document.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

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Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. Definitions

The fetal medicine service provides multi-disciplinary care to patients whose pregnancy has been complicated by concerns about their fetus (or fetuses in multiple pregnancies), or who have had fetal complications in previous pregnancies. This includes, but not exclusively:

- Suspicion or identification of a fetal structural or possible chromosomal anomaly that occurs at ultrasound screening includes:
- Raised Nuchal Transluceny (NT) assessed during screening for Edwards syndrome, Patau's syndrome and Downs syndrome as part of combined screening.
- Women who opt for a Prenatal diagnosis (PND) test following a higher chance screening result following combined or quadruple screening.
- One of the 11 physical conditions screened for at the Fetal Anomaly Screening / 20 week mid trimester scan NHS Fetal Anomaly Screening Programme (FASP): programme overview - GOV.UK.
- Any fetal structural anomaly or condition suspected by ultrasound screening.
- Pre-natal diagnosis, non-invasive and invasive testing, assessment and management of fetal medical and surgical problems including disorders of growth, placentation or metabolism, infection, alloimmunisation, exposure to teratogens and complex multiple pregnancies (New 2026).
- Expert clinical counselling and support for parents to help them make decisions about the management of the pregnancy and birth. This may include but is not limited to timing and type of delivery, prenatal therapeutic interventions, termination of pregnancy and potentially plans for either active or palliative neonatal care (New 2026).

2.2. Fetal Medicine Service (New 2026)

- The fetal medicine service works to locally agreed network clinical pathways of care to provide care for patients with difficult or complex fetal disorders as near to their home as possible.
- Royal Cornwall Fetal Medicine service is designated by commissioners as a level 2 fetal medicine service.
- The range of services provided by a level 2 Fetal medicine service include specialist consultation / counselling and ultrasound diagnosis, diagnostic invasive procedures, to include amniocentesis and CVS (if skills present by two or more clinicians). Therapeutic invasive procedures limited to singleton feticide and amnio drainage where skills are present by two or more clinicians.

- Fetal medicine services work in partnership with local services including the referring sonographers, obstetric teams, specialist midwives, termination of pregnancy services, genomic services and neonatal specialists.

- The Fetal medicine service works in a fetal medicine regional networked model of care to enable services to be delivered as part of a coordinated, combined whole system approach, including out of hours and weekend services as agreed by the fetal medicine regional network.

- The department has a named FASP screening clinical consultant lead, with the role identified within their job plan.

- FMU clinics, weekly fetonatal MDT meetings, and the monthly FMU business meeting agenda and minutes are coordinated by specialist midwives and specialist administrative resource.

2.3. Allocation of a Fetal Medicine appointment

2.3.1. Local Fetal Medicine Unit

2.3.1.1. A local fetal medicine appointment should be provided within 3 working days of the dating or anomaly scan, as per FASP standards. The day of the scan is considered as day 1.

2.3.1.2. If no local FMU routine clinic appointments are available within 3 working days this should be escalated to the screening coordinator and a plan of care made for an ad hoc local FMU clinic appointment within the national timeframe. If this cannot be arranged, a referral to a tertiary fetal medicine centre should be urgently considered.

2.3.1.3. The screening failsafe coordinator should inform the screening midwives of all new FASP referrals into fetal medicine, to enable commencement of screening support / provision of local or national FASP / prenatal diagnosis testing leaflets, digital consent forms and correspondence with community teams.

2.4. Referral to tertiary fetal medicine centre

2.4.1. If no local fetal medicine appointment exists within national standards, it is the responsibility of a fetal medicine consultant to consider referral to the regional fetal medicine unit at Bristol.

2.4.2. A tertiary FMU appointment should be received within 5 working days, as per FASP standards. The exception to this would be that if it's agreed by the patient/ referring team that the appointment is planned for a later gestation e.g. third trimester for birth planning appointment in Bristol. The day of scan when the anomaly was suspected is considered day 1. If no tertiary FMU appointments are available for immediate referrals within this timeframe this should be escalated to the antenatal and newborn screening coordinator and the referring fetal medicine consultant.

2.4.3. Referral to tertiary fetal medicine is made via Refer a Patient system:

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using the following drop downs:

- New Referral.
- St Michael's Hospital, University Hospital Bristol NHS Foundation Trust.
- Fetal Medicine.

2.4.4. The whole form must be completed for a referral to be accepted. The following investigation results should be attached to the referral form:

- Virology.
- Blood group.
- Haemoglobinopathy screen.
- First trimester screening.
- Anomaly scan.
- Fetal medicine reports.

2.5. **Clinical Genetics referral into FMU**

2.5.1. Clinical Genetics refer into FMU for the following two categories:

- Women who are already known to clinical genetics (through preconception/ previous obstetric history).
- Following genetics assessment completed in the current pregnancy, after receipt of genetics referral form from Community Midwifery.

2.5.2. Clinical genetics refer into FMU via a message into the screening team generic email.

2.5.3. It is the responsibility of clinical genetics to advise on:

- What genetic tests are required, for example Non-Invasive Prenatal Diagnosis (NIPD) / PND for QF-PCR and Micro array.
- The timeframe for FMU appointment provision (FASP timeframe to be seen within 3 days is NOT applicable).
- Provision of Genetic Test request forms.
- Clear instruction on which blood tubes are required.
- Confirmation of where Genetic tests should be sent.

2.5.4. Following receipt of Clinical Genetics referral:

Community Midwifery Team	To complete a timely booking appointment prior to genetic testing.
Hub USS Booking Administrator	To generate a timely dating USS (NB this may be at 9 weeks if NIPD bloods are required).
Screening Midwives / Team	To obtain NIPD bloods at USS. To organise timely PND procedure. QF-PCR T13, T18, T21 results to be communicated to the woman by screening midwives (and forwarded to clinical genetics).
Clinical Genetics	Micro-Array / NIPD results to be provided to woman by clinical genetics.

2.6. **Decline of Fetal Medicine clinic appointment**

Where women decline further management, the decision should be recorded in the maternity electronic healthcare record and routine care continued. An alert is added to the record for wider maternity and neonatal MDT awareness of the anomaly. The woman should be informed the case will be discussed at the weekly MDT fetonatal meeting for awareness.

2.7. **Prior to FMU appointment screening midwives to provide:**

- Individualised support to the woman and family, to include screening contact card.
- Information of the national charity Antenatal Results and Choices (ARC) Antenatal Results and Choices (ARC) – non-directive information and support before, during and after antenatal screening.
- **Scans performed in the hub:** Where the women prefers to leave immediately following suspicion of a fetal anomaly, or the screening midwife is not imminently available the screening team will follow up via phone / email / Attend Anywhere unless the woman has expressed otherwise, or in cases where a same / or next day fetal medicine appointment is provided.
- **Anomaly Scans performed at satellite centres**: The screening team will follow up via phone / email / Attend Anywhere within one day of the anomaly being suspected unless the woman has expressed otherwise or in cases where a same / or next day fetal medicine appointment is provided.
- Relevant local or FASP patient information leaflets, to include CVS and amniocentesis diagnostic tests: description in brief - GOV.UK (available in multiple languages) should be emailed to woman if applicable.
- Digital Concentric pre-natal diagnosis consent forms to be emailed to woman prior to FMU appointment if considered relevant, dependent on nature of anomaly suspected.

- Screening consultation to be documented within viewpoint and a copy provided to the woman directly or via email.

- Details added to the screening daily diary / board for onward tracking and plan identified for appropriate FMU support provision.

2.8. First Fetal Medicine Assessment

The following areas are assessed and documented as standard at first Fetal Medicine Consultant Assessment:

Relevant background information regarding medical, obstetric, social, family history.
Relevant prior tests/screening (e.g. first trimester combined screening, NIPT, antibodies).
Attempt at full anatomy review if suspected fetal abnormalities or biometry under the 3rd centile.
Attempt at uterine artery dopplers if EFW under the 3rd centile.
Assessment of suspected anomaly.
Informed offer of prenatal diagnosis, if clinically indicated.
Appropriate signposting to specialist charities, e.g Antenatal Results and Choices, screening team contact details.

All fetal medicine clinics are supported by a screening or sonography midwife. Each clinic has an outcome sheet of follow up actions required, as identified by the fetal medicine consultant. The screening midwives have responsibility for ensuring these actions are completed timely.

2.9. Clinical Pathways

2.9.1. Referral to Fetal Medicine for Fetal Echocardiograms

Screening fetal echocardiograms in those with a fetus at higher risk of congenital heart disease will be aimed to be performed between 19 to 23 weeks unless stated otherwise below. Fetal Echocardiography will be aimed to follow the core features of the British Congenital Cardiac Association (BCCA) Fetal Cardiology Standards.

https://static1.squarespace.com/static/66d1910d8e37ae3c9a83dc3a/t/67093da91db16875f25c62a1/1728658858590/BCCA_STANDARDS_FETAL_CARDIOLOGY_Sept_2021.pdf

2.9.1.1. As acknowledged by the BCCA, even in the most skilled hands, it sometimes may not be possible to complete a full assessment detailing all the structures. The report will reference what structures have been seen (and those that have not). Limitations will be explained to the patient. If there are concerns about abnormality, then referral to Bristol fetal cardiology will be recommended.

2.9.1.2. In some groups listed below the fetal heart may be scanned prior to 18 weeks as part of a fetal medicine review. The patient will be informed that the aim in these scans is not to perform a full detailed fetal echocardiogram as per BCCA standards, and the scan will be repeated later in pregnancy as a formal fetal echocardiogram.

2.9.1.3. Fetal echocardiograms can be referred at any gestation when congenital heart disease or fetal arrythmias are suspected (and will be seen urgently – within 3 working days of referral).

2.9.1.4. Referral can be made by community midwives at booking sonographers, or any member of the booking team by emailing rch-tr.Screening@nhs.net or calling 01872 253092. Where referral is accepted for fetal echocardiogram, unless the fetal medicine consultant agrees otherwise, the anomaly scan will still be planned in addition as routine at 19 weeks in clinical imaging.

2.9.1.5. Referral to fetal medicine for specialised fetal echocardiogram should be made in the following situations:

2.9.2. **Suspected congenital heart disease or arrhythmia**

a. Suspected congenital heart disease **(same day fetal medicine referral).**

b. Suspected fetal arrhythmia (FHR>180, FHR<110) (same day fetal medicine referral).

c. Fetal heart irregularity instead follow "Fetal heart irregularity including ectopic beats clinical guideline".

2.9.3. **Raised Nuchal Translucency**

Increased nuchal translucency – Nuchal translucency 3.5mm or more at first trimester combined screening.

- Those NT≥ 3.5mm or more will be seen in fetal medicine after their first trimester combined screening scan and then their anomaly scan will be performed in fetal medicine at 19-21 weeks with fetal echocardiogram.

- Those NT≥ 5mm will also be offered a fetal medicine review around 16 weeks.

2.9.4. **Family history**

First degree relative of the fetus has a diagnosis of congenital heart disease (in the absence of underlying chromosomal or genetic abnormality) that has required surgical intervention (excluding atrial septal defects and patent arterial ducts).

2.9.5. **Maternal indications**

- Pre-existing diabetes with higher HbA1c in the first trimester (> 48 mmol/mol).
- Maternal Phenylketonuria.
- Maternal medications with established higher risk of congenital heart disease (sodium valproate, carbamazepine, lithium, retinoic acid, chemotherapy e.g. methotrexate, NSAIDs).
- Maternal viral infections (rubella, coxsackie, CMV, toxoplasma, parvovirus).

2.9.6. **Fetal Medicine Indications**

- Fetal Trisomy.
- Monochorionic Twins.
- Any other fetal medicine finding associated with a higher chance of congenital heart disease (hydrops, pleural/pericardial effusions, ascites, congenital diaphragmatic hernia).
- Raised nuchal fold >6mm.

2.9.7. **Anti-Ro and Anti-La antibodies**

a. Anti-Ro/Anti La and First baby/ no previous baby with fetal heart block - 2% risk:

   - See in Fetal Med at 20 to 22w and 26 to 28 weeks (they have their anomaly scan in clinical imaging as usual).
   - CMW auscultation fortnightly 18 to 28 weeks, refer to fetal med for urgent review (next fetal med list) if FHR <110.

b. Anti-Ro/Anti La and previous baby with fetal heart block – 12 to 15% risk:

   - Recommend hydroxychloroquine 400mg daily (unless already taking). See in Fetal Med at around 16 weeks (we will offer referral/discussion with fetal cardiology at this appointment, fetal cardiology will personalise when follow-up scans will be e.g. 18w, 24w, 30w).
   - CMW auscultation weekly 16 to 28 weeks, refer to fetal med for urgent review (next fetal med list) if FHR <110.

2.9.8. **Repeat Fetal Echocardiogram in later pregnancy** (e.g. 28 to 32 weeks)

- Family history of left sided obstructive lesions including classical HLHS, coarctation of the aorta, aortic stenosis.

- Maternal anti-Ro/La antibodies (as above 26 to 28week).
- Persistent elevation of nuchal fold thickness (>6mm).
- First degree relative (e.g. previous sibling) with cardiomyopathy presenting in infancy.

2.9.9. **Referral to Paediatrics for ECHO as an infant**

- Family history of left sided obstructive lesions including classical HLHS, coarctation of the aorta, aortic stenosis.
- First degree relative (e.g. previous sibling) with cardiomyopathy presenting in infancy.
- Fetal congenital heart disease detected (as per Bristol fetal cardiology advice).

2.10. **Increased Nuchal Translucency**

2.10.1. Pregnancies with a Nuchal Translucency (NT) measurement ≥ 3.5mm should be referred to the antenatal and newborn screening team for onward management.

2.10.2. Where a NT measurement of ≥ 3.5 mm is recorded and combined screening is accepted, the blood sample will be taken and sent to the laboratory for analysis.

- The woman should be informed of the implications of a raised NT, to include no clinical significance, an increased chance of a cardiac, structural condition and an increased chance of a chromosomal condition.
- An appointment to be seen within the local fetal medicine clinic should be provided within 3 working days. The day of the scan appointment is considered day 1.
- Women should be informed to anticipate a higher chance first trimester screening result.
- Women should be provided with a digital or hard copy of the NHS England leaflet CVS and amniocentesis diagnostic tests: description in brief - GOV.UK. They should be informed of the option for a diagnostic screening test, with the risks, benefits and limitations fully explained, to include a 0.5% chance of miscarriage associated with diagnostic testing. Information should be provided that diagnostic testing will provide a result for T13/18/21 via QFPCR, with results available within 3 working days. A micro array will also be offered to provide a wider range of information on fetal karyotype, See below.

2.10.3. Different local pathways exist for raised NT, depending on the measurement: See flow chart Appendix 3. These include:

- Offer of QF-PCR and micro array testing.

- Obtaining parental bloods for karyotyping.
- For NT between 3.5mm to 5mm, the 18-20+6 anomaly scan will be completed by a fetal medicine consultant.
- For NT >5mm an additional 16/40 FMU appointment will be offered.

2.10.4. Women should be informed of NIPT (available only as part of the higher chance combined screening pathway) and should be advised it is limited to screening for T13/18/21 only and is hence not recommended.

2.10.5. NHS England genomics information is available regarding the risks associated with an increased NT, to include tables of NT measurement and chance of chromosomal anomaly / loss. This can be accessed at Nuchal translucency - Knowledge Hub

2.10.6. Following screening consultation, screening midwife to:

- Generate a Viewpoint Screening consultation report.
- Add E3 alert “care of fetal medicine”.
- Add E3 speech bubble note.
- Email community midwives.
- Add to fetal medicine tracker, stored in shared drive TR15 / RCHT FM Tracker.
- Add to Screening Daily diary / board.

2.11. Prenatal diagnosis testing – CVS or Amniocentesis

Pre-natal diagnosis may be offered to women by a Fetal medicine consultant following full clinical FMU review. This review will include a full assessment of the history, including screening and other investigations performed during the pregnancy, and an assessment of fetal anomaly and placental function. Counselling and investigations (including the offer of CVS and amniocentesis) are offered based on this personalised assessment. CVS or amniocentesis will be offered in line with FASP screening for Down’s syndrome, Edward’s syndrome, Patau’s syndrome and the 11 physical conditions screened for at the 20 week anomaly scan.

2.12. The offer of Prenatal Diagnosis

All women offered a pre-natal diagnosis (PND) test are informed of the following:

- How the procedure is performed.
- There is a 0.5% (1 in 200) risk of miscarriage for both CVS and amniocentesis. This risk lasts for up to two weeks following procedure. For third trimester amniocentesis the risk of preterm labour is thought to be 3 to 4%, based on limited studies (RCOG Greentop Guideline 2022).

- The timeframe for results.

- It is not always possible to get a result from the first PND. 6% of woman are offered a second procedure (NHS England 2025).

- Women who have declined infectious disease screening for Syphilis, HIV or Hepatitis B are not eligible for PND testing until an infectious disease result is known.

- Women who are screen positive for Syphilis, HIV or Hepatitis B will be counselled by the fetal medicine consultant about risks associated with PND and fetal transmission. Eligibility will be identified by the FMU consultant.

- PND is offered at RCHT for singleton pregnancies only.

- In the case of multiple pregnancies, counselling is offered locally but onward tertiary FMU referral is required for PND.

- National links to prenatal diagnostic testing options are provided to all women who are offered PND as part of FASP screening pathways.

2.13. **Prenatal Diagnostic testing options**

Chorionic Villi sampling (CVS).

- A prenatal diagnostic test, with a 0.5% risk of miscarriage where a sample of placental cells are taken and sent to the regional cytogenetics laboratory in Bristol.

- Usually completed between 11+2 – 14 weeks of pregnancy.

- On 1/3rd of all occasions it may not be possible to undertake a CVS due to placental location. In these instances, the offer will be a repeat CVS attempt in 1/52 or await amniocentesis testing >15 weeks.

- A quantitative fluorescent Polymerase Chain Reaction (QF-PCR) result for the 3 most common trisomy's, (T13, T18, T21), can be expected in 3 to 5 working days.

- There is a chance of requiring a further test on the original CVS due to placental mosaicism. The laboratories will report if a placental mosaicism is suspected and recommend if a further test is needed. Results from additional testing can take about two weeks.

- The QF-PCR result is emailed to the secure screening generic email and telephoned wherever possible to the woman on the day of receipt, by the screening coordinators.

- Where the result is received from the labs late in the working day, or the woman is not available on telephone call, screening midwives will make a professional judgement about whether to call / leave a voice mail advising a result is available.

- If the QF-PCR result identifies a chromosomal anomaly the woman will be offered an appointment with the screening midwives / fetal medicine consultant to discuss her options.

2.14. **Amniocentesis**

- A prenatal diagnostic test, with a 0.5% risk of miscarriage, where a sample of amniotic fluid is taken and sent to the regional cytogenetics laboratory in Bristol.

- Performed from 15 weeks onwards, but the optimum time is from 16 weeks.

- A QF-PCR result for the 3 most common trisomy's, (T13, T18, T21) expected in 3 to 5 working days.

- The result is emailed to the secure screening generic email and telephoned to the woman wherever possible on the day of receipt, by the screening midwives.

- If the result identifies a chromosomal anomaly the woman will be offered an appointment with the screening midwives.

2.15. **QF-PCR + Micro array.**

QF-PCR with additional micro array testing is offered to some cases of PND. The Micro array test uses laboratory methods to detect chromosome defects which are too small to be seen by routine culture and provides a wider range of information on fetal karyotype. If a clinically relevant result is detected by the array, parental bloods are tested to see if the detected anomaly has been inherited from either parent. Micro array testing is routinely offered for cases of:

- Raised NT 3.5mm or above.

- On detection of a structural anomaly at USS.

- Following request from clinical genetics.

Women are informed that the results from micro array testing will be available in 7 to 10 days.

2.16. **PND offer declined.**

2.16.1. All women will be informed that PND is a choice and of the right to decline.

2.16.2. Where a FMU Assessment is suggestive of a severe congenital anomaly / chromosomal condition and PND is declined, the fetal medicine will provide an individualized care discussion and plan. This may include a discussion of termination of the pregnancy.

2.17. Pre natal diagnosis Procedure

2.17.1. Prior to Pre-Natal Diagnostic testing

- A check is made to confirm that infectious disease bloods screening / and blood group has been completed and results known before any diagnostic procedure is offered.
- Procedure and Consent discussed with fetal medicine consultant / digital consent form signed.

2.17.2. Appendix 4 lists pre-checks / post checks required by the registered health professional assisting the FMU consultant with PND.

2.17.3. Completion of Pre-Natal Testing

- Pre-natal diagnostic procedures are completed only by Fetal Medicine Consultants who have achieved competency with Maternal Fetal Medicine subspeciality training, or requirements as per Royal College of Obstetricians and Gynaecologist Green-top Guideline No 8. Amniocentesis and Chorionic Villus Sampling (Green-top Guideline No. 8) | RCOG .
- A registered health professional (Screening Midwife / sonography midwife) or a senior Obstetrics and Gynaecology doctor (e.g. ST3+) is required to assist with all PND procedures.
- In addition see Standard Operating Procedures (SOPS) on shared drive “SOP Amniocentesis Procedure” and “SOP CVS Procedure)”.

2.17.4. Safety netting / checks completed following Pre-natal testing

2.17.4.1. A re-check of fetal heart.

2.17.4.2. Safety netting for concern re PV bleeding / Pain / SROM. Women are advised to phone the 24 hour maternity triage with concern, or in the instance of severe pain/ bleeding to contact Emergency Department.

2.17.4.3. It is the responsibility of the registered health professional assisting PND to ensure:

- Anti D is administered or returned to blood bank if procedure not possible.
- Genetics forms are completed for PND samples and parental bloods.
- Samples are clearly labeled.
- Inform Bristol prenatal laboratory of samples on the way.

2.17.5. **Documentation following Prenatal diagnosis**

2.17.5.1. Fetal medicine consultant

- Generate a Viewpoint report. A copy to be provided to the woman directly or sent via email following appointment.

2.17.5.2. Screening Midwife to:

- Add digital healthcare record alert “care of fetal medicine”.
- Add speech bubble / alert note “prenatal diagnosis completed”.
- Email update to community midwives.
- Add diagnostic testing information to fetal medicine tracker.
- If PND following a higher chance trisomy screening result – add to FASP positive results tracker.
- Add to Screening Daily diary / board for tracking of results.

2.17.6. **PND sample transport and tracking**

- All Prenatal diagnosis samples are sent for testing to the Bristol prenatal laboratory. Samples are taken directly from the RCHT fetal medicine hub to the RCHT post room and sent by Royal Mail Tracked 24-hour service.
- Details of each sample sent to the laboratory are emailed to the Bristol laboratory at SWGLHprenatal@nbt.nhs.uk on the day of sample transport. This email forms the failsafe process to ensure the laboratory is aware a sample is on the way. It is the responsibility of the laboratory to follow up any samples which are not received.

2.18. **Prenatal diagnosis results**

- Prenatal diagnosis results are received from the Bristol laboratory via email into the antenatal and newborn screening team email.
- The report is uploaded on the viewpoint system, which imports into the maternity electronic healthcare record. QF-PCR outcomes are reported verbally by phone to the woman, unless an alternative plan of care has been agreed by the fetal medicine consultant.

2.18.1. **Result identifies no chromosomal anomalies.**

The woman will be informed by the screening midwives that the result shows that the baby does not have the chromosomal anomaly that has been tested for. Onward care is in line with the plan agreed by the fetal medicine consultant and is documented on the digital healthcare record.

2.18.2. **Result identifies a chromosomal anomaly**

2.18.2.1. **T13, T18, T21 detected**

- When the conditions of T13/T18/T21 are detected by PND the screening midwives will contact the woman to inform, unless a previous care plan was agreed by the FMU consultant.

- If the laboratory result suggests an inconclusive or mosaic T13/T18 or T21 result this will be taken to a fetal medicine consultant who will contact the woman to inform of the result, the implications, their options and agree a management plan.

2.18.2.2. **Chromosomal anomaly detected, excluding T13, T18, T21.**

- When a chromosomal anomaly is detected by micro array, results will be communicated by either the fetal medicine consultant, or clinical genetics (depending on entry referral pathway).

- The woman / her partner will need time to absorb the information. They will be offered a follow-up consultation with a fetal medicine consultant, at a time that is right for them. They will be offered clinical genetics referral. A personalised management plan including tertiary FMU and other specialty referrals will be made for them depending on their wishes, the genetics results and other findings.

- Women should be informed and consent gained to report the pregnancy to the National congenital anomaly and rare disease registration service (NCARDRS).

2.18.2.3. **Choice to continue the pregnancy**

- Fetal medicine consultant to advise on an individualised plan of care to monitor the pregnancy in the Fetal Medicine department.

- A referral letter will be sent to the Neonatal team and a plan for birth developed.

- A written neonatal plan must be available in the woman's maternity electronic health record. It is the responsibility of the screening midwives to undertake tracking of this to ensure a copy is available on the maternal digital healthcare record.

- The ongoing progress of the woman and baby will be discussed at the weekly Fetonatal multidisciplinary team meeting (FNMTD) as required.

- The FNMDT may agree that advanced care planning is required. This may require parallel shared cared planning with tertiary FMU units, or hospices as appropriate. Responsibility for actions around advanced care planning will be discussed at the weekly FNMTD. Women may be offered appointments with the paediatric consultants to ensure their decisions are fully informed.

- Advanced care plans will be documented on the maternal digital health care record by the screening midwives.

2.18.2.4. Choice to terminate the pregnancy for fetal anomaly

- If a woman chooses not to continue her pregnancy she can be offered the choice of surgical or medical termination and care pathways commenced – see Termination of Pregnancy for Medical Reasons (TOPMR) Clinical Guideline.

- When there is any uncertainty as to whether an anomaly meets ground E of the Abortion act ('substantial risk…….seriously handicapped'), the FMU consultant will discuss with senior multidisciplinary colleagues (local or tertiary FMU doctors and midwives, neonatal doctors, radiologists and/or geneticists) before a termination is provided. This discussion will be fully documented.

  - The fetal medicine consultant should inform the women of the availability of postnatal cytogenetic testing options if clinically appropriate, with expected timeframes for results.

  - A woman's choice on cytogenetic testing should be included in the documented patient report.

  - Women should be informed that postmortem testing may be discussed with them during the Termination of pregnancy process if clinically relevant.

  - The following SOP should be followed to ensure timely and complete follow up of cytogenetic testing. This is available on the shared drive "Follow up Pathway for results after termination for fetal anomaly".

  - Tracking of Terminations / Cytogenetic results should occur on the shared fetal medicine / bereavement database located at TR15 /FMU+Bereavement.

2.18.2.5. **Feticide**

Feticide, a procedure to induce fetal demise is recommended >21+6 weeks of pregnancy once the decision for termination of pregnancy has been made by the parents. Feticide may be offered by the Fetal Medicine Consultant prior to 21+6 if considered clinically appropriate. The procedure is completed in line with Royal College of Obstetricians and Gynaecologists Guideline Termination of Pregnancy for Fetal Abnormality Termination of Pregnancy for Fetal Abnormality.

2.19. MDT communication pathways

2.19.1. Fetal Medicine, Neonatal and Genetics Multidisciplinary Team Meeting (MDT), the 'Fetonatal' Meeting

- The MDT takes place three times a month. Attendance includes Fetal Medicine Consultants and Screening Midwives, Consultant Paediatricians with an interest in neonatology, Sonographers and Clinical Genetics Consultant.
- The meeting enables the FMU team to inform other specialty colleagues of newly identified anomalies and to update on cases under surveillance. Mode, timing and place of delivery will be discussed and agreed.
- The neonatal team will update on the progress of babies currently on the Neonatal Unit and those with congenital anomalies who remain under paediatric review.
- Any anomalies newly identified after birth will be brought to the meeting. A clinical review of unexpected outcomes of screening will occur for all new cases identified postnatally. See SOP Clinical review of unexpected outcomes. This will include a process for reporting to National congenital rare disease reporting service (NCARDRS).
- The Clinical Genetic team will advise both FMU and Neonatal colleagues of genetic implications of an anomaly under discussion.
- A record of antenatal and neonatal cases discussed at this meeting will be kept on the FMU database. This record will only record new information relevant to on-going care obtained in these discussions. A record of attendance will be kept. Responsibility for actions identified at the MDT will be recorded on the FMU database.
- Any pertinent clinical decisions made will be added to the maternal healthcare record by the screening midwives and communicated to relevant professionals (e.g., labour suite board, community midwives).
- It is the responsibility of the neonatal team members attending to disseminate pertinent clinical information back to NNU colleagues.

2.19.2. **Referral to Neonatal services following confirmation of fetal anomaly**

When a fetal anomaly or other case with neonatal implications is identified in FMU:

- A copy of the Viewpoint report is sent to the generic fetonatal email: rcht.fetoneonataladvice@nhs.net
- This generic email is accessed daily by one of the neonatal consultants with responsibility for fetal medicine cases. The consultant will reply in writing to the Fetal Medicine Consultant / screening midwives to confirm a plan has been written for the early neonatal care. The Neonatal letter is e-mailed to the Neonatal IT Administrator for uploading on to the maternal digital health record. It is the responsibility of the admitting midwife to review the health record for any such documents. A copy of the neonatal plan is sent to the woman via post by the neonatal administration team.

2.19.3. **Referral to Clinical Genetics**

Fetal Medicine consultants refer into clinical genetics for consideration of additional genetic testing that may be appropriate for at risk pregnancies in which a genetic diagnosis would guide prenatal management.

2.19.4. **Rapid Prenatal exome sequencing - R21 testing**

2.19.4.1. Rapid prenatal exome sequencing is undertaken for a nationally agreed panel of genes known to cause disorders that may present prenatally. Details of eligibility criteria: R21: Rapid prenatal exome sequencing — Knowledge Hub.

2.19.4.2. R21 testing may only be requested by a clinical geneticist, usually following MDT discussion between the fetal medicine consultants and clinical geneticists.

2.19.4.3. Referral for R21 testing:

- Fetal medicine consultant to discuss potential for R21 exome or other genetic testing with woman / gain consent for referral into clinical genetics.
- Fetal medicine consultant to request for R21 / additional testing consideration via phone, email or via MDT to consultant geneticist and update screening.
- Screening team to email a completed regional clinical genetics referral form and copies of FMU reports to rde-tr.PCGreferrals@nhs.net
- Clinical genetics to make contact with woman to gain consent.

- Clinical genetics to confirm via screening team email whether R21 testing has been agreed.
- Screening team to liaise with clinical genetics re plans for PND testing.
- Screening team to ensure tracking and health record documentation of all results / reports and provide update to community midwifery team.
- Clinical genetics to provide results to woman.

2.19.5. **Referral to other professionals and agencies**

2.19.5.1. All newly identified fetal anomalies will be notified to the National Congenital Anomaly Rare Disease Reporting Service (NCARDRS).). Antenatal notifications are completed using the Viewpoint radiology system.

2.19.5.2. Postnatal notifications are completed using the following national form: NCARDRS: collecting postnatal data - NDRS.

2.19.5.3. Tracking of NCARDRS completion is within the FMU tracking database.

2.19.5.4. Referral will be made to organisations/clinicians for provision of additional support and information as relevant e.g. Cleft Lip and Palate Association (CLAPPA) and Bristol Cleft Team and Royal Cornwall Hospital Physiotherapists for talipes.

2.19.6. **Communication with the woman**

Communication with the woman is ongoing at every appointment and a copy of the Viewpoint report is inserted into her handheld notes after each visit. All Viewpoint reports are available for view within the digital health record. Patient written information is given where appropriate and national leaflets are used when available. When any additional information of importance to the woman (diagnosis or management) is obtained in discussion between health professionals, this will be communicated to the woman either by letter, telephone or at a follow up appointment. Women under the care of FMU may contact the department by telephone 01872 253092 with any concerns between appointments.

2.19.7. **Fetal cardiac anomalies**

For referrals due to a suspicion of a Fetal cardiology anomaly the FMU consultant will either:

- Remotely review USS images obtained with the sonographer and identify the most appropriate location for the next appointment.
- Assess at FMU face to face appointment.

A decision is made for one of the following:

- Initial FMU assessment at RCHT.
- A Telemedicine USS to be performed at RCHT with a link set up with Paediatric Cardiology Department at Bristol Children's Hospital.
- Tertiary referral for fetal cardiology assessment face-to-face in Bristol.

2.19.8. **Referrals to Bristol Cardiology:**

2.19.8.1. Screening team to complete Fetal Cardiology Referral form (see appendix 5) and email to: bristolfetalcardiology@uhbw.nhs.uk

2.19.8.2. Following any tertiary referral the screening team have responsibility for tracking outcomes of specialist assessment.

- Bristol consultation summary to be uploaded to RCHT digital health records.
- Copies sent to Neonatal consultants at rcht.fetoneonataladvice@nhs.net

2.19.8.3. RCHT have a cardiac sonographer champion who attends fetonatal meetings and reports on any cases which we not detected antenatal and required postnatal cardiac surgery. The SOP Unexpected outcomes of screening is followed.

2.19.9. **Fetal surgical anomalies / Second Opinion:**

2.19.9.1. Cases requiring neonatal surgery, or a second opinion are referred to the FMU tertiary unit at St Michael's Hospital in Bristol. Where there is any doubt or potential controversy about the diagnosis or management, a tertiary FM consultant discussion will be sought and documented on Viewpoint. Where there is major diagnostic uncertainty, a tertiary centre second opinion will be offered to the parents.

2.19.9.2. Plans for frequency and setting of antenatal follow-up and place of delivery are provided by the tertiary FMU.

2.19.10. **Tertiary FMU referral is made via referapatient, as per above.**

- Screening midwives have responsibility for tracking and documentation upload of tertiary outcome reports.
- Screening Midwives have responsibility for ensuring timely local follow up FMU appointments.
- Screening midwives to ensure FMU tertiary reports are sent to neonatal consultants at rcht.fetonataladvice@nhs.net with a request to review / amend any neonatal plan.

It is essential these actions are completed timely in case a woman may present locally in preterm labour.

2.19.11. **Fetofetal transfusion syndrome:**

2.19.11.1. All cases meeting Quintero Stage 1 disease or greater will be discussed with FMU colleagues in the tertiary centre in Bristol. A plan of ongoing care will be agreed and clear instructions obtained for referral for invasive treatment. This discussion is documented in the Viewpoint report.

2.19.11.2. Brain anomalies: When diagnostic accuracy or management would be aided by MRI, this will be requested to the Department of Neuroradiology at North Bristol NHS Trust. Email: MRIbookingqueries@NBT.nhs.uk

2.19.11.3. MRI reports will be uploaded to Maxims by Fetal Medicine Administrative staff.

2.19.12. **Complex Fetoneonatal MDT:**

2.19.12.1. Complex Congenital Anomalies, Extreme Growth Restriction, significant PPROM (prelabour preterm rupture of membranes) and Pulmonary Hypoplasia are all associated with significant perinatal morbidity and mortality. Wherever possible, babies who will require tertiary level NICU care should be delivered in the correct centre for that level of care.

2.19.12.2. Congenital anomalies are associated with preterm birth, and in cases where immediate tertiary management may be required, or where the effects of prematurity may preclude survival, it is important that there is consideration of the appropriateness of in-utero transfer and/or management in an LNU, in event of presentation in preterm labour or when IUT may not be possible.

2.19.12.3. There should be routine parental involvement in all decisions around care. This should be done in a timely manner, but also sensitively to allow parents time to consider and process information. It is also important that it is made clear that all decisions can be reexplored, with changes in clinical status or in case of change in parental view. It is also important to recognise the limits of medical care, and that it is not always appropriate to provide invasive/painful treatment, when there is limited chance of altering the outcome as this will cause unnecessary suffering.

2.19.12.4. The following process should occur in cases where there is a Fetal Medicine Diagnosis which will require Tertiary NICU / Specialist centre Delivery and:

- is likely to require immediate specialist care only available in tertiary centre.

OR

- is highly likely to be incompatible with survival if associated with preterm birth.

OR

- has a diagnosis where parallel palliative planning is required.

2.19.12.5. There should be a planned discussion in the local Fetoneonatal meeting at the earliest opportunity. If this is likely to be significantly delayed, or a sooner discussion or decision is required, the fetal medicine should contact the neonatal service consultant.

2.19.12.6. In all cases it is critical that there is appropriate involvement of local and regional expertise relevant to the case.

2.19.12.7. For cases of significant pulmonary hypoplasia / growth restriction, then the regional expertise of the tertiary NICU team in Derriford should be sought, as the normal location for care for these babies. The transitional care consultant is the appropriate consultant to contact and should be contacted by the local neonatal team for their advice / and or to request attendance at any planned complex fetoneonatal MDT.

2.19.12.8. For cases with significant congenital anomalies, then the regional expertise of the regional surgical/cardiac/neurosurgical team should be sought, as the normal location of care for these babies. The transitional care consultant is the appropriate consultant to contact and should be contacted by the local neonatal team for their advice / and or to request attendance at any planned complex fetoneonatal MDT.

2.19.12.9. Whenever possible a complex fetoneonatal MDT should be arranged, with involvement of the RCHT Neonatal team, RCHT Fetal Medicine Team, Relevant NICU team, and other specialties as determined by diagnosis. This would ideally be followed by a conversation involving the parents, or with an arranged teams / face to face meeting with the relevant specialists and / or tertiary relevant NICU team as appropriate.

2.19.12.10. See Appendix 3 for the flowchart of the complex fetoneonatal MDT pathway.

2.19.12.11. The outcome of this meeting should be documented on the Complex Fetoneonatal MDT Outcome Form (Appendix 4). This form can be copied and pasted into a Viewpoint 6 entry and then uploaded to Maxims and E3 as a report.

2.19.12.12. If appropriate a referral to palliative care should be made. If appropriate an RCHT TEP form should be completed and kept in the maternal handheld notes. There must be a clear re-review date on the form, and this should be noted on the fetoneonatal MDT spreadsheet, so that it can be updated when required. This form should make clear the actions needed for unexpected home delivery and for potential hospital delivery.

2.19.12.13. Relevant national and regional guidance

- Perinatal Palliative Care Guideline – South West Neonatal Network Futures - Futures
- CYPACP (Version 5) Ante-natal Advance Care Plan Ante-natal Advance Care Plan (with and without ReSPECT) – CYPACP
- BAPM Perinatal Palliative Care https://www.bapm.org/resources/palliative-care-in-perinatal-medicine-framework
- BAPM Extreme Preterm Birth: https://www.bapm.org/resources/80-perinatal-management-of-extreme-preterm-birth-before-27-weeks-of-gestation-2019

2.20. Maternal Medicine Cases

Cases that do not require FMU input but have anticipated implications for the neonate are communicated to the neonatal consultants via rcht.fetonataladvice@nhs.net. It is the responsibility of the community midwife to follow availability and outcomes of neonatal case reports that do not have FMU input.

2.21. Woman presenting acutely with a known fetal anomaly

2.21.1. When a woman presents in threatened or established preterm labour or requires urgent delivery for maternal or fetal compromise, it is the responsibility of the Obstetric senior doctor (ST3+) in liaison with the on call Consultant Obstetrician and Neonatal consultant to discuss the case as a matter of priority.

2.21.2. When there are problems with cot availability or delivery was planned to take place in the tertiary centre, the on call Obstetric and Neonatal Consultants will discuss the appropriateness of in utero transfer (In Utero Transfer Into and Out of Royal Cornwall Hospital Clinical Guideline). Senior involvement from both the obstetric and neonatal teams is appropriate when an emergency delivery is being considered at extremes of prematurity.

2.22. Failsafe

- Fetal medicine referrals are recorded on a database and used to track the screening outcome from point of entry into fetal medicine, until discharge from the service.
- The tracking database lists all prenatal genetic samples sent to the laboratory to ensure each prenatal sample taken has a reported outcome.
- The tracking database lists all cases which require a neonatal plan, with a colour code to identify when a neonatal plan has been requested, awaited, received.
- The neonatal team have a neonatal tracker to list all cases requiring a neonatal plan and to monitor progress to finalising a plan.
- Weekly failsafe tracking of all anomaly scans to include follow up of DNA – in line with the maternity DNA SOP.

2.23. Reporting and Governance

2.23.1. External Reporting and Monitoring

- Reporting to the South West FMU Operational Delivery Network Board. This meeting is attended by the FMU consultant lead.
- NHS England Screening Programme Board. This meeting is attended by the FMU FASP consultant lead, Screening Support Sonographer and the Screening Lead Midwife.
- Quarterly and annual data submission to NHS England FASP screening standards – S08a and b and PND timeframe Fetal anomaly screening programme: standards - GOV.UK.
- Quarterly Data submission to South West FMU Operational Delivery Network.
- NCARDRS reporting and completion of chasing lists.
- SSQD data reporting to NHS England.

2.23.2. Internal Reporting and Governance

2.23.2.1. **Monthly Fetal Medicine Meeting** - The monthly business meeting of the fetal medicine unit provides regular governance structure. A standard agenda template / minutes are provided for this meeting.

2.23.2.2. Issues for immediate escalation are taken to the fetal medicine consultant clinical lead, care group consultant clinical director and senior midwifery management / screening matron. Consideration is given to early NHS England Screening commissioning or quality assurance support / reporting is required if the issues relates to a FASP pathway

issue. All issues taken for immediate escalation will be reported to the next Obstetric and Maternity Business Governance meeting for the Division.

2.23.2.3. Onward escalation of issues are taken to the monthly maternity and obstetric business meeting

2.23.2.4. **Screening Operational Group Meetings – Twice yearly.** Attended by the FASP clinical consultant lead, Screening Midwife, and senior maternity management team. FASP reporting is a standard agenda item. Governance escalation pathways are evident in the Terms of Reference.

2.23.2.5. FASP performance reporting is included as part of the screening governance report, submitted Bi-monthly as a standard agenda item on the Obstetric and Maternity Business Governance meeting for the Division.

2.24. **Training**

2.24.1. Fetal Medicine Consultants: All fetal medicine consultant specialists have training in fetal medicine.

2.24.2. Midwife Sonographers: It is recommended that all sonographers complete FASP elearning for health modules every 24 months. A training record is maintained by the sonography lead.

2.24.3. Sonographers have time allocated to complete regular cardiology update sessions, with the cardiology champion having dedicated training time.

2.24.4. Antenatal Screening Team: An induction pack exists for midwives who join the Antenatal Screening team, to include training in Fetal Medicine PND procedures. Attendance at regional FMU and national Antenatal Results and Choices conferences is supported.

2.24.5. Maternity Staff receive annual training according to the training needs analysis (TNA). This has recommendation to complete E-Learning for Health online FASP training modules.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Record keeping by Obstetricians, Neonatologists, Midwives, Nurses, and other Allied Health Professionals.
Lead	Antenatal and Newborn Screening Coordinator.

Information Category	Detail of process and methodology for monitoring compliance
Tool	• Viewpoint report filed in the medical notes. • Was the view point report copied to the Lead Consultant Neonatologist. • Was a referral required to any other specialist/tertiary service. • Evidence of the required referral in the medical records. • Evidence that the case was discussed at the Fetonatal Meeting.
Frequency	Once during the period of this guideline or earlier if concerns are identified.
Reporting arrangements	Maternity Patient Safety or Audit Review Team.
Acting on recommendations and Lead(s)	• Deficiencies identified will be discussed at the Maternity Patient Safety Meeting / Audit Review Team. • An action plan will be developed. • An action plan lead will be identified and a time frame agreed for the action. • The action plan will be monitored by the Maternity Patient Safety Midwife.
Change in practice and lessons to be shared	• A lead member of the forum will be identified to take each change forward where appropriate. • Patient Safety Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity and Inclusion Policy or the Equality and Diversity website.

4.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Fetal Medicine Referral, Multi-disciplinary Team and Communication Clinical Guideline V4.0
This document replaces (exact title of previous version):	Fetal Abnormality Communication Clinical Guideline V3.0
Date Issued/Approved:	September 2026
Date Valid From:	September 2026
Date Valid To:	September 2029
Directorate/Department responsible (author/owner):	Sarah Bennett Day, Antenatal screening coordinator
Contact details:	01872 253092
Brief summary of contents:	This guideline describes the referral and communication process between the Fetal Medicine Unit (FMU), the Neonatal Team and other relevant specialist services, when a fetal anomaly is identified.
Suggested Keywords:	Fetal, Medicine, anomaly, neonatal, communication, scan, perinatal, morbidity.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	None required
Related Documents:	None required
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
September 2009	V1.0	Initial Version.	Mr Rob Holmes, Consultant Obstetrician
April 2012	V1.1	Updated to include Compliance Monitoring.	Mr Rob Holmes, Consultant Obstetrician
August 2012	V1.2	Changes made to Compliance Monitoring only.	Jan Clarkson, Maternity Risk Manager
18 September 2015	V1.3	Minor changes: Written information given to women and contact numbers. NEW Section 2.4 Referral to other agencies. Neonatal cases to be included in reviews.	Rob Holmes, Consultant Obstetrician
13 July 2018	V2.0	Full review. Changes made to sections: 2.1, 2.2, 2.3, 2.4, 2.7, 2.8.3, 2.8.4, 2.8.5 and 2.10.	Rob Holmes, Consultant Obstetrician
July 2021	V3.0	Full review. Updated guidance on electronic maternity records.	Rob Holmes, Consultant Obstetrician
September 2026	V4.0	Full review including addition of referrals for fetal echocardiograms.	Robbie Kerr, Consultant Obstetrician and Sarah Bennett Day, Antenatal screening coordinator

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

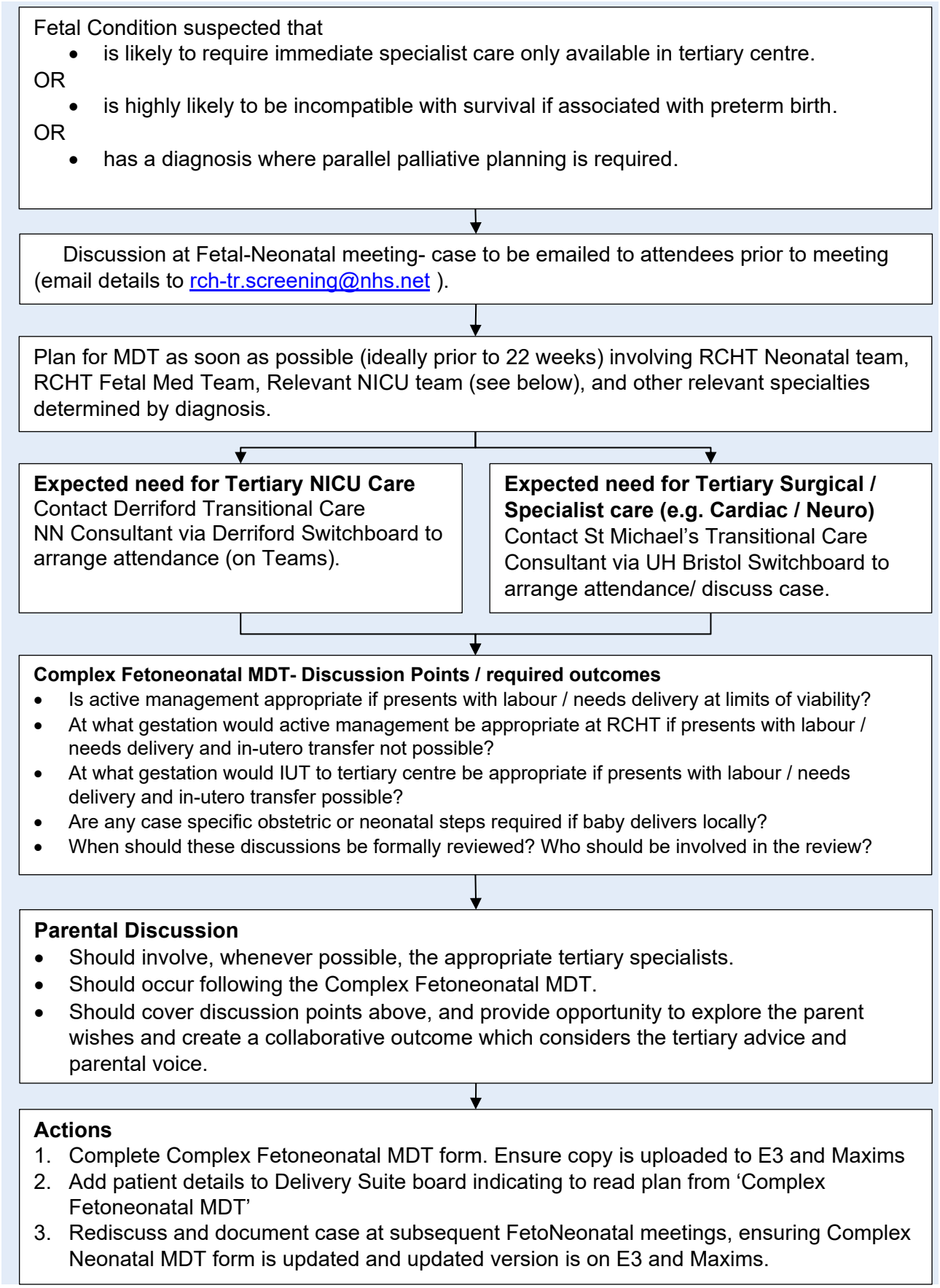
E11 QEIA Policy

For guidance, please see the QEIA Essentials – Quick Reference Guide or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

Appendix 3. Summary Flowchart of Complex Fetoneonatal MDT



Appendix 4. Complex Fetoneonatal MDT Discussion Outcome Form

Date:

Present:

Obstetric management if suspected threatened preterm birth:

Fetal monitoring plan (antenatal/intrapartum):

Neonatal plan:

Family aware of the above: Yes/ No If Yes Date_____

If no, clinician/date MDT discussion will be shared: _____

Is a TEP - DNACPR form planned?: Yes/ No If Yes Date of completion_____

Is an Advanced Care Plan planned?: Yes/No If Yes Date of completion_____

Date of review of the above MDT plan: _____

Has Delivery Suite Board been updated: Yes/No If Yes Date_____

MDT Statement:

All staff please note that this MDT management discussion is to help inform the oncall clinical team of the suggested management in the event of threatened preterm birth. It is not a replacement for senior clinical judgement and decision-making, and does not cover all clinical scenarios. In every scenario care must be planned for the safety of both mum and baby, and management should be planned to prioritise maternal safety. The planned care will depend on the clinical scenario (e.g. care on delivery suite, intravenous antibiotics in chorioamnionitis, use of TOCO to monitor contractions). Given the complexity of these scenarios consultants in obstetrics and neonatology should be involved in the event of a presentation/admission.

Appendix 5. Fetal Cardiology Referral Form

(stored in shared drive)

Fetal Cardiology

Fetal Cardiology Enquiries
Tel: 0117 342 5394

Email (referrals only):
ubh-tr.BristolFetalCardiology@nhs.net

University Hospitals Bristol
NHS Foundation Trust

Fetal Cardiology Department
St Michael's Hospital (Level E)
Southwell Street
Bristol
BS2 8EG
Main Switchboard : 0117 923 0000

Fetal Cardiology Referral

Please tick box to indicate if routine or urgent

Routine ☐	***Urgent (48-72 hrs)YES***

Date of Referral		Referring Hospital	RCHT
Referring Clinician	Robbie Kerr	Contact number	01872 253092
Reason for Referral ***(As much detail as possible in accordance to the referral guidelines)***			

Surname		**First Name**	
NHS No ESSENTIAL		**D.O.B**	
Address			
Patient Landline		Patient Mob:	
EDD		Gestation at referral:	Patient Email

Interpreter Required? Language:	Safeguarding issues?	Single Pregnancy ☐ Multiple Pregnancy ☐ BMI:	Gravidity: Parity:

GP Practice		GP's Name	
GP Address			

For Admin

18 wk	20 wk		Pt No.

Example Only