NHS
The Shrewsbury and Telford Hospital
NHS Trust

Routine 18^{+0} to 20^{+6} weeks Mid-Pregnancy Screening Scan

Version 4.3

Lead Person(s) : Fetal Medicine Consultants
Care Group : Women and Children's
First implemented : 11th December 2012
This version implemented : 24th June 2025
Planned Full Review : August 2026
Keywords : *Mid Pregnancy scan*
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Comments : References to SaTH Guidelines in the text pertain to the latest version of the Guideline on the intranet. Printed copies may not be the most up to date version.

For triennial review

Version	Implementation Date	History	Ratified By	Full Review Date
1	11th December 2012		MGG Maternity Governance	Dec 2015
2	6th July 2016	Full Version Review	MGG Maternity Governance	July 2019
2.1	5th October 2016	Addition to section 5.3 referral for GTT see section 5.3.5	MGG	July 2019
3	22nd August 2018	Full version review. Update to section 5.3 criteria for GTT	MGG Maternity Governance	July 2023
3.1	11th March 2019	• Amendments to paragraph 4.1 • Update to paragraph 5.2.1 • 5.3.5 location of placental edge • Addition of section 6 missed screening • Amendment to section 7 training for midwife sonographers.	MGG Maternity Governance February 2019	July 2023
3.2	20th January 2023	minor amendments reflecting current **changes** in practice	Maternity Governance	July 2023
3.3	16th March 2023	Auditable standards- Appendix 8		July 2023
4	21st August 2023	Full review	Maternity Governance	August 2026
4.1	19th July 2024	Minor amendments	Maternity Governance	August 2026

4.2	15th April 2025	Minor amendment- Appendix 10 updated and process for missed or late screening clarified	Maternity Governance	August 2026
4.3	24th June 2024	Minor wording changes in section 5.3.8 and additional additions made in section 5.2.5 regarding identification of possible 'missed screening for T21 and/or T18/13 ' following a recent incident/SIAF recommendation.	Maternity Governance	August 2026

1.0 Introduction

In this guideline we use the terms 'woman' or 'mother' throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

Women booked for care and delivery with SATH should be offered a mid-pregnancy screening scan.

The NHS Fetal Anomaly Screening programme (FASP) recommends the ultrasound scan which is performed between 18^{+0} to 20^{+6} weeks to screen for 11 physical conditions (Appendix 1).

The screening pathway must be completed by 23^{+0} weeks.

The scan should be performed in accordance with the NHS FASP base menu (see section 2) and fetal cardiac protocol.

If the scan cannot be performed within this timeframe, due to late booking or the woman is unable to accept appointment at the appropriate time, then the scan should be offered as soon as possible. However, the midwife sonographer should inform the woman that it may not be possible to complete the scan due to sub optimal fetal views in later pregnancy.

This guideline should be used in conjunction with the relevant maternity antenatal screening and maternity ultrasound guidelines.

2.0 Aim(s)

To offer NHS screening for fetal unexpected development, between 18^{+0} and 20^{+6} weeks to all pregnant women, so that appropriate and timely referral can be made for a Fetal Medicine Consultant scan if required.

3.0 Objectives

The main structures to be assessed at the 18+0 to 20+6 week scan are defined in the base menu (Appendix 2) and Fetal Cardiac Protocol (Appendix 3).

The purpose of the 20-week screening scan is to identify specified conditions that:

- benefit from treatment before or after birth
- need treatment in a specialist setting after birth to improve health outcomes
- could mean the baby may die shortly after birth
- lead to a discussion about the options of continuing or terminating the pregnancy

To determine placental location (NICE, 2021)

4.0 Definitions/Abbreviations

4.1 Mid-pregnancy screening scan – the ultrasound scan which is performed between 18^{+0} to 20^{+6} weeks to screen for 11 physical conditions (Appendix 1).

The purpose of the 20-week screening scan is to identify specified conditions that:

- benefit from treatment before or after birth

- need treatment in a specialist setting after birth to improve health outcomes
- could mean the baby may die shortly after birth
- lead to a discussion about the options of continuing or terminating the pregnancy

The scan should be performed in accordance with the NHS FASP base menu and fetal cardiac protocol.

The base menu shows the anatomical structures of the baby to be assessed. Unexpected development of these structures can indicate one of the 11 physical conditions screened for. Other conditions can also be detected but these are not part of the NHS FASP. This is because the data is insufficient to confidently predict the standard for detection that should be achieved.

4.2 MIS – Maternity Information System – electronic maternity records
(Viewpoint for ultrasound reports, Badgernotes for all maternity documentation)

5.0 Process

5.1 Pre-Scan Preparation

The pregnant woman will be provided with information at "first contact "and/or early pregnancy dating scan, about the 18+0-20+6 weeks mid -pregnancy scan. This information will include the purpose, limitations, benefits and consequences of the procedure as well as the implications of normal and unexpected scan findings.

The woman's choice to "accept" or "decline" the mid pregnancy screening scan will be recorded on the Maternity Information System (MIS); the appointment will be booked following this consent the dating scan.

5.2 The 18+0-20+6 weeks mid - pregnancy screening scan procedure

5.2.1 Fetal Assessment – refer to base menu (Appendix 2) and fetal cardiac protocol (Appendix 3). Images of the 6 specific fetal anatomical sections as described in the ultrasound scan base menu will be archived (Appendix 2):
1. head circumference demonstrating HC measurement and measurement of the atrium of the lateral ventricle
2. subocciptobregmatic view demonstrating measurement of the transcerebellar diameter
3. coronal view of the lips with nasal tip
4. abdominal circumference demonstrating AC measurement
5. femur length demonstrating FL measurement
6. sagittal view of the spine including sacrum and skin covering (or coronal views of the spine if sagittal image is not attainable due to fetal position)

5.2.2 Placental Location – See trust guidelines (Suspected Placenta Praevia and Suspected Placenta Praevia Accreta, Ultrasound Guideline)

5.2.3 Liquor volume visual assessment – no measurement required unless appears outside of normal range

5.2.4 Fetal gender - There is no requirement to determine fetal gender within the FASP in England; it is not part of the 18+0 to 20+6 FASP ultrasound scan base menu. If the woman requests to be told the fetal gender, the sonographer can disclose this if it is possible to determine from the ultrasound view achieved. If it is not possible to determine the fetal gender, no further ultrasound time or further appointment will be arranged. The woman will be advised of the limitations of ultrasound in determining fetal gender accurately.

5.2.5 Screening results from combined or quadruple test will be checked and will be uploaded to BN if not already done. Discussion about screening will be documented on the MIS. If a missed screening for T21 and/or T18/13 is identified, the pathway outlined in Section 6 will be followed. If the woman's gestation is 20w0d or under, the quadruple test can be offered and performed at this appointment.

5.3 Post Scan Procedure

5.3.1 On completion of the examination the woman will be informed of the scan findings.

5.3.2 If it has not been possible to complete the examination due to sub optimal views or fetal position a further single appointment will be arranged in 1- 2 weeks or up to 23 weeks gestation for completion.

5.3.3 Where a woman attends for a repeat ultrasound scan and the image quality remains compromised, there is no requirement to offer a further scan to complete screening. The woman should be informed that screening is incomplete, and this must be recorded (FASP, 2023).

5.3.4 Images of the 6 specific fetal anatomical sections as described in the ultrasound scan base menu (Appendix 2) will be archived on viewpoint report and Radiography Information System (CRIS). Hard copy images will be retained in instances where electronic image storage not available, with reason documented.
There is no NHS FASP requirement to archive images of the fetal cardiac protocol views.

5.3.5 If any unexpected development is suspected the midwife sonographer will explain the scan findings, the need for referral to Fetal Medicine Specialist for further review and give appropriate written information as available, or FMS scan referral information, see appendix 11. Relevant images will be attained and archived.

An appropriate referral to a Fetal Medicine Specialist (FMS) will be made for the next suitable appointment (FASP, 2024); this should be within 3 working days local referral, within 5 working days for Tertiary Centre referral (FASP-S08: referral: timeliness to intervention).
Referral to SATH FMS for fetal growth concerns at the mid-pregnancy screening scan, see Appendix 10

5.3.6 Referral to Level 2/tertiary Centre will be made by secure NHS email following pathway outlined in the SaTH 'Referral for Fetal Medicine Services Standard Operating Procedure' to designated Level 2 centre dependant on woman's postcode or level 3/tertiary centre (Fetal Medicine Unit, Birmingham Women's Hospital, FMU BWH).

Referral will be made using generic Regional Fetal Medicine form (Appendix 7) with copy of ultrasound report and relevant images, combined/quadruple/ screening tests, Maternal blood group with antibody typing attached.

5.3.7 Badgernotes Fetal Medicine plan and Risk section will be updated. Referral database will be updated. NCARDRS form will be completed and sent with relevant ultrasound

reports attached

5.3.8 If the leading edge of the placenta is within 2 cm of the internal os, a follow up placental location scan appointment will made for 32 weeks gestation if no previous caesarian section. The appointment will be made on a routine growth scan list if the placenta does not extend over the internal os, or made for a scan within a Consultant Antenatal Clinic if the placenta does extend over the internal os.

5.3.9 For cases where the placenta is anterior and low and there has been previous caesarian section/uterine surgery, referral will made to local Fetal Medicine Specialist / level 2 unit before 24 weeks gestation, as per the Placenta Praevia and Placenta Accreta: Diagnosis and Management guideline.

6.0 Failsafe

6.1 The midwife sonographer will follow up any Did Not Attend (DNA) appointments and rebook appointment if still required. DNA documentation will be completed

6.2 The maternity reception staff will inform the midwife sonographer at the end of the list if a woman has not booked a mid-pregnancy re-scan appointment following an incomplete first mid pregnancy screening scan. This will be booked if required.

Missed/Late Screening

In the event of a missed screen or late screening performed outside FASP specified range, refer to the Public Health England (PHE) Guidance 'Managing Safety Incidents in NHS Screening Programmes' published 2015, latest update Oct 2024.

- Report the incident on 'Datix', the Trust incident reporting system.
- Inform the Antenatal and Newborn (ANNB) Screening Lead Midwife.
- The ANNB Screening Midwife will complete a Screening Incident Assessment

Form (SIAF) to collect information on the suspected incident to determine its severity.

- The SIAF will be sent to the NHSE Screening Quality Assurance Service and the Screening and Immunisation Team for North Midlands (Shropshire and Staffordshire)
- The incident will be reviewed at the 'Maternity Risk Meeting'.
- The incident investigation will follow the Trust Risk Management Policy and PHE Guidance

7.0 Training

7.1 Midwife sonographers will hold an accredited ultrasound qualification, as specified by NHS FASP in Service Specification No 17 and FASP Fetal Anomaly Screening Handbook (FASP, 2024).

7.2 Midwife sonographers will have undertaken fetal echocardiography training

7.3 Midwife sonographers will attend continuous professional development training as required by NMC (2015) and FASP (2024) This should be funded by the provider (FASP, 2024).

7.4 Midwife sonographers will ensure that their frequency of practice affords the maintenance of skill levels (FASP,)

8.0 Monitoring/audit

8.1 Monitoring

8.1.1 Required data for KPI FA2- coverage of screening for the 18+0 to 20+6 week scan, will be reported quarterly to FASP.

8.1.2 For quality and monitoring of the screening pathway, data must be provided according to the following schedule or on request from PHE Screening:

- annual submission of data on national screening standards (FASP-S04:test:20 week screening scan, FASP-S08:referral:timelines to intervention (20 week screening scan))

8.1.3 For quality and monitoring of screening programme outcomes, information must be shared with the National Congenital Anomaly and Rare Disease Registration Service (NCARDRS) according to the following schedule or on request from PHE Screening:

- notification of all suspected and confirmed unexpected development from screening undertaken in pregnancy at the time of the scan
- follow up of specific information requests as required by NCARDRS

8.1.4 Undetected cases of unexpected development diagnosed following birth will be reviewed using the SQAS Clinical Review Template- fetal anomaly screening (2) (Appendix 9) by the SSS/lead sonographer and Antenatal Screening Co-ordinator
Cases will be discussed at monthly Feto-maternal multidisciplinary team meetings

8.2 Audit

Compliance with this guideline / SOP will be audited as part of the Shrewsbury and Telford Hospital NHS Trust's five-year rolling programme of NICE and local guideline audits, unless circumstances require an earlier or more frequent audit. The audit will be carried out using the auditable standards and the results will be reported and acted on in accordance with the Trust Clinical Audit Policy (CG25).

9.0 References

Fetal anomaly screening programme handbook - GOV.UK (www.gov.uk) latest update 19/02/2024

Fetal Anomaly Screening Standards valid for data collected from 1 April 2022.www.gov.uk/government/publications/fetal-anomaly-screening-programme-standards

Gornall AS, Kurnczuk JJ and Konje JC (2003). Antenatal detection of a single umbilical artery: does it matter? Prenatal Diagnosis. 23: 117-123.

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National Institute for Clinical Excellence. Quality Standard QS22. www.nice.org/guidance/qs22

Nursing and Midwifery Council. The Code. Professional standards of practice and behaviour for nurses, midwives and nursing associates (NMC 2015, last updated 10 October 2018) https://www.nmc.org.uk/standards/code/read-the-code-online

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www.gov.uk/topic

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 27a. Placenta Praevia and Placenta Accreta. Diagnosis and Management. September 2018, last updated 06.27.2022.

Royal College of Obstetricians and Gynaecologists (2016) Providing Quality of Care for Women. A Framework for maternity service standards

Appendix 1

The conditions screened for as a minimum in England (FASP 2022)

Conditions

Anencephaly

Open spina bifida

Cleft lip

Congenital Diaphragmatic hernia (CDH) left and right sided

Abdominal wall Defects: Gastroschisis and exomphalos

Serious cardiac anomalies includes the following:

- Transposition of the Great Arteries (TGA)
- Atrioventricular Septal Defect (AVSD)
- Tetralogy of Fallot (TOF)
- Hypoplastic Left Heart Syndrome (HLHS)
- Coarctation of the Aorta

Bilateral renal agenesis

Severe skeletal dysplasia

Edwards' syndrome (Trisomy 18)

Patau's syndrome (Trisomy 13)

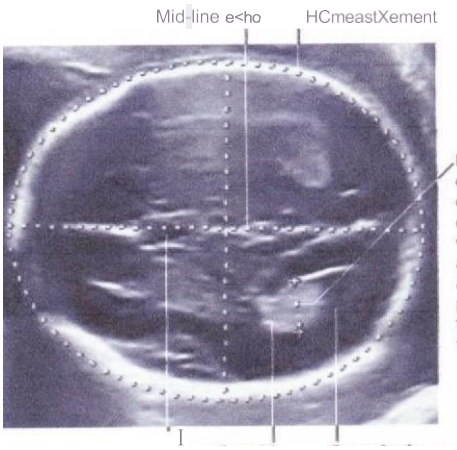
Appendix 2

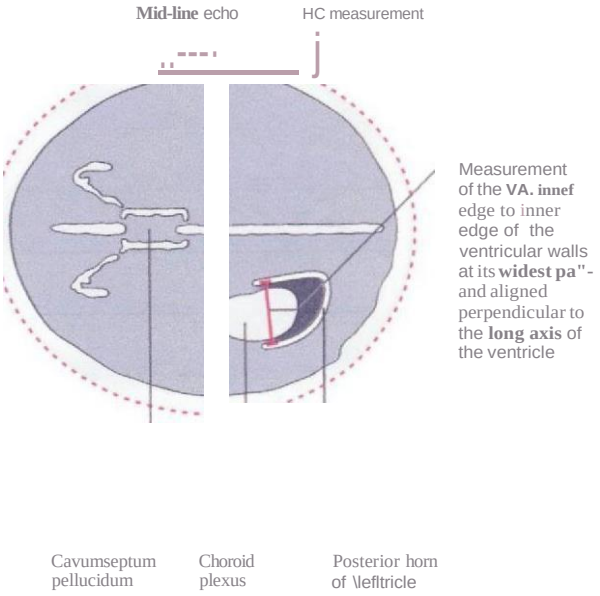
18+0 to 20+6 FASP Ultrasound Scan Base Menu

Structure/Area	Detail	Fetal Measurements*	Images/measurements to capture/archive
Head and neck • **Skull** • **Brain** • **Neck**	Head shape	*Head circumference (HC)	Yes, to include HC measurement, CSP, posterior horn and measurement of the ventricular atrium at the level of the glomus of the choroid plexus
	Cavum septum pellucidum (CSP)	Measurement not required	
	Ventricular Atrium (VA)	*Atrium of the lateral Ventricle	
	Cerebellum	*Transcerebellar diameter (TCD)	Yes, to include measurement of the TCD in the suboccipitobregmatic view
	Nuchal Fold (NF) Measure if appears large	Distance between the outer border of the occipital bone and the outer skin edge	Yes, if measurement ≥ 6mm
• **Facial Features**	Coronal view of lips & nasal tip	Measurement not required	Yes
• **Lungs** • **Heart**	Visceral situs/laterality of heart	Measurement not required	Annotate "LT" and "RT" on archived images to denote visceral situs/ laterality
	a) Four chamber view (FCV)		No
	b) Aorta (Ao) arising from left ventricle		No
	c) Pulmonary artery (PA) arising from right ventricle, or the 3 vessel view (3VV)		No
	d) 3 vessel and trachea view (3VT)		No

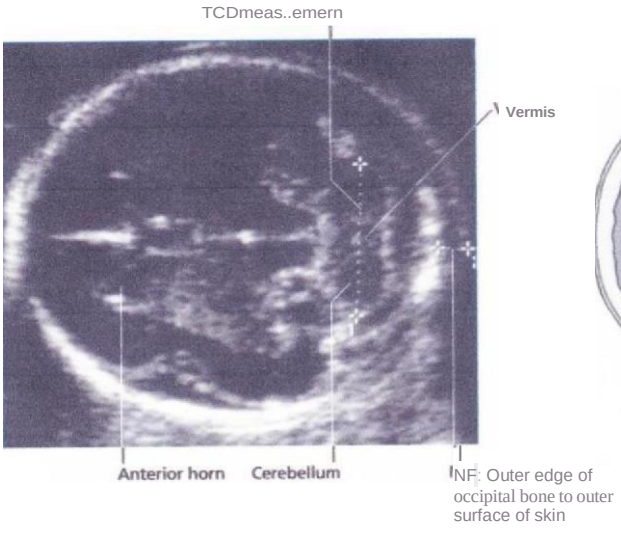
Structure/Area	Detail	Fetal Measurements*	Images/measurements to capture/archive
Abdominal content	Stomach & position	Measurement not required *Abdominal circumference (AC)	Yes
	Short intra-hepatic section of the umbilical vein **(UV)**		
	Abdominal wall and cord insertion		
	Diaphragm	Measurement not required	
	Kidneys Measure AP renal pelvis diameter if it appears large	Measurement not required unless renal pelvis AP diameter >7mm	Yes. if AP renal pelvis diameter measures >7mm
	Bladder	Measurement not required	
Spine • **Cervical** • **Thoracic** • **Lumbar** • **Sacral**	Vertebrae Skin covering	Measurement not required	Yes, image either sagittal or coronal plane
Limbs • **Upper & lower**	Femur, tibia & fibula (both legs)	*Femur length	Yes, image and measure a single femur only
	Metatarsals (both feet)	Digit count not required	
	Radius, ulna, humerus (both arms)	Measurement not required	
	Metacarpals {both hands)	Digit count not required	
Uterine cavity • **Uterine content**	Placenta	According to local policy/protocol	
	Amniotic fluid	According to local policy/protocol	

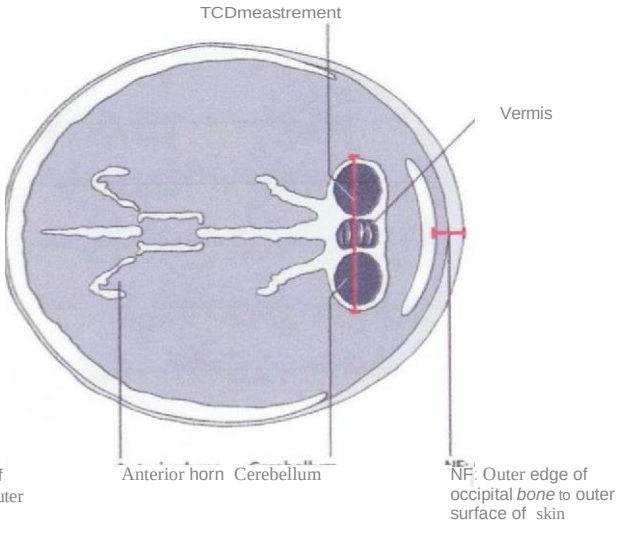
Head circumference (HC) and ventricular atrium (VA)



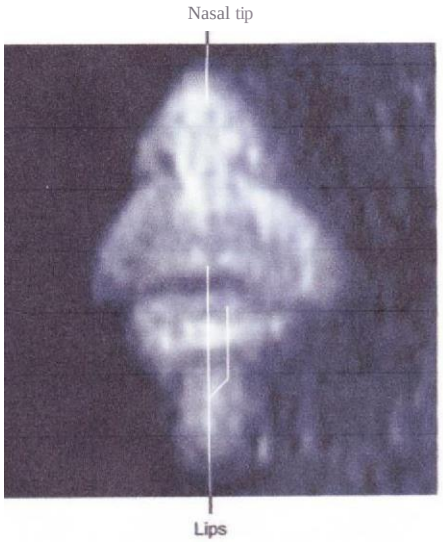


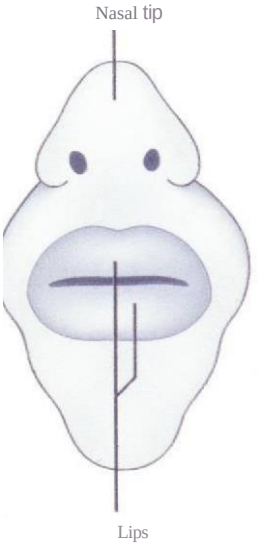
Transcerebellar diameter (TCD) and nuchal fold (NF)



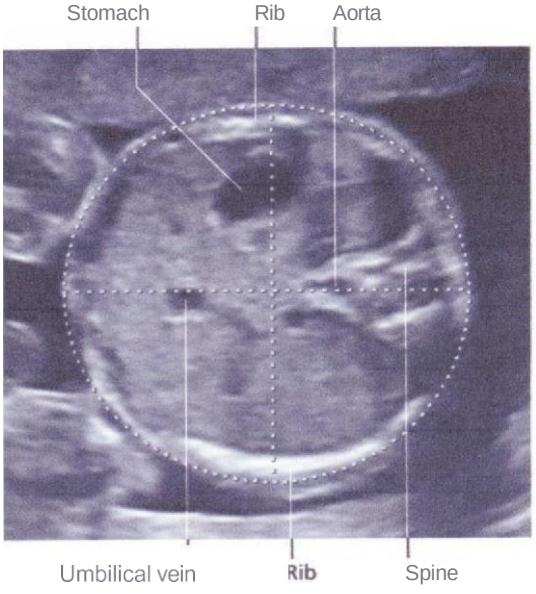


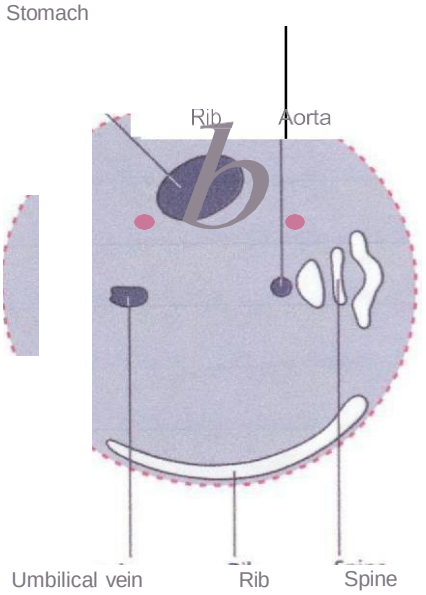
Lips and nasal tip



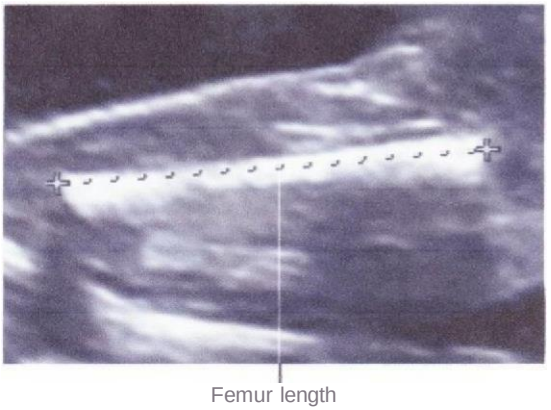


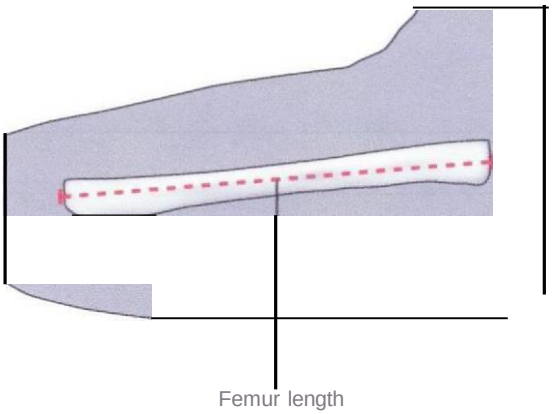
Abdominal circumference (AC)



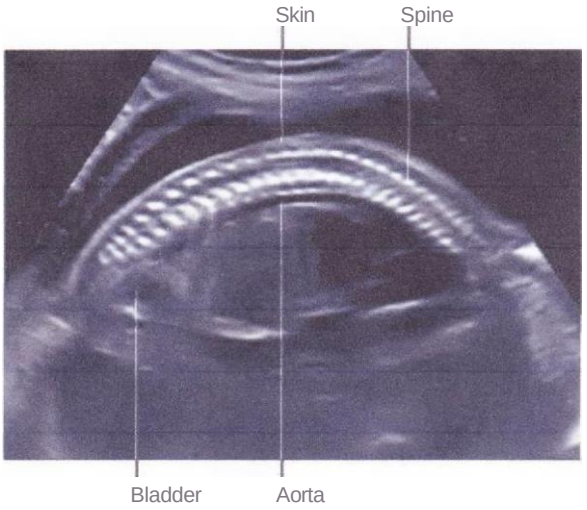


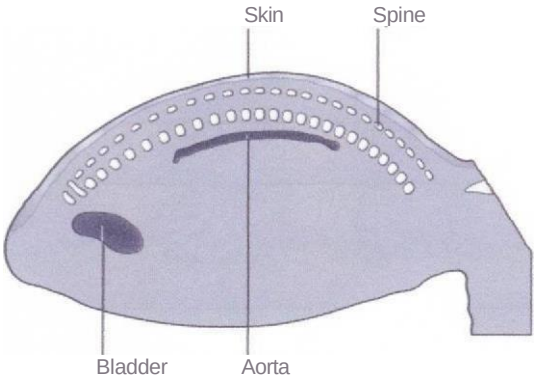
Femur length (FL)



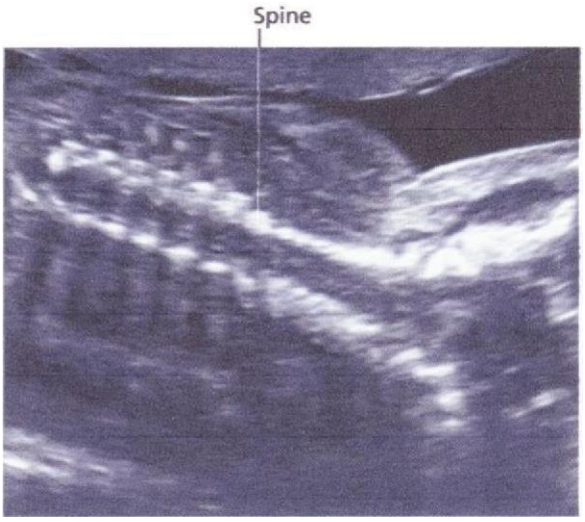


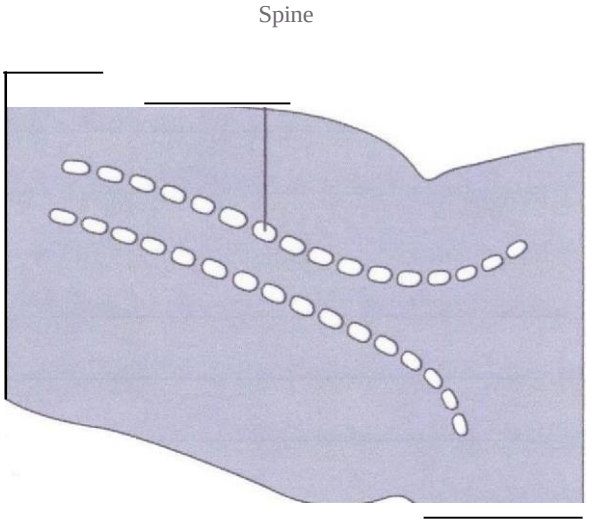
Sagittal spine



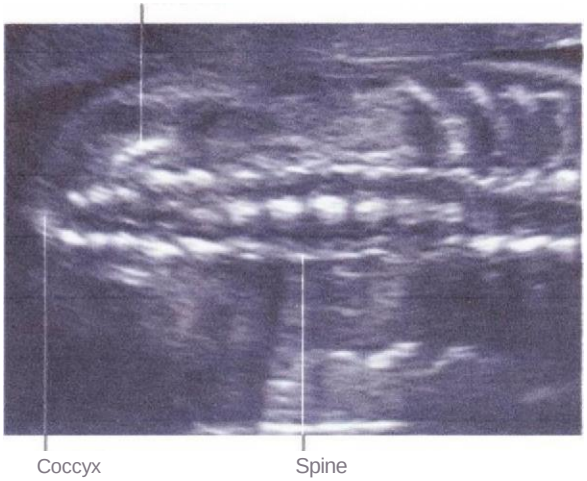


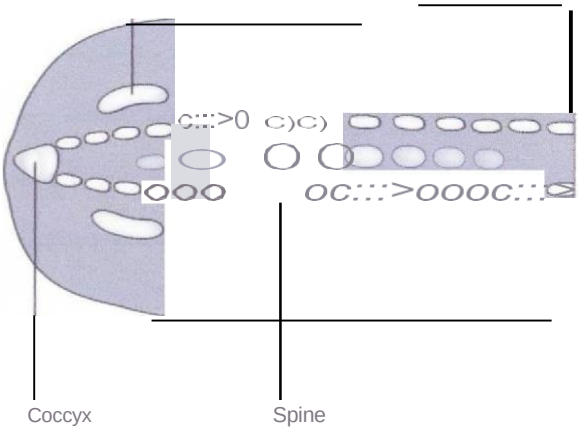
Coronal upper spine





Coronal lower spine

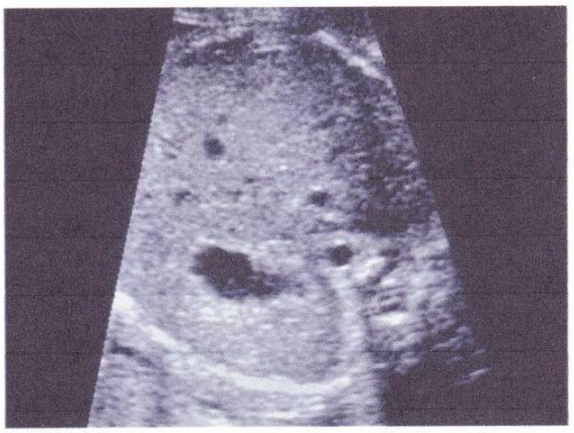


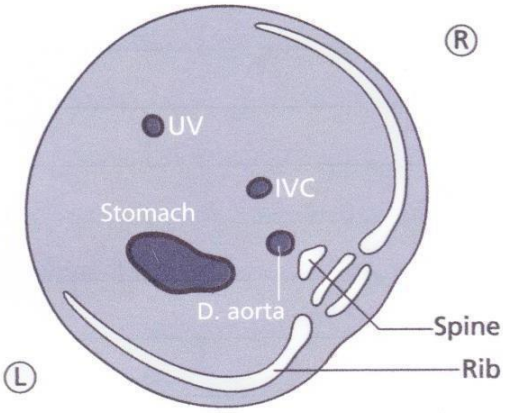


Appendix 3

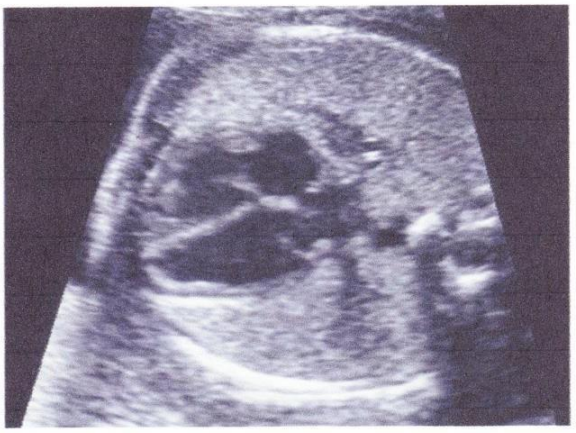
Fetal Cardiac Protocol

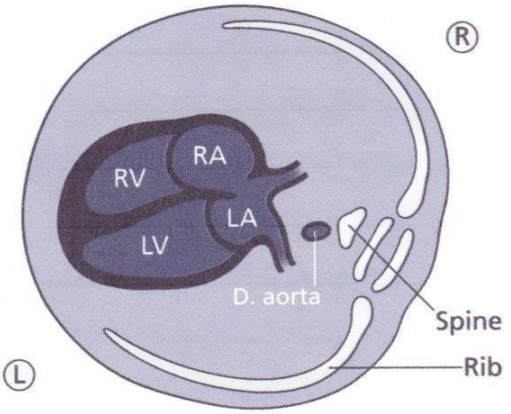
Visceral situs/laterality



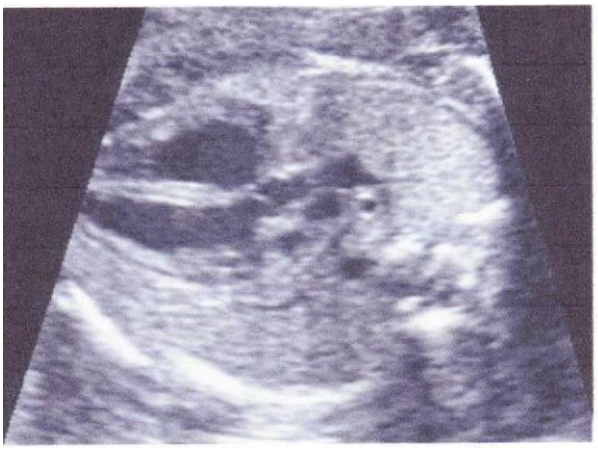


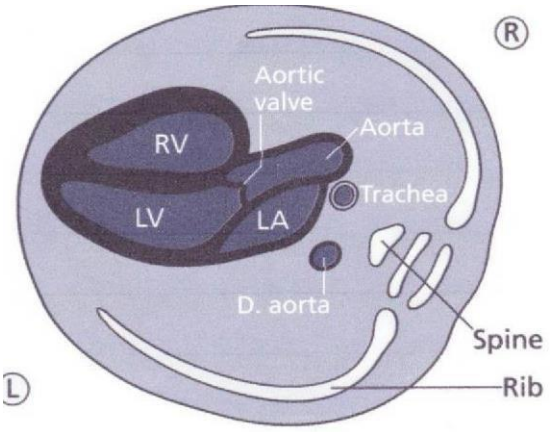
4 chamber view (4CH)



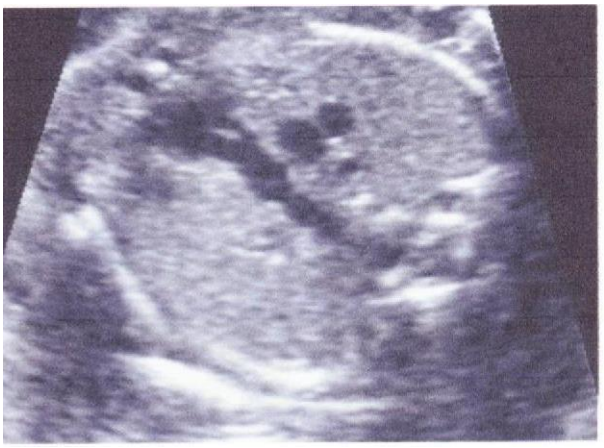


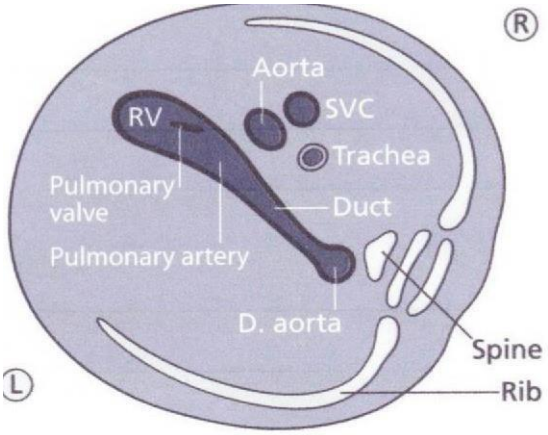
Aorta (AO)/left ventricular outflow tract



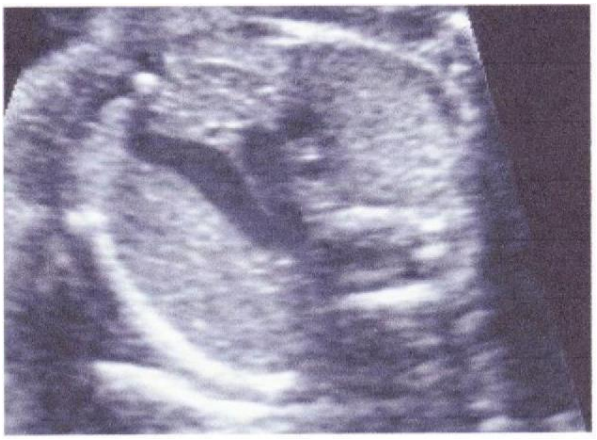


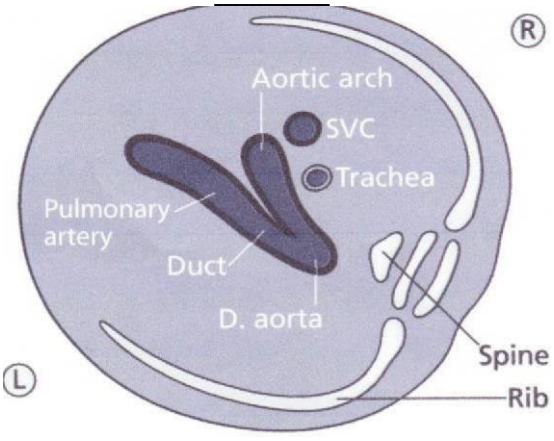
Pulmonary artery (PA)/right ventricular outflow tract or 3 vessel view (3VV)





3 vessel and trachea view (3VT)





Appendix 4

Normal variants

The national screening programme for Down's, Edward's and Patau's syndromes increasingly delivering higher detection rates for lower screen positive rates.

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 cyst(s)
- dilated cisterna magna
- echogenic foci in the heart
- two vessel cord

Normal Variant (see Trust local policy)

- two vessel cord (appendix 6)

Unexpected Ultrasound Findings:

However, the ultrasound findings listed below need to be reported and the woman referred for Fetal Medicine review as per the SaTH 'Referral for Fetal Medicine Services Standard operating Procedure'

- nuchal fold greater than 6 mm
- cerebral ventriculomegaly (atrium greater than 10 mm)
- echogenic bowel (with density equivalent to bone on same gain settings)
- RPD (AP measurement greater than 10 mm
- (RPD 7-9.9mm- see Trust local policy, appendix 5)

- HC, AC or FL measurements below 5th centile, EFW below 10th centile, compared to dating scan, on national charts,for SaTH referral, see Appendix 'Referral to FMS for fetal growth concerns at the mid-pregnancy screening scan'

Appendix 5

Isolated Renal Pelvis Dilatation (RPD) - Trust Local Guideline

Rationale RPD is one of the commonest findings found on the routine fetal anomaly scan. RPD often resolves during pregnancy but may persist until later in pregnancy and into childhood; it can be due to structural unexpected development in the renal tract. A measurement greater than 7mm of the antero-posterior (AP) diameter of the fetal renal pelvis, in the transverse plane, found at the routine mid pregnancy screening scan, will require referral and / or follow up scan.

Practice Guidelines

Mild Isolated RPD (7-9.9mm) – A follow up appointment, through a consultant antenatal clinic, should be made for a scan at 32 weeks gestation.

If the AP measurement of the fetal renal pelvis is less than 7mm at this stage, the woman can be reassured and referred back to her original antenatal care pathway.

If the AP measurement of the fetal renal pelvis is 7- 9.9 mm at this stage, and there is no evidence of calyceal involvement or other abnormal ultrasound finding, a neonatal alert form (NNA) should be initiated, and the woman booked for delivery at PRH (MLU or CU). This is to ensure that the baby can be reviewed following delivery by the neonatal team, and appropriate treatment and follow up can be initiated.

RPD greater than 10mm - An RPD measurement 10 mm or greater, at the 18+0- 20+6 week scan, or at the follow up scan at 32 weeks, necessitates a follow up appointment with a Fetal Medicine Consultant .as per the SaTH 'Referral for Fetal Medicine Services Standard operating Procedure'

Care following the ultrasound examination

It is important that the woman is given is given clear information about what has been found at the ultrasound examination and about the follow up investigations. The midwife sonographer will give an explanation of the ultrasound findings. The woman should also be given the Trust information leaflet on RPD, which she can take away and read in her own time.

Appendix 6

Single Umbilical Artery (SUA) - Trust local guideline

Rationale

Approximately 1% of fetuses will be found to have a SUA. Approximately 20% of these fetuses will have another anomaly, which may be major or minor (Gornall et al, 2003).
Fetuses with SUA and no other structural unexpected development are more likely to show growth restriction in the third trimester.

Practice Guidelines

All pregnancies found to have a SUA at the 18+0- 20+6 weeks scan, but no other unexpected development, need referral for growth scans in the third trimester. These should be made through a Consultant antenatal clinic at 32 and 36 weeks gestation.

Care following the ultrasound examination

It is important that the woman is given clear information about what has been found at the ultrasound examination and about the follow up investigations. The midwife sonographer will give an explanation of the ultrasound findings and planned follow up care.

Appendix 7

West Midlands Fetal Medicine Referral Form
Suspected Anomaly in a Singleton Fetus

REFERAL DATE		**NHS TRUST NAME**	**SATH**		
REFERRER		**CONTACT NUMBER**	01952565707		
OBSTETRICIAN		**CONTACT NUMBER**	01952565707		
PATIENT NAME		**CONTACT NUMBER**			
HOSPITAL NUMBER		**ADDRESS/POST CODE** **Princess Royal Hospital** **Apley Castle** **Telford** **TF1 6TF**			
NHS NUMBER					
DATE OF BIRTH					
GP NAME		**GP ADDRESS**			
HEIGHT IN CMS		**WEIGHT IN KG**		**BMI**	
FIRST LANGUAGE		**INTERPRETER REQUIRED**			

GRAVIDA			**PARITY**		
GESTATION			**E.D.D. BY SCAN**		
BLOOD GROUP / Rh STATUS / ANTIBODIES (ATTACH HARD COPY)			**HIV, HEP B STATUS IF POSITIVE VIRAL LOAD (ATTACH HARD COPY)**		
SCREENING/NIPT/KARYOTYPE RESULTS IF PERFORMED					
PREVIOUS OBSTETRIC HISTORY				**RELEVANT MEDICAL HISTORY**	
LIVING CHILDREN	**>37 WEEKS**		**<37 WEEKS**		
NEONATAL DEATHS	**>37 WEEKS**		**<37 WEEKS**		
MISCARRIAGES	**< 12 WEEKS**		**<23 WEEKS**		
STILL BIRTHS				**CURRENT MEDICATION**	
TERMINATIONS					

PLEASE STATE INDICATION FOR REFERRAL, SECOND OPINION, EXAMINATION OR PROCEDURE REQUIRED (and attach also a copy of the most recent USS performed prior to referral)

APPENDIX 8 – Auditable Standards

Routine 18+0 to 20+6 weeks Mid-Pregnancy Screening Scan

1.0 Process

1.1 Pre-Scan Preparation

- The pregnant woman will be provided with information at "first contact "and or early pregnancy dating scan about the 18+0-20+6 weeks mid -pregnancy scan. This information will include the purpose, limitations, benefits and consequences of the procedure as well as the implications of normal and unexpected scan findings.
- The woman's choice to "accept" or "decline" the mid pregnancy screening scan will be recorded on the Maternity Information System

1.2 The 18+0-20+6 weeks mid - pregnancy screening scan procedure

1.2.1 Fetal Assessment – refer to Appendix 1 and fetal cardiac protocol Appendix 2. Images of the 6 specific fetal anatomical sections as described in the ultrasound scan base menu will be archived:

- head circumference demonstrating HC measurement and measurement of the atrium of the lateral ventricle
- suboccipitobregmatic view demonstrating measurement of the transcerebellar diameter
- coronal view of the lips with nasal tip
- abdominal circumference demonstrating AC measurement
- femur length demonstrating FL measurement
- sagittal view of the spine including sacrum and skin covering (or coronal views of the spine if sagittal image not attainable due to fetal position)

1.2.2 Placental Location

- Included in Suspected Placenta Praevia and Suspected Placenta Praevia Accreta, Ultrasound Guideline

1.2.3 Liquor volume visual assessment

- no measurement required unless appears outside of normal range

1.3 Post Scan Procedure

1.3.1 On completion of the scan examination the woman will be informed of the scan findings

1.3.2 If it has not been possible to complete the examination due to sub optimal views or fetal position a further single appointment will be arranged in1- 2 weeks or up to 23 weeks gestation for completion.

1.3.3 Where a woman attends for a repeat ultrasound scan and the image quality remains compromised, there is no requirement to offer a further scan to complete screening. The woman should be informed that screening is incomplete, and this must be recorded

1.3.4 Any unexpected development is suspected

- the midwife sonographer will explain the scan findings and give appropriate written information as available. Relevant images will be attained and archived.
- An appropriate referral to a Fetal Medicine Specialist will be made for the next suitable appointment this should be within 3 working days local referral, within 5 working days for Tertiary referral when no local FMS available. Trust FMS will be contacted if no local FMS appointment available within 3 working days to discuss possibility of urgent appointment.
- When no local FMS available, referral will be made by secure NHS email to tertiary centre (Fetal medicine Unit, Birmingham Women's Hospital) and copy of ultrasound attached.

- Badgernotes Fetal Medicine plan and Risk section will be updated

1.3.5 If the leading edge of the placenta is within 2 cm of the internal os, a follow up placental location scan appointment will made for 32 weeks gestation as per the suspected placenta praevia guideline

1.3.6 The MIS will be completed.

Appendix 9
SQAS Clinical review Template- fetal anomaly screening (2)

Clinical review template – fetal anomaly screening (2)

Summary of unexpected outcome: *insert here*

Population- cohort identification

Was the woman eligible for the offer of screening **(20-week screening scan)**?	
Was screening offered?	
Was the offer timely?	
Did the woman receive screening information? Was it documented? Was the information in an accessible format? Was an interpreter/translation services used if required?	
Was the acceptance or decline of the offer of screening noted?	

Screening test

Was the test performed at the right time? Comment on DNA if relevant.	
Was the test completed? Are ultrasound slots allocated sufficient time as specified nationally?	
Was a repeat scan required? Was this completed? Was it timely?	
Equipment – was there a maintenance programme and internal quality checks in place, example ultrasound specific settings as per national guidance?	
Was there appropriate specified training/continuous professional development (CPD) in place for staff?	

Screening results

Was the result accurate - does the USS department perform the 20-week scan in accordance with the NHS FASP base menu and fetal cardiac protocol?	

Was the result communicated to the screening team?	
Was the result documented?	
Was the result discussed with the woman?	

Referral

Was the woman offered follow up or intervention? Was this timely (met national standards)?	
Were any birth plans required for management of the pregnancy, birth and the neonate? Were these completed (or updated if relevant) and received by appropriate teams?	

Diagnosis/Intervention

Did the woman accept referral to specialist team? Was this documented?	
Where accepted, was the intervention completed? Comment on DNA if relevant.	
Was a result/plan identified by the referral centre?	
Was the woman aware of the result/plan?	
Were any birth plans required for management of the pregnancy and the neonate? Were these completed (or updated if relevant) and received by appropriate teams?	

Intervention/treatment/outcome

Was the intervention/treatment completed?	
Was referral to further care or specialist services was required? Was this completed and documented?	
Outcome and reporting – reporting to NCARDRS required and completed?	

Other considerations

Were any health inequalities identified?	
Were there other contributory factors?	

Learning identified by the clinical review

The following are learning points from the clinical review:

- *Insert here*
- *Insert here*
- *Insert here*

Actions taken to improve the screening service

- *Insert here*
- *Insert here*
- *Insert here*

Appendix 10 -Referral to FMS for fetal growth concerns at the mid-pregnancy screening scan

Isolated HC below the 5th centile (Chitty)

The smaller the HC, the worse the outcome

A small HC with normal abdominal circumference (AC) and femur length (FL) (asymmetrical small HC) may be caused by:

- maternal infection
- environmental exposures
- malformations of the CNS
- congenital heart defects
- karyotypic anomalies

A small HC with concomitant small AC and FL (symmetric small HC) may be caused by such things as:

- early growth impairment of the fetus
- genetic disease (chromosomal aberrations or a syndrome)
- small growth potential

Midwife sonographer management

- Check facial profile and save image
- Consider viral screen
- Recheck combined test/quad test result if available
- Refer FMS (1st centile within 3 days, 2-4th centile in two weeks)

Isolated FL below the 5th centile (Chitty)

A short femur might be an indicator for

- A constitutional, genetically determined small child (SGA)
- Fetal growth restriction (FGR)
- Trisomy 21 or other aneuploides
- Skeletal dysplasia

Midwife sonographer management

- Check bone shape and density of all long bones and save image of FL
- Recheck combined test/quad test result if available
- Refer FMS (1st centile within 3 days, 2-4th centile in two weeks)

EFW (Hadlock)

If EFW is between 3-10th centile and biometric measurements are all above 5th centile, perform uterine artery doppler.

- An abnormal uterine artery doppler should prompt referral to fetal medicine in two weeks
- A normal uterine artery doppler with EFW 3-10th centile at 20 week scan requires SGS from 28 weeks gestation
- If EFW is <3rd centile refer to FMS in two weeks

Appendix 11 - Patient Information

Information for Patients

Fetal Medicine Specialist Scan

NHS
The Shrewsbury and Telford Hospital
NHS Trust

At your appointment today you agreed to see the Fetal Medicine Specialist at the Shrewsbury and Telford Hospitals.

You need to see the specialist because we need to either:

- carry out a detailed ultrasound scan
- look for growth or placenta issues
- talk to you about screening results

At the appointment we will do a more detailed examination of your baby. We will give you further information and advice about your plan of care.

If we cannot give you an appointment today, we will contact you. This is usually within with 1 working day. The appointment will show on your BadgerNet. Call if you have not heard from us after 2 days. The phone number is below.

Please allow up to 2 hours for this appointment. We are often busy, and you may have to wait for your scan.

We may need to do further tests during your appointment. We will talk to you about this.

At the appointment we will give you information that is specific to your pregnancy.

If you choose to look for further information we suggest:

- NHS websites
- FASP (Fetal Anomaly Screening programme).

If you have any questions or concerns, please contact us, Monday to Friday 8.45am to 4.45pm.

Maternity Ultrasound – 01743 261143 or 01952 565707

ARC (Antenatal Results and Choices) is a charity. They offer impartial information and support to help you decide on your next steps. Go to http://www.arc-uk.org/

Partnering

Further information is available from:

Feedback

We appreciate and encourage feedback which can be shared in a number of ways through the hospital website. Scan the QR code to give feedback. www.sath.nhs.uk/patients-visitors/patient-experience/feedback-hub/

Patient Advice and Liaison Service (PALS)

PALS will act on your behalf when handling patient and family concerns, they can also help you get support from other local or national agencies. PALS, is a confidential service.

Royal Shrewsbury Hospital, Tel: 0800 783 0057 or 01743 261691

Princess Royal Hospital, Tel: 01952 282888

Other Sources of Information

NHS 111

A fast and easy way to get the right help, whatever the time. NHS 111 is available 24 hours a day, 365 days of the year.

111 (free from a landline or mobile) www.nhs.uk

Self Help & Support Groups

A selection of websites providing access to good quality health information, local organisations and community groups is available from the library. www.library.sath.nhs.uk/find/patients/

Information in Other Languages or Formats

If you require this information in a different way such as easy read, a different language, larger print, audio or braille please tell a member of staff or contact the Patient Experience Team;

sath.patientexperience@nhs.net or 01743 261000 ext. 2503.

Your information

Information about you and your healthcare is held by the NHS. You can find out more about how we hold your information and how it is used on our website: www.sath.nhs.uk

Website: www.sath.nhs.uk
Information Produced by: Maternity
Date of Publication: April 2025
Due for Review on: April 2028

Version: 1
ID: WC/433

NHS PATIENT INFORMATION PANEL 2025