ANTENATAL SCREENING FOR DOWNS, EDWARDS AND PATAUS SYNDROME

Developed in response to: RCOG guideline
Contributes to CQC Regulation 9, 12

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Issuing Directorate Women’s and Children’s
Approved by DRAG Chairman’s Action
Approved on 18th June 2018
EMG Sign off Date July 2018
Implementation Date 16th July 2018
Next Review Date May 2021
Author/Contact for Information Emma Neate, Antenatal Newborn Screening Co-ordinator

Policy to be followed by (target staff) Midwives, Obstetricians, Radiology
Distribution Method Intranet and Website. Notified on Staff Focus

Related Trust Policies (to be read in conjunction with)
04071 Standard Infection Prevention
04072 Hand Hygiene
04272 Guideline for Maternity Care
08045 Guideline for Amniocentesis for Antenatal Diagnosis
08046 Guideline for Interpreting and Acting on CVS sample and Amniocentesis Results
09062 Maternity Care
06036 Guideline for Maternity Record Keeping including Documentation in Handheld Records
06031 Receiving and Acting on Test Results in Maternity by both Hospital and Community
09127 Interpreting and Translation Policy
09113 Guideline for Calling Paediatric staff and for obtaining Paediatric Referral

Document Review History:

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<td>Nicola Leslie</td>
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<td>Nicola Leslie, Antenatal Newborn Screening Co-ordinator</td>
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Appendix A – Neonatal Alert Form
Appendix B - Antenatal Screening for Downs, Edwards and Pataus Syndrome Pathway
1.0 Purpose

1.1 To offer first trimester screening for Downs, Edwards and Patau’s syndrome to all patients registered with the trust (booked) before 14 weeks of pregnancy.

1.2 To offer second trimester serum screening to patients who present at ultrasound on or after 14 weeks, but before 20 weeks.

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Background

3.1 The screening programme has evolved from its establishment in 2001 when the majority of screening was performed using maternal biochemistry method in the second trimester. The recommended method of screening is now first trimester screening, combining maternal age, biochemistry and ultrasound measurement of fetal nuchal translucency to provide a pregnant woman with the risk of having a baby with Down’s or Edwards’/Patau’s syndromes.

4.0 Aetiology

4.1 Inside the cells of our bodies there are tiny structures called chromosomes. These chromosomes carry the genes that determine how we develop. There are 23 pairs of chromosomes in each cell. Problems can occur when the sperm or egg cells are produced which can lead to a baby having an extra chromosome.

4.2 Down’s syndrome:

4.2.1 People with Down’s syndrome (T21) have extra chromosome 21 in the cells of their body. A baby born with T21 will have a learning disability. They may have communication problems and difficulty managing some everyday tasks. It is impossible to know what level of learning disability a baby with T21 will have. It can vary from mild to severe.

4.2.2 Some health problems are more common in people with T21, for example, heart conditions, and problems with the digestive system, hearing and vision. Some problems can be serious but many can be treated. With good healthcare, someone with Down’s syndrome is expected to live to around 60 years. People with Down’s syndrome have distinctive facial features including almond shaped eyes. Like all children, they also inherit features from their parent. T21 affects 1 in every 1000 births.

4.3 Edward’s and Patau’s:

4.3.1 Sadly, most babies with T18 or T13 will die before they are born, be stillborn or die shortly after birth. Some babies may survive to adulthood but this is rare.

4.3.2 In Edwards’ syndrome (T18) there is an extra copy of chromosome 18 in each cell. All babies born with T18 will have a wide range of problems, which are usually extremely serious – these may include major brain abnormalities. Babies affected by T18 can have heart problems, unusual head and facial features, growth problems and be unable to stand or walk. T18 affects about 3 of every 10,000 births.
4.3.3 In Patau’s syndrome (T13) there is an extra copy of chromosome 13 in each cell. All babies born with T13 will have a wide range of problems, which are usually extremely serious – these may include major brain abnormalities. Babies affected by T13 can have heart problems, a cleft lip and palate, growth problems, poorly formed eyes and ears, problems with their kidneys and are unable to stand or walk. **T13 affects about 2 of every 10,000 births.**

5.0 Incidence

5.1 The early pregnancy scan
The scan has several purposes. It is to:
- Confirm viability
- Ascertain if it is a singleton or multiple pregnancy
- Estimate gestational age
- Detect major structural anomalies that may be identified in early pregnancy e.g. anencephaly

5.2 First trimester combined test
The combined test uses maternal age, the nuchal translucency measurement (NT) and two biochemical tests, free beta hCG and PAPP-A, together with the gestational age calculated from crown rump length (CRL) measurement, to calculate the risk of the pregnancy being affected by T21 or T18/T13. **The optimal time to perform the combined test is between 11 weeks 2 days to 14 weeks 1 day of gestation, which corresponds to a CRL of 45.0mm to 84.0mm.**

6.0 Aims

6.1 To offer screening and diagnosis to all women who attend for antenatal care before 20 weeks of pregnancy.

6.2 To provide up to date high quality information on the screening process to support women to make an informed decision whether to accept or decline the offer of screening.

6.3 First trimester combined screening will be offered to all women who present for ultrasound scan between 11 weeks + 2 days to 14 weeks + 1 day (11+2 to 14 +1).

6.4 Second trimester serum screening will be offered to women who present at ultrasound scan between 14 weeks + 2 days and 20 weeks.

6.5 Provide information and support to enable women and their partners to make a decision on the outcome of their pregnancy.

6.6 For women with a confirmed diagnosis as a result of screening, who choose to continue with the pregnancy, provide optimal management for pregnancy, birth and the newborn period.

6.7 For women with a confirmed diagnosis as a result of screening, who opt for termination of pregnancy to ensure we provide optimal care and support, including bereavement support.

7.0 Objectives

7.1 To identify and offer screening to all women, who attend for care under 20 weeks of pregnancy.

7.2 All pregnant women should be provided with written information ‘Screening tests for you and your baby’ prior to their booking appointment. This is available in English and 12 other
8.0 Informed Consent for Downs, Edwards and Patau's Screening

8.1 All women will be given verbal information regarding screening available to them at the point of accessing care, this should include a discussion on the screening process and time frame.

8.2 All women should be informed of the screening available for Down's, Edward's and Patau's syndrome as early as possible in pregnancy, with at least 24 hours before they are asked to make an decisions.

8.3 All patients should be offered:

- No screening
- Screening for T21 and T18 / T13
- Screening for T21 only
- Screening for T18 / T13 only

8.4 A specimen form (Appendix A) should be completed for the women ideally at the booking appointment. All pregnant women should be provided with written information ‘Screening tests for you and your baby’ prior to their booking appointment. This is available in English and 12 other languages, via www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief.

8.5 For women who do not have English as a first language, they must be offered interpreting services to help them make an informed choice about screening. It is not acceptable to use friends or family to translate.

8.6 Where English is not the patient’s first language an appropriate interpreter should be used to enable the woman to understand the information the information that she has been given.
8.7 The offer of screening and the decision to accept or decline should be recorded in the women
handheld records maternity notes and on the maternity computer system. All women who
decline Down’s, Edward’s and Patau’s syndrome screening will be offered a scan to the date
pregnancy and check for viability dating and detailed anomaly scan at 18 - 20+6 weeks of
pregnancy.

9.0 Down’s, Edward’s and Patau’s Screening

9.1 All women will be offered a dating scan and a screening test for Down’s, Edward’s and Patau’s
syndrome. The preferred screening test for Downs screening will be 1st trimester combined
screening, this is offered between 11weeks and 2 days and 14 weeks and 1 day gestation.

9.2 Women with a failed pregnancy will be supported and referred to the Early Pregnancy Unit
(EPU) for on-going management.

9.3 Women access antenatal care later than 14 weeks and 1 day gestation can be offered a 2nd
trimester serum – screening, between 14 week and 2 days - 20 weeks gestation.
(Refer to appendix B)

9.7 Public Health England recommend that women should opt for one Downs, Edwars and
Pataus Screening test. If women have a Down’s screening result from an external non-invasive
prenatal test (NIPT – also known as Harmony Screening) then combined screening should
not be offered. Potential confusion can occur if the results are inconsistent in terms of the
risk.

10.0 First Trimester Combined Screening

10.1 First trimester combined test
The combined test uses maternal age, the nuchal translucency measurement (NT) and two
biochemical tests, free beta hCG and PAPP-A, together with the gestational age calculated
from crown rump length (CRL) measurement, to calculate the risk of the pregnancy being
affected by T21 or T18/T13. **The optimal time to perform the combined test is between 11
weeks and 2 days to 14 weeks and 1 day of gestation, which corresponds to a CRL of
45.0mm to 84.0mm**

10.2 In cases where screening is accepted but it is not possible to obtain the NT measurement at
the first appointment, a least one other attempt should be offered, this may be on the same
day or at a later date. If it is not possible to obtain and accurate NT measurement despite
‘twice on the couch’ then further attempts do not have to be offered and the woman should be
referred in to the second trimester screening pathway

10.3. If the ultrasound measurement shows that the CRL is less than 45.0mm, the woman should be
recalled for a further scan to measure the NT. If the CRL is greater than 84.0mm, then second
trimester quadruple test should be offered.

10.4 A maternal blood specimen should be taken after the ultrasound scan and the combined test
results made available within a few days of the biochemistry results being authorised by the
laboratory.

10.5 When calculating a risk for T21 and /or T18/T13 syndromes, the nuchal translucency
measurement must be used in combination with a maternal serum screening test.

**The nuchal translucency measurement must not be used in isolation.**
Where women have chosen not to accept screening for Down’s, Edwards’ and Patau’s syndromes, but choose to accept an early pregnancy scan, structural anomalies may still be identified, including an NT of $\geq 3.5$mm. Women should be aware that any such anomaly will be reported to enable appropriate offer of additional screening.

### 11.0 Second Trimester Screening

11.1 The quadruple test uses maternal age and four biochemical markers measured from 14 weeks 2 days until 20 weeks 0 days – AFP, hCG (total, intact or free beta subunit), uE3 and inhibin-A. Although this combination of markers has a lower detection and standardised screen positive rate than the combined test, it is the nationally recommended screening strategy in the second trimester. The optimum time for testing in the second trimester is around 16 weeks gestational age.

11.2 There will always be a need for a screening test in the second trimester for those women who book too late for first trimester testing or when an NT measurement cannot be obtained (despite twice on the couch) in the first trimester. An ultrasound scan will be required to date the pregnancy and a fetal head circumference is the recommenced measurement used for women presenting in the second trimester.

11.3 **Twins / Multiple Fetus Detected on Scan**

- Women with twin pregnancies are eligible for 1\textsuperscript{st} and 2\textsuperscript{nd} trimester screening.

- When ultrasound shows that there is an empty second sac, the biochemical markers appear no different to those in a singleton pregnancy and the combined test can be used to calculate the risk. If ultrasound shows there is a second sac containing a fetus with no fetal heart pulsations (‘Vanished Twin’) It is possible that there could be a contribution to the maternal biochemical markers for many weeks. The risk must be calculated by the laboratory. Therefore blood forms should be completed as ‘Vanished Twin for age and NT risk only’.

- 1\textsuperscript{st} and 2\textsuperscript{nd} Trimester screening cannot be used for any multiple pregnancies greater than two, please refer patient to the screening team for further management.

### 12.0 Results

12.1 The results of first and second trimester screening are entered into a software programme which calculates the risk for a woman of having a baby with Downs, Edwards or Patau syndrome.

### 13.0 Low Risk Results

13.1 Defined as having a less than 1 in 150 chance for 1\textsuperscript{st} Trimester Screening and 1 in 150 chance for 2\textsuperscript{nd} Trimester Screening chance of having a baby with Downs Syndrome.

13.2 All low risk results are emailed to the Antenatal Screening team for failsafe purpose. A standard letter is sent to the women to inform her that she has a low chance result, which should be receive within 10 days after the blood test.

13.3 The community midwife will discuss these results with the woman at her 16-18 week antenatal check.
14.0 **High Risk Results**

14.1 High risk results are defined as results greater than than1 in 150 chance for 1st Trimester Screening and 1 in 150 chance for 2nd Trimester Screening for Down’s, Edward’s and Patau’s.

14.2 All high risk results are emailed to the Antenatal Screening team.

14.3 Women with increased chanced results will be notified of the results within 3 working days of the Screening office receiving the results. The Antenatal Screening team will contact the woman to discuss the result, either by phone or in the Antenatal Clinic. Names and contact telephone numbers will be given for advice and support i.e. The Downs Syndrome Association, Langdon Down Centre, 2A, Langdon Park, Teddington, TW11 9PS Tel: 0845 230 0372 www.downs-syndrome.org.uk or the Support Organisation for Trisomy 13/18 (SOFT) tel: 0121 351 3122 | email: enquiries@soft.org.uk http://soft.org.uk/

14.4 Discussion with women will take place, with the following options offered:

- No further testing
- CVS or amniocentesis
- Private NIPT Screening
- Detailed anatomy scan with fetal medicine

14.4 If the patient wishes to have CVS or amniocentesis, she will be given verbal and written information to enable them to decide whether to have the procedure.

14.5 Chorionic Villus Sampling (CVS) is an abdominal invasive procedure performed under continuous ultrasound guidance. The CSV can be performed from 11 weeks of pregnancy to obtain a sample of placental tissue for chromosomal or genetic analysis. For every 100 women who have this test one will miscarry.

14.6 Amniocentesis is an invasive procedure undertaken from about 15 completed weeks (15+0) onwards to obtain a sample of amniotic fluid surrounding the fetus. Using an aseptic technique whilst under continuous ultrasound guidance, a sterile needle is passed through the mother’s abdomen, uterus and amniotic sac. A sample of amniotic fluid is aspirated and sent for chromosomal or genetic analysis. For every 100 women who have this test one will miscarry.

14.7 Amniocentesis can be offered and MEHT after 16 weeks of pregnancy.

14.8 In twin pregnancies invasive prenatal diagnosis should be conducted at a tertiary fetal medicine unit due to the specialised nature of the procedures and the increased risk of miscarriage.

14.9 CVS procedures are undertaken at tertiary units, University College Hospital, London, Kings College Hospital, London. Any appointments at a tertiary unit will be arranged by the antenatal screening team. Maps for the appropriate hospital are available from the antenatal screening team office.

(Refer to the guideline entitled ‘Guideline for Interpreting and Acting on CVS sample and Amniocentesis Results’; register number 08046)

14.6 To action normal and abnormal results please refer to the guideline for interpreting and acting on chorionic villus sample (CVS) and amniocentesis results; register number 08046.
14.8 If the women wishes to continue the pregnancy with no further testing, the Antenatal Screening team will formulate a plan of care; with a referral to the Tertiary Unit for a cardiac scan, (if the nuchal translucency measures 3.5 mm or above).

14.9 Following the cardiac scan results and subsequent discussion with the Antenatal Screening team, the patient may wish to continue with the pregnancy.

14.10 A neonatal alert form will be completed. A copy of the alert form is retained for the screening office records and a copy is forwarded to the named paediatric consultant for a plan of care post-delivery. (Refer to the ‘Guideline for calling paediatric staff and for obtaining paediatric referral’; register number 09113) (Refer to Appendix B)

14.11 When the named paediatric consultant has completed the neonatal alert form with a care plan, a copy will be retained in the neonatal folder. A further copy will be sent to the Antenatal Screening team; who will then provide a subsequent copy for the Labour Ward folder. The Antenatal Screening team will provide a copy which should be filed in the patient’s lilac folder.

15.0 Record Keeping

15.1 In terms of record keeping, it is essential to confirm the patient’s name and date of birth before giving out information.

15.2 If you are in a hospital setting, ensure that the hospital notes are available.

15.3 All conversations, plans of care and decisions must be documented in the patient’s health care records.

16.0 Staff and Training

16.1 All midwifery and obstetric staff must attend yearly mandatory training, which includes skills and drills training, involving an antenatal screening update.

16.2 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

17.0 Infection Prevention

17.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively ‘decontaminate their hands’ before and after each procedure.

17.2 All staff should ensure that they follow Trust guidelines on infection control, using Aseptic Non-Touch Technique (ANTT) when carrying out procedures i.e. obtaining blood samples.

18.0 Audit and Monitoring

18.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women’s and Children’s Clinical Audit Group will identify a lead for the audit.

18.2 As a minimum the following specific requirements will be monitored:
   - Designated lead for antenatal screening in the maternity service
Antenatal screening tests, which follow the UK National Screening Committee guidance

- System for ensuring that appropriate tests are undertaken within appropriate timescales
- System for ensuring that appropriate tests are undertaken when patients book late
- Process for the review of the results
- Process for reporting all results to patients
- Process for reporting results to other relevant healthcare professionals
- Process for ensuring that patients with screen positive test results are referred and managed within appropriate timescales
- Maternity service’s expectations for staff training, as identified in the training needs analysis
- Process for audit, multidisciplinary review of results and subsequent monitoring of action plans

18.3 A review of a suitable sample will be audited from the health care records of patients who have delivered to evidence the process for ensuring that patients with screen positive test results are referred and managed within appropriate timescales. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

18.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

18.5 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

18.6 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

18.7 Key findings and learning points will be disseminated to relevant staff.

19.0 Guideline Management

19.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust’s intranet site.

19.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

19.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. ‘Spot checks’ are performed on all clinical guidelines quarterly.

19.4 Quarterly Clinical Practices group meetings are held to discuss ‘guidelines’. During this meeting the practice development midwife can highlight any areas for further training; possibly involving ‘workshops’ or to be included in future ‘skills and drills’ mandatory training sessions.
20.0 Communication

20.1 A quarterly ‘maternity newsletter’ is issued and available to all staff including an update on the latest ‘guidelines’ information such as a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly.

20.2 Approved guidelines are published monthly in the Trust’s Focus Magazine that is sent via email to all staff.

20.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

20.4 Regular memos are posted on the guideline notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

21.0 References

Fetal Anomaly Screening Programme - Screening for Downs Syndrome: UK NSC Policy recommendations 2011–2014 Model of Best Practice


“Screening Tests for You and Your Baby” UK National Screening Committee (2017)

NHS Public Health Functions Agreement 2015-16 (2014) Service Specification No.16. NHS Fetal Anomaly Screening Programme. Screening for Down’s, Edward’s and Patau’s Syndromes (Trisomy 21, 18, 13)
Appendix A

DOWN'S, EDWARDS' & PATAU'S SYNDROMES SCREENING

Clinical Biochemistry, Broomfield Hospital, Chelmsford. CM1 7ET. 01245 516968 / 514162

PLEASE ENSURE NON GEL SERUM TUBE IS USED
INFORMATION FOR COMPLETION OF THIS REQUEST FORM

TYPE OF SCREEN REQUIRED
- First Trimester screening is available between 11+2 and 14+1 weeks of gestation and with CRL measurement between
45mm and 84mm.
- Second Trimester screening is available between 14+2 and 20+6 weeks of gestation.

IVF Pregnancies
- For IVF Pregnancies, the lab needs to know the age of the person who donated the egg, at the time it was donated.
The information required is:
  ○ Is the egg the patients own?
  ○ If NO, what is the age in years of the egg donor when they donated?
  ○ If YES, is the egg fresh - if YES, need no further action
    - If NO, need to know how long the egg has been frozen

FAMILY ORIGIN INFORMATION

AFRICAN OR AFRICAN-CARIBBEAN (BLACK):
Caribbean Islands, Africa (excluding North Africa)

SOUTH ASIAN (ASIAN):
India or African-Indian, Pakistan, Bangladesh

SOUTH EAST ASIAN (ASIAN):
China, Thailand, Malaysia, Vietnam, Philippines etc

OTHER NON EUROPEAN (OTHER):
North Africa, South America etc Middle East (Saudi Arabia, Iran etc)

SOUTHERN & OTHER EUROPEAN (WHITE):
Cyprus, Greece, Turkey, Italy, Portugal, Spain, any other Mediterranean country, Albania, Czech Republic, Poland, Romania, Russia etc

UNITED KINGDOM (WHITE):
England, Scotland, N Ireland, Wales

NORTHERN EUROPEAN (WHITE):
Austria, Belgium, Ireland, France, Germany, Netherlands, Scandinavia, Switzerland etc
Any other European family origins e.g. Australia, N America, S Africa

For further information please go to the website:
www.gov.uk/fetal-anomaly-screening-programme-overview

For Laboratory Use Only:-
Typed in by ______________ Checked by ____________ Authorised by ____________
## Neonatal Alert Form

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<td>EDD</td>
<td>Gestation</td>
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### Background history & problem summary

### Delivery Plans

- **Broomfield Hospital**: □
- **Not Decided**: □
- **Other Hospital**: ____________________________

### Neonatal Alert Form Criteria

- Multiple pregnancy (higher order > 2 fetus)
- Hepatitis B positive mother
- HIV positive mother
- Previous baby with GBBS sepsis / meningitis
- Significant structural abnormalities diagnosed on ultrasound scan
- All cases that require referral to specialist units for treatment or advice
- Mothers with high antibody titres e.g. Anti-D, C and Kell
- Severe oligohydramnios / IUGR
- Abnormal dopplers
- Genetic / hereditary conditions in the immediate family that may affect the fetus
- Social e.g. drug abuse, alcohol abuse in this pregnancy
- Any other condition that will require paediatric input at birth

### Postnatal Plan (paediatric)

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<tr>
<td>Print Name</td>
<td>Signature</td>
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14
Pathway for Antenatal Screening for Downs, Edwards and Pataus Syndrome

1. Pregnancy confirmed
   Gestation <13 weeks

2. At booking appointment
   screening discussed, combined test offered

3. Accept
   Decline

4. 1st trimester scan
   appointment made
   Request form completed

5. Scan performed
   11+2 – 14+1
   (11 weeks + 2 days to 14 weeks + 1 day)

6. NT measurement performed
   with consent
   Blood form and weight
   completed by sonographer

7. On the same day bloods
   taken and sent to Biochemistry, Broomfield Hospital

8. Results to Screening team

9. Low Risk Result
   (>1:150)

10. Result posted to woman by Biochemistry
    Copy to Screening team
    Record kept in maternity notes

11. Record in maternity notes

12. Unaffected fetus
13. Affected fetus

14. Prenatal diagnosis accepted and performed

15. High Risk Result
   (<1:150)
   Screening team informs woman of result
   Prenatal diagnosis offered

16. Prenatal Diagnosis declined

17. Continue with pregnancy.
    Record outcome and inform screening laboratory
    Neonatal alert

18. Counselling appointment
    Options discussed

19. Continuing

20. Termination arranged

21. Paediatric notification
    Referral to Children with Disabilities Team

22. Gestation <11 weeks
    Scan re-booked

23. Non-viable pregnancy
    Refer to EPU

24. Dating scan only appointment made

25. Dating scan only.
    Referral to Screening team to discuss 2nd trimester

26. Gestation 14+2 – 20 weeks

27. Referral to Screening team

28. Continuing

29. Termination

30. Paediatric notification
    Referral to Children with Disabilities Team

31. Unaffected fetus

32. Affected fetus

33. Record in maternity notes