Midwife Sonographer Documents

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1. Scope of Practice

The purpose of this document is to outline the roles, responsibilities, and scope of practice of the Midwife sonography team. This will allow clear guidance for all health professionals to understand and refer women to the most appropriate department/clinician for their care.

Core Responsibilities

- **Perform Ultrasound Examinations**
  - Third trimester Obstetric assessments (e.g., fetal viability, biometry, amniotic fluid, umbilical artery studies). Uterine artery Doppler, Middle cerebral artery Doppler and Ductus Venosus Doppler can be requested by appropriate clinicians and within current guidelines and scope of practice.
  - Transvaginal Measurement of cervical length only for women attending Pre-term Birth surveillance Clinic from 14 to 24 weeks gestation. This will also confirm the presence of cardiac activity, placental site, liquor volume and stomach and bladder.

- **Interpret and Report Findings**
  - Provide clinical interpretations within their scope of practice.
  - Identify normal and abnormal findings.
  - Communicate findings appropriately to women and Obstetric teams.

- **Contribute to Clinical Care**
  - Integrate ultrasound findings into maternity care. Midwives are autonomous practitioners/clinicians. They are therefore able to make appropriate decisions regarding follow-up care within their scope of practice, NMC code (Nursing and Midwifery Council) and relevant local and National guidelines.
  - Refer to fetal medicine or obstetric consultants when abnormalities are detected.

- **Maintain Professional and Clinical Standards**
  - Work within appropriate guidelines (e.g., ISUOG, NICE, Perinatal Institute) including local and national policies and guidelines.
  - Keep up with continuing professional development (CPD).
  - Regular Image review and Audit as per BMUS (British Medical Ultrasound Society) guidelines.

Limits and Boundaries

Midwife sonographers **Do Not**:

- Diagnose or manage conditions beyond their capabilities of training.
- Perform non-obstetric scans unless separately qualified (e.g., abdominal, MSK).

- Undertake invasive procedures unless specifically trained (e.g., CVS or amniocentesis).
- Perform Fetal dating or Anomaly ultrasound scans.
- Early Pregnancy Ultrasound scans.
- Perform Ultrasound scans on any woman receiving care under fetal medicine department.
- Women who have a multiple Pregnancy.
- Any Woman who has Abdominal Pain or PV (per vaginal) bleeding.
- Any woman who has not had a departmental/ASW (Antenatal Screening Wales) standard anomaly scan. Any woman who has had an anomaly scan outside of the United Kingdom.
- Known fetal ectopic beats.

Regulatory and Training Considerations

- **Qualifications**: Must have completed (CASE) accredited training within a recognized higher Education facility. Gain a Postgraduate Certificate (PgCert) in Third trimester Obstetric/Doppler Ultrasound at level 7.
- **Registration**: Must be registered with the NMC.
- **Standards**: Follow national standards, such as those from: Society of Radiographers, BMUS, RCM (Royal College of Midwives) and RCOG (Royal College of Obstetricians and Gynecologists).

2. Midwife Sonographer Pathways

Community Midwife/AAU/ADAU Referral

- First instance of FHM <10th
- Slow growth (as per GAP 2.0)
- Accelerated growth (as per GAP 2.0)
- Presentation Scan (from >36/40)
- Suspected Polyhydramnios
- Altered Fetal Movements

Criteria Exclusions

- Multiple Pregnancy
- Any pregnancy under the care of Fetal Medicine
- Dating and anomaly scans
- <24/40 (unless attending our PTB Clinic)
- EPU
- PV bleeding/APH/ Abdo pain/Scar pain
- Women in labour/contracting or having regular tightening's
- Women who have not had a documented anomaly scan in the UK
- Late booker without a full anomaly

Please note: Growth scans require an interval of 14 days to be able to assess growth velocity effectively.

Serial Scan Clinics

MLC – 1 Risk Factor

- Increased BMI >35-39.9
- Previous SGA
- All Smokers (inc. smoking at conception)
- Low PAPP-A <0.415
- BMI <18

Shared Care – 2 Risk Factors

- Previous SGA
- Increased BMI >35-39.9
- Previous SGA
- All Smokers (inc. smoking at conception)
- Low PAPP-A <0.415
- BMI <18
- Maternal age > 40 years
- Previous LSCS

Altered Fetal Movements

- AFM women as per Policy (>24/40)
- No FMs by 24/40

Antenatal Clinic Women

We support main scan by scanning women for ANC providing that they are seen by an Obstetrician/Relevant Clinician immediately following the scan.

Midwife Sonographers' email: sbu.midwifescanreferrals@wales.nhs.uk

Any **urgent** concerns contact us on: (01792)704075 or Ext 34075

3. Midwife Sonographer Growth Scan Referrals SOP

Standard Operating Procedure SOP	

Midwife Sonographers - Growth Scan Referrals

Introduction and Aim

This SOP is for health professionals within Swansea Bay Maternity Services to support autonomous clinical practice for the care of women who require referral for a growth assessment scan by the midwife sonographers.

Objectives

- To support practice based on approved clinical research evidence
- To provide clear a pathway to guide clinical practice

To support women to make informed choices regarding their care

Scope

This guideline applies to all healthcare professionals involved with Maternity care in the Swansea Bay University Health Board

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has not been completed.
Documents to read alongside this Procedure	Antenatal care guideline GAP/GROW guideline Small for Gestational age guideline Standard Operating Procedure for Midwife-led serial scan surveillance All Wales Altered Fetal Movement Guideline (2022)
Author	Tania Peverley, Amy Collins, Katie Wintle, Claire Lingham, Jayne Bowden

3.1 Background

This SOP is to facilitate autonomous clinical practice for the care of women who require referral for a growth assessment scan by the midwife sonographers. If any of the scan findings are found to be abnormal, the woman will be promptly referred to a senior Obstetrician for review.

As recommended by perinatal institute, implementation of the Gap Grow pathway aims to balance the need to identify, investigate and appropriately manage pregnancies, with the aim to avoid unnecessary intervention.

Small for gestational age (SGA) is associated with stillbirth, neonatal death and perinatal morbidity. Whilst large for gestational age (LGA) is associated with birth complications and perinatal morbidity. Antenatal detection of SGA/LGA significantly reduces these risks; it also prompts further fetal surveillance and investigation.

The Perinatal Institutes newly implemented Grow 2.0 digital charts auto plot the measurements and this enables and ensures prompt and timely referral of women who trigger for a growth scan.

3.2 Eligible women:

- FHM indicating slow Growth on Grow 2.0
- Static Fundal Height Measurement
- Accelerated Fundal Height Measurement > 36 weeks on Grow 2.0.
- Altered Fetal Movements as per All Wales Guideline
- Presentation Scan from **36/40**
- First Instance of a Fundal Height Measurement <10th centile.
- Suspected Polyhydramnios (tense abdomen and unable to palpate fetal parts)
- No fetal movements felt by 24 weeks (Fetal heartbeat needs to be confirmed prior to scan via antenatal check)

  NB: Serial FH measurements that are above 97th centile and are linear **DO NOT** require a scan and women should be reassured that the FH measurement is NOT a prediction of a large baby as it measures the uterus and its contents, not just the fetus.

3.3 Exclusions:

- Multiple pregnancies
- Women under the care of fetal medicine
- Ectopic fetal heartbeat
- PV bleeding/Antepartum Haemorrhage (APH)/Abdominal pain/Scar pain
- Women who have not had a documented anomaly scan in the UK
- Late booker without a full anomaly scan

3.4 Standard Operating Procedure:

Referrals accepted from community midwives, antenatal day assessment unit (ADAU) and AAU (Antenatal Assessment Unit) in line with criteria stated above. Referrals should, be made by emailing a completed referral form (located on the Z-Drive) to our generic email account. SBU.midwifescanreferrals@wales.nhs.uk

Community midwives: Please reassure women that these referrals are ***non-urgent*** and are undertaken within 3 working days of receipt of a referral (providing they meet the referral criteria). Please do not give the women the midwife sonographer's direct phone number or ask them to call and check on their scan referrals' progress, as this hinders the department's workflow.

AAU (Antenatal Assessment Unit) patients seen overnight: blue radiology request forms that are completed can be brought to the midwife sonographer's post box outside room 5 & 6 in the ANC. The midwife sonographer will contact the woman for an appointment first thing in the morning. Please do not give out contact numbers or ask women to ring. We will contact the woman once forms are vetted.

Midwife surveillance only - if growth is within the normal parameters (i.e., between the 10th and 97th Centiles, normal liquor volume and normal umbilical artery Doppler), women will be referred back to their community midwife to continue MLC with FHM. If there is a first instance of slow growth and the EFW is > the 10th centile (with normal liquor and umbilical doppler), then the woman will be brought back for a repeat growth scan in 2 weeks. It is important that the community midwife continues with the FHMs during this time.

Referral and review by senior obstetrician - if there are any abnormal findings reported in the growth scan, the woman should be referred to a senior obstetrician the same day via ADAU/AAU for further management plan. If growth is plotting above 97th centile but below 37/40 gestation, an appointment in the next obstetric clinic will be made. If over 37/40 gestation, then the woman must be reviewed the same day in ADAU/AAU.

Clinical Judgement – The Grow 2.0 digital charts are a tool to be used to assist you in assessing the clinical picture of the fetus and mother. The information box to the left of the chart will provide you with a range of expected growth of the fetus. However, clinicians need to consider the entire clinical picture when planning care for the woman and fetus.

3.5 References

1. Hugh, O. Gardosi, J. (2022). Ultrasound in Obstetrics and Gynaecology DOI:10.1002/uog.24860).

2. RCOG Green Top guideline, 2024

3. Perinatal Institute of maternal and child health. Growth Assessment protocol. 2020

4. Saving Babies' lives: a care bundle for reducing perinatal mortality. V3, April 2025.

5. Standard Operating Procedure for Midwife-led serial scan surveillance (MSSS). 2018. Swansea Bay University Health Board.

6. Perinatal Institute: Growth Assessment Protocol, GAP Guidance V4, August 2025.

3.6 Pathway for Growth Scan Referrals for Midwife Sonographers

Woman referred for growth assessment USS with midwife sonographers via email. You will then get a Read receipt if requested.

Sbu.midwifescanreferrals@wales.nhs.uk

Accepted

Woman contacted with date & time of scan.

Declined

Referring midwife contacted with explanation of decision.

Is the growth USS normal?

YES

- On / >10th centile
- On / <97th centile
- Normal liquor volume
- Normal Doppler
- If slow growth, follow midwife scan review SOP

Document discharge & continue with planned antenatal care ensuring the woman has a follow up appointment with her community midwife

NO

For senior Obstetric review in ADAU or AAU (out of hours) to discuss findings with Obstetrician if:

- >97th centile or <10th centile
- Slow growth on Grow 2.0
- Abnormal AFI
- Abnormal Doppler
- Detection of abnormality
- If growth is ↑97th centile but gestation below 37/40 next ANC appointment with consultant can be arranged.

4. Midwife Surveillance Scan Clinic

Standard Operating Procedure SOP	

Midwife Surveillance Scan Clinic

Introduction and Aim

This Standard Operating Procedure (SOP) is for health professionals within Swansea Bay Maternity Services. This is to support autonomous clinical practice for the care of women, who require referral for a growth scan with one risk factor identified for a Small for Gestational Age (SGA) baby. Women who would otherwise be receiving midwife led care.

Objectives

- To support practice based on approved clinical research evidence
- To provide clear a pathway to guide clinical practice
- To support women to make informed choices regarding their care

Scope

This SOP applies to all healthcare professionals involved with Maternity care in the Swansea Bay University Health Board

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has not been completed.
Documents to read alongside this Procedure	Antenatal care guideline SBUHB Perinatal Institute GAP/GROW guideline All Wales SGA guideline (2021) Standard Operating Procedure for Midwife-led serial scan surveillance (2021) All Wales Altered Fetal Movement Guideline (2021) Nice Guidelines, routine antenatal care (2021) Screening for diabetes pathway (2024)
Authors	Tania Peverley, Amy Collins, Katie Wintle, Claire Lingham & Jayne Bowden

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
2		18/10/2024	Updated document GROW 2.0 added/All Wales document added/Diabetes screening added/3 weekly scanning added/Maternal age and low BMI added.

4.1 Background
This SOP is to facilitate autonomous clinical practice for the care of women who require midwife surveillance serial growth assessment scans, who would otherwise be receiving midwife led care. If any of the scan findings are found to be abnormal the woman will be promptly referred to a senior Obstetrician for review.

As recommended by perinatal institute, implementation of the Gap care pathway aims to balance the need to identify, investigate and appropriately manage pregnancies, with the aim to avoid unnecessary intervention.

Small for gestational age (SGA) is associated with stillbirth, neonatal death and perinatal morbidity. Whilst large for gestational age (LGA) is associated with birth complications and perinatal morbidity. The significance of antenatal detection of suspected Large for gestational age (LGA) is unclear and the effects of intervention to reduce perinatal morbidity and mortality is still being explored.

Antenatal detection of SGA/LGA significantly reduces these risks; it also prompts further fetal surveillance and investigation.

4.2 Eligible women:
Women with only 1 of the risk factors identified below who would otherwise be Midwife Led Care are eligible for care in the midwife serial scan surveillance clinic (MSSC)

- Previous SGA
- Raised BMI 35-39.9 (in line with BMI>30 policy)
- All Smokers (including those smoking at conception)
- Low Papp-A
- Low BMI <18

4.3 Exclusions:

- Any known fetal abnormality requiring input from fetal medicine.
- Multiple pregnancy.
- Women who have **more than 1 risk factor** identified. (They will need obstetric input through their pregnancy and will be referred to our trial Shared care clinic).
- Any maternal medical history i.e., hypertension, diabetes, auto-immune disease.
- Any high-risk changes to the pregnancy such as PROM (Premature rupture of membranes), placenta praevia, PET (pre-eclampsia) for example the woman will exit the SOP and become obstetric led care.

4.4 Standard Operating Procedure:

- Referrals accepted from community midwives and antenatal clinic in line with the criteria stated above.

- Referrals can be made by completing the necessary referral form and placing it in our allocated folder in the ANC office.
- The woman will then be contacted via post with an appointment to attend for their first growth surveillance scan and subsequent appointments will be discussed at this appointment.
- USS will be performed 3 at week intervals starting at 28 weeks as per SBUHB policy and Perinatal Institute GAP programme, unless there is a clinical requirement to perform more frequently.
- Women on serial scans do not require Fundal height measurements to be performed.

All women will who attend MSSC will have a full antenatal check in line with NICE guidelines. This will include, BP, urinalysis, and a discussion around fetal movements. Carbon Monoxide (CO) checks and maternal weight will be recorded at the appropriate times. Any previous investigations undertaken e.g., bloods or MSU will also be checked and actioned if appropriate.

Midwife surveillance only –
If estimated fetal growth is within the normal parameters on GROW 2.0 with normal liquor volume and normal umbilical artery Doppler, women will continue under Midwife Led Care. Any concerns regarding the USS or the antenatal check the woman will be referred to ADAU/AAU for review by an obstetrician. If there is a first instance of slow growth >10th centile, the midwife sonographer's will refer to their midwife scan review SOP and schedule a growth scan for 2 weeks.

Referral and review by senior obstetrician –
- If the growth is static i.e. No change in EFW since previous USS
- If the EFW calculates as Slow on GROW 2.0 on more than one occasion or falls below the 10th centile
- If EFW plots below the 10th centile
- If EFW plots above 97th centile at <37/40 gestation an appointment in the next obstetric clinic will be made however, if >37/40 gestation, then the woman will be reviewed the same day in ADAU/AAU. Consider diabetic screening following the appropriate pathway.
- Doppler or liquor volume are abnormal
- Any concerns regarding the antenatal check the woman will be asked to attend ADAU/AAU for review by obstetrician.

Women who have exited the midwife serial scan surveillance clinic pathway can still have the scans performed by the midwife sonographers for continuity, however, they will then attend the relevant obstetric clinic for review and a further plan of care.
If there is the need for any fetal medicine input following the USS, the midwife sonographers will **NOT** continue any further care/USS as this is outside of their scope of practice.

4.5 References

1. RCOG Green Top guideline, 2024
2. Perinatal Institute of maternal and child health. Growth Assessment protocol. 2023 https://perinatal.org.uk/GAPguidance.pdf
3. NHS England Saving Babies Lives Version 3. 2023 - https://www.england.nhs.uk/wp-content/uploads/2019/03/Saving-Babies-Lives-Care-Bundle-Version-Two-Updated-Final-Version.pdf
4. Standard Operating Procedure for Midwife-led serial scan surveillance clinic (MSSSC). 2018. Swansea Bay University Health Board.
5. NICE Guidelines, Routine antenatal Clinical Care. 2021
6. Screening for diabetes pathway (2024) N. John. SBUHB

NB: *The Perinatal Institute have an online calculator that can determine fetal growth velocity. (Link Below) This can be used on out of area women not on GROW 2.0 system. Laravel (perinatal.org.uk)

4.6 Pathway for Midwife Surveillance Scan Clinic

Woman referred to midwife sonographers for serial growth scan surveillance. Referral form on Z-drive. Please place in ANC folder.

(Folder in ANC office)

↓

Eligible women with only
1 risk factor:

- Previous SGA
- Raised BMI (35-39.9)
- Smokers (including at conception)
- Low PAPP-A
- Low BMI <18

↓

Is the Growth USS normal?

↙ ↘

YES

- EFW on / >10th centile
- EFW On / < 97th centile
- Normal liquor volume
- Normal Doppler
- First instance of slow growth but >10th centile

↓

Document, discharge & continue with planned antenatal care ensuring next USS is booked

NO

For senior Obstetric review in ADAU or AAU (out of hours) to discuss findings with Obstetrician if:

- If EFW >97th centile or <10th centile
- Static growth
- Abnormal AFI
- Abnormal Doppler
- Detection of an abnormality
- If EFW is >97th centile but gestation below 37/40 next ANC apt with obstetrician to be arranged. Diabetes pathway should also be used in conjunction with this for any further investigations.

5. Shared Antenatal Care

Standard Operating Procedure SOP	

Midwife Sonographers – Shared Antenatal Care

Introduction and Aim

This Standard Operating Procedure (SOP) is to facilitate the expansion of SBUHB's midwife sonography department to enable an increase in scanning capacity. This will be a multidisciplinary approach to enable the support of autonomous clinical practice for the shared care of women who require serial growth scans.

Objectives

- To support practice supported by approved clinical research evidence
- To provide a clear pathway to guide clinical practice
- To provide a multidisciplinary approach to streamline women's antenatal care
- Assisting the appropriate utilisation of ANC appointments for women with an increased risk for SGA/FGR
- To facilitate 3 weekly serial growth scans in line with GAP/GROW

Scope

This Standard Operating Procedure applies to all healthcare professionals involved with Maternity care in the Swansea Bay University Health Board

Equality Health Impact Assessment	An Equality Health Impact Assessment (EHIA) has not been completed.
Documents to read alongside this Procedure	Pathway for consultant led women with 2 risk factors who are eligible for serial growth scans within the midwife sonography department. Antenatal care guideline SBUHB Perinatal Institute GAP/GROW guideline (2.0) All Wales Small for Gestational age guideline 2021 SBUHB Ultrasound protocol 2024 All Wales Altered Fetal Movement Guideline 2021 Nice Guidelines, routine antenatal care 2021
Authors	Tania Peverley, Amy Collins, Katie Wintle, Claire Lingham & Jayne Bowden

5.1 Background

In Wales there is currently a Welsh Government Mandate to utilise the Perinatal Institutes GAP/GROW programme for maternity care. This is in response to the increase in undetected small for gestational age babies where care is often managed inappropriately. The Perinatal Institutes Gap/ Grow pathways main objective is to balance the need to identify, investigate and appropriately manage pregnancies with the aim of avoiding unnecessary intervention.

Until recently Swansea Bay University Health Board (SBUHB) has been unable to follow the recommended 3 weekly Growth scans due to lack of capacity in radiology ultrasound and obstetric led Antenatal clinics.

This was placed on the health boards' risk register as we were not able to follow the recommended guidance.

In order for the 3 weekly growth scans to be implemented, the midwife sonography team is due to undertake a proportion of the growth scans/care. There is strict criteria of eligible women and a comprehensive pathway to enable shared care between the midwife sonographers and the obstetricians. This assists with the appropriate utilisation of ANC appointments for women with an increased risk for SGA/FGR, providing the women with a multidisciplinary, holistic plan of care.

If a woman following the shared care pathway and has normal scans in the midwife sonography clinics, this will mean that three of the five ANC slots they would usually utilise would be free to use for other women therefore, increasing scan capacity. A multidisciplinary approach is essential for it to work effectively

5.2 Eligible women:

Women with only **2** of the risk factors identified below will be included in the shared care clinics:

- Previous SGA
- Raised BMI (35-39.9)
- All smokers (including those smoking at conception)
- Low PAPP-A
- Maternal age >40 years
- Low BMI (<18)
- Previous caesarean section
- Previous Postpartum Haemorrhage (<1500 mls)
- Previous IUD/Stillbirth

5.3 Exclusions:

- Women with more than 2 risk factors on the list (see above)
- Women with other medical/obstetric conditions
- Any woman under the care of fetal medicine
- Any fetus with an anomaly discovered in the third trimester
- Ongoing or recurrent AFM
- Ectopic fetal heartbeat
- Multiple uterine fibroids or a single fibroid measuring ≥6cms

- Substance misuse
  - Significant antepartum haemorrhage
  - Previous PET/Current hypertension
  - Grand-Multip
  - PPH>1500L
  - Late booker
  - No departmental anomaly scan in the UK

The above list is not exhaustive and a thorough evaluation of the maternity notes is required to ensure the correct management of care is planned for the woman.

5.4 Standard Operating Procedure:

- Eligible women will be identified at dating by the antenatal clinic midwives who will evaluate the maternity notes.
- Once identified as suitable for the shared care clinic, an obstetric ANC appointment will be arranged for 28 weeks which will include a scan with the midwife sonographers. ANC midwives will need to clearly document the 2 risk factors on the scan request form.
- Re-confirmation of eligibility for inclusion for the shared care clinic will be discussed and documented during their first appointment with the obstetrician
- If the obstetrician does not consider the woman to be eligible for the shared care clinic, the decision should be documented clearly in the maternity notes and on the scan form. The woman shall remain Obstetric led care and USS with the main radiology sonographers.
- If the obstetrician is happy for the shared care clinic pathway to be commenced, it is the responsibility of the obstetrician to **clearly document** this plan in the maternity notes and on the scan form. The obstetrician will need to complete a scan form for the 31-week scan and document EDD, risk factors and for serial scans. The woman will attend the same day as the antenatal clinic of her named obstetrician to enable review of the scan by them if there were any concerns.
- **ALL** women on this pathway will have an appointment with an obstetrician at 37/40. The 37-week obstetric ANC appointment is a crucial part of the pathway as it will include a birth plan discussion. Following discussion with the woman the mode of delivery and location **MUST** be clearly documented by the obstetrician.
- If there is **no** evidence of clear documentation from the 37-week ANC appointment the woman will be placed back into the Obstetric clinic at the 40-week scan appointment on the same day as an extra.

5.5 References

Perinatal Institute of maternal and child health. Growth Assessment protocol. 2023 https://perinatal.org.uk/GAPguidance.pdf

5.6 Pathway for Consultant Led Women with 2 Risk Factors Eligible for Growth Scans with the Midwife Sonographers

Eligible women: Combination of only 2 of the risk factors indicated below

- Previous SGA
- Raised BMI (35-39.9)
- Smoker (including at conception)
- Low PAPP-A
- Maternal age >40 years
- Low BMI (<18)
- Previous caesarean section
- Previous Postpartum Haemorrhage (PPH) <1500mls

The initial ANC appointment will be at or before 28 weeks with a clear plan documented by the obstetrician for further management.

The women will be scanned by the midwife sonographers at 3 weekly intervals.

Serial Scans performed at the following gestations: 28/31/34/37/40 weeks

Is the Growth USS normal?

↙ ↘

YES

- EFW on / >10th centile
- EFW On / <97th centile
- Normal liquor volume
- Normal Doppler
- If slow growth refer to midwife scan review SOP

Continue 3 weekly serial scans with the midwife sonographers.

Routine antenatal care with antenatal check performed and next ultrasound scan booked appropriately.

See **consultant at 37 weeks** to

NO

If abnormal finding with the growth scan. Walk into ANC appointment on same day of abnormal finding for review by obstetrician. Following scans can be facilitated by midwife sonography service, however woman attends clinic alongside ultrasound growth scan.

Reasons for exiting shared care pathway

- EFW <10th centile
- Abnormal AFI
- Abnormal Doppler
- Detection of an abnormality
- If EFW is >97th centile but gestation below 37/40 next ANC appt with consultant can

6 Midwife Sonographer Scan Review SOP

Midwives should use their clinical judgement and if concerned or patient wishes refer to the on-call team for review.

Is Growth linear, Liquor normal and Doppler normal?	Reassure, ensure follow up with CMW or next growth scan if needed
Normal Liquor and Doppler but slow growth velocity using Grow 2.0	If under 37/40 and first scan with drop in growth velocity arrange follow up scan in 2/52. Emphasise need to report concerns around fetal movements. Ensure has fetal movements leaflet. If second sequential scan with drop in growth refer to on call team / ANC within 7 days If >37/40 for same dav obstetric review
Normal growth but reduced/Increased liquor. Normal Doppler	ALL: Advise about fetal movements. Ensure has fetal movements leaflet. Arrange OLC with ANC appointment with next scan. LV reported low but AFI >50mm and under 37/40: Assess for risk of SROM (if suspected refer AAU). Arrange scan for 2 weeks with growth, LV and doppler. LV low with DVP <2cm OR AFI <50mm and under 37/40: Assess for risk of SROM (if suspected refer AAU). Arrange twice weekly CTG. Arrange scan for LV and doppler 1 week. High AFI under 37/40: Check GTT result – if not had GTT arrange GTT/Refer to Diabetic Midwife. Rescan 2/52 Low or high LV 37/40+ - same day obstetric review
Abnormal Doppler	If raised PI ONLY and <37/40 advice about fetal movements, ensure has fetal movements leaflet. Arrange twice weekly scan. Arrange ANC within 1 week. Absent / Reversed EDF OR >37/40 for same day obstetric review
More than one deviation from normal eg tailing growth AND reduced liquor	Same day obstetric review

7 SOP for the Antenatal Pre-Term Birth Surveillance Clinic

This Document should be read in conjunction with the **All-Wales Pre-Term Birth Guideline 2023.**

Introduction and Aim

8% of all births will occur before 37 completed weeks of gestation. 70% of these are spontaneous following onset of spontaneous contractions or preterm pre-labour rupture of membranes (PPROM). Preterm birth is the biggest cause of neonatal morbidity and mortality in the UK. Most women who present with threatened preterm labour will go on to deliver at term, even in the absence of intervention. It is essential to recognise those women who are at the highest risk to target interventions to those who will benefit the most, minimising unnecessary treatment. (1)

Objectives

- To identify women who are at risk of Pre-Term Birth
- To refer to the Pre-Term birth Surveillance Clinic for assessment and plan of care.
- To counsel women regarding the risks and implications that have been identified of Pre term birth
- To provide evidence-based care to women in line with the All-Wales Pre-Term Pre- Birth Guideline

Scope

This SOP applies to Obstetricians, Midwives, Midwife Sonographers and Sonographers involved in the care of women who are identified as being at risk of pre-term birth (PTB)
The Pre-Term Birth Surveillance Clinic will be overseen by Obstetricians Madhuchanda Dey and Najiya Ali in conjunction with the Midwife Sonographers.
The clinic will be scheduled on Wednesday mornings in the midwife sonographer's room (5).

- Women should be identified at Booking or when attending the antenatal clinic following their dating scan. The woman/Birthing person should be informed that due to their medical/obstetric history that they are being referred to and will be seen in the PTB clinic.
- An appointment to be seen in the PTB clinic should be made by 14 – 18 weeks gestation dependant on the woman's risk factor.
- Women who are identified at risk of PTB will be placed in one of the two categories' below (see appendix 1).

7.1 High and Intermediate Risk factors of preterm birth

High Risk: See ≥ 14 weeks gestation
Previous spontaneous vaginal birth or mid-trimester loss (16-34 weeks). **Does NOT include preterm LSCS for Obstetric complications/MTOP/Silent miscarriage**
Previous preterm prelabour rupture of membranes <34/40
Previous use of cervical cerclage or use of progesterone to prevent PTB.
Known uterine variant i.e. (unicornuate/bicornuate uterus/ uterine septum
Intrauterine Adhesions (Ashermann's Syndrome)
History of trachelectomy (for cervical cancer)

High risk women should be referred and seen in the pre-term birth clinic by 14-16 weeks' gestation. A plan of care will be discussed and developed together with the woman and the consultant obstetrician.
Serial transvaginal scans will be offered every 2-4 weeks for women in the high-risk category from 14-16 weeks until 24 weeks gestation.

Intermediate risk: See ≥ 18 weeks gestation
Previous birth by caesarean section at full dilatation
History of significant cervical excisional event i.e., LLETZ where >15mm depth removed/more than 1 LLETZ procedure carried out/cone biopsy (knife or laser, typically carried out under general anaesthetic). ****This information can be found on Welsh Clinical Portal****

Women who are in the intermediate risk category will be offered a minimum of 1 TVS between 18-22 weeks gestation and further risk assessed.

NB If women who have an intermediate risk factor have had a TERM DELIVERY after the risk factor event, the risk of preterm birth is LOW and there is no need for cervical length screening.

Once the women have been discharged from the PTB clinic they will attend their nominated Consultant Obstetrician clinic/ Community midwife and will NOT stay under the lead obstetricians for the PTB clinic.

7.2 References

1: All Wales Pre-term Birth Guideline; All Wales Maternity and Neonatal Guideline 2023

7.3 Pre-Term Birth Surveillance Clinic Referral Form

Name: DOB: NHS no: Address:	EDD: Current Gestation: Scan form completed along with referral form: ☐

High Risk: See ≥ 14 weeks gestation	Tick
Previous spontaneous vaginal birth or mid-trimester loss (16-34 weeks). **Does NOT include preterm LSCS for Obstetric complications/MTOP/Silent miscarriage**	
Previous preterm pre-labour rupture of membranes <34/40	
Previous use of cervical cerclage or use of progesterone to prevent PTB.	
Known uterine variant i.e. (unicornuate/bicornuate uterus/ uterine septum	
Intrauterine Adhesions (Ashermann's Syndrome)	
History of trachelectomy (for cervical cancer)	

Intermediate risk: See ≥ 18 weeks gestation	Tick
Previous birth by caesarean section at full dilatation	
History of significant cervical excisional event i.e., LLETZ where >15mm depth removed/more than 1 LLETZ procedure carried out/cone biopsy (knife or laser, typically carried out under general anaesthetic). ****This information can be found on Welsh Clinical Portal****	

****If the woman with an intermediate risk factor has had a TERM DELIVERY after the risk factor event, the risk of preterm birth is LOW and therefore, there is no need for cervical length screening****

Referrer's Name/signature: Date:

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval by Maternity Quality & Safety Group

Title of Guideline:	Midwife Sonographer SOPs
Name(s) of Author:	Tania Peverley, Katie Wintle, Amy Collins
Chair of Group or Committee supporting submission:	Antenatal forum
Issue / Version No:	1
Next Review / Guideline Expiry:	
Details of persons included in consultation process:	
Brief outline giving reasons for document being submitted for ratification	
Name of Pharmacist (mandatory if drugs involved):	
Please list any policies/guidelines this document will supercede:	SOP for Growth Scan Referrals to Midwife Sonographers Midwife sonography pathways SOP for Midwife Surveillance Serial Scan Clinics SOP for shared antenatal care
Date approved by Antenatal Forum	November 2024
Keywords	Midwife sonographer, growth scan Midwife sonographer, growth scan, risk factors, shared care