East Sussex Healthcare
NHS Trust

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FOI Ref: 26/148

26th June 2026

Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

Under the Freedom of Information Act 2000, please provide the following information for the last five calendar years (2021–2025), broken down by year. Where counts are small, you may apply your standard disclosure controls in line with your usual practice.

1. How many deliveries recorded ICD-10 codes O73.0 or O73.1 (Retained placenta, with or without haemorrhage)?

2021	2022	2023	2024	2025
25	30	23	19	26

2. Of the cases in Question 1, how many also recorded a postpartum haemorrhage (PPH) of 1,000ml or more?

2023	2025
2	1

Please note that we record PPH from 500mls not 1000mls.

3. How many deliveries recorded any of the following ICD-10 codes:

a. O43.21 (placenta accreta)
b. O43.22 (placenta increta)
c. O43.23 (placenta percreta)

If you are unable to distinguish between these subcodes within your dataset/reporting extract, please confirm whether PAS cases are captured under ICD-10 code O43.2 (Morbidly adherent placenta), and provide the count for O43.2 instead.

Clarification was sought with regard to your definition of PAS and confirmation was received as follows:

Suspected placenta accreta spectrum refers to a diagnosis where there are indicators of placenta accreta spectrum, and a patient is placed on either a care pathway within your hospital or referred to a specialist tertiary centre.

Please see the table below for the number of deliveries within East Sussex Healthcare NHS Trust (ESHT), captured under ICD-10 code.

2021	2022	2023	2024	2025
9	12	2	5	10

Please note that we do not record this information broken down into subcategories, as requested.

4. Of the PAS-coded cases in Question 3, how many were documented antenatally as "suspected PAS" where this is captured in a structured/reportable way (for example, a specific coded field, dropdown, flag, problem list entry, or other reportable attribute)?

If this is not held in a structured/reportable way, please confirm this and briefly state how (if at all) antenatal suspicion is recorded (e.g., free text in ultrasound reports/clinical notes).

Routinely, within our local guidance, if a woman has a previous Lower Segment Caesarean Section (LSCS) and a low-lying placenta at 32/40, they are referred to the fetal medicine obstetric consultant, who will review for a MRI scan via our maternity digital system. Reporting will be free text on our digital system and scan reports.

5. How many women underwent peripartum hysterectomy where the primary recorded indication was PAS or suspected PAS? If available, please differentiate between planned and emergency hysterectomies.

None.

6. How many deliveries involved Manual Removal of Placenta (MROP)?

2021	2022	2023	2024	2025
5	44	29	36	47

Please note that the recorded numbers are low in 2021 as the Trust changed its maternity IT system during that year; data from the older system is no longer available.

7. **Of the MROP cases in Question 6, how many also recorded a PPH of 1,000ml or more?**

2021	2022	2023	2024	2025
0	4	7	5	12

Please note that the recorded numbers are low in 2021 as the Trust changed its maternity IT system during that year; data from the older system is no longer available.

8. **Is diagnostic and management training for Placenta Accreta Spectrum (PAS) a mandatory requirement for frontline maternity staff? (Yes/No. If Yes, please specify which staff groups this applies to.)**

No, diagnostic and management training for Placenta Accreta Spectrum is not a mandatory requirement.

9. **In the last 24 months, has the Trust included a PAS-specific scenario (distinct from general haemorrhage) in mandatory Skills & Drills, PROMPT, or other obstetric emergency training?**

Yes, on PROMPT.

10. **Does the Trust have a written "Hard Stop" protocol for manual removal of a sticky or retained placenta (for example, a defined time limit or limit on number of attempts before escalation to a suspected PAS pathway)?**

No, ESHT does not have a "Hard Stop" protocol for manual removal of a sticky or retained placenta.

11. **In the Trust's maternity electronic patient record system (or radiology reporting workflow), is antenatal "suspected PAS" captured as:**
– a structured/coded field or flag (reportable), – free text only, or – not recorded?

On USS/MRI/Electronic patient record.

12. **Which ultrasound guideline or reporting template does the Trust use when identifying or documenting suspected PAS? (For example, RCOG guidance, FIGO guidance, an internal Trust guideline, or other.) If you refer to any internal policy, guideline, SOP, template, training document, or pathway in your response, please attach a copy (or provide a link to the published version) for reference.**

ESHT use Royal College of Obstetricians & Gynaecologists (RCOG) and International Society of Ultrasound in Obstetrics and Gynaecology (ISUOG) and local guidance as attached.

Please note that we have redacted the names of the Trust's IT Systems, names of staff that no longer work for the Trust, personal email addresses and phone numbers, and are applying Sections and 31(1)(a), 40(2) and 44 respectively, please see below:

Section 31(1)(a)

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- *NHS England — London » Synnovis Ransomware Cyber-Attack*
- *NHS England confirm patient data stolen in cyber attack - BBC News*
- *Merseyside: Three more hospitals hit by cyber attack - BBC News*

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term ''public interest'' does not refer to the private or commercial interests of a requestor; its meaning is for the "public good". The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the FOI portal whatdotheyknow.com who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can

be heavily fined should it be found to have acted in a negligent way which results in a personal data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in Section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the Network and Information Systems (NIS) Regulations Act 2018 can be found here – The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK

Your request asks for policy documents which unfortunately mention specific details regarding our IT Systems which, for the reasons explained above, would be inappropriate to release into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust's IT systems and infrastructure. The Trust's capacity to defend itself from such acts relates to the purposes of crime prevention and therefore Section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the information you are seeking to be exempt under Section 31(1)(a) [law enforcement] of the FOIA and the names of the IT systems within the policy is being withheld. The full wording of Section 31 can be found here: Freedom of Information Act 2000

Section 31 is a qualified exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- *Organisations must do more to combat the growing threat of cyber attacks | ICO*

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:
"Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.

Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August 2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating."

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is 'of interest' to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust's transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust's IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services
- Public interest in maintaining the integrity and security of the Trust's systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service

disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take a cautious approach to requests of this nature and appreciate your understanding in this matter.

Section 40(2)

I can confirm that we hold this information, but it is exempt under Section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individuals and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

Section 44

We are unable to provide the contact details of staff as we consider this information to be exempt from release in accordance with Section 44 of the Freedom of Information Act (Prohibition on disclosure) and would refer to the Privacy and Electronic Communications EC Directive Regulations 2003 which provide specific rules on electronic communication services, including marketing (by phone, fax, email or text) and keeping communications services secure. We will not provide any information that could result in the transmission of unsolicited communications which may place an unacceptable risk to our email network and could also have a detrimental impact on patient care and treatment.

The contact number for the Trust is accessible on the Trust website http://www.esht.nhs.uk.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

13. How many deliveries did the Trust record in total in each year (2021–2025)?

2021	2022	2023	2024	2025
283	2936	2764	2737	2832

Please note that the recorded numbers are low in 2021 as the Trust changed its maternity IT system during that year; data from the older system is no longer available.

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at esh-tr.foi@nhs.net quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team
East Sussex Healthcare NHS Trust
0300 131 4716
Core Hours of Business: Monday to Friday 9.00am to 4.00pm

East Sussex Healthcare NHS Trust

Clinical Guideline for the Management of Placenta Praevia including Management of Placenta Accreta Spectrum and Placenta Percreta

Document ID Number	697
Version:	V4
Ratified by:	Women and Children's Governance and accountability
Date ratified:	October 2023
Name of author and title:	Nicky Roberts, Consultant Obstetrician and Gynaecologist
Date Originally Written:	October 2005
Date current version completed:	October 2023
Name of responsible committee/individual:	Chair of the Guideline Implementation Group for Maternity Services
Date issued:	27 October 2023
Review date:	October 2026
Target audience:	All Staff
Compliance with CQC outcome	Regulation 9 Person centred Care Regulation 10 Dignity and Respect Regulation 11 Need for Consent Regulation 12 Safe Care and Treatment Regulation 15 Premises and Equipment Regulation 19 Fit and Proper Persons Employed
Compliance with any other external requirements (e.g. Information Governance)	RCOG Green-top Guideline No. 27a September 2018 Placenta Praevia and Placenta Accreta Diagnosis and Management. RCOG Green Top Guideline Green-top Guideline No. 27b Vasa Praevia - Diagnosis and management September 2018

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1 2005216	October 2005	[redacted]	New Guideline	
V2 2008197	September 2008		Clinical Update	
V2.1 2013015	January 2013	Catherine O'Callaghan & Nicky Roberts	Clinical Update	
V2.2	April 2016	Nicky Roberts	Clinical Review	
V3	2019	Nicky Roberts	Clinical Review	Updated USS information and planning for delivery and slight change to Title
V4	May 2023	Nicky Roberts	Clinical Review	New pathways added into Appendix C

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Guideline Implementation Group	Obstetrics and Gynaecology	October 2008 Sept 2009
Women and Children's Clinical Directorate Team		October 2008
Strategic Business Unit Women's Health Operational Meeting.		September 2009
Guideline Implementation Group	Obstetrics and Gynaecology	September 2012
Clinical Unit – Integrated Division	Obstetrics and Gynaecology	November 2012
Women and Children's Guideline Implementation Group		May 2016
Women, Children's and sexual health accountability meeting		May 2016
Women and Children's Guideline Implementation group		June 2019
Women and Children's Governance and Accountability		June 2019
Medicines Optimisation group		Sept 2019
Women and Children's Guideline Implementation group		September 2023
Women and Children's Governance and Accountability		October 2023

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

Table of Contents

1. Introduction

Placenta praevia exists when the placenta is inserted wholly or in part into the lower urine segment of the uterus. Maternal and fetal morbidity and mortality from placenta praevia and placenta praevia accreta are considerable (Hall 2004). The number of cases of placenta praevia and its complications including placenta accreta will continue to increase because of the rising incidence of caesarean section and maternal age (RCOG 2018).

2. Rationale

To provide guidance for clinical staff on the management of placenta praevia including placenta accreta and Placenta percreta.

3. Scope

This document applies to all staff caring for women within the maternity services at ESHT.

4. Definitions

The term *placenta praevia* should be used when the placenta lies directly over the internal os.

For pregnancies at more than 16 weeks of gestation the term low-lying placenta should be used when the placental edge is less than 20 mm from the internal os on transabdominal or transvaginal scanning (TVS).

If the placenta is thought to be low lying (less than 20 mm from the internal os) or praevia (covering the os) at the routine fetal anomaly scan, a follow-up ultrasound examination including a TVS is recommended at 32 weeks of gestation to diagnose persistent low-lying placenta and/or placenta praevia.

Major Placenta Praevia
Placenta lying over or within 2cm of the internal os.

Minor Placenta Praevia
Placental edge more than 2 cm but within 4cm of the internal cervical os.

Placenta Accreta
Abnormally adherent placenta into the muscle layer of the uterus

Placenta Increta
Abnormally adherent placenta into the perimetrium of the uterus

Placenta Praevia
Placental implantation in the lower uterine segment

Placenta Praevia Percreta
Abnormally adherent placenta through the muscle layer of the uterus

Vasa praevia
Fetal vessels coursing through the membranes over the internal cervical os and below the fetal presenting part, unprotected by placental tissue

5. Accountabilities

5.1. Midwives and Obstetricians

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guideline

5.2. Management

- To ensure the guideline is reviewed as required in line with the Trust and National guidelines
- To ensure the guideline is accessible to all relevant staff
- To monitor the audit process

6. Process

6.1. Diagnosis

Placental location is routinely reported at the anomaly scan.

All women who have had a previous caesarean section should be strongly advised to have their placental site determined.

Clinicians should be aware that TVS for the diagnosis of placenta praevia or low-lying placenta is superior to transabdominal and transperineal approaches and is safe. [New 2018]

In women with a persistent low-lying placenta or placenta praevia at 32 weeks of gestation who remain asymptomatic, an additional TVS is recommended at around 36 weeks of gestation to inform discussion about mode of delivery. [New 2018]

Regarding placenta praevia in women with a previous caesarean section if there is any doubt regarding the depth of invasion an MRI can be used along with ultrasound scanning in determining if the placenta is accreta or percreta.

The definitive diagnosis of most low-lying placentas will be achieved with ultrasound imaging.

Full explanation of the condition should be given to the woman with on-going support throughout pregnancy.

6.2. Antenatal Management of Low-lying placenta or Placenta Praevia

6.2.1. Asymptomatic women (low-lying placenta or placenta praevia)

Women with asymptomatic placenta praevia or a low-lying placenta in the third trimester should be counselled about the risks of preterm delivery and obstetric haemorrhage, and their care should be tailored to their individual needs.

Women with asymptomatic placenta praevia confirmed at the 32-week follow-up scan and managed at home should be encouraged to ensure they have safety precautions in place, including having someone available to help them as necessary and ready access to the hospital.

Women whose placenta extends over the internal cervical os should be offered another transabdominal scan at 32 weeks.

To support the respiratory effort of the infant at birth, a single course of antenatal corticosteroids administration will be considered on an individual basis for women between 34^{+0}- 35^{+6} weeks where birth is being planned early or the threat of pre-term birth exists. After discussion and agreement between the Consultant and the woman steroids can be given prior to 34+0 weeks – please see ESHT – 532 ***Pre-term Labour Including Antenatal Steroid Therapy and Tocolysis and Pre-term Birth Clinical Guideline*** for details on dose and timing.

Occasionally in-patient management may be considered appropriate with placenta praevia in the third trimester at the discretion of the Consultant Obstetrician.

If the woman is an in-patient and at high risk of haemorrhage care as follows:

- A fresh group and save blood sample should be taken weekly
- IV access with a large bore cannulae (16-/18- gauge) in situ
- 4 Units of blood should be cross matched
- Anaesthetic assessment should be arranged
- Consider completing the consent form for Emergency caesarean section that can be kept with the woman in case an emergency situation arises while an inpatient

6.3. Management of Vaginal Bleeding

Care of women who present with vaginal bleeding should be managed on an individual basis according to their clinical needs

No woman who presents with vaginal bleeding should undergo a vaginal examination (digital or speculum) unless the placental location is reliably known and excludes placenta praevia.

Expectant management should be considered when gestational age is less than 37 weeks, the bleeding is mild and the woman is not in labour.

For immediate management of women with significant bleeding refer to ESHT guidelines:

Clinical Guideline for Antepartum Haemorrhage (APH)

Clinical Guideline for the Management of Postpartum Haemorrhage and Major Obstetric Haemorrhage

Anti-D immunoglobulin should be offered to rhesus negative women whose baby is known to be Rh+ve after the cell free fetal DNA (cffDNA) test at 16 weeks or women who declined and the status of the baby is unknown or late booker or inconclusive result from the test. This will be to provide protection to the baby from developing Haemolytic Disease of the Fetus and Newborn (HDFN).

If a Rh-ve woman has had a cell free fetal DNA (cffDNA) test and the baby is Rh-ve then Anti-D immunoglobulin is not required. Cord blood will be taken at birth to confirm the Rhesus status of the baby.

Refer to - Clinical Guideline for the Prevention of Rhesus isoimmunisation in Rhesus negative women in pregnancy

Maternal anaemia should be corrected prior to delivery. Oral Iron should be administered if Haemoglobin < 105gl. The decision to transfuse should be made on an individual basis.

Tocolysis may be appropriate in certain situations. A Consultant Obstetrician should make this decision.

Magnesium Sulphate prophylaxis for fetal neuroprotection should be considered - **Please follow the ESHT *Clinical Guideline Magnesium Sulphate for Fetal Neuroprophylaxis and Prevention of Cerebral Palsy.***

6.4. Labour/Birth

The mode of delivery should be based on clinical judgement.

As a minimum requirement for a planned caesarean section for a woman with placenta praevia, the surgical procedure should be carried out by an appropriately experienced operator.

In cases of planned caesarean section for placenta praevia or a low-lying placenta, a senior Obstetrician (usually a consultant) and senior anaesthetist (usually a consultant) should be present within the delivery or theatre suite where the surgery is occurring.

When an emergency arises, the senior obstetrician and senior anaesthetist should be alerted immediately and attend urgently if not already present.

Regional anaesthesia is considered safe and is associated with lower risks of haemorrhage than general anaesthesia for caesarean delivery in women with placenta praevia or a low-lying placenta. Women with anterior placenta praevia or a low-lying placenta should be advised that it may be necessary to convert to general anaesthesia if required and asked to consent to this.

Women with a placental edge within 2cm of the internal cervical os require a caesarean section.

If this distance is more than 2cm an attempt at vaginal birth is appropriate.

Precautions need to be taken to anticipate haemorrhagic complications.

Management of women undergoing a vaginal birth

- Refer to ESHT guideline - ***Clinical Guideline for Care in Labour (First, Second and Third Stage)***
- A 16- gauge cannulae (grey) should be inserted, as soon as the women is in established labour
- Electronic fetal monitoring should be used continuously throughout labour

6.5. Management of a Woman with Placenta Praevia Undergoing Caesarean Section

As a minimum requirement for a planned caesarean section for a woman with placenta praevia, the surgical procedure should be carried out by an appropriately experienced operator.

In cases of planned caesarean section for placenta praevia or a low-lying placenta, a senior Obstetrician (usually a consultant) and senior anaesthetist (usually a consultant) should be present within the delivery or theatre suite where the surgery is occurring.

When an emergency arises, the senior obstetrician and senior anaesthetist should be alerted immediately and attend urgently.

Regional anaesthesia is considered safe and is associated with lower risks of haemorrhage than general anaesthesia for caesarean delivery in women with placenta praevia or a low-lying placenta. Women with anterior placenta praevia or a low-lying placenta should be advised that it may be necessary to convert to general anaesthesia if required and asked to consent to this.

Prior to surgery, full discussions about delivery, risks of haemorrhage, subsequent management of haemorrhage and the possible need for blood transfusion should take place if possible.

Consultant obstetricians and consultant anaesthetists should be involved in planning delivery at an early stage whenever time allows.

The risk of placenta accreta / percreta and therefore the possibility of Caesarean hysterectomy should be discussed as part of the consent process.

At least four units of cross matched blood must be available, in a cool box, in theatre at the time of the surgery if possible.

Two wide bore cannulae (14-/16- gauge (brown/grey)) should be inserted, prior to surgery.

Close liaison with the hospital transfusion laboratory is essential for women presenting with placenta praevia or a low-lying placenta.

Rapid infusion and fluid warming devices should be immediately available.

Cell salvage is recommended for women where the anticipated blood loss is great enough to induce anaemia, in particular, in women who would decline blood products.

Red cells, fresh frozen plasma, and cryoprecipitate or fibrinogen concentrate are all kept by blood bank

In the case of haemorrhage refer to ESHT Guidelines:

Clinical Guideline for Antepartum Haemorrhage (APH)

Clinical Guideline for the Management of Postpartum Haemorrhage and Major Obstetric Haemorrhage

6.6. Antenatal diagnosis, management and outcome of women with placenta accreta spectrum

The management of Placenta Accreta Spectrum requires a large multidisciplinary team and forward planning.

An individualised management plan for birth will be made between the woman and the consultant

Women with a history of previous caesarean section seen to have an anterior low-lying placenta or placenta praevia at the routine fetal anomaly scan should be specifically screened for placenta accreta spectrum.

A referral to the fetal medicine consultant should be made for evaluation at 28 - 30 weeks and a referral to Antenatal Clinic to discuss the possibility of placenta accreta spectrum disorder

Clinicians should be aware that the diagnostic value of MRI and ultrasound imaging in detecting placenta accreta spectrum is similar when performed by experts.

MRI may be used to complement ultrasound imaging to assess the depth of invasion and lateral extension of myometrial invasion, especially with posterior placentation and/or in women with ultrasound signs suggesting parametrial invasion.

See appendix B for referral and reporting for an MRI

In the absence of risk factors for preterm delivery in women with placenta accreta spectrum, planned delivery at 35+0 to 36+6 weeks of gestation provides the best balance between fetal maturity and the risk of unscheduled delivery.

Planning delivery of women with suspected placenta accreta spectrum

Once the diagnosis of placenta accreta spectrum is made, a contingency plan for emergency delivery should be developed in partnership with the woman, including the use of the local Trust protocol for the management of maternal haemorrhage.

The elective delivery of women with placenta accreta spectrum should be managed by a multidisciplinary team, which should include senior anaesthetists, obstetricians and gynaecologists with appropriate experience in managing the condition and other surgical specialties if indicated. In an emergency, the most senior clinicians available should be involved.

Badgernet alerts critical alerts and adding to risk assessment so the Guideline title will be highlighted on the pregnancy summary page.

The six elements considered to be reflective of good care are and recorded in the Placenta Accreta Spectrum care bundle are

- Consultant obstetrician planning and directly supervising delivery.
- Consultant anaesthetist planning and directly supervising anaesthesia at delivery.
- Blood and blood products available.
- Multidisciplinary involvement in preoperative planning.
- Discussion and consent, including possible interventions (such as hysterectomy, leaving the placenta in situ, cell salvage and interventional radiology).
- Local availability of a level 2 critical care bed.

6.7. What surgical approach should be used for women with placenta accreta spectrum?

Caesarean section hysterectomy with the placenta left in situ is preferable to attempting to separate it from the uterine wall.

When the extent of the placenta accreta is limited in depth and surface area, and the entire placental implantation area is accessible and visualised (i.e. completely anterior, fundal or posterior without deep pelvic invasion), uterus preserving surgery may be appropriate, including partial myometrial resection.

Uterus preserving surgical techniques should only be attempted by surgeons working in teams with appropriate expertise to manage such cases and after appropriate counselling regarding risks and with informed consent.

There are currently insufficient data to recommend the routine use of ureteric stents in placenta accreta spectrum. The use of stents may have a role when the urinary bladder is invaded by placental tissue.

Elective peripartum hysterectomy may be unacceptable to women desiring uterine preservation or considered inappropriate by the surgical team. In such cases, leaving the placenta in situ should be considered.

When the placenta is left in situ, local arrangements need to be made to ensure regular review, ultrasound examination and access to emergency care should the woman experience complications, such as bleeding or infection.

6.8. The Role of Interventional Radiology

Arterial balloon occlusion and embolisation can prevent major blood loss avoiding the need for blood transfusion and hysterectomy.

There is a role for interventional radiology in both the emergency and the elective setting.

Interventional radiology can be used prophylactically where there is a known case of suspected placenta accreta.

Emergency intervention should be considered in the management of postpartum haemorrhage, secondary to atonic uterus, surgical complications at the time of caesarean section or bleeding following postpartum hysterectomy.

This service is not available 24 hours a day however if one of the interventional radiologists is on call then they can be contacted via switchboard out of hours. Contact details refer to ***Appendix A***.

6.9. Postpartum management (PPH).

The woman should be closely observed for haemorrhage. There is an increased risk of PPH because the lower uterine segment does not have the contractibility of the upper segment, reducing compression of the open vessels.

For management of PPH refer to ESHT Guideline **Clinical Guideline for the Management of Postpartum Haemorrhage and Major Obstetric Haemorrhage**

6.10. How are women with undiagnosed or unsuspected placenta accreta spectrum best managed at delivery?

If at the time of an elective repeat caesarean section, where both mother and baby are stable, it is immediately apparent that placenta percreta is present on opening the abdomen, the caesarean section should be delayed until the appropriate staff and resources have been assembled and adequate blood products are available.

In case of unsuspected placenta accreta spectrum diagnosed after the birth of the baby, the placenta should be left in situ and an emergency hysterectomy performed.

6.11. Vasa Praevia – Diagnosis and Management

Vasa praevia occurs when the fetal vessels run through the free placental membranes. Unprotected by placental tissue or Wharton's jelly of the umbilical cord, a vasa praevia is likely to rupture in active labour, or when amniotomy is performed to induce or augment labour, in particular when located near or over the cervix, under the fetal presenting part.

Vasa praevia is classified as type I when the vessel is connected to a velamentous umbilical cord, and type II when it connects the placenta with a succenturiate or accessory lobe.

If there is a clinical suspicion of Vasa praevia due to a velamentous cord insertion or a succenturiate/accessory lobe then referral to the Fetal Medicine Consultant should be made to clarify the diagnosis.

The performance of ultrasound in diagnosing vasa praevia at the time of the routine fetal anomaly scan has a high diagnostic accuracy with a low false-positive rate.

A combination of both transabdominal and transvaginal colour Doppler imaging (CDI) ultrasonography provides the best diagnostic accuracy for vasa praevia.

There is insufficient evidence to support universal screening for vasa praevia at the time of the routine mid pregnancy fetal anomaly scan in the general population.

Although targeted midpregnancy ultrasound screening of pregnancies at higher risk of vasa praevia may reduce perinatal loss, the balance of benefit versus harm remains undetermined and further research in this area is required.

7. Special Considerations

When using this guideline, you may need to refer to the following guidelines:

Clinical Guideline for Antepartum Haemorrhage (APH)

Clinical Guideline for the Prevention of Rhesus isoimmunisation in Rhesus negative women in pregnancy

Clinical Guideline for the Management of Postpartum Haemorrhage and Major Obstetric Haemorrhage

Clinical Guideline for Care in Labour (First, Second and Third Stage)

Clinical Guideline for Pre-term Labour Including Antenatal Steroid Therapy and Tocolysis and Pre-term Birth

8. Evidence Base/References

Boyle. M. 2002. Emergencies around Childbirth. Radcliffe Medical Press: Oxford.

Calleja-Agius, J., Custo, R., Brincat, M.P. and N. Calleja. 2006. Placental abruption and placenta praevia. European Clinics in Obstetrics & Gynaecology. 2: 121 – 127

Cox, C and K.Grady.2002. Managing Obstetrics Emergencies. Oxford: Bios Publishing Ltd

Centre for Maternal and Child Enquires (CMACE). 2011. Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom 2006–2008. London: CMACE.

Enkin, M., Keirse, M.J., Neilson, J., Crowther, C., Duley,L., Hodnett,E. and J. Hofmeyr. 2000. A guide to effective care in Obstetrics & Gynaecology 3rd edition: Bleeding in the latter half of pregnancy. Oxford: UP.

Hall, M.H. 2004. Haemorrhage. In: Lewis, G. Editor. Why Mothers Die 2000–2002. The Sixth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. London: RCOG Press.

Parekh, N. Husaini, S. and I. Russell. 2000. Caesarean Section for Placenta Praevia: A Retrospective Study of Anaesthetic Management. British journal of Anaesthesia. 84 (6): 725-730.

RCOG Green-top Guideline No. 27a September 2018 Placenta Praevia and Placenta Accreta Diagnosis and Management

RCOG Green Top Guideline Green-top Guideline No. 27b Vasa Praevia - Diagnosis and management September 2018

9. Competencies and Training Requirements

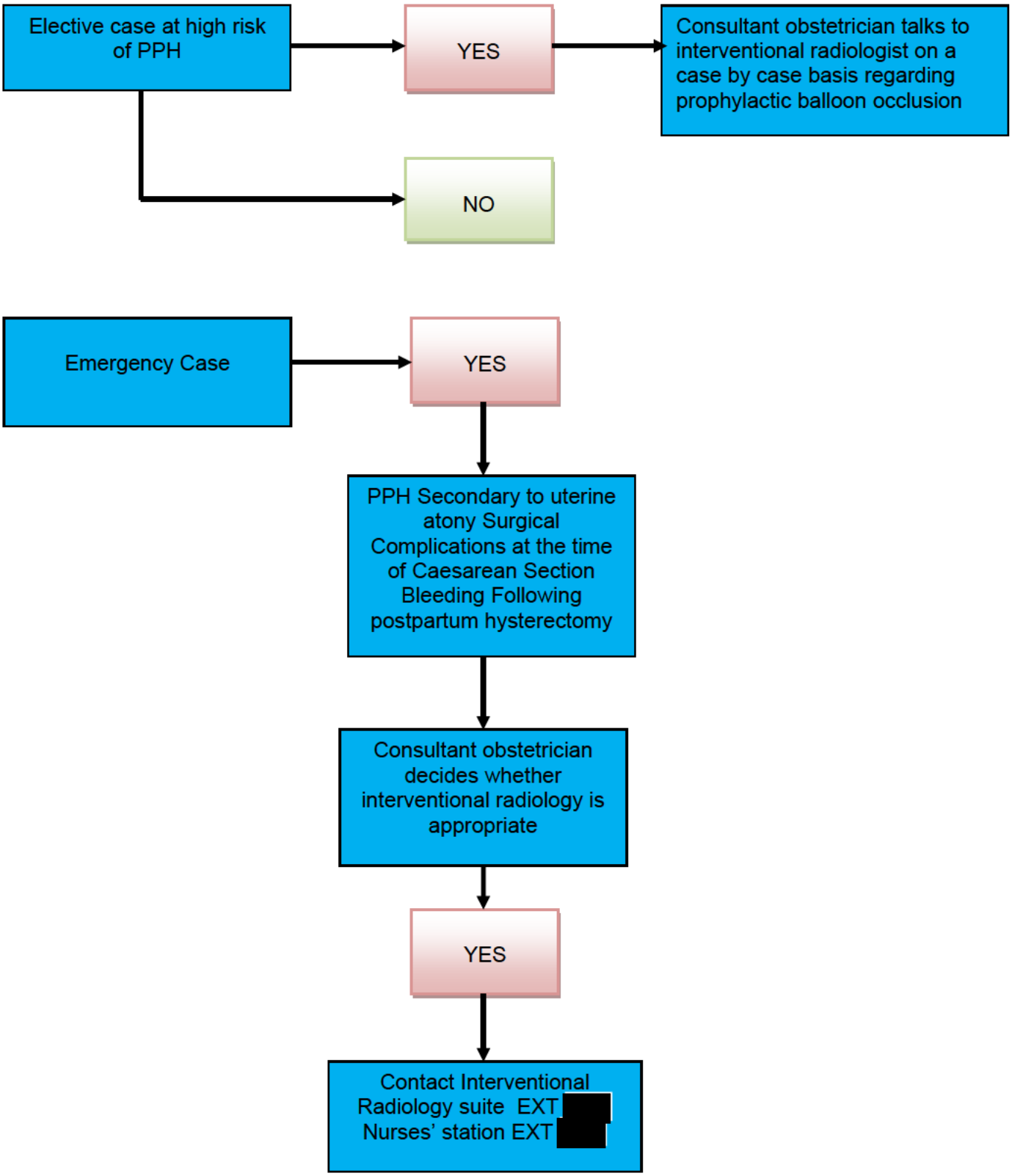
Training Needs analysis

10. Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Placenta Praevia Care Bundle	Consultant Obstetrician	Audit Any [redacted] cases	Ongoing	Obstetrics and Gynaecology audit meetings and any other appropriate meetings	Clinical Services Managers Midwifery matrons Clinical unit Obstetrics lead	Consultant Obstetrician Audit lead

Appendix A: Elective and Emergency Interventional Radiology in Obstetrics

Treatment algorithm for the use of elective and emergency interventional radiology in obstetrics (NB this service is only available if an interventional radiologist is on-call and therefore not available 24 hours a day)



Appendix B: Placenta Praevia Care Bundle

PAS Label

East Sussex Healthcare Placenta Praevia care bundle

Associated Guideline Clinical Guideline for management of placenta praevia including management of placenta accreta and placenta percreta

Name Obstetrician:	Please tick appropriate answer
Consultant Obstetrician planned and directly supervising	Yes ☐ No ☐
Consultant obstetric anaesthetist planned and directly supervising anaesthetic at delivery	Yes ☐ No ☐
Blood and blood products available on site	Yes ☐ No ☐
Multidisciplinary involvement in pre-op planning	Yes ☐ No ☐
Discussion and consent includes possible intervention (such as hysterectomy, leaving placenta in situ, cell salvage and interventional radiology)	Yes ☐ No ☐
Local availability of level 2 critical care bed	Yes ☐ No ☐
Initials of obstetrician completing the care bundle	Yes ☐ No ☐

Outcome	
Type of LSCS:	Elective / Emergency
Gestation at delivery	
No. of Previous LSCS	
Placenta Accreta:	Yes/No
Operation Performed:	LSCS / classical / hysterectomy / placenta left in
Total blood loss	
Blood transfused:	Yes / No
Total no. of donor units transfused:	
Cell salvage available:	Yes / No
Cell salvage used:	Yes / No
Volume of cell saved blood transfused:	
Balloon tamponade used:	Yes / No
Compression sutures used:	Yes / No
Any radiology intervention used:	Yes / No, Pre-op / emergency Please specify..
Was this patient a Jehovah's Witness:	Yes / No
Was this patient transferred from another hospital for specialist care:	Yes / no
Maternal outcome:	Remained on Labour ward for observation / HDU / ITU / Postnatal ward / Death

Please see overleaf after completion of the care bundle

Please answer questions after completion of the care bundle

1:	Is this the first time you have used the placenta praevia after previous LSCS care bundle? Yes ☐ No ☐
2:	How did you find using the care bundle? ☐ Quite easy ☐ Very easy ☐ Quite difficult ☐ Very difficult
3:	How long did it take you to complete the placenta praevia care bundle? Minutes……..
4:	How helpful was the care bundle to your clinical practice ☐ Quite Helpful ☐ Very helpful ☐ It was not really helpful ☐ I fail to see it's relevance
5:	What difference did the placenta praevia care bundle make to the management of the woman ☐ It helped with the preparation for delivery ☐ It got in the way ☐ It made no difference
6:	Please use the space below to make any other comments on the care bundle:

Thank you

Appendix C:

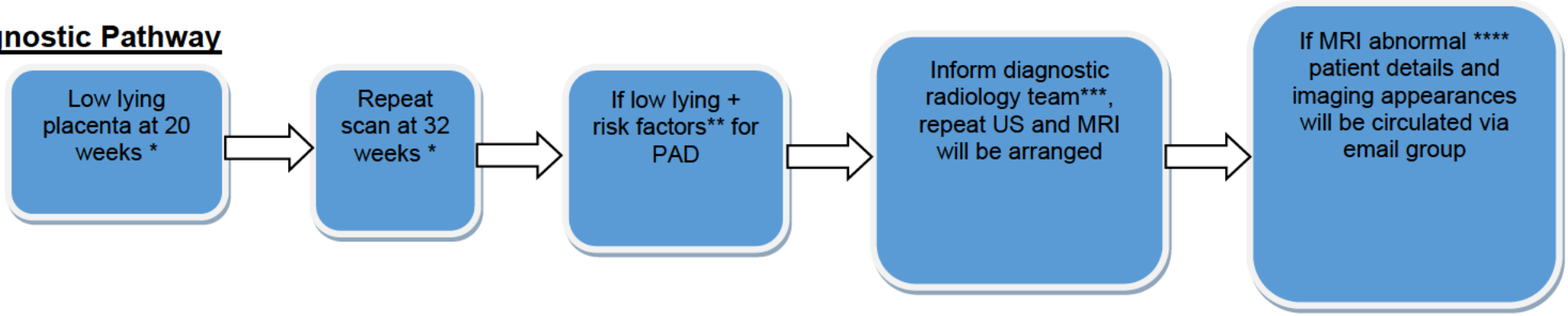
Pathway for investigation and management of patients with suspected placental adhesive disorder

Rationale – based on NICE guidelines CG132 section 1.2.6 – see appendix 1

Definitions

Acreta – placenta attached to uterine wall with no myometrial invasion (at surgery there is often heavy bleeding from implantation site after forced/piecemeal removal of placenta)
Increta – placenta invades myometrium (manual removal of placenta partially or totally impossible, no cleavage plane between placenta and uterus)
Percreta – placental invasion beyond uterine serosa (need for hysterectomy/other pelvic surgery if invading other organs)

Diagnostic Pathway



*** If high level of suspicion at the 20 week scan of an accreta or percreta refer to Fetal Medicine Consultant for rescan at 28 - 30 weeks**

****Risk factors – Previous C-section, placenta praevia, previous uterine rupture**

***** FC/EO/JH/JJ/CB**

******If MRI is normal the results will be communicated to the obstetrician rather than the whole team**

Limitations of MRI

MRI is unreliable for detecting accreta but will recognize secondary signs of PAD
We will provide information to facilitate surgical planning

- Area invaded
- Degree of neovascularization
- Areas to avoid
- Blood supply (i.e. S1/S2 uterus) to determine the need for interventional radiology input

Interventional Radiology

Prophylactic placement of balloons is required in cases of suspected increta or percreta*

In cases of suspected accreta, IR team to be made aware of the date/time of caesarian section in case they are required to attend as an emergency

Pathway for investigation and management of patients with suspected placental adhesive disorder

Rationale – based on NICE guidelines CG132 section 1.2.6 – see appendix 1

Email Group

[redacted]	**Consultant Radiology**	[redacted]	**Consultant Obstetrics**
[redacted]	**Consultant IR**	[redacted]	**MRI EDGH**
[redacted]	**IR Matron**	[redacted]	**MRI CQ**
[redacted]	**IR Matron**		
[redacted]	**Consultant Radiology (not for reporting)**	[redacted]	**Consultant IR**
[redacted]	**Consultant Radiology (not for reporting)**	[redacted]	**Consultant IR**

Minimum Information required for MRI

- Date of US scan
- USS diagnosis
- Gestational age
- Previous pregnancies
- Previous CS? Type of incision?
- History of other uterine instrumentation
- Other obstetric complications in this or previous pregnancies?
- Smoker?

Minimum Audit Dataset

US findings

- Date of US scan
- Gestational age at USS
- USS diagnosis
- Previous pregnancies
- Placenta praevia
- Placenta location
- Previous CS? Elective?Emergency? Number?

This Delivery

- Para/Grava
- Blood loss
- Blood transfusion
- Smoker?
- UAE
- Hysterectomy
- Pathological report
- Other surgical details

Appendix: D

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	**Clinical Guideline for the Management of Placenta Praevia including Management of Placenta Accreta Spectrum and Placenta Percreta**
Date of completion	September 2023
Name of the person(s) completing this form	Nicky Roberts Obstetric Consultant
Brief description of the aims of the Strategy/ Policy/ Service	To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth
Which Department owns the strategy/ policy/ function	Women and Children's
Version number	V3.1
Pre Equality analysis considerations	
Who will be affected by this work? **E.g. staff, patients, service users, partner organisations etc.**	This document applies to all staff caring for women within the maternity services at East Sussex Healthcare Trust.
Review date	October 2026
If negative impacts have been identified that you need support mitigating please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	**Name:** **Date:**
Have you sent the final copy to the EDHR Team?	

2. EIA Analysis

<table>
<tr><td></td><td>☺ 😐 ☹</td><td>Evidence:</td></tr>
<tr><td>Will the proposal impact the safety of patients', carers' visitors and/or staff?

Safe: Protected from abuse and avoidable harm.</td><td>Choose:
Positive
Neutral
Negative</td><td>To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth ensuring safe outcomes for the mother and the baby.</td></tr>
<tr><td>HCPEquality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
<table>
<tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr>
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<tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr>
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<tr><td>Is the proposal of change effective?

Effective: Peoples care, treatment and support achieves good outcomes, That staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics</td><td>Choose:
Positive
Neutral
Negative</td><td>To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth ensuring safe outcomes for the mother and the baby.</td></tr>
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<tr><td>What impact will this have on people receiving a positive experience of care?</td><td>Choose:
Positive
Neutral
Negative</td><td>To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth ensuring safe outcomes for the mother and the baby.</td></tr>
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<tr><td>Does the proposal impact on the responsiveness to people's needs?</td><td>Choose:
Positive
Neutral
Negative</td><td>To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth ensuring safe outcomes for the mother and the baby.</td></tr>
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<tr><td>What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?</td><td>Choose:
Positive
Neutral
Negative</td><td>To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth ensuring safe outcomes for the mother and the baby. This Guidance is all inclusive</td></tr>
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<tr><td colspan="3">Access
Could the proposal impact positively or negatively on any of the following:</td></tr>
</table>

<table>
<tr><td>• Patient Choice</td><td>Choose:
Positive
Neutral
Negative</td><td>This Guidance is all inclusive</td></tr>
<tr><td>• Access</td><td>Choose:
Positive
Neutral
Negative</td><td>This Guidance is all inclusive</td></tr>
<tr><td>• Integration</td><td>Choose:
Positive
Neutral
Negative</td><td>This Guidance is all inclusive</td></tr>
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<tr><td>Engagement and Involvement
How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:</td><td>Choose:
Positive
Neutral
Negative</td><td>This Guideline has been approved by an MDT process</td></tr>
<tr><td>Equality Consideration
Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</td><td></td><td>
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Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact.	Choose: Positive Neutral Negative	
Characteristic	**Rating** ☺ ☹ 😐	**Description**
Race	Choose: Positive Neutral Negative	This Guideline is all inclusive
Age	Choose: Positive Neutral Negative	This Guideline is all inclusive
Disability and Carers	Choose: Positive Neutral Negative	This Guideline is all inclusive
Religion or belief	Choose: Positive Neutral Negative	This Guideline is all inclusive
Sex	Choose: Positive Neutral Negative	This Guideline is all inclusive
Sexual orientation	Choose: Positive Neutral Negative	This Guideline is all inclusive

Gender re-assignment	Choose: Positive Neutral Negative	This Guideline is all inclusive
Pregnancy and maternity	Choose: Positive Neutral Negative	To provide guidance for clinical staff on the management and care of the woman and her baby where there is Placenta praevia / accreta etc is identified. To assess the risks of fetal complications due to the known risks and ensure safest mode and place of birth ensuring safe outcomes for the mother and the baby and is all inclusive
Marriage and civil partnership	Choose: Positive Neutral Negative	This Guideline is all inclusive

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

A2	Right to life	N
A3	Prohibition of torture, inhuman or degrading treatment	N
A4	Prohibition of slavery and forced labour	N
A5	Right to liberty and security	N
A6 &7	Rights to a fair trial; and no punishment without law	N
A8	Right to respect for private and family life, home and correspondence	N
A9	Freedom of thought, conscience and religion	N
A10	Freedom of expression	N
A11	Freedom of assembly and association	N
A12	Right to marry and found a family	N
Protocols		
P1.A1	Protection of property	N
P1.A2	Right to education	N
P1.A3	Right to free elections	N