

Email: foi.tsdfd@nhs.net
Our Ref: TSD10372

Dear Sir/Madam

Request for Information

We are writing to confirm that we have now completed our search for the information you requested.

A copy of the information is below:

Please provide the following information for the last five calendar years (2021–2025), broken down by year.

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

2021	
2022	
2023	
2024	
2025	

Due to historic recording limitations, system constraints, and data warehouse processing issues, the Trust is unable to provide accurate data on the number of deliveries that recorded ICD-10 codes O73.0 or O73.1.

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

2021	
2022	
2023	
2024	
2025	

Due to historic recording limitations, system constraints, and data warehouse processing issues, the Trust is unable to provide accurate data on the number of cases in Question 1 that also recorded a postpartum haemorrhage of 1,000ml or more.

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

- O43.21 (placenta accreta)
- O43.22 (placenta increta)
- 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.

	O43.21 (placenta accreta)	O43.22 (placenta increta)	O43.23 (placenta percreta)
2021			
2022			
2023			
2024			
2025			

Due to historic recording limitations, system constraints, and data warehouse processing issues, the Trust is unable to provide accurate data on the number of deliveries recorded with ICD-10 codes O43.21, O43.22, or O43.23.

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).

	O43.21 (placenta accreta)	O43.22 (placenta increta)	O43.23 (placenta percreta)
2021			
2022			
2023			
2024			
2025			

Antenatal suspected PAS is not held in a structured or reportable field. Where recorded, it may be documented in free text within ultrasound reports or clinical notes. Due to historic recording limitations, system constraints, and data warehouse processing issues, the Trust is unable to provide accurate data on these cases.

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.

2021	0
2022	0
2023	0
2024	0
2025	0

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

2021	
2022	
2023	
2024	
2025	

Due to historic recording limitations, system constraints, and data warehouse processing issues, the Trust is unable to provide accurate data on the number of deliveries involving manual removal of placenta.

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

2021	
2022	
2023	
2024	
2025	

Due to historic recording limitations, system constraints, and data warehouse processing issues, the Trust is unable to provide accurate data on the number of deliveries involving manual removal of placenta or the recorded PPH of 1,000ml or more.

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

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?

No

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)?

Please see our Retained Placenta V9 (G0288) policy attached.

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?

Free text only

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.

The Trust follows RCOG guidance when identifying or documenting suspected Placenta Accreta Spectrum (PAS).

The Trust also uses its local policy, Anomaly Scans (G1407), including Appendix 4 – Sonographer Management of Placental Localisation at 20 Weeks. Please see attached.

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

2021	2,066
2022	1,883
2023	1,724
2024	1,702
2025	1,767

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If you wish to discuss any of the above, please contact us, quoting the FOI reference number above.

If you are unhappy with the way in which we have handled your request, please contact the Data Protection and Freedom of Information Lead in the first instance. If you wish to make a formal complaint, you should write to our Complaints Manager at Torbay and

South Devon NHS Foundation Trust, First Floor Bowyer Building, Torbay Hospital, Torquay TQ2 7AA or by email to tsdft.feedback@nhs.net

If you are not content with the outcome of your complaint or the internal review, you may apply directly to the Information Commissioner for a decision. Generally, the Information Commissioner will only make a decision once you have exhausted the complaints and/or internal review process provided by us. The Information Commissioner can be contacted at: The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF or through this link <https://ico.org.uk/global/contact-us/>

Yours sincerely,

Freedom of Information Team

Document Type:		Guideline	
Reference Number :	0288	Version Number: 9	Next Review Date: 28 February 2029
Title:	Retained Placenta		
Document Author:	Matron – Inpatient Maternity & Gynaecology Services		
Applicability:	All Patients		

Introduction

Retained placenta can complicate 1-3% of deliveries and is diagnosed when the placenta is not delivered within:

- 30 minutes after birth with **Active management** of third stage
- 1 hour after birth with **Physiological management** of third stage

In many cases retained placenta is associated with postpartum haemorrhage (PPH) and can result in significant maternal morbidity and mortality. The woman should not be left unattended before the 3rd stage is completed.

A retained placenta will not necessarily be accompanied by haemorrhage, but a haemorrhage can occur at any point. This may be concealed; therefore, it is essential to monitor the woman closely, using a Modified Obstetric Early Warning chart (MEOWS), to identify early deterioration in her condition. This must be commenced at the point of diagnosing retained placenta.

If there is active bleeding at any stage call the Obstetric Registrar on duty and follow management below. Record BP and pulse according to maternal condition or at least every 15 minutes.

If there is severe bleeding follow Post Partum Haemorrhage protocol – [Ref 1127](#)

Risk factors for retained placenta:

- Related to poor uterine contraction- full bladder, multiparity, prolonged use of oxytocin
- Abnormal placentation- previous uterine surgery, IVF, PAS
- Others- snapped cord, congenital uterine anomalies, prior retained placenta

Steps to assist the normal delivery of the placenta and membranes:

consider performing these steps if no signs of placental separation after 20 minutes of active management.

- Encourage the woman to adopt an upright position to allow gravity to assist
- Put the baby to the breast or consider nipple stimulation
- If not already in use, apply an under buttock drape with a conical collection pocket to facilitate quantitative blood loss (found in all delivery room cupboards and instrumental trolley).
- Empty bladder- Consider an indwelling urinary catheter
- Handle the uterus as little as possible
- Call registrar on call if concerns regarding bleeding or patient becomes haemodynamically unstable
- Remember that persistent steady blood loss can result in an underestimate of a significant PPH.
- If birth occurs in the bereavement suite, including following mid-trimester loss, and a retained placenta ensues, the same protocol should be followed as those who have delivered a live baby. Timings should not be delayed due to pregnancy loss, which is a risk factor for retained placenta and PPH. Following a mid-trimester loss, the placenta is more often retained due to an incompletely dilated cervix, so as long as the patient is stable, further attempts at delivery with the aid of gravity should be made.

Homebirth / Newton Abbot Birthing Rooms

If a delay in third stage is suspected in a woman having physiological management of third stage, recommend an active management of third stage. Once the diagnosis of delay in the third stage has been made, the woman must be transferred to the Maternity Unit **immediately**. Please refer to [appendix 2](#).

Please refer to maternal transfer by ambulance guideline [Ref 1219](#)

The delivery suite co-ordinator should be informed of the need to transfer the woman, the current EBL and haemodynamic state and the co-ordinator will inform the Obstetric Registrar of the expected transfer.

A paramedic ambulance should be requested. IV access must be secured prior to transfer and the midwife must accompany the woman in the ambulance for the transfer.

Management ([see appendix 1](#))

- Secure IV access and send off a full blood count (FBC) and blood group (G&S). Consider U&E and clotting screen.
- If there is already PPH or maternal compromise, commence 1 litre IV Hartmanns or saline stat. Consider 1g TXA IV stat.
- Obstetric registrar to offer vaginal examination to assess the need to undertake manual removal of the placenta (MROP) - Examination in the room is appropriate with verbal consent and if signs of separation have occurred, provided analgesia is adequate. Be

prepared to abandon attempts and move patient to theatre if there is active bleeding, patient discomfort or patient preference.

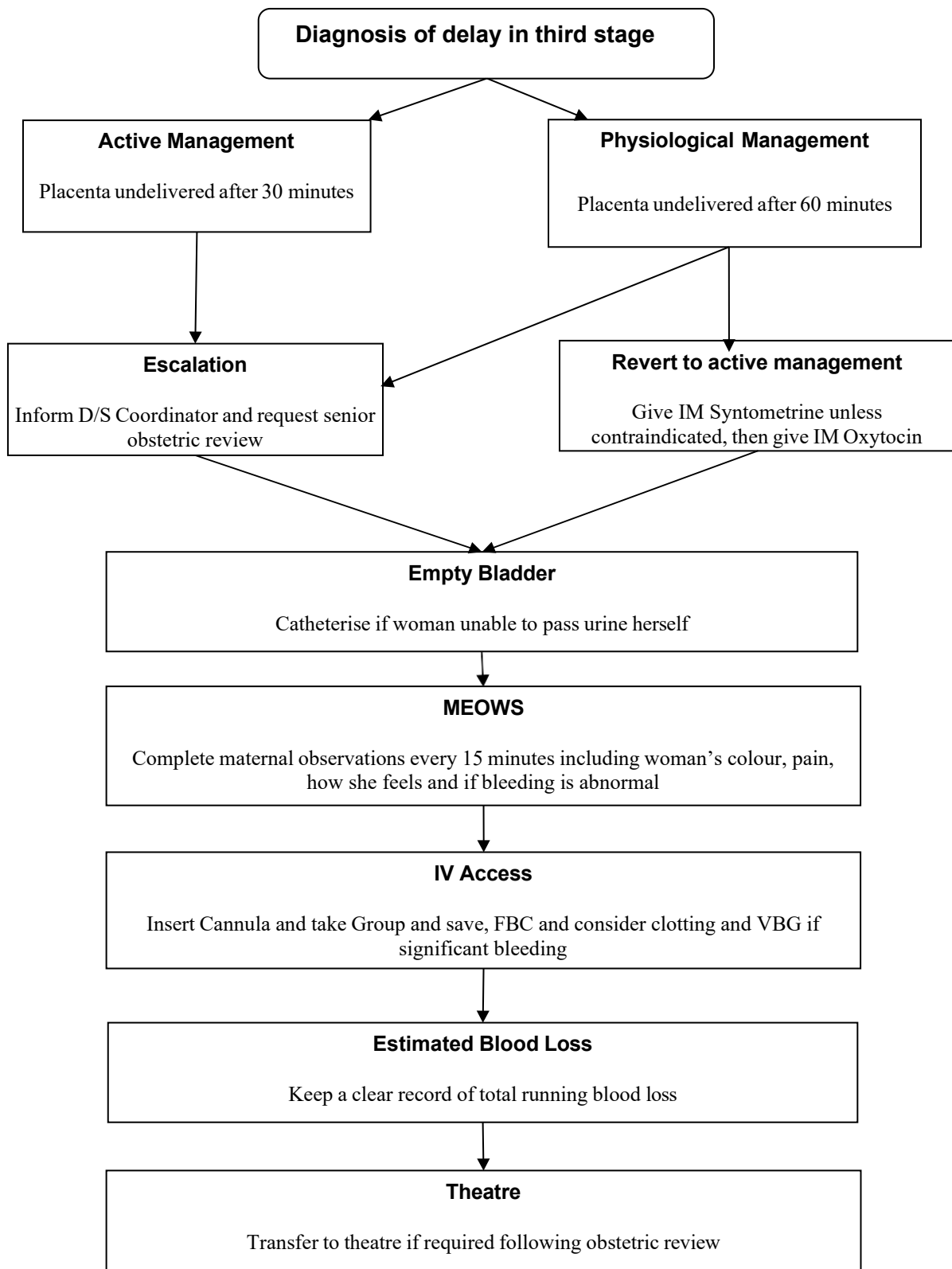
- Use of umbilical vein uterotonic drugs is **no longer recommended**.
- Obtain informed consent for theatre.
- Inform anaesthetist and theatre staff.
- If there is excessive bleeding or signs of maternal shock at any time, inform the obstetrician immediately and arrange immediate transfer into theatre using 2222 Obstetric emergency (and MOH when appropriate). This would be considered a “Category 1” obstetric emergency.
- Inform the anaesthetist of the current MEOWS score and EBL in order that appropriate anaesthesia is chosen.
- Even if there is no or minimal active bleeding, there should not be delays in transferring to Theatre as PPH risk remains. This would be considered a “Category 2” obstetric emergency.

Consent for MROP should include:

Risks of bleeding, infection, trauma to uterus or cervix, failure to remove all tissue, blood transfusion, repeat procedure, balloon insertion, laparotomy and hysterectomy.

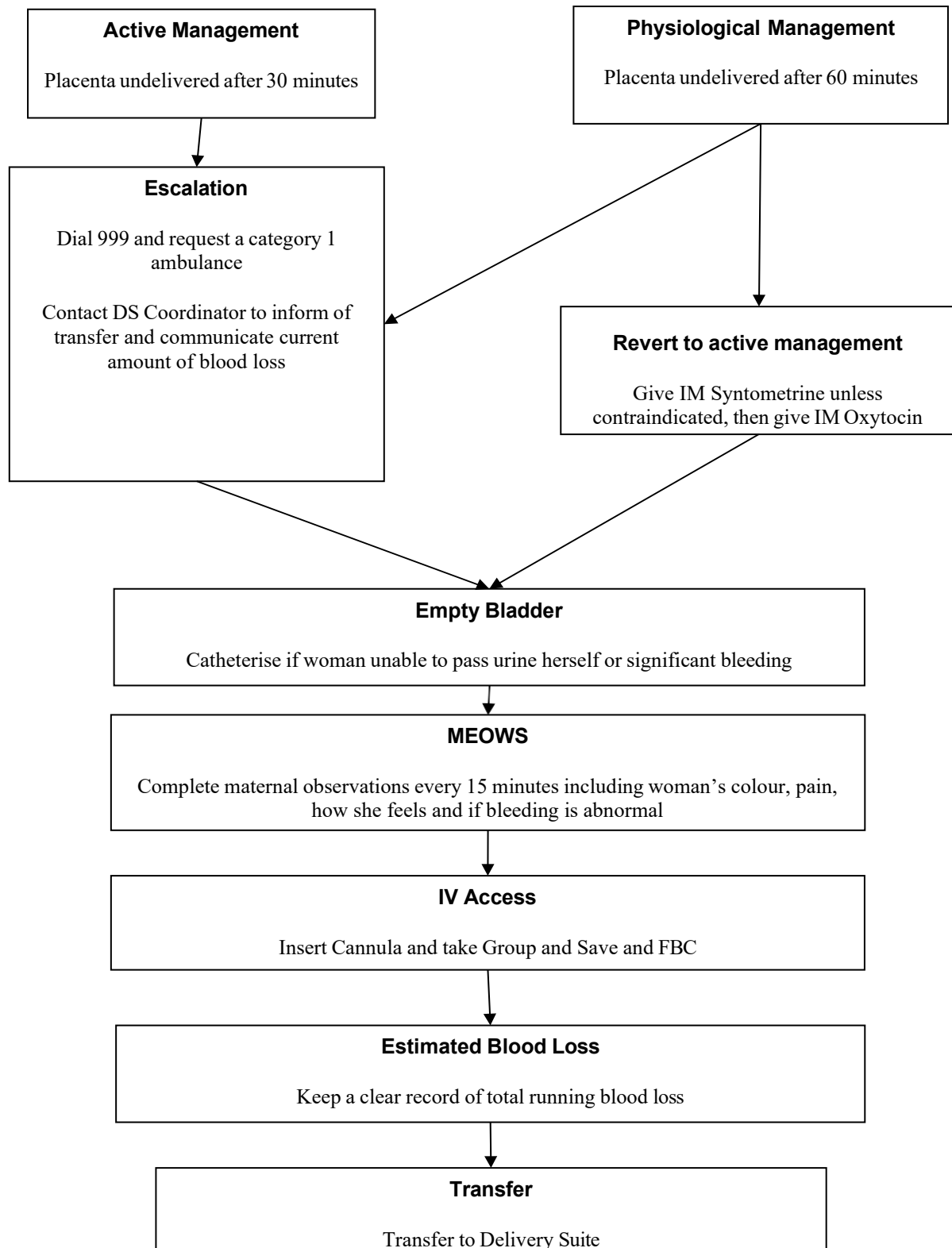
Manual Removal of Placenta (MROP)- to be performed only in theatre

- Ensure analgesia is functional
- Aseptic technique - clean and drape
- IV Antibiotic cover – similar to caesarean section prophylaxis with 1.2g of co-amoxiclav – this does not need to be continued unless there are clinical markers of infection.
- Empty the bladder
- Stabilise fundus with non-dominant hand
- Gently insert dominant hand through cervix and identify the placental plane
- Consider uterine relaxation with 250mcg terbutaline or GTN spray 2 puffs if uterus is contracted and cervix is partially closed preventing insertion of hand.
- If plane between placenta and uterus not easily defined consider adherent placenta especially in presence of risk factors for abnormal placentation and inform on-call consultant. Do not pull on cord or placenta while still adherent.
- Using the side of your hand and a sweeping motion sweep the placenta from the uterine wall
- Guard the fundus to avoid uterine inversion
- Grasp the uppermost portion of the placenta and aim to remove the whole placenta in one piece
- Check the cavity is empty - **if in doubt call obstetric consultant on call**
- Massage fundus
- Give bolus of oxytocic
- Commence 40IU IV syntocinon infusion over 4 hours.
- Inspect for vaginal/ perineal/cervical tears and repair as required
- Document in notes and debrief patient when appropriate
- DATIX to be completed if PPH or other complications
- **Patients who have had a retained placenta should be advised that all future deliveries should occur in an obstetric led unit as they have a higher risk of post-partum haemorrhage.**

Management: Retained placenta in Acute setting

Appendix 2

Retained placenta in community setting



Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	0288		
Document title:	Retained Placenta		
Purpose of document:	Guideline		
Date of issue:	13/03/2026	Next review date:	28/02/2029
Version:	9	Last review date:	26/02/2026
Author:	Matron – Inpatient Maternity & Gynaecology Services		
Directorate:	Obstetrics & Gynaecology		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Clinical Director of Pharmacy Consultant Lead for Delivery Suite		
Date approved:	26/02/2026		
Links or overlaps with other policies:	1127 – Post Partum Haemorrhage		

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	<i>Please select</i> Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	☐	☐
Does this document have training implications? <i>If yes please state:</i>	☐	☐
Does this document have financial implications? <i>If yes please state:</i>	☐	☐
Is this document a direct replacement for another?	☐	☐

<i>If yes please state which documents are being replaced:</i>		

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
1 May 2001	1	New	Head of Midwifery, Clinical Director
1 June 2002	2	Revised	Head of Midwifery, Clinical Director
1 March 2003	3	Amended	Head of Midwifery, Clinical Director
8 April 2004	4	Revised	Head of Midwifery, Clinical Director
24 June 2004	5	Amended	Head of Midwifery, Clinical Director
15 February 2007	5	Date Change	Associate Director of Nursing/Midwifery, Medicines Governance Group
3 April 2008	6	Revised	Delivery Suite Forum, Medicines Governance Group
17 July 2008	7	Revised	Delivery Suite Forum, Clinical Director of Pharmacy
27 January 2011	7	Document Control Added	
17 November 2011	8	Revised	Consultant Lead for Delivery Suite Clinical Director of Pharmacy
31 December 2014	8	Date change	Consultant Lead for Delivery Suite Clinical Director of Pharmacy
22 February 2018	8	Date change	Matron – Inpatient Maternity & Gynaecology Services
23 April 2021	8	Date change	Clinical Director of Pharmacy Consultant Lead for Delivery Suite
26/02/2026	9	Ratified and reviewed without medication changes	Consultant Obstetrician & Gynaecologist

Document Type:	Guideline	
Reference Number : 1407	Version Number: 6.1	Next Review Date: 30 April 2028
Title:	18-20+6 Weeks Routine Anomaly Scan	
Document Author:	Consultant Obstetrician	
Applicability:	All staff conducting obstetric ultrasound examinations	

OBJECTIVE

- To ensure that departmental and national guidelines are adhered to.
- To ensure the quality of screening for fetal anomaly is measurable.
- To ensure continuity of patient care for all women attending Torbay Hospital antenatal service.

SCOPE

An ultrasound scan is routinely offered at 18-20+6 weeks gestation following a first trimester screening/dating scan (FTSC usually performed between 11+2-14+1weeks).

NHS FASP Standard 6.3: All women should be offered a single further scan by 22+6 (completed) weeks to complete screening examination if the image quality of the first scan is compromised by one of the following:

- Increased BMI
- Uterine fibroids
- Abdominal scarring
- Suboptimal fetal position

Anomaly scans for women with twin dichorionic pregnancies should have a double appointment. The anomaly scan including rescans should be completed by 22+6 weeks gestation. If the anomaly scan cannot be completed at the second appointment this will be explained to the patient and logged in the Viewpoint report. The department will not offer more than one rescan for fetal anomaly screening (NHS FASP 6.4).

The request form for the anomaly scan is usually generated at the FTSC appointment by the advanced practitioner in Ultrasound (APU) and should indicate the correct date for the anomaly scan

Late Bookers (women presenting later than 20 weeks gestation)

- Patients presenting at > 24 weeks – rescan in 2 weeks to confirm dates and look for signs of IUGR
- Perform as much of routine anomaly scan as possible – document restricted by gestational age if appropriate.
- If HC not measurable, date by FL and repeat HC 2 weeks later.

Main objectives of the screening programme

1. Ensure access to a uniform screening programme which conforms to an agreed level of quality.
 2. Provide information for women so that they can exercise informed choice.
Offer a choice to women about their screening options and pregnancy management.
 3. Identify abnormalities either incompatible with life or associated with morbidity at a time when choice can operate about continuation of the pregnancy or termination.
 4. Identify abnormalities which may benefit from antenatal treatment.
 5. Identify abnormalities which require early intervention following delivery.
- The fetal anomaly screening ultrasound should be performed between 18 +0 – 20+6 Weeks
 - The head circumference (HC) should be used for estimating fetal gestational age after 13+6 weeks of pregnancy.
 - The femur length (FL) should also be measured and should agree with gestational age calculated from the HC within plus or minus seven days. If the difference is more or less than seven days, then referral for a second opinion should be considered.

The purpose of the scan is to perform a structural survey of the fetus and monitor well-being (including growth measurements where appropriate), liquor, placental lie and document maternal pelvic pathology e.g. fibroids. These guidelines document correct procedure for this. Further information regarding scans which are incomplete, inconclusive or when an abnormality is identified is included in Appendix A.

APPOINTMENT

The scan appointment is arranged by patient choice at the reception in the antenatal clinic (ANC) if high risk or call centre if low risk.

- If attending as a late booker or when a 12 week dating/ FTSC scan has not been performed the anomaly appointment is based on Last Menstrual Period (LMP) or fundal height following a midwife/GP referral via ANC reception. Any late booking scans are urgent therefore should be booked by ANC reception.

Patients with history of abnormality which may go undetected by routine anomaly scan or previous TOP for severe cardiac anomaly may be discussed with one of the Fetal Medicine Specialists (FMS).

The following groups of patients **can** have their anomaly scans arranged as normal with APU's.

- 1) epilepsy on anti-convulsant, diabetics, antidepressants, antipsychotics, anti-inflammatory disease modifiers
- 2) previous fetal abnormality normally identifiable with routine scan views.
- 3) Family history congenital cardiac anomaly

All scan requests will be entered onto CRIS by admin staff and request forms correctly completed scanned into the appointment event. If any changes to the appointment are made the CRIS event will be altered or cancelled accordingly by the admin staff. Any messages or relevant information regarding the patient must be entered into the comment box on CRIS by the admin clerk or midwife to inform the APU at the scan.

DNA policy- If a patient does not attend for scan the administration team contact the community midwife team directly and wait response whether to rebook or not. If during a consultant clinic the ANC midwives contact the community team midwife for follow up. Patients are greeted at reception and asked to wait in Area 1. The receptionist will attend the patient on System1 and CRIS to make sure they appear on the sonographer's day list. The CRIS episode will be closed by the Advanced Practitioner (APU) following the scan and auto reported to indicate that a report is located within the Viewpoint database.

Late attenders –

Women who attend their antenatal scan appointments 15 mins late or more may not be scanned at the discretion of the sonographer.

The receptionist will ask the radiology support worker (or the sonographer if no RSW) to see if there is another available slot during the session. If there is an available slot, let the patient know and they may need to wait. Change patient appointment time.

If there is no available slot, inform the patient and arrange the next available scan appt.

If there is no RSW or sonographer immediately available to ask, please rebook next available scan appt.

If these patients are also due to be seen by a doctor this will need to be discussed with the clinic midwife/obstetrician to see if they will be seen without a scan.

Children in scan rooms

We do not allow children to attend ultrasound appointments. There are no childcare facilities provided in ultrasound waiting areas and children should not be left unaccompanied under any circumstances. If a patient attends with children their scan will be postponed and rebooked.

METHOD

The routine anomaly scan clinics will be booked according to risk status of the pregnancy and management pathway: either as a High or Low risk pregnancy. Scan worklists should be printed each morning for all scans on CRIS and checked by clerical team for booking in. **In the event of CRIS/PAS failure leading to inability to attend the visit then the referral form, which is a copy of the First Trimester scan report, will be available on the AirMid app.**

The appointments will be booked at 30-minute intervals for singleton pregnancies and double appointments for twins. A 40-minute appointment slot is booked when Uterine Artery Dopplers (UtAD) are required with the anomaly scan. These are usually booked at 8.30 every morning. Clerks should adhere to bookings at 30 minutes as required for training lists. Patients are greeted at reception and demographic data checked especially date of Birth and address, any changes to details noted and amended on the Patient administration service (PAS) immediately. They are then asked to wait in Area 1. The receptionist will attend patients onto the Day List for CRIS into designated rooms. The CRIS episode will be

closed by the Advanced Practitioner (APU) following the scan and auto reported to indicate report on Viewpoint.

Hospital notes will not be routinely requested for low-risk appointments only for high risk.

SCANNING PROCEDURE

- 1) The Advanced Practitioner (APU) will select the patient from Viewpoint (VP) by entering the hospital number which imports the data from PAS. Previous scan reports and relevant obstetric history will be noted.
- 2) The APU calls the patient into the scan room and confirms identity with date of birth and correctly pulls the details from the worklist onto the scanning machine. Any corrections to information should be taken to the front reception for the admin staff to amend. **It is imperative that the patient identification is uploaded onto the scanning machine before any image capture.** Any images taken without patient identification will be unknown on the PACS system and so it is the responsibility of the practitioner to correctly pull the patients identification from CRIS or enter manually with correct format. If you have started a scan without ID on your screen you should inform the PACS administrator as soon as possible (telephone 55060).
- 3) Indication for scan will be confirmed with patient and logged as Anomaly or Rescan Anomaly OR First contact late Booker for Dating and anomaly check. Verbal consent for anomaly scanning is documented in viewpoint. Any other relevant history should be recorded on VP. Always include any relevant medical condition such as diabetes or common teratogenic drugs such as anticonvulsants in indication for referral.
- 4) The anomaly scan is performed according to guidelines later in this document.

The following structures should be assessed and reported against Viewpoint **boxed areas**:

Heart action - Confirm fetal heart beating, observe as a priority at beginning of scan

Placenta site - see **Appendix 4** for follow up if considered low.

Umbilical cord – Check for vessels. If only 2 vessels are present perform UtAD.

Amniotic fluid -Assess position of fetus and subjectively assess liquor volume (measure AFI if appears abnormal)

Head shape - shape normal.

Brain - Cerebellum, skull intact, all ventricles, choroid plexus, Cavum septum pellucidum

Face - upper lip/nose tip

Spine - whole spine, longitudinal, coronal and transverse views including skin line.

Neck/Skin - Neck – masses or nuchal fold > 6mm

Thorax - lung echogenicity and diaphragm (longitudinal axis)

Heart - 4 basic views

- Situs/laterality (correctly sited assess against stomach)
- Four chamber view
- Left ventricular outflow tract (LVOT- aorta AO)
- Right ventricular outflow tract (RVOT- pulmonary artery PA) or 3 vessel view - PA, AO and superior vena cava (SVC).
- 3 Vessel Trachea view

The use of colour flow Doppler is encouraged.

Abdomen - is the abdominal wall intact, show cord insertion.

GIT - Stomach (left sided).

Kidneys and bladder – identify

Genitalia - at parental (maternal) request. Fetus can be sexed and given verbally only; this does not show on the report. (See page 7 'Fetal Sexing')

Extremities - all four limbs including hands and feet (check all long bones but fingers and toes are not counted)

Skeleton - check for normal proportions and bowing of the long bones, check the limbs move normally.

Measurements taken routinely:

Head circumference HC

Abdominal circumference AC

Femur length FL

Leading edge of the placenta to the internal cervical os. This should be confirmed with a vaginal scan for greatest accuracy if any concerns - refer to Appendix 4.

Additional measurements required.

Amniotic fluid index AFI (if suspicion of abnormal fluid level).

Humerus or Tibia (if the FL is abnormal)

Kidney length (if abnormal appearance)

Measure fetal pathology, such as mass or cyst, fluid collection.

Cervix length if required, transvaginal scan most accurate.

Placenta

- Image required os to leading edge.
- All women require follow-up imaging if the leading edge of the placenta is less than 20mm away from the internal cervical os or covers it at 20 weeks.
 - TVS improves the accuracy of placental localisation e.g. in the second trimester TVS will reclassify 26–60% of cases meaning fewer women will need follow-up.
 - It is safe so any suspected diagnosis of low-lying placenta / placenta praevia should be confirmed by TVS if required (e.g. high BMI, poor visualisation, or posterior placenta)
- Women with a previous caesarean section (CS) require a higher index of suspicion. The chance of persistence of the placenta praevia requiring abdominal delivery was 50% in women with a previous CS compared with 11% in those with no uterine scar. If the placenta lies anteriorly with the leading edge less than 20mms away from the os on TV scan at 20 weeks, a follow-up scan at 24 weeks can help identify if it is implanted into the caesarean section scar – Refer to Appendix 4
- At present, vasa praevia should not be screened for routinely as it does not fulfil the criteria for a screening programme. However, if there is any concern about the presence of cord vessels crossing the cervix, this should be excluded using colour doppler in the presence of a velamentous cord insertion or a succenturiate / bilobed placenta.

Table 1: 18+0 – 20+6 weeks' fetal anomaly screening ultrasound base menu

Routine Image to PACS	Structure	Section	Calliper placement	Criteria for review and/or referral* + Image to PACS
Yes	Head circumference (HC) <i>BPD is not routinely require &</i> Atrium of the lateral ventricle	transventricular plane at level of the glomus of choroid plexus and demonstrating septum cavum pellucidum	Calculated using cross method Measure and image inner border of medial wall to inner border of lateral wall, perpendicular to ventricular cavity	1. Disparity with gestational age equivalent FL >7days. 2. If < 3 rd centile for referral to FMS equal to or greater than 10mm
Yes	Transverse cerebellar diameter (TCD)	transcerebellar plane (suboccipitobregmatic)	Linear, maximum diameter, outer border to outer border	'banana' shape, absent
	Nuchal skin fold (NST)	transcerebellar plane	Outer border of occiput to outer border of overlying skin	greater than 6mm
Yes	Face	coronal view of lips and nasal tip	measurements not required	abnormal appearance
	Heart	a) 4 chamber view b) left ventricular outflow tract c) right ventricular outflow tract or 3 vessel view d) 3 vessel / trachea view	measurements not required	abnormal appearance
Yes	Abdominal circumference (AC)	stomach and short intra-hepatic section of umbilical vein	Calculated using cross method	If < 3 rd centile for referral to FMS
Yes	Abdominal wall	insertion of umbilical cord into fetal abdomen	measurements not required	abnormal appearance
	Both kidneys	cross section of each, demonstrating maximum diameter of AP renal pelvis Measure if appears increased	inner border of anterior wall to inner border of posterior wall of renal pelvis	greater than 7mm AP or hydronephrosis / hydroureter

	Bladder	Sagittal and transverse (must be seen) Check vessels around bladder. If only 2 vessels are present perform UtAD.	measurements not required	abnormal appearance/absent Megacystic bladder = >7mm 1 st trimester >30mm 2 nd trimester >60mm 3 rd trimester
Sagittal (preferred) or coronal view of spine including sacrum	Spine	Sagittal, coronal and transverse, demonstrating vertebrae, sacrum and skin covering	measurements not required	abnormal appearance
Yes	Femur (FL)	full femoral diaphysis at as close to 90 degrees to ultrasound beam. 1 leg only	linear measurement from one end of the diaphysis to other, disregarding the curvature	1. abnormal appearance 2. If < 3 rd centile for referral to FMS
	Extremities - hands - feet	presence of metacarpals in both hands & metatarsals in both feet	Visible not counted	abnormal appearance
Yes	Placental site	midline sagittal section of uterus demonstrating relationship between leading edge of placenta and internal os (TVS criteria)	Measurement of leading edge to internal cervical os	All low-lying placentas (< 2cm from os) or placenta praevia (covering os) for rescan at 32 weeks +/- TVS 28 week rescan for suspected placenta accreta

*Refer for detailed scan = refer to FMS to be seen/scanned within 3 working days (5 days if referral elsewhere) unless otherwise stated.

Maternal checks

Survey maternal uterus and ovaries if indicated e.g. because of previous pathology.

Transfer measurement data to VP from the ultrasound machine. Check accuracy of the measurements and delete any erroneous numbers if necessary, before transfer. Reduced transcription error and hence greater accuracy can be provided by machine transfer of measurements.

After the scan, patients are asked to wait in Area A main reception. Low risk patients with a normal scan result can be discharged by the APU when the report has been compiled and printed. For high-risk the patient's hospital notes are placed in the consultant tray for assessment. For any patients requiring follow up with clinic midwife, a copy of the scan report should be placed into the correct tray in the ANC midwife's office. Patients requiring vaccinations only have their name documented on the vaccination sheet in the ANC office.

REPORTING

Viewpoint is used to document the obstetric report. The drop-down menus for reporting should always be used – if any staff feel that these are inadequate for their reporting needs this should be raised with the Viewpoint Administrators ([REDACTED], [REDACTED] or the PACS team). A descriptive report can be included.

Anomaly should be used rather than abnormality in reporting (UK NSC guideline)

VP details

With the implementation of VP6 in August 2023 please see appendix 6 user guide for anomaly scans

- 1) Ensure that the mandatory fields are filled in, these are highlighted with an asterix.
- 2) Operator 1 and exam subtype entered. Always enter any other staff member present as other operator (this will print on the report).
- 3) If breaking bad news log if the patient was accompanied or not with an explanation of what the patient has been told about the suspected abnormality. Explain that the clinic midwife will see them with a plan of what will happen next but that the Midwife may not have any additional information about the diagnosed condition for them (Trust BBN policy). State where they are waiting to be seen for counselling.
- 4) Document indication and all anatomy and measurements taken.
- 5) Log the device/procedure, view of image (satisfactory, moderate, or poor).
- 6) Diagnosis- this is important for follow up if required.
- 7) Recommendation if required.
- 8) Free text your conclusion of scan findings with concise description, limitations and any further management arranged, for example ('referred to clinic midwife for counselling' etc)
- 9) Print.
The appropriate routine growth charts should be included in the report print out.
- 10) Abnormal reports- Copies of reports should be provided and sent to the GP by the fetal consultant and appropriate follow up arranged and documented.

IMAGING

The 6 Routine views are taken onto PACS, these must show correct anatomy, at correct magnification and orientation. Annotation is always advisable. If there is a specific concern images and or Cine loop capture must be recorded to demonstrate normality in that case.

Images of all anomalies and significant negative findings should be recorded.

Consider demonstrating the relationship of pathology and anatomy (e.g. use 4D/ 3D imaging for face and limbs, colour Doppler to highlight heart flows, cord insertion).

In the event of an anomaly, it is good practice to review images before patient leaves the dept.

The fetal medicine consultants will commonly review images to confirm diagnosis rather than rescan patient.

Amniotic Fluid Index: Four separate vertical depths (with probe perpendicular to floor and in transverse orientation to show anterior and posterior uterine wall), measure each quadrant in cm and add together. An AFI is only required if there is an abnormal deepest vertical pool (DVP) of > 8cm.

FETAL SEXING

The mother may request sexing of her baby, and this can be offered at the anomaly scan if the baby is in a suitable position. If both parents attend, fetal sexing should be agreed by both parties. Fetal sexing is given verbally – this does not show on the report. We do not write this information down for parents to open later. We require the mother to want to know the sex of her baby and for her to agree to be told the gender – we do not tell other relatives and keep the information from the mother even if she appears to agree to this. **As sexing is not part of the routine scan checklist and procedure no extra time should be taken to perform and no rescan offered if genitalia are not visible.** A private 4D scan is an alternative for this and may be arranged separately.

Sexing can be included as part of a clinically indicated scan – ([ref 0881](#))

SELLING ULTRASOUND IMAGES

Thermal images - All images must be correctly named and dated and offered for £5.00 receipt in the ultrasound wallet.

The best possible image of the baby is obtained and stored in PACS. Parents may purchase as many copies of this image as they require for £5 per print.

Thermal fetal images (for parents) when abnormality is discovered are offered to the parents immediately (no charge made). If declined these are stored in the medical notes in an image wallet and sealed in an envelope detailing '*Fetal images- baby of (mothers name) notes no. PLEASE RETAIN FOR MOTHER*'

PATIENT CARE

Any concern regarding the well-being or condition of the mother or fetus at the scan as observed by the APU should be indicated to clinic staff.

The midwife and /or doctor in clinic should be made aware if the patient is distressed / unwell and a quiet room provided.

If a low-risk patient needs to be referred for midwife review, a copy of the scan report should be passed onto the designated support midwife. The patient should be given the relevant information sheet by the clinic midwife to inform them of the discovered abnormality if available.

ACTION IN EVENT OF INCONCLUSIVE SCAN OR SUSPECTED ABNORMALITY

NATIONAL CONGENITAL ANOMALY AND RARE DISEASE REGISTRATION SERVICE (NCARDRS)

NCARDRS has replaced the SOUTHWEST CONGENITAL ABNORMALITY REPORTING scheme (SWCAR):

The NCARDRS on-line form (refer to protocol folders to find this form) **MUST** be filled in by the staff member who initially suspects a problem even if diagnosis is not clear. This is emailed to the address at the bottom of the form and to [REDACTED] (Obstetric Lead). Report the completion of the card into Viewpoint Comments. Excluding mild renal pelvis dilatation (RPD) and do not notify soft markers.

Rescans for suspected anomaly should occur by 22 weeks, as feticide is recommended prior to termination from 21+6 depending on the clinical circumstances.

The APU should inform the parent(s) of their suspicions, and they should be referred to the clinic midwife for post-scan management. Use the comment in Viewpoint in the diagnosis/recommendations box. 'The patient has been informed that there is an abnormal scan finding which requires a follow up appointment with a Fetal Medicine Specialist.'

Appendix A groups scan findings under anatomical and physiological grouped headings: neurological, cardiac & chest, neck, abdominal, urogenital, skeletal, placental/liquor, growth and maternal pathology and advises action.

The FMS must be informed of all structural abnormalities (all abnormalities should be handed over in person to clinic staff).

A fetal medicine referral should be made within 1 working day and entered on the fetal medicine file.

Further examination/counselling at Torbay should be arranged within 3 working days of the referral being received or 5 working days if referred to an external fetal medicine unit.

NHS FASP Audit - 11 conditions screened for, updated 8th October 2024.

Conditions	National Detection rate (%)
Anencephaly	98
Spina bifida	90
Cleft lip	75
Diaphragmatic hernia	60
Gastroschisis	98
Exomphalos	80
Serious cardiac conditions including transposition of the great arteries, atrioventricular septal defect, tetralogy of fallot and hypoplastic left heart syndrome	50
Bilateral renal agenesis	84
Severe skeletal dysplasia	60
Edwards' syndrome (Trisomy 18)	95
Patau's syndrome (Trisomy 13)	95

SOFT MARKERS

At the 18+0 – 21+6 weeks' fetal anomaly screening scan, the following appearances **should be reported and referred for further management**

(NHS Fetal Anomaly Screening Programme 'Soft maker' screening policy/statement March 2009)

1. Nuchal oedema (> greater than 6mm)
2. Ventriculomegaly (atrium $\geq$ 10 mm or above)
3. Echogenic bowel (equivalent to bone density)
4. Renal pelvic dilatation (> greater than 7 mm AP)
5. Small measurements compared to the dating scan (< less than the 3rd centile)¹
6. Facial clefting

Examples of findings previously classified as 'markers' in the RCOG (2000) '*Routine Ultrasound Screening in Pregnancy: Protocol, Standards and Training*' document which **should not be recorded or referred for further management** (whether single or multiple, in a screened or unscreened woman) as these are considered 'normal variants'. These include:

1. Choroid plexus cyst(s)
2. Head shape
3. Cysterna magna
4. Echogenic foci
5. 2 vessel cord

'The National Down's Syndrome screening implementation advisory group and the fetal anomaly USS steering group recommend that at the time of mid trimester anomaly scan, a Down's Syndrome risk following 1st or 2nd trimester screening should not be recalculated up or down due to

the presence or absence of a single USS marker of less predictive power than increased nuchal fold (Smith Bindman et al 2001).'

1 Chitty chart

2 Unless a skull abnormality is suspected

3 Unless a brain malformation is suspected

Follow-up

Make it clear in the report if patient needs any follow up and with whom. If further scans are required report appropriately. Always state a provisional diagnosis on your report.

Soft markers are not as significant in a screened population- see National screening committee guidance.

ANC midwife to complete fetal anomaly checklist as per CNST requirements (copy for anomaly file and hospital notes.)

Reports for any baby with an anomaly or requiring post-natal paediatric plan or non-renal scan should be placed in the blue hospital notes, documented on SystemOne and copied to [REDACTED] Neonatal Lead, (+/- [REDACTED] Radiologist), SCBU, General Practitioner, CMW team and obs/paeds file in ANC to accompany the paediatric referral proforma.

Renal anomalies should be directed to [REDACTED] (Paediatrician) and copied as above.

APU to provide copies, ANC MW to send on.

See individual protocols for more details and further management.

Tertiary referral

Bristol Fetal Medicine Unit

For cardiology: Bristol Royal Infirmary Children's Hospital

See appendix for local referral to Exeter/Plymouth

INCOMPLETE SCANS

If poor fetal position or maternal habitus prevent visualisation, one rescan can be arranged.

The rescan appointment should be made in order that a diagnosis can be reached before 23 completed weeks gestation.

The scan should **only** include those views not completed earlier. Completed views and biometry should not be repeated, except where the biometry is required for estimating fetal weight.

Rescans should be arranged for 2 weeks provided that the rescan is completed by 22+6.

If after 2 scans the anomaly scan is still not completed this should be discussed with the patient and unless there are exceptional circumstances (high risk for abnormality e.g. diabetes/heart) no further appointments for anomaly scans should be made.

Growth anomaly Refer to FMS to consider amniocentesis.

To complete (particularly if any anomaly suspected)

If having difficulty with completing scan independent of BMI or fetal position, ask another APU to scan the patient during that clinic. Refer to FMS if additional views are still required.

Breaking 'bad news'

See Ref: [0213](#) Breaking Bad News Guidelines

The APU should inform the woman/couple of their suspicions (if reasonably confident) and that a further opinion and consultation will be arranged.

Bad news could be regarded as any news that is not 'normal'. The Breaking Bad News guidelines for the Trust and dept should be followed.

All APU's will be aware that many parents experience considerable anxiety over any comment and finding. Care should be taken not to unduly increase their anxiety.

Lone working policy.

The APU should be aware of this policy and adhere to safe working practice at all times, if any assistance is required, they should bring it to the attention of the midwife in the clinic and chaperoning if required organised with a colleague or administration clerk. Any incidents or near misses should be brought to the attention of the line manager by completing an Incident form as soon as they occur, ensure all relevant information and actions are documented accurately.

Recalculation of Down's syndrome screening risk following ultrasound examination at the mid pregnancy ultrasound scan "The National Down's Syndrome Screening Implementation Advisory

Group and the Fetal Anomaly Ultrasound Steering Group recommend that at the time of a routine mid pregnancy fetal anomaly ultrasound scan, a Down's syndrome risk generated by a nationally accepted screening method, either 1st or 2nd trimester, should not be recalculated up or down due to the presence or absence of a single ultrasound marker of less predictive power than increased nuchal fold (Smith-Bindman et al, National Down's Syndrome Screening and Fetal Anomaly Ultrasound Screening Programmes.

Linked policies and guidelines

Ref [0881](#): Sale of Ultrasound images
Ref: [0213](#): Breaking Bad News Guidelines
Ref [0847](#): FTSC and Dating Ante natal Scans
Ref [0875](#): Fetal medicine
Ref [0520](#): Renal Tract Dilatation in the Newborn
[Ref 12 : Uterine Artery Doppler SOP.](#)

[Appendix 1: Torbay Hospital Fetal Medicine Referral](#)

[Appendix 2: Management of Fetal Anomalies](#)

[Appendix 3: Indication for detailed scan with fetal medicine specialist](#)

[Appendix 4: Low placenta at 20 weeks.](#)

Appendix 5: [South West Placenta Accreta Spectrum \(PAS\) Network Pathway](#)

[Appendix 6: Anomaly scan user guide for VP6](#)

[Appendix 7: Algorithm for UtAD 2023](#)

[Appendix 8: Referral pathway for UtAD](#)

[Appendix 9: South West regional referral pathway for fetal hydronephrosis/renal pelvis dilatation \(RPD\)](#)

Appendix 1

Torbay Hospital Fetal Medicine Referral

Hospital	RD &E Exeter	Derriford Plymouth
Consultants	On Call consultant to be reviewed to ensure capacity to accept	
Dept	Antenatal Clinic and Assessment Matron	Screening Midwife ANC
Phone	01392 406540	01752 439792

Date of Referral	
Name of patient	
Date of Birth	
Hospital Number	
Address	
Postcode	
Please do not use printed labels	
Phone Number	
Mobile Number	
Form filled in by: Consultant:	
Scan gestation. EDD	
Prenatal diagnosis Requested	FMS on leave: yes/no CVS/Amniocentesis
HIV/Hepatitis status	
Blood group	<i>Fax result if rhesus negative</i>
Clinical indication	
Scan report attached yes/no	

ANC, Torbay Hospital will remain responsible for notifying the patient of the results.

Please ensure that ANC, Torbay Hospital is aware of the appointment time of any prenatal diagnosis and arrange for the results to be faxed directly to ANC, Torbay to ensure timely follow-up.



Management of Fetal Anomalies

Appendix 2

NEUROLOGICAL	USS MANAGEMENT	ANC MANAGEMENT	NcardsSw
Cleft lip/palate	Refer for detailed scan	<i>Isolated cleft lip/palate associated with 1% risk of chromosomal anomaly in unscreened population.</i> At the initial diagnosis: CLAPA information and cleft team contacts. Refer to cleft team within 24 hours for contact within 24 hours of receiving the referral. Counsel low risk indication for amniocentesis.	Yes
Ventriculomegaly atrium diameter $\geq$ 10mm (mild) 12-15mm moderate Hydrocephalus/severe $\geq$ 15mm Echogenic foci	Refer for detailed scan. Refer for detailed scan	<i>Association with chromosomal anomalies, 1-2% if mild isolated ventriculomegaly</i> Counsel indication for amniocentesis. Check viral studies. Check viral studies	Yes
NECK			
cystic hygroma/ nuchal oedema > 6mm Hydrops	AP measurement in post fossa view (at trans cerebellar level: outer skull to on-inner border of skin) refer for detailed scan. Report any anomalous fluid collections. Refer for detailed scan + MCA Doppler.	Counsel indication for amniocentesis. Information leaflet <i>High risk of chromosomal anomalies 1 in 3.</i> <i>Nuchal oedema increases risk Down's Syndrome to 1 in 10 (x 5 risk).</i> <i>Cystic hygroma particularly associated with Turner's syndrome in half (x 17 risk).</i> <i>Also, association with cardiac anomalies and syndromes</i> Counsel indication for amniocentesis. + Check viral studies	Yes

CARDIAC or CHEST	USS MANAGEMENT	ANC MANAGEMENT	NcardrsSw
Suspected abnormality of chest/heart	Refer for detailed scan if unsure/poor views. Refer to Bristol if confident that heart is abnormal and copy reports to FMS for subsequent follow-up.	Transfer to FMS who will arrange any necessary follow-up +/- amniocentesis and paediatric referral after receipt of report from Bristol.	Yes
ABDOMINAL	USS MANAGEMENT	ANC MANAGEMENT	SWCAR
Absent or very small stomach diameters 3 rd centile.	<i>Explain stomach fills and empties and rescanning to image it when full. (No need to create anxiety at first view). Rescan 3 times during clinic – if still absent/small in 2 out of 3 diameters. Refer for detailed scan.</i>	<i>If confirmed: Suspicious of oesophageal atresia, significantly associated with trisomies including Down's Syndrome.</i> Counsel indication for amniocentesis.	No
Exomphalos	Refer for detailed scan	Counsel indication for amniocentesis.	Yes
Gastroschisis	Refer for detailed scan	FMS will refer to Bristol for 34/40 care planning appointment. Plan delivery at Bristol. ADVICE SHEET	Yes
Echogenic bowel 0.5% of scans Soft marker Must be as bright as bone Take off harmonics	Examine placenta for signs of bleeding. Refer for detailed scan.	<i>Increases risk of Down's Syndrome x 3 age (if unscreened) or screened result or approx. 5% risk</i> Counsel indication for amniocentesis. ANC to offer viral studies (CMV 2%), both maternal and paternal cystic fibrosis blood tests (result 1-week) (2%). Ascertain any history of bleeding. Growth scans monthly from 24/40 for risk of placental insufficiency/ IUGR/ Still birth. May be normal variant of no functional significance. No P/N FU required. ADVICE SHEET	No

Other isolated abdominal echogenic foci	Examine fetus for signs of infection/other echogenic foci in head/heart and liver. No further scans	ANC to check viral studies and arrange FMS ANC review.	<i>No</i>
Abdominal/ pelvic echolucent lesions	Differential diagnosis: ovarian cyst (clinical indication for sexing as most likely diagnosis in female fetus and rarely of any consequence unless huge), mesenteric cyst, intestinal duplication cyst. Refer for detailed scan AT 28 WEEKS	Consultation only FMS ANC if requested. Paediatric referral will be arranged by FMS if still required at review. Post-natal scan only required if still demonstrable at 34 weeks.	<i>No</i>

UROGENITAL	USS MANAGEMENT	ANC MANAGEMENT	NcardsSw
Urogenital tract including unilateral hydronephrosis, multicystic kidney, duplex kidney.	Refer for detailed scan AT 28 WEEKS	Consultation only FMS ANC if requested	Yes
Suspected urethral valves	Bilateral hydronephrosis/megacystis in male fetus Refer to FMS	Follow SW Regional referral pathway – See Appendix 9. Counsel indication for amniocentesis.	Yes
Mild renal pelvic dilatation 1-2% of scans	RPD > 7mm at any gestation – refer to FMS <i>May indicate urinary tract obstruction or normal variant</i>	Follow SW Regional referral pathway – See Appendix 9. Advice sheet	No
Isolated RPD > 7-10mm after 36 weeks	Document unilateral/bilateral, ureters, bladder /wall+/-fetal sex (clinical indication for fetal sexing if bilateral ureteric dilatation/hydronephrosis). cc Dr A Janzen (paediatrician), Radiologist,, SCBU, General Practitioner and CMW team.	Follow SW Regional referral pathway – See Appendix 9. Document requirement for neonatal scan in hand held and hospital notes & baby FU sticker (Ref 0520 : Renal Tract Dilatation in the Newborn). • Early scan 2-3 days after delivery + prophylactic antibiotics if abnormal bladder, bilateral hydronephrosis/ureteric dilatation, or unilateral dilatation & single kidney. • Routine scan 2-4 weeks after delivery	yes

SKELETAL	USS MANAGEMENT	ANC MANAGEMENT	NcardrsSw
Major abnormality of head or spine e.g. anencephaly or large open neural tube defect	Inform woman of findings. Date by FL if necessary Consider urgent 2 nd opinion sonographer/FMS	Refer to on call Registrar/Consultant if termination of pregnancy for fatal or severe undisputable anomaly requested. Detailed scan to be arranged by ANC if unsure or wishes to consider continuing with pregnancy. ARC leaflet	Yes
Talipes	Refer for detailed scan	<i>Associated with trisomies particularly Tri 18 in 5% of cases particularly if other anomalies present.</i> <i>!% association if isolated.</i> Counsel indication for amniocentesis. ADVICE SHEET	Yes
BIOMETRY	USS MANAGEMENT	ANC MANAGEMENT	
FL < 3 rd centile	1. abnormal appearance: Refer for detailed scan 2. In association with HC and AC, all of which below 3rd centile: Refer to FMS Isolated short femur requires referral to ANC midwife	Consider amniocentesis. If normal centiles maintained see customised growth charts from 24 weeks.	
HC < 3 rd centile.	1. Disparity with gestational age equivalent of FL >7days. 2. In association with AC ±FL, both/all of which below 3rd centile. Refer to FMS Isolated refer to ANC midwife	Consider amniocentesis. If normal centiles maintained see customised growth charts* from 24 weeks. <i>Microcephaly is rarely diagnosable, particularly before 28 weeks.</i>	
AC < 3 rd centile.	in association with HC ±FL, both/all of which below 3rd centile. Refer to FMS	Consider amniocentesis. If normal centiles maintained see customised growth charts* from 24 weeks.	
AC>97 th centile	FAC > 97 th centile on the graph (not bar chart) at any gestation	Refer to Clinic midwife for post scan management – if less than 34 weeks gestation have a GTT, if more than 34 weeks - CBG	
EFW < 3rd centile on VP	Perform Uterine Artery Dopplers Refer to ANC midwife.	Refer to FMS.	

EFW < 10 th centile on VP	Perform Uterine Artery Dopplers Refer to ANC midwife.	If UtAD normal refer for serial growth scans from 32 weeks. If abnormal refer to FMS.	
EFW > 10 th centile on VP but any biometry between the 3 rd and 10 th centile	Refer to ANC midwife.	Refer for growth scan at 28 weeks on consultant clinic.	

FETAL SEXING	Inform parents degree of uncertainty.		
Medical Indications:	Risk of sex-linked disorders e.g. haemophilia, bilateral ureteric dilatation / megacystis, echolucent abdomino-pelvic cyst, uncertain chorionicity. Document on report.		
Parental request	VP: unknown if declined.		

PLACENTA LIQUOR	USS MANAGEMENT	ANC MANAGEMENT	
Unidentified chorionicity or monochorionic multiple pregnancy in late booker	Inform woman of need for further information Indication for fetal sexing and separate deepest vertical pool (DVP) liquor volumes. Refer for detailed scan in 2 weeks if normal DVP, 1 week if either DVP is abnormal.	Book ALL monochorionic twins and any triplets FMS for fortnightly USS from 16-17 weeks. Book dichorionic twins for monthly USS from 24-36 weeks. ADVICE SHEETS	

Low lying placenta (leading edge within 20 mm of the internal cervical os) or placenta praevia (covering os) Previous LSCS with an anterior placenta.	Perform TVS to visualise accurately as required. Rescan at 32 weeks and 36 weeks (+ TVS) on consultant clinic as required. From 36 weeks document relationship and thickness of presenting part to leading edge of placenta If the anterior placenta is within 20 mms of the internal cervical os or covering it with previous CS scar refer to FMS @ 24/40 Document FH + presentation but no biometry in 3rd trimester placental localisation scans	Reassure that majority of placentas noted low on early scan and further TVS will check position. Likely to be minor praevia, usually allow vaginal delivery (90%).. More likely to be major praevia (50%) which requires caesarean delivery (50%). If still praevia at 32 weeks 90% remain major. Rescan TVS 36 weeks. Women with 1 major or 2 minor risk factors associated with a low-lying placenta (<20mm at 20/40) or placenta praevia refer to local fetal medicine consultants @24/40 to refer to Bristol by 28/40 if required. See Appendix 5	
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Other placenta pathology eg	Placental teratoma (large >5cm); monthly growth scans for small risk of hydrops Anomalous cord insertion Report to request review of images at next FMS ANC	Arrange FMS ANC where images can be reviewed and further FU arranged.	
Amniotic bands (thin wispy strands floating in liquor)	Finding of no significance if free-floating and do not constrict the fetus. (Majority are insignificant) If multiple for D/W FMS.	Not routine to offer rescan. Follow up with FMS may be advised following image review	
Synechiae (broad 'shelves' of placenta crossing the cavity)	Image and report only if thick, cutting off at least 1/3 of cavity or low in cervix and might affect presentation and/or birth. Otherwise ignore. (Majority are insignificant)	If significant arrange FMS ANC where images can be reviewed and further FU arranged	
Anhydramnios	- locate kidneys, bladder and stomach. Inform woman of findings	Refer to on call Registrar/Consultant	
Polyhydramnios suspected if DVP > 8cm	Confirm poly with AFI. Deepest pool > 8cm perform AFI – if over 25 cms call it polyhydramnios Normal AFI - report finding but no further follow-up. Abnormal AFI – Identify stomach. If normal: Repeat scan in 4 weeks.	Arrange early GTT & repeat scan in 4 weeks. If GTT normal it should still be repeated at 28 weeks if there are other risk factors for GDM.	Polyhydramnios suspected if DVP > Viewpoint 95 th centile.
Intrauterine Death (From fetal size of 10 weeks)	Growth parameters, liquor volume	Refer to on call Registrar if not high-risk clinic. Maternal thrombophilia screen, Placental and (& fetal skin if 3 rd trimester) chromosomes	

MATERNAL PATHOLOGY	USS MANAGEMENT	ANC MANAGEMENT	
Fibroids	Common finding. Image large fibroids > 4cm and include description in report especially location. Large (> 4cm) cervical or low fibroids within 3 cm of internal os require rescan +/- TVS at 36 weeks. Document relationship to presenting part.	Large cervical or low fibroids may be significant for presentation and/or birth. Explain that further scans will check position. May need to be TVS if position difficult to determine. ADVICE SHEET	
Adnexal masses	Do not report single simple echolucent ovarian cysts < 5cm. Do not require rescan as likely to be physiological. Report > 5cm or complex and advise rescan 3/12 post-natal. Only rescan in pregnancy if features suggestive of malignancy. <i>Viewpoint/overall diagnosis/other</i>	Document need for maternal post-natal pelvic scan in 'special instructions' box hand-held notes. Postnatal TA +/-TV USS of pelvis to be arranged at the time of presentation from ANC for 3 months from EDD, with GOPD FU via Secretary of Consultant on call for evening/next ANC. <i>50% of cysts >5cm will resolve spontaneously. Do not leave it to be arranged post-natally.</i>	

UTERINE ARTERY DOPPLERS FROM APRIL 2024 (REF 12)	USS MANAGEMENT	ANC MANAGEMENT	
To be performed when requested for high-risk women or see above for EFW parameters. See Appendix 7	Normal UtAD refer for serial USS from 32 weeks. Abnormal UTAD & EFW > or = 10th centile for serial growth scans from 28 weeks Abnormal uterine artery Doppler and AC or EFW < 10th centile refer to FMS. See Appendix 8		

Appendix 3

INDICATIONS FOR DETAILED SCAN WITH FMS:	Additional USS MANAGEMENT	ANC MANAGEMENT
- Nuchal translucency $\geq 3.5\text{mm}$ at FTSC - EFW < 3rd centile on VP - Teratogenic drugs with specific anomalies e.g. lithium, Warfarin, NOT anticonvulsants - Personal history or previously affected child with eg NTD, Gastroschisis/diaphragmatic hernia - Personal history or previously affected child with Cleft lip/palate - Genetic/structural abnormality or syndrome not addressed in routine scan - Monochorionic twins - Maternal chickenpox (varicella) before 28 wks No additional scans/FU required if maternal infection > 28 weeks - Maternal parvo virus before 20 wks. - Single scan required 4 weeks later if maternal infection 20-28 weeks to exclude increasingly small risk from fetal infection. No additional scan from infection at >28 weeks	- Cardiac scan at 22-23 weeks - FMS - Cardiac scan at 22-23 weeks 16 weeks - Not indicated - Detailed anomaly scan 16-17 weeks 5 weeks post rash from 16 weeks. Routine anomaly within 5 weeks of rash/seroconversion. - Doppler MCA 4-weeks post rash/seroconversion Routine anomaly within 4 weeks. 2 weekly Doppler MCA until 12 weeks post exposure	Increased risk of cardiac/syndromic anomalies. <i>Information leaflet</i> Increased risk recurrence Paediatric referral for eye and hearing checks. Neonatal (not cord) blood test for IGM. Repeated at 7 months for IGG No paediatric referral/cord bloods unless USS signs anaemia

• Personal history or previously affected child with congenital heart anomaly requiring intervention within 1 year of age. • Condition that would not be detected routine cardiac views.	• Cardiac scan at 22-23 weeks • 18 week scan if previous TOP for severe cardiac anomaly.	Offer Bristol cardiology referral from 18 weeks if missed antenatal diagnosis or patient preference.
DETAILED SCAN NOT INDICATED Distant family history of above Personal history or previous child with non-recurring abnormality or not detectable on USS Any history of ASD/PDA (failed closure of a physiological feature of fetal circulation) Drugs not considered to be strongly teratogenic, eg antidepressants	Routine scan ONLY	<i>If in doubt forward request to FMS for vetting.</i>
RE-SCANS Poor fetal position or maternal habitus prevent visualisation.	Explain difficulty in visualisation. One limited rescan only in 1-2 weeks, by 23 complete weeks. ONLY rescan for uncompleted structures DO NOT repeat full survey or biometry.	<i>Explain limitations of scans. refer for FMS scan if poor view but suspicious of anomaly or at high risk of anomaly e.g. diabetic / teratogenic drugs.</i>

ANC

Viral studies: Serial blood serology for CMV, Toxoplasma and parvo virus, at the time and from saved booking bloods on request form. Results 2 weeks

Cystic fibrosis: paired maternal and paternal in EDTA. Results 1 week

Book any follow-up telephone result appointments in Maternity Assessment Diary.

APU

NCARDS: Notify if structural abnormality excluding mild RPD. Do not notify soft markers.

Rescans for suspected anomaly should occur by 23 weeks though feticide may be recommended prior to termination from 21+6 weeks.

The APU should inform the parent(s) of their suspicions, to whom all comments should be available, further information is available from the specialist midwife and that a further opinion/consultation will be arranged. Record what is said to the patient on the Viewpoint report.

Appendix 4

Sonographer management of placental localisation at 20 weeks

Leading edge of placenta > 20mm away from cervical os - NO FURTHER SCAN

Low lying placenta (<20mm from the internal os) or placenta praevia (covering the os) on TA (consider TVS if high BMI, difficult visualisation and/or posterior placenta)

**Posterior placenta or anterior placenta with no previous LSCS
refer for scan at 32 weeks with APU**



32 weeks scan (including TVS and growth if required)

If > 20mm away, no further follow up - discharge

If asymptomatic and remains low lying, rescan at 36 weeks on low risk, if praevia rescan at 36 weeks on high risk.

If recurrent bleeding for obstetric review - refer to ANC midwife



**36 weeks scan
(including TVS and growth if required)**

Measure leading edge of placenta to internal os. Report thickness of leading edge and positioning of presenting part in relation to it. If covering the os report as major placenta praevia

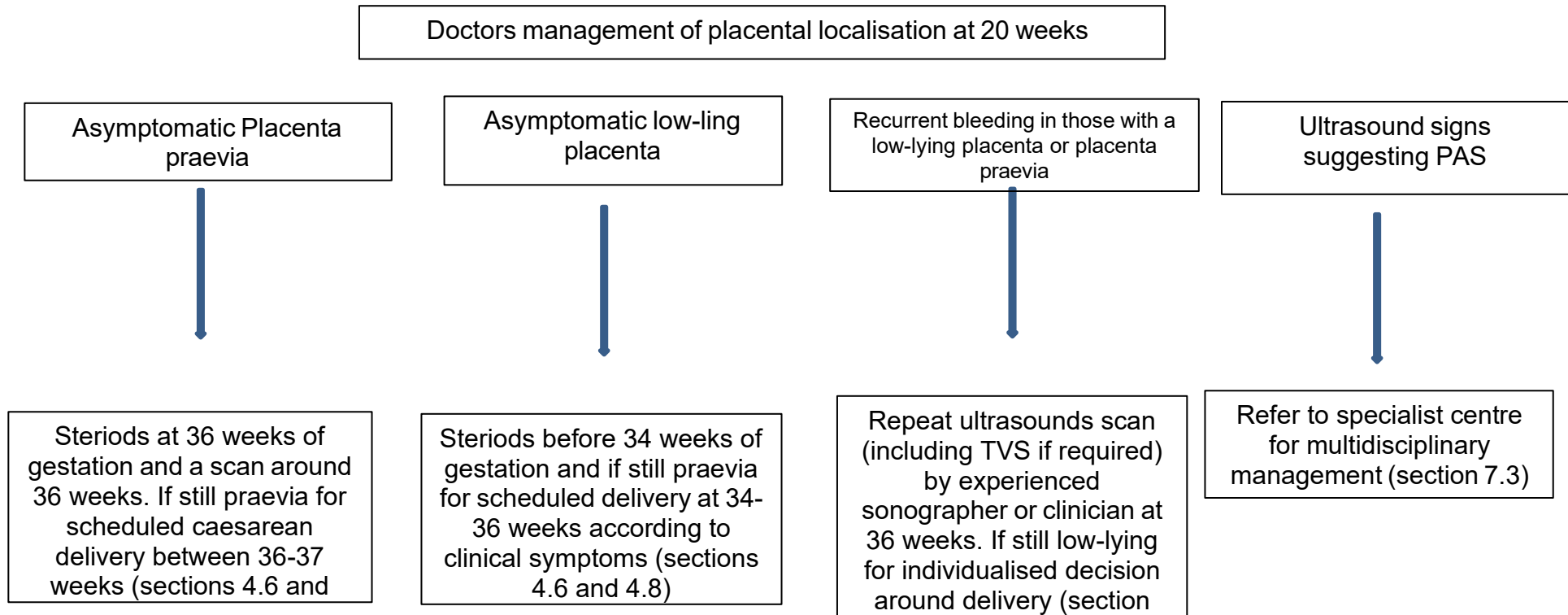
All for Obstetrician review.

**If previous LSCS with anterior placenta or
previous history of PAS (placenta accreta
spectrum)**

Refer for scan at 24 weeks with FMS



**FMS
APPOINTMENT**



South West Placenta Accreta Spectrum (PAS) Network Pathway

Referral Criteria

Women with 1 major or 2 minor risk factors associated with a low lying placenta (<20mm at 20/40) or placenta praevia refer to local fetal medicine consultants @24/40 in order to refer to Bristol by 28/40 if required.

Major risk factors	Minor risk factors
Previous caesarean section AND low anterior placenta +/-praevia	Previous history of PAS Previous history of retained placenta / manual removal of placenta Asherman's syndrome
Previous myomectomy with cavity breach	Previous endometrial curettage (including surgical management of miscarriage, surgical termination of pregnancy, hysteroscopy) +/- uterine perforation Endometrial ablation Assisted reproductive technology

EXCEPTION= Scar ectopic AND wanting to continue pregnancy after first trimester –please refer as soon as possible to NBT FMU.

How to refer



- Platform used to refer patients
- Link found at: <https://www.referapatient.org/refer-a-patient>
- Select 'new referral', type in 'PAS' and select 'PAS South West Network'
- Please use for all correspondence

Anomaly scans

- After entering password into VP choose obstetrics from pop up window.
- Go to patient list tab and input HN, double click on patient to pull up VP screen as above.
- Check patient details top left box – add any messages as appropriate.
- Click on new case or exam – middle box on left.
- Choose exam subtype – Anomaly or completion of anomaly and any further operators as required in 3.
- Complete **Indication** – main report
- Click on **History** - please add if patient has had a previous section by going into medical history and previous surgery or has a latex allergy – if not already documented.
- **Perform examination.**
- **Method** - click on device/procedure and view – use dropdowns as appropriate.
- **Pregnancy** – Check number of fetus' is correct. If twins a new box opens on the right to put dichorionic etc.
- **Dating** – Will already be populated if previous exams. If new to trust enter known EDD in external assessment and Agreed EDD will populate, or if first exam, date by HC by clicking on U/S.
- Click on **Fetal Biometry** - add measurements. If transferring from U/S machine, please ensure you delete measurements not required.
- **General Evaluation** – Use dropdowns for cardiac activity and fetal movements. Click on **Placenta** and **Amniotic fluid** and document accordingly. WE do not report on umbilical cord in the routine anomaly scan.
- **Fetal Anatomy** – report accordingly. Any abnormal comment will open the fetal anatomy box. This can be tabbed through for each section if multiple anomalies are found.
- Click on **Maternal structures** if required – Tab through uterus/ovaries/POD and enter drop downs as appropriate.
- Click in **Diagnosis** – use appropriate drop downs - anomaly scan complete etc.
Choose drop downs as required for anomaly or multiples etc.
- **Comments section** – Go into anomaly scan comments as required see below and any other comments as required.

Maternal De

Anomaly scan comments

- ☐ EFW at anomaly < 10th centile for referral to clinic midwife fo...
- ☐ The AC lies above the 97th centile.
- ☐ Known previous LSCS.
- ☐ The patient has been informed there is an anomaly on the ultras...
- ☐ Interpreter present during scan, and required at all further sc...
- ☐ For review in Consultant clinic
- ☐ For review and referred to ANC midwife
- ☐ For review in MAU following scan
- ☐ Renal pelvic dilatation noted
- ☐ Echogenic bowel noted
- ☐ Fetal stomach not seen
- ☐ NcardsSW form completed.
- ☐ NcardsSW form not completed.
- ☐ The patient arrived late for their appointment today. As such, ...

Invasive Pro

Diagnosis

Comment

Recommend

Follow-up

Addendum

Anomaly

- ☐ Fetal movements seen during scan.
- ☐ Intertwin membrane seen floating free...
- ☐ Limitations of ultrasound
- ☐ Anomaly scan comments
- ☐ Placental comments
- ☐ Amniotic fluid
- ☐ Cervical length comments
- ☐ Pelvic pathology

Jane Morey [Obstetrics Department]

14:30

- **Recommendation** – as appropriate
- **Follow up** – onward referral as required if concerns or anomaly suspected.

Check report preview – see below - click again to go back to reporting page

Report preview (F5)

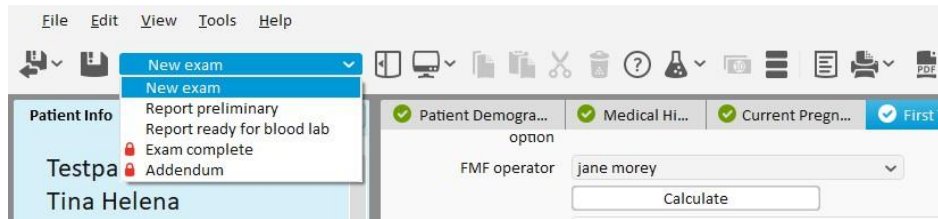
ge... Patient Demographics Medical History Current Pregnancy Early Preg. Images (0) Graphs (0) Documents (0)

Agreed dating based on ultrasound (CRL) 8 W + 0 D 28/03/2024



then print

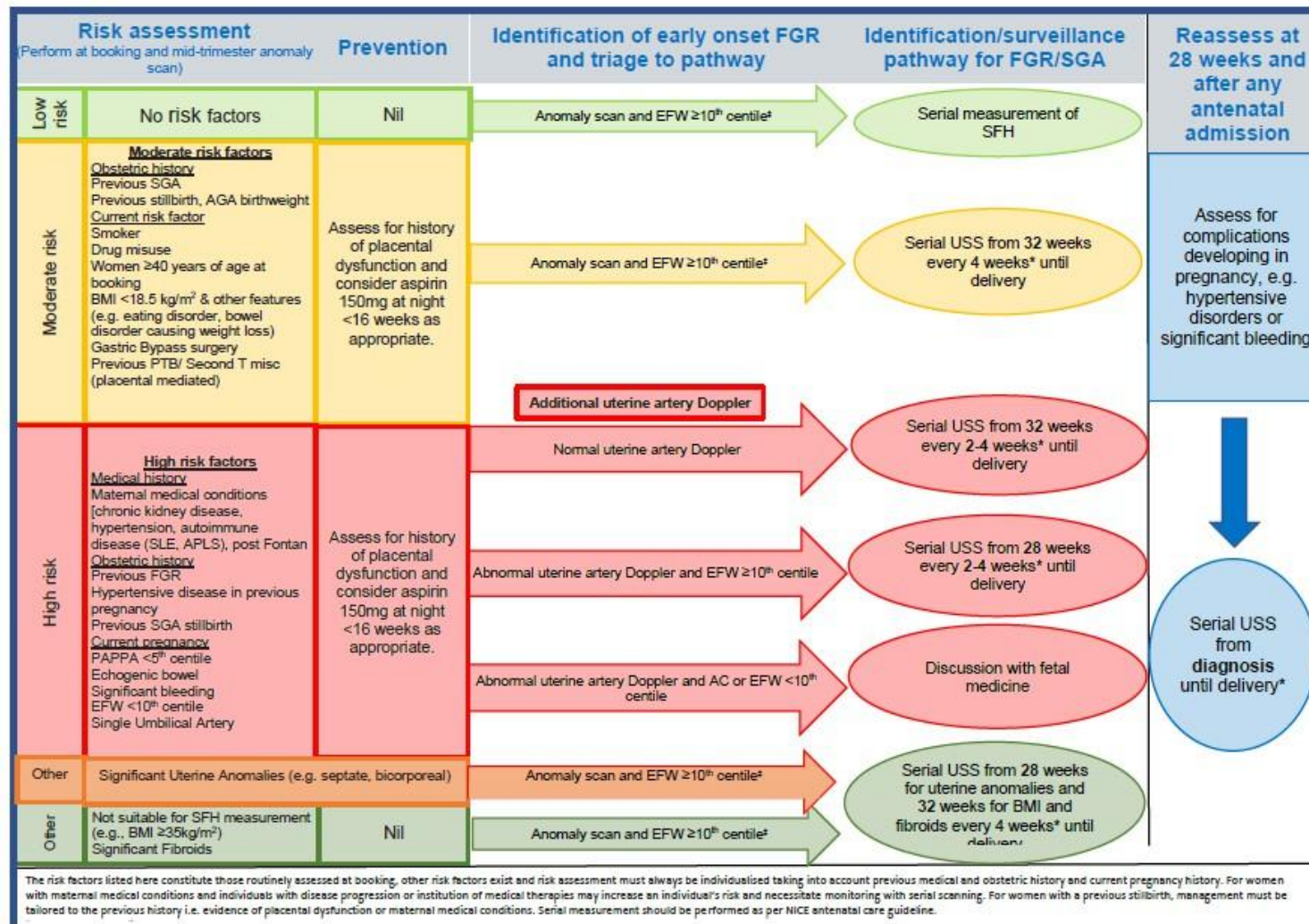
Finally go to new exam box and click on Exam complete. See below.



This will then end and save patient.

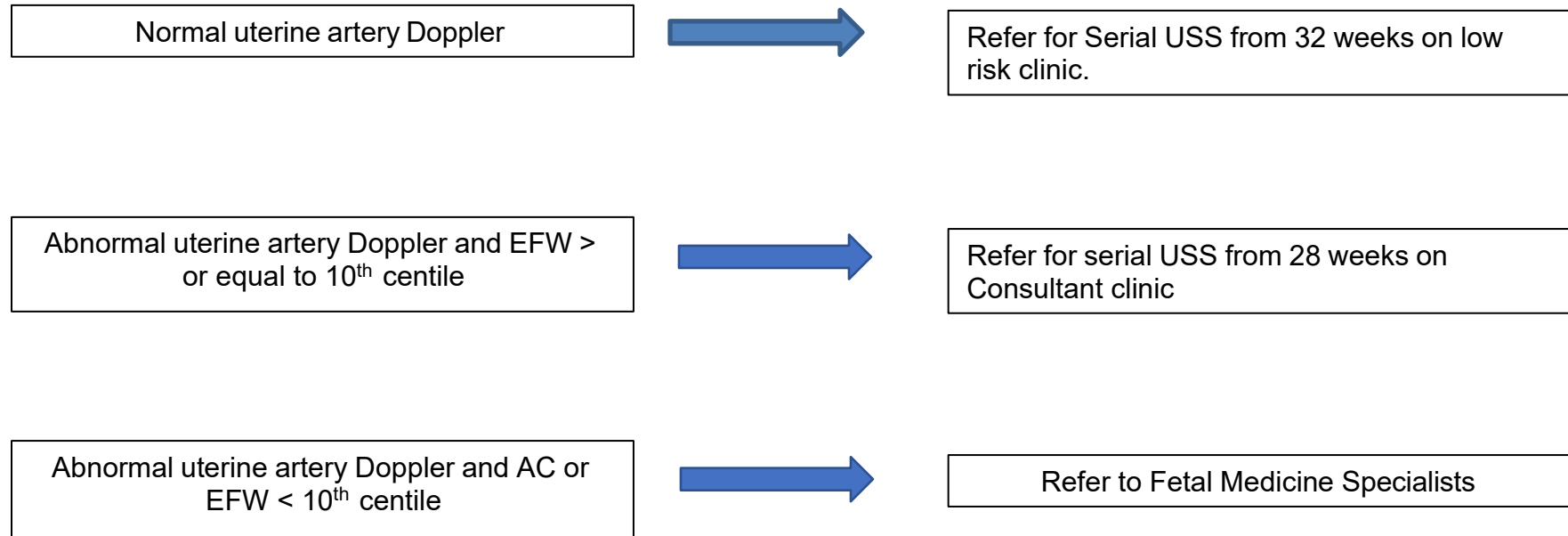
Appendix 7

Figure 6: Algorithm for using uterine artery Doppler as a screening tool for risk of early onset FGR.

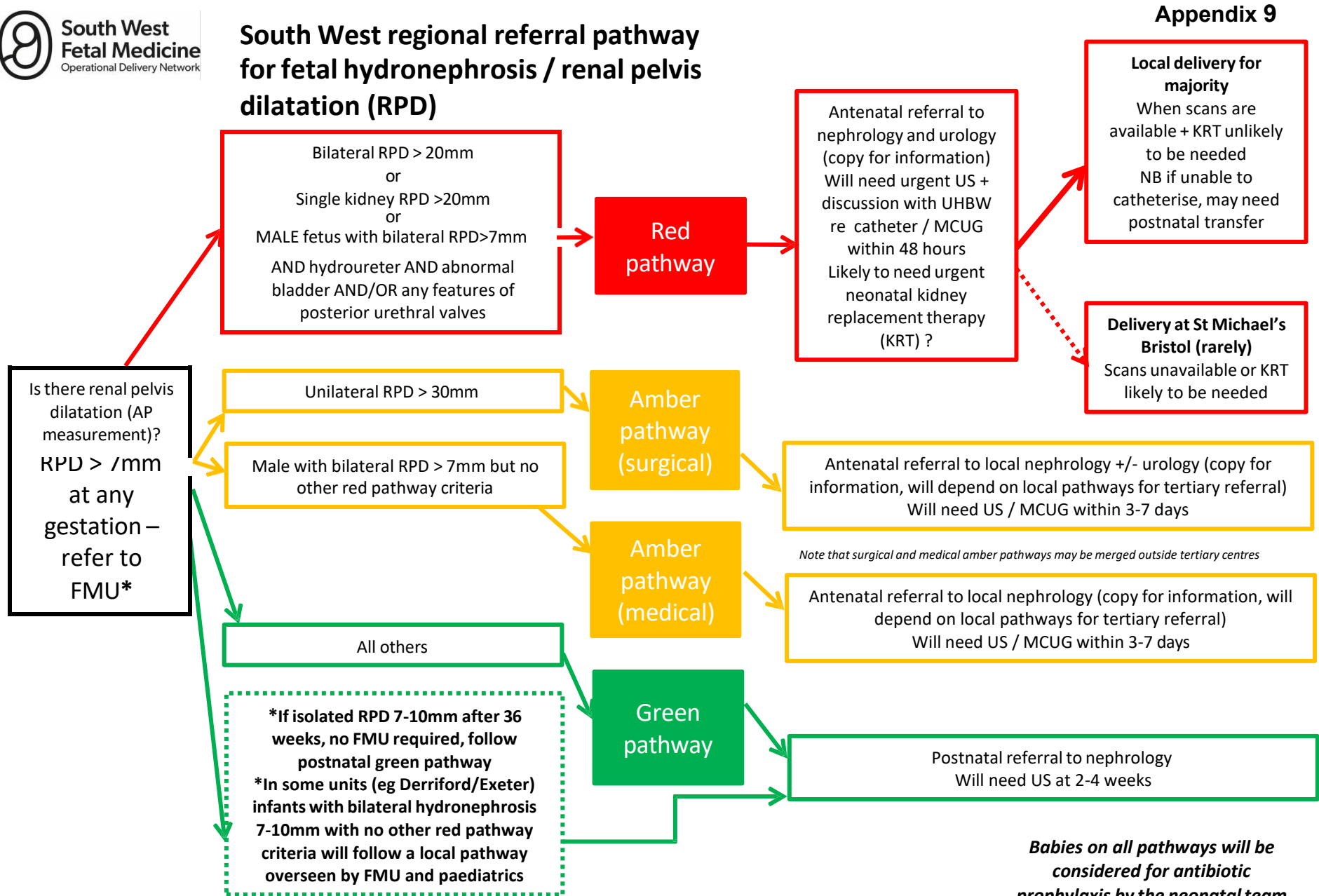


Appendix 8

Referral Pathway for Uterine Artery Dopplers



South West regional referral pathway for fetal hydronephrosis / renal pelvis dilatation (RPD)



Babies on all pathways will be considered for antibiotic prophylaxis by the neonatal team – see local neonatal guideline

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	1407		
Document title:	18-20+6 Weeks Routine Anomaly Scan		
Purpose of document:	Guideline		
Date of issue:	30 April 2025	Next review date:	30 April 2028
Version:	6.1	Last review date:	30 April 2025
Author:	Consultant Obstetrician		
Directorate:	Obstetrics		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Obstetrics and Gynaecology Risk Management Meeting Clinical Director of Pharmacy		
Date approved:	09 April 2025		
Links or overlaps with other policies:	0881: Sale of Ultrasound images 0213: Breaking Bad News Guidelines 0847: FTSC and Dating Ante natal Scans		

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select Yes No	
Does this document have implications regarding the Care Act? <i>If yes please state:</i>	☐	☐
Does this document have training implications? <i>If yes please state:</i>	☐	☐

Does this document have financial implications? <i>If yes please state:</i>			☐	☐
Is this document a direct replacement for another? <i>If yes please state which documents are being replaced:</i>			☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
30 June 2011	1	New	Superintendent Advanced Practitioner in Ultrasound
4 July 2013	2	Revised	Superintendent Advanced Practitioner in Ultrasound
20 November 2015	3	Revised	Superintendent Advanced Practitioner in Ultrasound
September 2018	4	Revised	Obstetrics and Gynaecology Risk Management Meeting
6 March 2020	4	Revised	Obstetrics and Gynaecology Risk Management Meeting
21 July 2023	5	Revised	Clinical service lead for Obstetrics and Gynaecology Governance Pharmacist & Medication Safety Officer
30 April 2025	6.1	Revised Amended 01.04.25	Clinical service lead for Obstetrics and Gynaecology Governance Pharmacist & Medication Safety Officer

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

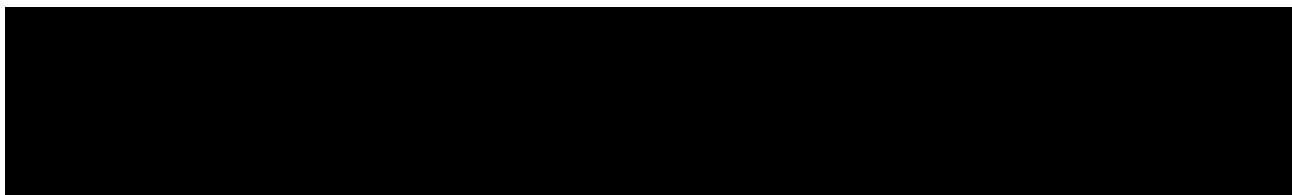
Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) *(for use when writing policies)*

Policy Title (and number)		Version and Date	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users ☐ Staff ☐ Other, please state...			
Could the policy treat people from protected groups less favourably than the general population?			
<i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes ☐ No ☐	Gender Reassignment	Yes ☐ No ☐
Race	Yes ☐ No ☐	Disability	Yes ☐ No ☐
Gender	Yes ☐ No ☐	Pregnancy/Maternity	Yes ☐ No ☐
Sexual Orientation			Yes ☐ No ☐
Religion/Belief (non)			Yes ☐ No ☐
Marriage/ Civil Partnership			Yes ☐ No ☐
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers¹; travellers²; homeless³; convictions; social isolation⁴; refugees)			Yes ☐ No ☐
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language ⁵ used throughout?			Yes ☐ No ☐ NA ☐
Are the services outlined in the policy fully accessible ⁶ ?			Yes ☐ No ☐ NA ☐
Does the policy encourage individualised and person-centred care?			Yes ☐ No ☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes ☐ No ☐ NA ☐
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes ☐ No ☐
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Who was consulted when drafting this policy?			
Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐	
Staff ☐	General Public ☐	Other, please state...	
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes ☐ No ☐
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	
AUTHORISATION:			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form	Signature		

Validated by (line manager)		Signature	
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Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user

² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them

³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge

⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated

⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives

⁶ Consider both physical access to services and how information/ communication is available in an accessible format

⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our [GDPR](#) page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdf@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [Data Protection](#) site on the public internet.