NHS England

Consultation Guide: Abnormally invasive placenta service specifications

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Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it, and
- given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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1 About this guide

NHS England is committed to working with a wide range of patients, patient groups and other stakeholders in the development of its commissioning of specialised services. A public consultation is an opportunity to check whether proposals are right and supported, the public understand their impact, and identify any alternatives before decisions are made.

We have launched this consultation to seek views on a new service specification for specialist maternity care for women diagnosed with abnormally invasive placenta. The consultation will run from 16 August to 15 October 2018.

At the end of the consultation period, all feedback will be considered and amendments made to the service specifications as appropriate.

2 Context

Abnormally invasive placenta (AIP) is a rare and potentially fatal pregnancy complication where the placenta (an organ attached to the lining of the womb during pregnancy; the placenta provides oxygen and nutrients to growing foetuses; the fetus's umbilical cord develops from the placenta) is abnormally adherent to the womb (accreta), invades into the wall of the womb (increta) or even through the wall and out into the pelvis (percreta). If an attempt is made to forcibly remove the placenta catastrophic maternal haemorrhage can ensue.

AIP appears to be the result of the placenta implanting over scarring to the uterus from previous uterine surgery and so can occur anywhere that there is scarring. The most common uterine surgery however, and demonstrably the single greatest risk factor for AIP, is previous caesarean delivery (CD). As a previous CD scar is usually in the anterior lower segment of the uterus if the placenta implants over it, this results in AIP complicating a placenta previa. This combination poses multiple problems including increased risk of antenatal bleeding, difficult access to the baby for delivery and the relatively poor contractility of the lower segment leading to greater blood loss.

AIP is a heterogeneous condition with multiple potential management strategies but there is no doubt that at the severe end of the spectrum it is extremely dangerous. The maternal mortality rate with the severe AIP (percreta) has been estimated to be as high as 7% (2) (900 times the background risk of maternal death). AIP is also associated with increased risk of harm to the baby including a 40% incidence of low birth weight and a perinatal mortality rate which is three times higher than that of the normal population.

A soon to be published observational study, led by clinicians in Oxford, contacted all 154 obstetric led units in England asking for details regarding the intended place of delivery for antenatally diagnosed AIP and the estimated numbers of cases treated over the last 5 years (2012-2017). One hundred and fourteen units replied to the survey (74%). Extrapolating their numbers to all the units in England gives an estimate of approximately 344 procedures per year, an incidence of 5.2 cases per 10,000 births.

For planning purposes we have estimated that the total number of procedures for all centres in England is 344 per year.

3 What we want to achieve?

Multiple studies have shown that both maternal mortality and morbidity are reduced when women with AIP deliver in an AIP centre with a multidisciplinary care team who have experience in managing the risks and challenges presented by AIP. This relies on both recognition of the women at risk of AIP and accurate antenatal diagnosis, a challenge highlighted in the 7th Confidential Enquiry into Maternal and Child Health (CEMACH) report 'Saving Mothers' Lives'; 2011).

At this point time, there are no commissioned AIP centres in England and the service specification describes the standards that must be delivered by such centres. The service specification will also be used to inform the procurement programme that NHS England has put in place in order to commission AIP centres from April 2019.

The service specification was developed by the AIP Service Specification Working Group overseen by the Specialised Women's Services Clinical Reference Group.

4 Overview of the specifications being consulted upon

Delivery for women diagnosed with placenta accreta spectrum should take place in a specialist centre with logistic support for immediate access to blood products, adult intensive care unit and a neonatal intensive care unit (NICU) by a multidisciplinary team with expertise in complex pelvic surgery.

The service specification describes the scope, care pathway and clinical dependencies for specialist maternity care for women diagnosed with abnormally invasive placenta.

What will change?
Following public consultation, NHS England, will for the first time, commission specialist maternity care for women diagnosed with abnormally invasive placenta. As part of the procurement programme, hospitals will be able to bid to be one of the 10 - 20 centres that will be commissioned across England.

5 What questions are we asking?

1 Is the service specification clear?

If not, what needs to be clarified?

2 **Section 2.1** describes the care pathway and in the **elective pathway section** reference is made to the referral of women with a history of previous AIP or an ultrasound suspicion of AIP at any gestation or for women with risk factors, after ultrasound confirmation of low lying placenta at 28 weeks. Do you agree with this or do you think it should be less than 28 weeks.

If you think it should be less than 28 weeks can you say what it should be and your reasons?

3 **Section 2.1** describes the **non-elective** pathway. What are you views regarding this part of the service specification?

4 **Section 2.1** describes interdependence with other services and describes then as **essential services**, interdependent services and related services. Do you agree with the list of essential services? If no can you please outline why? Can you also list any other services that you would say are essential and explain why?

5 **Section 3** describes the population and the population needs. Is this part of the service specification clear?

6 **Section 4** describes **the aims of the service.** Do you agree with the description that is outlined in this part of the service specification?

If no – can you please outline why?

7 Please detail any other changes that you think should be made to the service specification and explain why the changes are necessary

6 How to give your views

The consultation period runs from 16 August 2018 and will last for 60 days.

Your views will help NHS England to further shape and refine the service specification for specialist maternity care for women diagnosed with abnormally invasive placenta.

- **Complete the online survey:** https://www.engage.england.nhs.uk/
  Before completing the survey please read the draft services specifications on the consultation home page.

- **Email us: england.scengagement@nhs.net**

- **Write to us: Specialist maternity care for women diagnosed with abnormally invasive placenta. Complex gynaecology and female urology consultation, NHS England, Floor 3B, Skipton House, 80 London Road, London, SE1 6LH.**