Guideline for the management of placenta praevia, placenta praevia accreta and Vasa praevia

Author/Owner	**Birth Centre lead Consultant/ Guideline Group**	
Equality Impact Assessment	N/A if clinical guideline or procedure	
Version	8	
Status	Reviewed	
Publication date	07/04/2021	
Review date	24/02/2024	
Approval recommended by	Maternity guideline group	Date: 01/10/2020
	Women's Business and Governance Meeting	Date: 23/10/2020
Approved by	CBU 3 Overarching Governance Meeting	Date: 24/02/2021
Distribution	Barnsley Hospital NHS Foundation Trust – intranet Please note that the intranet version of this document is the only version that is maintained. Any printed copies must therefore be viewed as "uncontrolled" and as such, may not necessarily contain the latest updates and amendments	

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1.0 Introduction

Maternal and fetal morbidity and mortality from placenta praevia, morbidly adherent placenta (including placenta praevia accreta) and vasa praevia are considerable and are associated with high demands on health resources.

The incidence of placenta praevia and/or placenta accreta has increased with the rise in the number of caesarean sections performed and increased maternal age. Vasa praevia is rare but is associated with high perinatal mortality and morbidity (RCOG 2018).

Maternal complications in the placenta accreta spectrum are primarily the result of massive haemorrhage. Median estimated blood loss in cohorts of placenta accreta spectrum ranges from 2000 to 7800 ml and the median number of units of blood transfused is 5 units (RCOG 2018).

Antenatal diagnosis of placenta accreta spectrum is therefore crucial in planning its management and has been shown to reduce maternal peripartum haemorrhage, maternal morbidity and mortality.

2.0 Objective

To ensure that women with suspected or diagnosed placenta praevia, morbidly adherent placenta (including placenta praevia accreta) and vasa praevia are managed appropriately in the antenatal period and in labour. Additionally, to ensure they are given correct evidence-based information regarding their condition, management plans, risks and outcomes.

3.0 Scope

This guideline applies to all medical and midwifery staff working on the maternity unit and maternity staff working in community.

4.0 Main body of the document

4.1 Definitions

Definitions	Occurrence
A 'low lying' placenta	Is for most pregnancies greater than 16 weeks where the placental edge is less than 2cms from the internal OS
Placenta praevia	Occurs when the placenta lies directly over the internal OS
Placenta praevia accreta	Occurs when either the whole or part of the placenta is lying in the lower uterine segment with placenta accreta. This is often associated with previous caesarean section with an anterior placenta over the old scar line
Placenta accreta spectrum (Placenta accreta, Placenta increta, Placenta percreta) *NB for ease of description the term placenta accreta spectrum will be used in this guideline as a general term for the above three conditions*	Occurs when the placental tissue penetrates through the decidua basalis of the placenta and into the myometrium Placenta accreta- The chorionic villi adhere superficially to the myometrium, without interposing the decidua basalis Placenta increta- The chorionic villi penetrate deeply into the uterine myometrium down to the serosa Placenta percreta- The chorionic villous tissue perforates through the entire uterine wall and may invade the surrounding pelvic organs, such as the bladder.
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. Type 1- When the vessel is connected to a velamentous umbilical cord Type 2- When the vessel connects to the placenta with a succenturiate or accessory lobe

4.2 Major risk factors

The major risk factors for placenta praevia
History of praevia in a previous pregnancy
Previous caesarean delivery • This risk rises as the number of prior caesarean sections increases • 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
Assisted reproductive technology (ART)
Maternal smoking
Advanced maternal age has been associated with a slight increase in the risk but this effect may be due to parity

The major risk factors for placenta accreta spectrum
History of accreta in a previous pregnancy
Previous caesarean delivery • This risk rises as the number of prior caesarean sections increases • 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. 'The woman will be referred to her consultant to discuss the scan findings and the risks associated with placenta accreta, including the possibility of requiring a hysterectomy. The circumstances in which referral to a tertiary unit may be required should also be discussed. • The woman will be referred to her consultant clinic to discuss the scan findings and follow up plans
Other uterine surgery

4.3 Diagnosis of Placenta Praevia, Placenta accreta spectrum or Vasa praevia

Gestation	Scan
18-20+6 weeks	Placental localisation is a part of the anatomy ultrasound scan (USS) Placenta accreta screening in women with previous history of caesarean section/ previous uterine surgery
Third trimester	A repeat scan to check placental localisation should be performed at 32

	weeks, unless previous caesarean section when it should be performed at 28 weeks to allow more time for referral to a tertiary unit. Clinicians should be aware that Transvaginal Ultrasound Scan (TVS) for the diagnosis of placenta praevia or a low-lying placenta is superior to transabdominal and transperineal approaches and is safe.

When a diagnosis is made of placenta praevia, placenta accreta spectrum or vasa praevia please ensure the woman receives the RCOG leaflet Placenta praevia, placenta accreta and vasa praevia (Appendix 3).

NB clinical suspicions should be raised in women with painless unprovoked vaginal bleeding, an abnormal lie and a high presenting part particularly if USS has not been performed or has not excluded a placenta praevia.

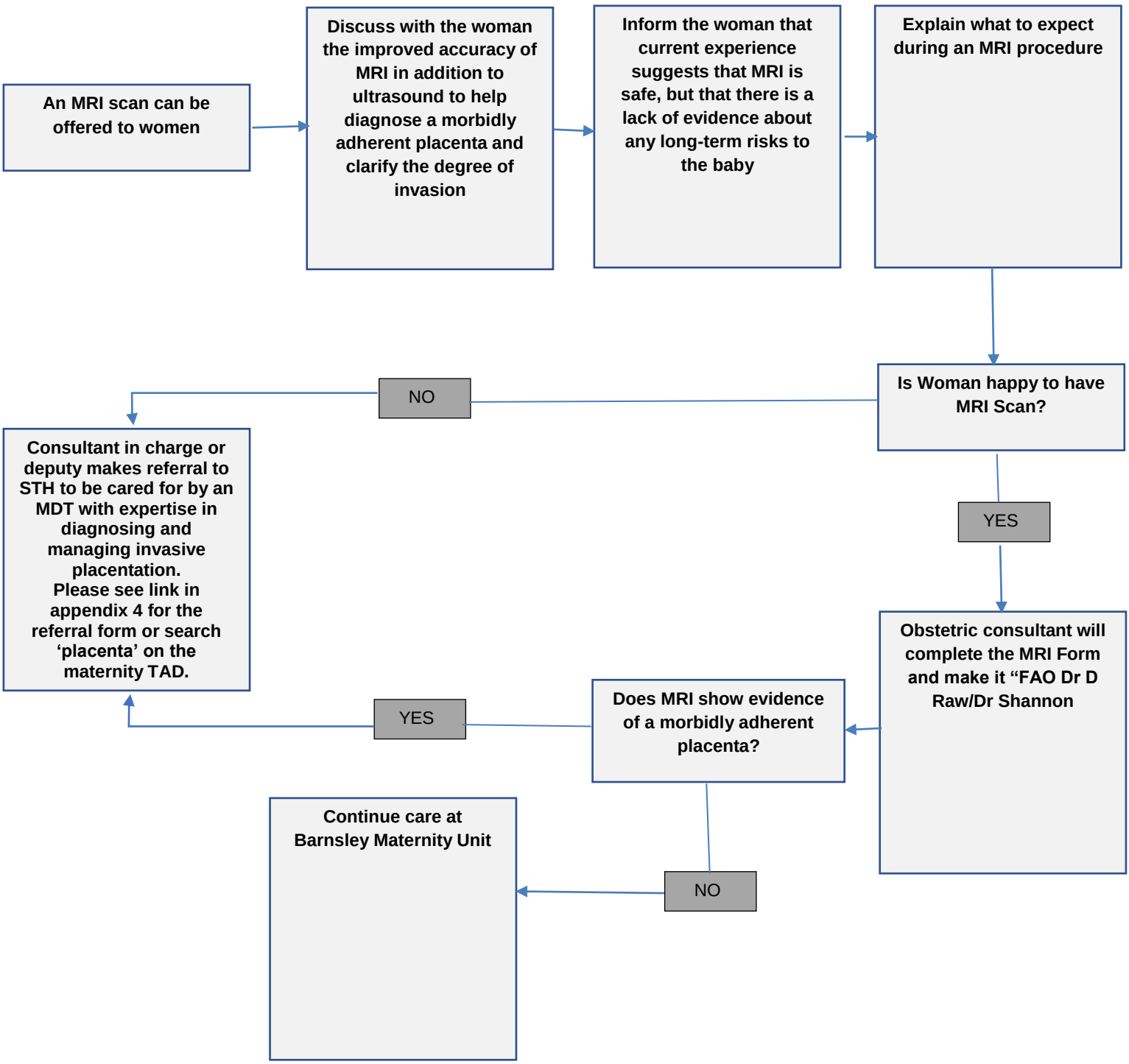
4.4 Antenatal management

Gestation	Placenta	Scan
28 weeks	If previous caesarean section and if the placenta lies anteriorly and reaches the cervical OS	Perform USS with colour flow Doppler to facilitate management and delivery planning
	If placenta covers or overlaps the OS at 18-20+6week scan	Perform USS
	If low lying placenta where the woman is asymptomatic	Perform USS under midwifery led care unless there are other indications to refer for shared care
	Placenta praevia where the woman is asymptomatic	USS with colour flow Doppler to facilitate management and delivery planning
	If suspected placenta accreta	
Around 36 weeks	If persistent low-lying placenta or placenta praevia at 32 weeks and the woman remains asymptomatic	An additional TVS is recommended to inform discussion about mode of delivery

4.4.1 Imaging

- Ultrasound imaging should be performed by a skilled operator with experience in diagnosing placenta accreta spectrum.
- Clinicians should be aware that the diagnostic value of Magnetic Resonance Imaging (MRI) and ultrasound imaging in detecting placenta accreta spectrum is similar when performed by experts. When arranging the MRI these should be marked for the attention of Dr Raw and Dr Shannon (consultant radiologists).
- 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.

4.4.2 Procedure where placenta accreta is suspected but not confirmed following USS



NB - Women with a previous caesarean section who have either a placenta praevia or an anterior placenta overlying an old caesarean section scar at 32 weeks are at risk of placenta accreta and therefore should be managed as if they have placenta accreta

4.4.3 Clinical settings and antenatal management

Antenatal management as outpatient	Antenatal management as Inpatient
If the woman is to be managed on an outpatient basis this should be based on individual circumstances such as her proximity to the hospital and support available at home The woman should be advised to attend the hospital immediately if she experiences bleeding, contractions or pain (including supra pubic period like aches).	If the woman is cared for as an inpatient then a management plan for the availability of blood products should be made in particular if the woman has atypical antibodies (in these cases discussions should involve the haematologist and blood bank).
Maternal anaemia should be monitored and managed in women with placenta praevia, morbidly adherent placenta and placenta praevia accreta	

4.4.4 Women with recurrent bleeding (low-lying placenta or placenta praevia)

- Women who experience vaginal bleeding will have an individual management plan agreed with their consultant according to their needs which will include delivery planning or conservative management.
- Antenatal care should be tailored to the woman's needs and consideration given to the following:

Considerations for individual antenatal management plans **Women with recurrent bleeding (low-lying placenta or placenta praevia)**
Hospitalisation, based upon individual needs and social circumstances - distance between home and hospital - availability of transportation
Previous bleeding episodes
Haematology laboratory results
Acceptance of receiving donor blood or blood products
Where hospital admission has been decided, an assessment of risk factors for venous thromboembolism in pregnancy should be performed. - This will need to balance the risk of developing a venous thromboembolism against the risk of bleeding from a placenta praevia or low lying placenta - Women who are hospitalised should be encouraged to mobilise, maintain hydration and wear anti-embolism stockings

Any woman being treated at home in the third trimester should be counselled to attend hospital immediately if she experiences: - Any bleeding, including spotting - Contractions - Pain, including vague suprapubic period-like aches

Considerations if conservative management is advocated
The consultant will discuss with the woman and decide whether inpatient or outpatient care is required
If the woman is managed as an outpatient she will require specific instructions/information regarding: • Lifestyle • Sexual Intercourse • Monitoring of fetal wellbeing • When to return to hospital
Conservative management of a placenta accreta in a woman who is bleeding is unlikely to be successful and will waste time Plans for delivery should be made – these will include where possible transfer to a tertiary unit

4.4.5 Use of tocolytics in women who bleed

- The decision to use tocolysis must be discussed with the obstetric consultant on call.
- Tocolysis for women presenting with symptomatic placenta praevia or a low-lying placenta may be considered for 48 hours to facilitate administration of antenatal corticosteroids.
- If delivery is indicated based on maternal or fetal concerns, tocolysis should not be used in an attempt to prolong gestation.

4.5 Delivery Planning

In cases of placenta praevia which persists into the third trimester counselling about the risks of preterm delivery and haemorrhage must be given, the woman and her partner should also be given the opportunity to discuss delivery including:

- Mode of delivery
- Indications for blood transfusion
- Hysterectomy

A plan of care will be developed considering the woman's wishes regarding management.

In cases of suspected placenta praevia accreta the woman should be reviewed by her Consultant obstetrician in the antenatal period where management options and risks will be discussed including:

- Skin and uterine incisions
- Conservative management of the placenta
- Hysterectomy
- Massive hemorrhage

4.5.1 Mode of Delivery

- Decisions regarding mode of delivery will be based on clinical judgment underpinned by sonographic evidence:
  - If the placental edge is less than 2 centimeters from the internal OS in the third trimester delivery by caesarean section is likely.
- A transvaginal scan may be indicated prior to elective surgery if the head has engaged to determine how far the lower edge of the placenta is from the internal OS (the lower segment continues to develop after 36 weeks).

4.5.2 Delivery Timing

Delivery timing should be tailored according to antenatal symptoms			
Antenatal symptoms	Women presenting with uncomplicated placenta praevia	Women presenting with placenta praevia or a low-lying placenta and a history of vaginal bleeding or other associated risk factors for preterm delivery	In women with placenta accreta spectrum presenting with absence of risk factors for preterm delivery
Administer steroids to all women if not had previously:			
Delivery timing	Between 37+0 and 38+0 weeks	Late preterm 34+0 to 36+6 weeks	Planned delivery at 35+0 to 36+6 weeks provides the best balance between fetal maturity and the risk of unscheduled delivery

4.5.3 Management of the delivery – Placenta praevia

Placenta praevia in women who have no previous history of caesarean section carries a risk of massive haemorrhage and hysterectomy.

Clinical setting	Delivery should be carried out in a unit with access to blood bank and high dependency care a home birth would therefore not be safe or appropriate
Consent	Consent for the operation should include discussions regarding risks of: - Caesarean section - Massive obstetric haemorrhage - Blood transfusion - Hysterectomy Any plans to decline blood or blood products should be discussed openly and documented.
Anaesthesia	Regional anaesthesia is considered safe and is associated with lower risks of haemorrhage than general anesthesia for caesarean delivery in women with placenta praevia or a low-lying placenta. Women with an anterior placenta praevia or a low-lying placenta should be advised that it may be necessary to convert to a general anaesthetic if required and consent should be gained for this.
Clinical personnel	A consultant obstetrician and a consultant anaesthetist should be present during a planned procedure. In an emergency, the consultants should be alerted with a view to attending as soon as possible. A junior doctor should not be left unsupervised and a senior experienced obstetrician should be scrubbed.

4.5.4 Management of the delivery – Placenta accreta spectrum

Clinical setting	Delivery should take place in a tertiary centre with logistic support for immediate access to blood products, adult intensive care unit and Neonatal Intensive Care Unit (NICU) by a multidisciplinary team with expertise in complex pelvic surgery. Consideration should be given to the woman regarding transfer to a unit where interventional radiology is performed especially if the woman refuses blood products.
Consent	Any woman giving consent for caesarean section should understand the risks associated with caesarean section in general and the specific risks of placenta accreta spectrum i.e. • Risk of massive obstetric haemorrhage • Increased risk of lower urinary tract damage • The need for blood transfusion • The risk of hysterectomy
Clinical Personnel - Multidisciplinary Team (MDT) review and plan	If the woman presents in labour an MDT review and plan will be required and should be managed using the following care bundle • A consultant obstetrician will plan and directly supervise the delivery • A consultant anaesthetist will plan and directly supervise the anaesthetic • Alert blood bank to ensure blood and blood products will be available • Pre-op planning will be multi-disciplinary • There will be facilities to provide level two or three care if required

4.5.5 Management of undiagnosed/ unsuspected placenta accreta spectrum

- The consultant obstetrician and anaesthetist should be contacted with a view to attending as soon as possible.
- In cases of placenta accreta the surgeon should consider opening the uterus at a site distant from the placenta and attempt to deliver the baby without disturbing the placenta.
- Cutting directly through the placenta is associated with increased bleeding and a higher risk of hysterectomy.

The following scenarios are possibilities:

1. Placenta separates	It should be delivered and any haemorrhage dealt with.
2. Placenta partially separates	The separated segments should be removed. Adherent portions can be left in place or hysterectomy can be considered. Please note these women are at particular risk of massive haemorrhage and should be managed accordingly.
3. Placenta fails to separate	It should be left in place. The uterus closed or a hysterectomy should be performed. This is less likely to cause blood loss than trying to separate it.

- 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
    - Adequate blood products are available
- This may involve closure of the maternal abdomen and urgent transfer to a specialist unit for delivery.

NB – in all cases the following management requirements should be met.

4.5.6 Expectant management (leaving the placenta in situ)

- Elective peripartum hysterectomy may be unacceptable to women desiring uterine preservation or it may be 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.

4.6 Postnatal Care

The woman will be nursed in the area most appropriate to her condition e.g. high dependency (HDU) or intensive care (ICU).

If the woman has a retained placenta:

- The woman will be warned about the risks of haemorrhage and infection (Prophylactic antibiotics may reduce the risk of infection)
- The woman will have serial serum Beta Human Chorionic Gonadotrophin (BHCG) measurements and follow up USS may also be considered

4.7 Debriefing

Postnatal follow-up must include debriefing which will include:

- An explanation of what happened, why it happened and any implications for future pregnancy or fertility
- Particularly in women where conservative treatment of placenta accreta spectrum has been successful, they should be informed of the risk of recurrence

4.8 Vasa Praevia

4.8.1 Vasa Praevia risk

The risk in ruptured vasa praevia is to the fetus as the mortality rate is at least 60% despite urgent caesarean delivery (RCOG 2018). The average blood volume for a fetus is 80-100mls/kg therefore loss of relatively small amounts of blood is significant.

- However, when diagnosed antenatally by USS and followed by a planned caesarean section the survival rate increases to 95%.

4.8.2 Diagnosis

Vasa praevia can be diagnosed using colour Doppler ultrasound on transvaginal scan but is not routinely screened for.
There is insufficient evidence to support universal screening for vasa praevia at the time of the routine fetal anomaly scan in the general population.
However, in a woman with antepartum bleeding and a risk of vasa praevia, USS should check for the possibility of vasa praevia. Diagnosis of vasa praevia needs to be confirmed in the third trimester as in some cases (especially with velamentous insertion of the cord) fetal vessels will move away from the internal os.

Although targeted 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.
In the intrapartum period, in the absence of vaginal bleeding it may be diagnosed by palpation of the fetal vessels in the membranes on vaginal examination. It can be confirmed by direct visualisation using an amnioscope.
Vasa praevia should be suspected if there is vaginal bleeding associated with membrane rupture and fetal compromise.

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

4.8.3 Management (when diagnosed antenatally)

USS	To avoid unnecessary anxiety, admissions, prematurity and caesarean section, it is essential to confirm persistence of vasa praevia by USS in the third trimester.
Timing of Delivery	Because of the speed at which fetal exsanguination can occur and the high perinatal mortality rate associated with ruptured vasa praevia, delivery should not be delayed while trying to confirm the diagnosis, particularly if there is evidence that fetal wellbeing is compromised. In the presence of confirmed vasa praevia in the third trimester, elective caesarean section should ideally be carried out prior to the onset of labour.
Hospitalisation	A decision for prophylactic hospitalisation from 30–32 weeks in women with confirmed vasa praevia should be individualised and based on a combination of factors, including multiple pregnancy, antenatal bleeding and threatened preterm labour.
Premature rupture of membranes and/or labour at viable gestational ages	In women with vasa praevia who develop premature rupture of membranes and/or labour at viable gestational ages, a caesarean section should be performed without delay.

4.8.4 Delivery (When vasa praevia confirmed)

- The ultimate management goal for confirmed vasa praevia should be to deliver before rupture of membranes whilst minimising the impact of iatrogenic prematurity.
- Based on available data, planned caesarean delivery for vasa praevia at 34–36 weeks is reasonable in asymptomatic women.
- Administration of corticosteroids for fetal lung maturity should be recommended from 32 weeks due to the increased risk of preterm delivery.

4.8.5 Management of women with undiagnosed vasa praevia at delivery

- Emergency caesarean section delivery and neonatal resuscitation, including the use of blood transfusion if required, are essential in the management of ruptured vasa praevia diagnosed during labour.
- Placental pathological examination should be performed to confirm the diagnosis of vasa praevia, in particular when stillbirth has occurred or where there has been acute fetal compromise during delivery.

5.0 Roles and responsibilities

5.1 Midwives

To work as part of a multi-disciplinary team in developing and executing management plans for women with placenta praevia, placenta praevia accreta and vasa praevia.
To refer to senior obstetricians when appropriate.

5.2 Obstetricians

To develop comprehensive management plans for pregnancy and delivery and convey to the multi-disciplinary team.

5.3 Paediatricians

To attend delivery when their presence is requested.

5.4 Anaesthetists

To attend when their presence is requested and provide anaesthesia to the women for operations and procedures as appropriate. To work as part of a multi-disciplinary team in developing and executing management plans for women with placenta praevia, placenta praevia accreta and vasa praevia.

6.0 Associated documents and references

RCOG (Royal College of Obstetricians and Gynaecologists) (2018) Placenta Praevia and Placenta Accreta: Diagnosis and Management. Green-top Guideline No. 27a
https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.15306

7.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

Any adverse incidents relating to the management of placenta praevia will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the governance midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for the management of placenta praevia, placenta praevia accreta and vasa praevia will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1
Equality Impact Assessment – required for policy only

Appendix 2
Glossary of terms

ART	Assisted reproductive technology
USS	Ultrasound Scan
TVS	Transvaginal Ultrasound Scan
MRI	Magnetic Resonance Imaging
NICU	Neonatal Intensive Care Unit
MDT	Multidisciplinary Team
BHCG	Beta Human Chorionic Gonadotrophin
CDI	Colour Doppler Imaging

Appendix 3

RCOG Placenta praevia, placenta accreta and vasa praevia information leaflet (2018)
https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-placenta-praevia-placenta-accreta-and-vasa-praevia.pdf

Appendix 4

Abnormally invasive placenta referral form.docx

Appendix 5 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	01/10/2020
Reviewed at Women's Business and Governance meeting	23/10/2020
Approved by CBU 3 Overarching Governance Meeting	24/02/2021
Approved at Trust Clinical Guidelines Group	25/03/2021
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	**Guideline**
Document title	**Guideline for the management of placenta praevia, placenta praevia accreta and Vasa praevia**
Document author (Job title and team)	**Birth Centre Lead obstetric consultant/ Guideline group**
New or reviewed document	**Reviewed**
List staff groups/departments consulted with during document development	**Consultant obstetricians, senior midwives**
Approval recommended by (meeting and dates):	**Maternity guideline group 01/10/2020** **Women's Services Business & Governance 23/10/2020** **CBU 3 Business and Governance meeting 24/02/2021**
Date of next review (maximum 3 years)	**24/02/2024**
Key words for search criteria on intranet (max 10 words)	**Placenta, praevia, accreta, vasa**
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	**Name: Charlotte Cole** **Designation: Practice Educator Midwife**

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU3 Business and Governance **Date approved: 24/02/2024** **Date Clinical Governance Administrator informed of approval: 25/08/2021** **Date uploaded to Trust Approved Documents page: 31/08/2021**