Royal Cornwall Hospitals
NHS Trust

Multiple Pregnancies Clinical Guideline

V4.1

March 2025

1. Aim/Purpose of this Guideline

1.1. To provide Midwives and Obstetricians with guidance on the management of multiple pregnancies during the antenatal and intrapartum period.

1.2. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

1.3. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Any multiple pregnancy carries increased risk compared to a singleton pregnancy. Dichorionic and monochorionic pregnancies share increased risk of pre-term birth, pre-eclampsia, fetal growth restriction and postpartum haemorrhage. Monochorionic pregnancies have the additional risk of twin-to-twin transfusion syndrome (TTTS) which requires screening during the pregnancy.

2.2. Ultrasound Diagnosis

Aim to determine the following in the same first trimester scan when crown–rump length measures from 45 mm to 84 mm (at approximately 11+0 weeks to 13+6 weeks):

- Gestational age (Use the largest fetal crown rump length (CRL)).
- Chorionicity (Refer to Section 2.3).

- Describe the position of each fetus in the uterus (upper/lower; left/ right). and assign the lower sac with respect to the cervix to fetus A and the higher sac fetus B. This should be documented in the Comments box of the Early Pregnancy Ultrasound on the Viewpoint database. Labelling should take place at all subsequent scans (see section 2.8.2).

- Placental sites and fetal positions should be documented at each scan. If the woman is aware of the fetal sex, this also should be documented in the same field 'e.g. presenting twin, cephalic, maternal right, male.' There will be times where localising the site of cord insertion is not possible. This can be documented that the cord insertion couldn't be visualised and isn't an indication for an earlier or additional scan (NEW 2024).

- Cord insertion should be attempted at the first routine second trimester scan (16/40 for MCDA twins, 20/40 for DCDA twins). Labelling with cord insertions may then continue with follow-up scans and should be documented if any uncertainty of labelling 'e.g. presenting twin, maternal right, cord insertion to right, male'(NEW 2024).

- Triplets or higher order multiple pregnancies should be referred urgently to the Fetal Medicine Unit (FMU) after the first scan at which the diagnosis is made (including referral from the Infertility Service).

- Families will receive information and counselling from a healthcare professional with experience of caring for women with multiple pregnancy prior to screening tests being performed. This includes first trimester combined screening.

2.3. **Chorionicity**

Determine Chorionicity using:

- Number of placental masses and the lambda or T-sign and/or membrane thickness.

- For women presenting after 14+0 weeks, use all of the above features and discordant fetal sex.

- Store an electronic image of the membrane attachment on InsightWeb.

- Obtain a second opinion from a trained midwife sonographer or consultant if there is any doubt about chorionicity, especially in cases where the first scan is performed after 14 weeks.

- If chorionicity is unable to be determined (for example, because the family have booked later in pregnancy) the pregnancy should be managed as a monochorionic pregnancy until proven otherwise.

2.4. Referral arrangements

- Once the diagnosis is made, the sonographer should refer to the multiple pregnancy service by email to rcht.multiplepregnancyservice@nhs.net. The appropriate antenatal multiple care pathway should be filed in the handheld notes. The multiple pregnancy information pack should be provided to the family.

- In monochorionic pregnancies if there is significant CRL, nuchal translucency (NT) or amniotic fluid discrepancy at 12 weeks potentially indicating early TTTS, the case should be discussed with an FM consultant.

2.5. Antenatal Care

2.5.1. Care will be shared between the RCHT multiple pregnancy service and the area community midwife team. The RCHT multiple pregnancy core team consists of their local area community midwife, named multiple pregnancy obstetricians, a multiple pregnancy specialist midwife, midwife sonographers and sonographers in clinical imaging.

2.5.2. The routine care provided to multiple pregnancies is outlined in the antenatal care pathway in Appendix 3 and Appendix 4. The schedule of appointments is a minimum standard for twin pregnancy and should be individualised in the presence of additional risks or complications.

2.5.3. Mode and timing of birth should be discussed. This should include the risks and benefits.

- All families with multiple pregnancies should be advised that birth should take place in the Delivery Suite.

- Admission should be arranged on clinical grounds as for singleton pregnancies.

- Timing for elective birth (induction or Caesarean Section) will be discussed in multiple pregnancy clinic by the team, though there may be indications for earlier birth due to pregnancy complications and these decisions may be made by the on-call team.

- Be aware of higher incidence of anaemia in women with twin and triplet pregnancies. Perform Full Blood Count (FBC) at 20-24 weeks to identify early supplementation with iron or folic acid. If Hb is below 120g/l above 20 weeks gestation, commence iron supplementation as per Anaemia: Diagnosis and Treatment throughout Pregnancy, Labour and Post-Partum Period Clinical Guideline (cornwall.nhs.uk).

2.5.4. The core team will consider whether any impending or established complications require additional multidisciplinary expertise. The on-call team may also consider involvement of these professionals. The following colleagues should be considered:

- Fetal Medicine Consultant.

- Maternal Medicine Consultant.

- Perinatal mental health professional.
- Wren team.
- Pelvic health physiotherapist.
- Infant feeding specialist midwife.
- Dietician.
- Anaesthetics.

2.6. **Hypertension**

Refer to the National Institute for Health and Care Excellence (NICE) Guideline on hypertension in pregnancy.

- Measure blood pressure (BP) and test urine for proteinuria at each appointment.
- Advise women with a multiple pregnancy to take 150mg of aspirin daily from 12 weeks until 36 weeks gestation (as it increases the risk of PPH after this gestation) if they have one or more of the following risk factors for pre-eclampsia or growth restriction:
  - First pregnancy.
  - ≥40 years at booking.
  - Pregnancy interval of more than 10 years.
  - Booking BMI ≥35.
  - Family history of pre-eclampsia.
  - Low PAPPA (<0.42 MoMs).
  - Maternal medical conditions* (e.g., hypertension (current/ past BP ≥140/90), chronic kidney disease, autoimmune disease (SLE, RA, APLS), diabetes).
  - Previous pregnancy hypertension.
  - Previous FGR (birth weight <3rd centile or evidence of placental dysfunction**).
  - Previous stillbirth if birth weight <10th centile or evidence of placental dysfunction**.
  - Previous preterm birth or loss 14w to 34w if birth weight <10th centile or evidence of placental dysfunction**.

*If conditions not listed and uncertain contact obstetrician.

**Check Maxims for letter with plan if unclear review past scans / placental histology / contact obstetrician.

2.7. Twin-to-twin transfusion syndrome (TTTS)

- Do not monitor for TTTS in the first trimester.
- If there are any signs of TTTS the follow up interval will be at the discretion of the FM Consultant.
- All women/people with a monochorionic twin pregnancy must be informed of the possibility of TTTS and the symptoms and signs to report as a matter of urgency (sudden increase in girth, abdominal pain, or tightening's). The woman should not be reassured by a recent normal scan or delay seeking help because a follow up scan is in the near future.
- The FM Consultant will liaise closely with tertiary centre FM colleagues in Bristol in any case that meets TTTS Quintero stage 1 or more.

2.8. Frequency of Antenatal Appointments

2.8.1. Monochorionic Diamniotic (MCDA) Twins

The schedule of antenatal appointments for MCDA twins can be found in the antenatal care pathway in Appendix 4.

2.8.2. Dichorionic Diamniotic (DCDA) Twins

The schedule of antenatal appointments for DCDA twins can be found in the antenatal care pathway in Appendix 3.

2.8.3. Monochorionic monoamniotic (MCMA) and conjoined twins and higher order multiples

Individualised care and scans led by Fetal Medicine Consultant.

2.9. Serial scans

2.9.1. Frequency and location

- DCDA: Every 4 weeks from 20 weeks. 20-week fetal anomaly Ultrasound Scan (USS) to be performed in local community area staffed by Main Department Sonographers. Ongoing serial scans to be performed in The Hub, RCHT by specialist midwife sonographers.
- MCDA: 2 weekly from 16 weeks in the Hub performed by specialist midwife sonographers. FM Consultants perform the anomaly scan and plan individualised care for potential and established TTTS.
- Higher order multiples: An individualised plan determined by FM consultant.

- Multiple pregnancies where scan findings indicate complications will have fetal medicine consultant led scans and have individualised decisions regarding additional Dopplers (e.g. middle cerebral artery and ductus venous Dopplers) (NEW 2024).

- DCDA growth scans to include liquor volume and placental site and fetal presentation for each twin. Perform umbilical artery pulsatility index (PI) and confirm positive end-diastolic flow at every scan after the 20-week scan. Mid-cerebral artery PI will be performed from 32 weeks gestation onwards if any scan findings suggest late fetal growth restriction. These should be documented on the scan report.

- MCDA growth scans to include liquor volume, assessment of the amniotic membrane (should be free-floating) and assessment of each fetal bladder (should be visible and normal size). Liquor volume and placental site and fetal presentation should be documented. Perform umbilical artery PI and confirm positive end-diastolic flow at every scan. Middle cerebral artery PI and PSV (peak systolic velocity) should be performed at every scan from 32 weeks onwards. These should be documented on the scan report.

- Cervical length scan will be offered between 16- and 20-weeks gestation in multiple pregnancy clinic for all people with a multiple pregnancy. If cervix found to be <25mm, vaginal progesterone 200mg will be offered once daily at bedtime (NEW 2024).

- A multi-professional discussion (involving at least two consultants with a special interest in preterm birth prevention or multiple pregnancy) will take place when the cervical length is less than 25mm. This will include a confirmed follow-up plan (e.g. reassessment in 2 weeks) and whether cervical cerclage will be offered. In the event of progressive shortening a re-discussion will occur (NEW 2024).

2.9.2. Documentation specific to multiple pregnancies:

- Label and document the fetuses on all scan Viewpoint database reports.

- All scans should be labelled as ‘Multiple Pregnancy’ with the correct chronicity and amnionicity. The reason for the scan should also be identified (e.g., growth).

2.9.3. Calculate Estimated Fetal Weight (EFW) discordance on every scan from 20 weeks:

- A discordance of 20% or greater or EFW or AC under the 10th centile should prompt a fetal medicine consultant holistic assessment of the pregnancy including the other scan findings and consideration of best place to continue their scans (multiple pregnancy clinic or fetal medicine). In these circumstances with no other scan concerns MCDA twins will be followed up weekly, and DCDA twins weekly or fortnightly, depending on the global assessment. If the gestation is 32 weeks or more, then Mid – Cerebral Artery pulsatility Index (MCA PI) in addition should be measured. If it is chosen to follow-up these cases in multiple pregnancy clinic, the consultant should be in attendance for the scan (NEW 2024).

- An EFW discordance of 25% or greater should be discussed with a fetal medicine consultant, and follow-up arranged in a consultant fetal medicine clinic. These cases should be referred to a tertiary level fetal medicine centre. If referral is declined, then a discussion should occur with a tertiary fetal medicine centre.

- An EFW discordance is achieved by calculating the difference in the EFW between the twins and dividing by the larger EFW. Viewpoint can be relied on for the calculation of fetal discordance.

2.9.4. A consultant opinion from a tertiary level fetal medicine centre should be sought for:

- Pregnancies with a shared amnion.
- EFW discordance of 25% or more.
- Fetal anomaly (chromosomal or structural).
- Discordant fetal death.
- TTTS.
- Twin reverse arterial perfusion sequence (TRAP).
- Suspected Twin anaemia polycythemia sequence (TAPS).

2.10. **Counselling and information**

- Information will be shared with opportunities for counselling and discussion at every appointment in the multiple pregnancy clinic and with the multiple pregnancy specialist midwife.

- The main obstetric elements of this information and counselling are outlined in ‘Information and counselling’ in the multiple pregnancy care pathway – see Appendix 3 and Appendix 4. This list is not exhaustive and specific discussions will be documented in the electronic record. This information will include the specific risks to mother and fetus in a multiple pregnancy but will be shared in a sensitive and balanced manner.

- The multiple pregnancy information pack, once available, will also provide written information about multiple pregnancy, the care pathway, and potential complications and risks.

2.11. Birth

2.11.1. Families should be appropriately informed that with a twin pregnancy, 60 out of 100 pregnancies result in spontaneous birth before 37 weeks of gestation. With a triplet pregnancy, about 75 out of 100 pregnancies result in spontaneous preterm birth before 35 weeks of gestation.

2.11.2. Explain that spontaneous preterm birth in multiple pregnancies is associated with a higher chance of admission to the neonatal unit.

2.11.3. Where labour occurs or birth is planned preterm then the multiple pregnancy obstetric consultant or on-call obstetric team should liaise with the neonatal team. Families should be offered neonatal counselling, if possible, prior to preterm birth.

2.11.4. Explain to families who are expecting DCDA twins that planned birth from 37+0 weeks gestation does not appear to be associated with increased chance of severe neonatal adverse outcomes AND that continuing the pregnancy beyond 37+6 increases the chance of IUD.

2.11.5. Offer planned birth at 37 weeks gestation for women with an uncomplicated DCDA twin pregnancy.

2.11.6. Offer planned birth at 36 weeks gestation for women with uncomplicated MCDA twin pregnancy.

2.11.7. Offer planned birth between 32+0 and 33+6 for women with an uncomplicated MCMA twin pregnancy.

2.11.8. Triplet pregnancies should be offered elective caesarean birth from 35 weeks after a course of maternal antenatal steroids.

2.11.9. If CS birth is planned before 37 weeks, then a discussion should be had with the woman/person about the potential benefits/risks for maternal steroids for fetal lung maturation, and the lack of evidence specific to multiple pregnancy.

2.11.10. Women who decline birth at the recommended timing should be offered a weekly scan and consultant review.

2.12. Mode of birth

2.12.1. Monochorionic diamniotic and dichorionic diamniotic

2.12.1.1. Families with an uncomplicated DCDA or MCDA twin pregnancy should be advised that planning a vaginal birth or elective caesarean birth are both safe options provided all of the following apply:

- There have been no additional risk factors.

- The pregnancy has progressed beyond 32 weeks of gestation.
- There are no obstetric contraindications to labour.
- The presenting fetus is in a cephalic presentation.
- There is not a significant EFW discordance between the twins.

2.12.1.2. Families planning a vaginal birth should be informed that:

- Over a third of families planning a vaginal birth have a caesarean birth.
- A small number of people who have a vaginal birth with the presenting baby go on to have an unplanned emergency caesarean birth for their second baby.

2.12.1.3. Families planning a caesarean birth should be informed that:

- Almost all people who plan to have an elective caesarean birth go on to have one, however a few women go on to have a vaginal birth before the planned elective caesarean date.

2.12.1.4. Caesarean birth should be offered to women/people in spontaneous labour from 26 weeks if the first twin is not cephalic.

2.12.1.5. Mode of birth should be assessed on individual circumstances for women in preterm spontaneous labour before 26 weeks. Risks of caesarean birth and chance of survival of babies should be taken into account.

2.12.2. Monoamniotic Monochorionic

Offer a caesarean section to families with monoamniotic monochorionic twin pregnancy at the time of planned birth between 32+0 and 33+6 weeks of gestation. Caesarean birth should be recommended sooner if clinically indicated based on individual circumstances. Caesarean birth should be considered in the case of preterm spontaneous labour if gestational age suggests reasonable chance of survival unless presenting twin is close to vaginal birth; this should be at the advice of a senior obstetrician.

2.12.3. Triplet pregnancy

Caesarean section should be recommended to families with triplet pregnancy at the time of planned birth (35 weeks) or after if any individual clinical complications indicate earlier timing of birth. In the case of established preterm spontaneous labour and gestational age suggests reasonable chance of survival of the babies, caesarean birth should be recommended.

2.13. Intrapartum Management

2.13.1. Management of First Stage of Labour

2.13.1.1. Refer to Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline V3.0 (cornwall.nhs.uk)

2.13.1.2. CTG should be offered for all multiple pregnancies in labour from 26w0d. There will be some circumstances where monitoring is not possible (e.g., raised BMI and early gestation) and in these circumstances an obstetric review should be sought. In these circumstances a CTG trace with much loss of contact may still be beneficial overall. There may be circumstances where CTG continuous monitoring is not appropriate (e.g., If there is an agreed neonatal plan for comfort care with no resuscitation).

2.13.1.3. Continuous electronic fetal monitoring (EFM) of both twins and maternal pulse oximetry is required. See Intrapartum Continuous Electronic Fetal Monitoring (CEFM) and ST Analysis Clinical Guideline V1.1 (cornwall.nhs.uk).

2.13.1.4. Bedside ultrasound should be performed at the beginning of labour to establish fetal position and confirm both fetal heart rates.

2.13.1.5. Obtaining IV access at the beginning of labour is recommended. At this point, an FBC and G+S should be taken.

2.13.1.6. It should be very clearly marked on the EFM trace which is Twin 1 (anticipated to be first born) and which is Twin 2, and this should remain consistent throughout labour.

2.13.1.7. Refer to the scan report for identification of Twin A and Twin B. It should be noted at the onset of labour which twin (A or B) corresponds to Twin 1 / Twin 2 and documented in the notes.

2.13.1.8. There should be early recourse to the use of a fetal scalp electrode on Twin 1 to enable ST analysis to aid CTG interpretation of that twin and to aid separate identification of the two fetal hearts.

2.13.1.9. The use of an oxytocin infusion requires the same care and indications as for singleton pregnancy.

2.13.1.10. Epidural analgesia should be offered to people with a multiple pregnancy opting for a vaginal birth. They should be advised that epidural is likely to improve the chance of optimal timing of assisted vaginal birth if this is required. It may also enable a quicker birth by emergency caesarean if this is indicated. It would also enable adequate analgesia if internal version were indicated.

2.13.1.11. Abnormal EFM changes for the first twin should be managed using ST analysis as for a singleton. The whole clinical picture should be taken into account.

2.13.2. Management of Second Stage of Labour

2.13.2.1. Refer to Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline V3.0 (cornwall.nhs.uk)

2.13.2.2. The management of the second stage of labour for the first twin should not deviate from that outlined for a singleton pregnancy – except that the whole delivery is led by an experienced obstetrician who remains present in the room or immediately available throughout the second and third stage.

2.13.2.3. The resuscitaire's should be prepared and the on-call ANNP/ST for neonatology should be informed when the woman achieves full cervical dilatation/begins active pushing.

2.13.2.4. The on-call anaesthetist should also be alerted.

2.13.3. After Delivery of the First Baby

2.13.3.1. DCDA twins: delayed cord clamping ≥60s for both twins as routine– and ensure clear identification of the first twin cord.

2.13.3.2. MCDA twins:

There is no clear evidence of the optimal management with regards to timing of cord clamping in MCDA twins. There is a small risk of interfetal transfusion (and this is greater in the event of compromise of either/both twins). Evidence is limited to allow this risk to be quantified. Evidence from preterm singletons however has indicated that optimal cord clamping has multiple benefits, reduces the risk of hospital mortality, and reduces the risk of neonatal blood transfusion. Given this, cord clamping timing can be individualised. The risk of acute interfetal transfusion is likely higher in the event of CTG concerns or scan concerns (e.g. EFW discordance >20%, TTTS) and in these situations early cord clamping should be considered.

2.13.3.3. Palpate the maternal abdomen.

2.13.3.4. Ensure a longitudinal lie (confirm with ultrasound if any doubt).

2.13.3.5. Oxytocin infusion should be commenced and titrated as per the attending obstetrician. It is appropriate to titrate this at shorter intervals compared to oxytocin in the first stage.

2.13.3.6. Alert: The maternal contractions may cease after the first delivery. Studies have shown that a longer inter twin interval is associated with a lower arterial cord gas. The maternity team should recommend oxytocin if there is inadequate uterine activity after the first twin's birth and strongly recommend if 20 minutes has already passed.

2.13.3.7. Twin 2 should be closely monitored with CTG throughout the second stage.

2.13.3.8. A vaginal examination should be performed to check the presenting part is entering the pelvis. Membranes must NOT be ruptured until the presenting part is within the pelvis.

2.13.3.9. If twin 2 is not longitudinal, abdominal palpation will determine the appropriateness of external version to cephalic or breech. If this is unsuccessful, consideration should be given to internal podalic version and breech extraction.

2.13.3.10. Standard management of second stage, but with low threshold for assistance.

2.13.3.11. Following the birth of all babies, consider double clamping the cord to enable umbilical gases to be sampled. Ensure samples are correctly labelled for each baby.

2.13.3.12. If Twin 2 is born more than 15 minutes after Twin 1 – note that cord gases will be unreliable after this time and should not be taken.

2.13.4. Management of Third Stage of Labour

- Refer to ThirdStageofLabourClinicalGuideline.pdf (cornwall.nhs.uk)

- Families with multiple pregnancy should be advised to have an active management of the third stage of labour.

Alert: Syntometrine should only be given following the birth of the 2nd twin.

- 40IU Oxytocin in 500ml Normal Saline at a rate of 125mls per hour to run over 4 hours can be offered (esp. if additional risk factors for PPH) because of the increased risk of postpartum haemorrhage. Otherwise, management follows standard guidance.

2.14. **Documentation**

Complete a Twin Vaginal Delivery Proforma and/or a Caesarean Section Proforma depending upon the mode of delivery.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	The audit will take into account record keeping by Obstetricians, Midwives, and other Allied Health Professionals.
Lead	Multiple Birth Specialist Midwife/Audit Midwife.
Tool	• Has the Information and Counselling checklist been completed? • Has it been documented that information has been provided to the woman on the risks and benefits of different modes of delivery? • Has a plan been documented to agree the timing and place of birth? • Was it clearly identified on the EFM trace which was Twin 1 and which was Twin 2? • Was a suitably experienced Obstetrician available/present during the second stage, delivery and third stage of labour? • Following delivery of the first twin was the lie of the second twin clearly identified? • Following the birth of the 1st twin was oxytocin commenced or a rationale documented if not commenced? • Following the birth of Twin 2 was a oxytocin infusion commenced?
Frequency	1% or 10 sets, whichever is the greater, of all health records of women who have had multiple births (of which at least half are vaginal births), will be audited over the lifetime of the guideline or earlier if indicated.
Reporting arrangements	Audit Review Team (ART).
Acting on recommendations and Lead(s)	• Any deficiencies identified during the audit they will be discussed at the Maternity Patient Safety Management Meeting and an action plan developed. • Action leads will be identified and a time frame for the action to be completed. • The action plan will be monitored by the Multiple pregnancy specialist Midwife until all actions complete.
Change in practice and lessons to be shared	• Patient Safety Management Newsletter. • ART.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Multiple Pregnancies Clinical Guideline V4.1
This document replaces (exact title of previous version):	Multiple Pregnancies Clinical Guideline V4.0
Date Issued/Approved:	March 2025
Date Valid From:	March 2025
Date Valid To:	May 2027
Directorate / Department responsible (author/owner):	Lucy Wolfendale, Multiple Pregnancy Specialist Midwife
Contact details:	01872 25 2729
Brief summary of contents:	To provide Midwives and Obstetricians with guidance of the management of multiple pregnancies in the ante natal and intrapartum period.
Suggested Keywords:	Multiple pregnancy, In utero, Transfer, Twin.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Tamara Thirlby
Links to key external standards:	None Required

Information Category	Detailed Information
Related Documents:	• Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline V3.0 (cornwall.nhs.uk) • ThirdStageofLabourClinicalGuideline.pdf (cornwall.nhs.uk) • RCOG Green top Guideline No 51 • Sepulveda W, Sebire NJ, Hughes K, Odibo A, Nicolaides KH. Thelambda sign at 10–14 weeks of gestation as a predictor of chorionicity in twin pregnancies(1996) Ultrasound Obstet Gynecol 7:421-3. • Quintero RAM. Stage-based treatment of twin-twin transfusion syndrome (2003) Am J Obstet Gynecol 188:1333–40. • NICE (2019) Clinical Guideline Twin and triplet Pregnancy.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical/Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
2006	V1.0	Initial Issue.	Mr Jones, Consultant Obstetrician
November 2010	V1.1	Addition of ante natal management.	Mr Jones, Consultant Obstetrician
February 2012	V1.2	Updated in line with NICE guidance.	Dr Karen Watkins, Consultant Obstetrician

Date	Version Number	Summary of Changes	Changes Made by
September 12	V1.3	Changes to compliance monitoring tool only.	Dr Karen Watkins, Consultant Obstetrician
20 October 2015	V1.4	Minor changes only.	Dr Karen Watkins, Consultant Obstetrician
17 May 2018	V2.0	Updates to 2.2, 2.3, 2.4, 2.5, 2.7, 2.8, 2.9, 2.10, 2.11, 2.12, 2.14 see new 2018 in body of text.	Dr Rob Holmes, Obstetric Consultant
September 2019	V2.1	2.6.1 Addition to state that the BMI score must be based upon the measurement of BMI at the dating scan.	Sarah-Jane Pedler, Practice Development Midwife
February 2022	V3.0	Full review and update. Aspirin dose changed to 150mg to align with national agenda., low PAPPA and history of fetal growth restriction added to criteria. Wording of Feto Fetal Transfusion Syndrome to Twin-Twin Transfusion Syndrome. Contraindication of delayed cord clamping in MCDA twins. Removal of 2.14.	Rob Holmes, Obstetric Consultant
May 2024	V4.0	Full update in line with national guidance and new multiple pregnancy specialist team.	Lucy Wolfendale, Multiple Pregnancy Specialist Midwife
March 2025	V4.1	Additions to 2.2, 2.91 and 2.9.3	Lucy Wolfendale, Multiple Pregnancy Specialist Midwife

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Multiple Pregnancies Clinical Guideline V4.1
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Catherine Wills, Practice Development Midwife.
Contact details:	01872 255019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To provide Midwives and Obstetricians with guidance of the management of multiple pregnancies in the ante natal and intrapartum period.
2. Policy Objectives	To ensure multiple pregnancies are managed as per NICE evidence-based guidance.
3. Policy Intended Outcomes	Safe delivery of multiple pregnancies.
4. How will you measure each outcome?	Audit Midwife will audit compliance with guideline.
5. Who is intended to benefit from the policy?	All pregnant women with a multiple pregnancy.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group.
6c. What was the outcome of the consultation?	Guideline agreed.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, Practice Development Midwife.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Antenatal Care Pathway – DCDA Twins

CHA4883: Antenatal Care Pathway - DCDA Twins

Appendix 4. Antenatal Care Pathway – MCDA Twins

CHA4884: Antenatal Care Pathway - MCDA Twins