Appendix A – Public Health Intelligence Request

Request Number (please quote for further queries)	PHIR-2013-0006
Request from	Andrew Charlwood Overview & Scrutiny Manager Assurance Directorate Barnet Council
Request Date	8th April 2013
Details of request	Maternity Services (Caesarean Births) To consider a report from the Director of Public Health on caesarean births to include detail on: comparative London statistics; any abnormal trends; and reasons for inductions (local and national)
Response by	Carole Furlong

Summary

The data on caesarean section shows that rates in Barnet are slightly higher in the two local NHS hospital Trusts that serve Barnet than the national rate. The national guidelines introduced in 2011 mean that actions to interventions aimed at reducing the number of caesarean births are limited as women have the right to make an informed choice about whether to have a caesarean section or not. Available data does not identify the reason for planned caesarean sections.

Data on induction of the start of labour are unreliable and no conclusion can be drawn from them.

Caesarean Section - definition

Caesarean section (CS) is a surgical operation in which in which an obstetrician makes an incision through a woman's abdomen and uterus to deliver her baby. CS may be planned (elective) where there is a known risk e.g if the baby is in a position that makes normal delivery problematic or unplanned (emergency or non-elective) where a complication arises either during the pregnancy or during labour.

National Guidelines

The National Institute for Health and Clinical Excellence (NICE) has developed guidelines (CG132) to help ensure consistent quality care for women who:

- have had a caesarean section (CS) in the past and are now pregnant again or
- have a clinical indication for a CS or
- are considering a CS when there is no other indication.

These guidelines provide evidence-based information for healthcare professionals and women.

The guidelines do not cover the risks and benefits of caesarean section when it is used for specific medical conditions that arise during pregnancy, such as pre-eclampsia, where the mother or baby have a rare or complex condition such as a severe heart condition or any extra care that might be needed if mother or baby develop specific medical conditions in the course of the pregnancy or labour.

The guidelines say that women considering a CS should be information about risk (see Fig 1)

Figure 1 Planned caesarean section compared with planned vaginal birth for women with an uncomplicated pregnancy and no previous caesarean section

Planned caesarean section may reduce the risk of the following in women:

- perineal and abdominal pain during birth and 3 days postpartum
- injury to vagina
- early postpartum haemorrhage
- obstetric shock.

Planned caesarean section may increase the risk of the following in babies:

- neonatal intensive care unit admission.

Planned caesarean section may increase the risk of the following in women:

- longer hospital stay
- hysterectomy caused by postpartum haemorrhage
- cardiac arrest.

The NICE guidelines were updated in 2011 and now include guidance on maternal requests for CS. The guidance states that

- When a woman requests a CS because she has anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help her address her

anxiety in a supportive manner.
- If after this discussion and offer of support (whether the offer was taken up or not), a vaginal birth is still not an acceptable option, offer a planned CS.
- If the obstetrician is unwilling to perform a CS, they should refer the woman to an obstetrician who will carry out the CS.

Implication of the guidance
The NICE guidelines mean that previous attempts by commissioners to limit the number of caesarean sections due to personal preference are no longer possible. A woman has the right to choose to have her baby by CS if she understands the risks and is making an informed choice.

Birth data – availability and limitations of data

This report has been compiled using the publicly available data as the Public Health Intelligence team do not currently have access to the maternity episodes files. These data are available to the Barnet Clinical Commissioning group through the North East and Central London Commissioning Support Unit. The nationally published data is by provider rather than commissioner grouping. The CSU should be able to extract and analyse this data for maternity episodes of women registered with Barnet GPs and possibly for those resident in Barnet.

As the data is by provider Trust, where there are multiple maternity units within the Trust, data is amalgamated. For example, the data for Barnet and Chase Farm Hospitals will include both the Barnet Consultant-led services and the Chase Farm consultant-led services as well as the birthing centres and midwifery led services.

Without access to the case level data, we have made an assumption that the majority of women in Barnet give birth in one of two hospital Trusts: Barnet and Chase farm NHS Trust and The Royal Free Hospital NHS Trust. The following information is based on the available data for these two trusts with comparator data for all Trusts in London and the England average. A summary of all routinely available statistics for the local trusts and for London is included in the appendix.

Rate of Caesarean Section Births

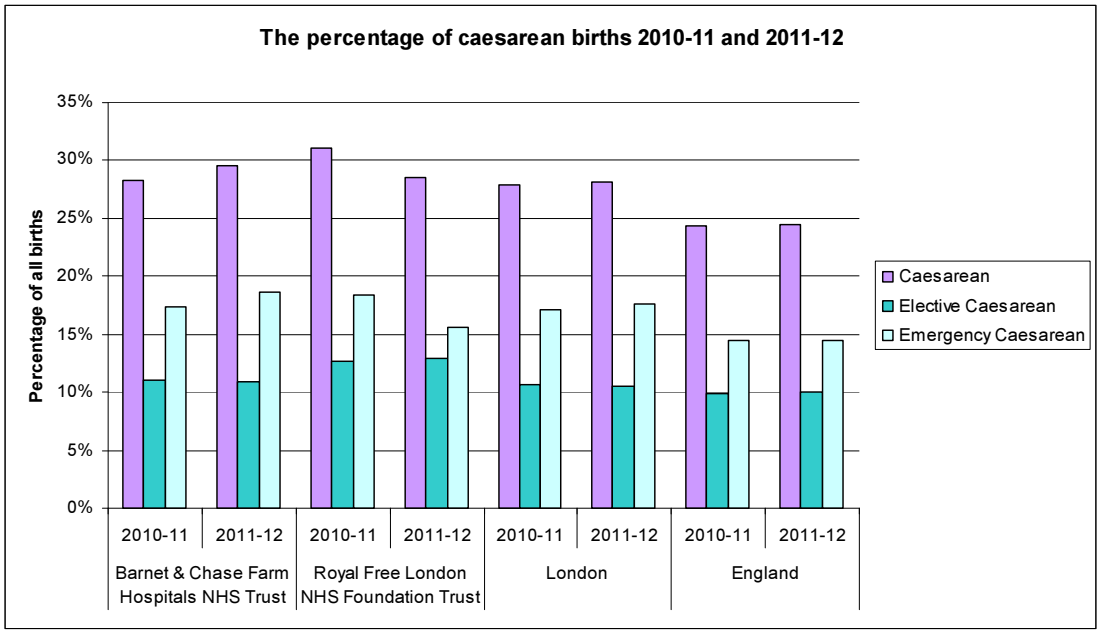
Across England 24.5% of births are by caesarean section, with 10% being elective (planned) and 14.5% emergency. The total CS rates in London are

around 3% higher than those for England as a whole. This is almost all due to a higher rate of emergency CS.

In both of the individual Trusts the rates are higher than those for London as a whole. In the Royal Free, the rates of both elective and emergency CS were higher than London. There was a drop in the rate of emergency CS in the Royal Free between 2010-11 and 2011-12 which was due to reduced number of emergency CS. This coincides with a drop in the total births in the Trust and suggests a change in referral patterns rather than in Trust practice.

In Barnet and Chase Farm, the rates of elective CS was slightly higher than those seen nationally but there was a 4% higher rate of emergency CS which had increased from the 2010-11 rate.

The following table shows that the rate of caesarean births occurring in the two named Trusts, London as a whole and England as a whole.



The data we have available does not give reasons for either the elective or the emergency CS. This analysis would need to be requested from the CCG and/or individual Trusts.

Induction – Definition and guidelines

Induction is a method of artificially starting labour. There are NICE guidelines concerning induction (CG70) It may be offered or recommended to women for a number of reasons but the most common is that the pregnancy is overdue

(usually over 41 or 42 weeks). Other reasons include

- If the membrane have ruptured (waters broken) but spontaneous labour hasn't started within a day or so. This can lead to increased risk of infection;
- If the woman has a medical condition requiring early labour e.g. due to diabetes or an acute condition, such as pre-eclampsia or kidney disease, that threatens either the woman's or the baby's health;
- Occasionally, personal reasons can be considered e.g. if a partner in the armed forces is due to be posted abroad and would otherwise miss the birth; or
- If the woman is concerned about complications or has had a previous baby that was stillborn

Induction often results in a more painful labour with a higher chance the need for intervention e.g. forceps or ventous.

NICE recommends membrane sweeping (detaching the membranes from the cervix) to promote spontaneous labour. If labour does not start, vaginal prostaglandin E2 (PGE2) is recommended. Surgical rupture of the membranes and intravenous syntocin are not recommended as first line treatments unless there are contraindications.

Local and National Data

The available data is again at NHS Trust level. The summary data gives the method of onset of labour but does not give a cause for those that were induced. The table below shows that spontaneous labour was the most common onset. With the local Trusts having higher rates than those of London or England as a whole. However, this data is incomplete. Nationally, 10% of electronic records submitted to the NHS Information Centre do not specify the method of onset of labour. The data for Barnet and Chase Farm hospitals appears to show that one fifth of labours were surgically induced and none medically induced. Similarly, the Royal Free appears to have one sixth of births both surgically and medically induced. A quick look at other Trust in England shows that this is a problem of coding. The data on method of induction must be considered unreliable. Although the rate of total inductions is probably correct no further inference can be made.

Method of onset of labour	Barnet and Chase Farm		Royal Free		London		England	
Spontaneous	65%	64%	69%	69%	58%	59%	59%	59%
Caesarean	16%	15%	13%	14%	10%	11%	10%	11%
Surgical Induction	20%	20%	**	<1%	3%	3%	4%	4%

Medical Induction	0%	0%	**	<1%	10%	10%	10%	11%
Surgical and Medical Induction	0%	0%	17%	16%	3%	3%	5%	5%
Total Inductions	20%	20%	17%	17%	16%	16%	19%	19%
Unknown	<1%	<1%	<1%	1%	16%	12%	12%	10%

The CCG could be asked to report on this but given the apparent poor quality of the data, it is unlikely that it would provide any more information. The individual Trusts could be asked about induction and the reasons for it but looking at the information we have, it is unlikely that this would uncover any systematic problems.

Annex

Barnet and Chase Farm Hospitals NHS Trust

In 2011-12

- There were 6,493 recorded deliveries representing a decrease of 300 from the previous year (2010-11), when there were 6,793 deliveries.
- 3,883 (66.2%) women have their first antenatal assessment within 10 - 14 weeks of gestation where this date is known and data is available; 624 (9.6%) women had their first antenatal assessment within an unknown time period.
- 3,664 (62.4%) were seen for their first antenatal assessment within 12 weeks of gestation, where this date is known and data is available.
- The 38 - 40 weeks gestation length group has the highest number of deliveries 4,712 (76.0% where known). Gestation length is unknown for 294 (4.5%) deliveries.
- Spontaneous onset accounts for the greatest percentage of deliveries, representing 4,155 (approximately 64.2% where the method of onset is known). 24 (0.4%) deliveries had an unknown method of onset.
- Where known, there were 1,317 deliveries where the method of onset of labour was induction (approximately 20.4%).
- The greatest percentage of deliveries have a spontaneous method of delivery, representing 3,727 (approximately 57.9% where known). Caesareans account for 1,921 (approximately 29.9%) deliveries where the delivery method is known.
- Of the 3,727 deliveries where the method of delivery was spontaneous; 305 (8.2%) involved an episiotomy.

Royal Free London NHS Foundation Trust

In 2011-12

- There were 3,070 recorded deliveries representing a decrease of 105 from the previous year (2010-11), when there were 3,175 deliveries.
- 1,511 (55.2%) women have their first antenatal assessment within 10 - 14 weeks of gestation where this date is known and data is available; 331 (10.8%) had their first antenatal assessment within an unknown time period.
- 1,856 (67.8%) were seen for their first antenatal assessment within 12 weeks of gestation, where this date is known and data is available.
- The 38 - 40 weeks gestation length group has the highest number of deliveries 2,146 (70.6% where known). Gestation length is unknown

for 31 (1.0%) deliveries.

- Spontaneous onset accounts for the greatest percentage of deliveries, representing 2,117 (approximately 69.4% where the method of onset is known). 19 (0.6%) deliveries had an unknown method of onset.
- Where known, there were 518 deliveries where the method of onset of labour was induction (approximately 17.0%).
- The greatest percentage of deliveries have a spontaneous method of delivery, representing 1,778 (approximately 58.2% where known). Caesareans account for 875 (approximately 28.6%) deliveries where the delivery method is known.
- Of the 1,778 deliveries where the method of delivery was spontaneous; 146 (8.2%) involved an episiotomy.

London Strategic Health Authority

In 2011-12

- There were 128,320 recorded deliveries representing a decrease of 4,133 from the previous year (2010-11), when there were 132,453 deliveries.
- 53,663 (54.6%) women have their first antenatal assessment within 10 - 14 weeks of gestation where this date is known and data is available; 30,091 (23.4%) had their first antenatal assessment within an unknown time period.
- 66,416 (67.6%) were seen for their first antenatal assessment within 12 weeks of gestation, where this date is known and data is available.
- The 38 - 40 weeks gestation length group has the highest number of deliveries 73,209 (65.5% where known). Gestation length is unknown for 16,496 (12.9%) deliveries.
- Spontaneous onset accounts for the greatest percentage of deliveries, representing 75,667 (approximately 67.3% where the method of onset is known). 15,895 (12.4%) deliveries had an unknown method of onset.
- Where known, there were 22,313 deliveries where the method of onset of labour was induction (approximately 19.8%).
- The greatest percentage of deliveries have a spontaneous method of delivery, representing 72,812 (approximately 57.5% where known). Caesareans account for 36,051 (approximately 28.5%) deliveries where the delivery method is known.
- Of the 72,812 deliveries where the method of delivery was spontaneous; 6,826 (9.4%) involved an episiotomy.