NHS
Somerset
Clinical Commissioning Group

PLANNED ELECECTIVE CAESAREAN SECTION CRITERIA BASED ACCESS (CBA) POLICY

Version:	1819 v2
Recommendation by:	Somerset CCG Clinical Commissioning Policy Forum (CCPF)
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Target audience:	**SCCG**: • NHS Providers • GP Practices • Contracts Team **Medical Directors:** • Taunton & Somerset NHS FT • Yeovil District Hospital NHS FT • Royal United Hospitals Bath NHS FT • Somerset Partnership NHS FT
Application Form	EBI Generic application form if appropriate Consultant to apply

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VERSION CONTROL

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DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1819 v1	February 2019	CEC amended layout & wording inclusion of Consultant to apply for EBI, name change from IFR to EBI

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	N/A
Quality Impact Assessment QIA. Date:	January 2019
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1 GENERAL PRINCIPLES (CBA)

1.1 Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the CCG's Evidenced Based Interventions Panel (EBIP) by submission of an EBI application

1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment

1.3 Treatment should only be undertaken where the criteria have been met and there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment

1.4 Referring patients to secondary care without them meeting the criteria or funding approval having been secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment

1.5 On limited occasions, the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy

1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment

1.7 The CCG does not commission surgery for cosmetic purposes alone

1.8 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.9 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 POLICY - CRITERIA BASED ACCESS

2.1 Planned Elective Caesarean is routinely commissioned when clinically indicated **except** for conditions listed below:

2.2 Planned Elective caesarean section (CS) is not routinely commissioned on the grounds of HIV status to prevent mother-to-child transmission of HIV to:

- Pregnant women on highly active anti-retroviral therapy (HAART) with a viral load of less than 400 copies per ml **OR**
- Pregnant women on any anti-retroviral therapy with a viral load of less than 50 copies per ml

2.3 Planned Elective caesarean section (CS) is not routinely commissioned for pregnant women with conditions listed below:

2.3.1 with 'small for gestational age' babies (NICE 1.2.4) (unless a specific clinical concern is identified)

2.3.2 with otherwise uncomplicated twin pregnancies at term where the presentation of the first twin is cephalic (NICE 1.2.2)

2.3.3 with hepatitis B who have received immunoglobulin and vaccination. (NICE 1.2.8.6)

2.3.4 who are infected with hepatitis C (NICE 1.2.8)

2.3.5 with a BMI >50 as sole clinical indication (NICE 1.2.10)

2.3.6 who have had less than five previous caesarean sections (NICE 1.8.2) (unless a specific clinical concern is identified)

2.4 Planned Elective caesarean section (CS) is **not routinely commissioned** for pregnant women with anxiety about childbirth who have not received appropriate support from a healthcare professional with expertise in providing perinatal mental health support (as defined below) to help her address her anxiety in a supportive manner (NICE 1.2.9.3)

Definitions

2.4.1 Healthcare professional with expertise in perinatal mental health support. Someone, usually from the maternity team, who has an interest and expertise in providing support to women with higher than normal anxiety levels, to the extent that they are requesting a caesarean section

Referral

2.4.2 The referral could be an informal referral within a maternity team or formal referral to another member of staff in a different team

- Anxiety that goes beyond the general anxiety that women have about childbirth. This refers to women whose anxiety is preventing them from wanting to attempt a vaginal birth

2.4.3 If after discussion and offer of support (including perinatal mental health support (as defined above) for women with anxiety about childbirth), a vaginal birth is still not an acceptable option, then a planned caesarean is commissioned

2.5 Maternal request is not on its own an indication for caesarean section and is not routinely commissioned

3 BACKGROUND

3.1 For nearly 30 years, the international health-care community has considered the ideal rate for caesarean section to be between 10% and 15%

3.2 This has been based on the following statement by a panel of reproductive health experts at a meeting organized by the World Health Organization in 1985, in Fortaleza, Brazil: “There is no justification for any region to have a rate higher than 10–15%” (14)

The panel’s conclusion was drawn from a review of the limited data available at the time, mainly from northern European countries that demonstrated good maternal and perinatal outcomes with this rate of caesarean section

3.3 In April 2015, WHO released a new statement summarizing the results of systematic reviews and analysis of the available data on caesarean births

3.4 In light of the evidence, the panel of experts convened by WHO concluded in the statement that, at population level, caesarean section rates higher than 10% were not associated with reductions in rates of maternal and new-born mortality (12,13)

3.5 The statement notes, however, that the association between caesarean section rates and other relevant outcomes such as stillbirths, maternal and perinatal morbidity, paediatric outcomes and psychological or social well-being could not be determined due to the lack of data on these outcomes at the population level

3.6 The scarcity of data is a limitation of this evidence that needs to be borne in mind when interpreting the WHO statement

3.7 Although the ideal or optimal caesarean rate is unknown, WHO emphasizes that caesarean section is effective in saving maternal and infant lives, but only when it is used for medically indicated reasons

3.8 Ultimately, every effort should be made to provide caesarean sections to women in need, rather than striving to achieve a specific rate

Evidence Summary

3.9 As with any surgery, caesarean section is associated with short- and long-term risks. These can extend many years beyond the current delivery and affect the health of the woman, the child and future pregnancies

3.10 Caesarean section increases the likelihood of requiring a blood transfusion,

the risks of anaesthesia complications, organ injury, infection, thromboembolic disease and neonatal respiratory distress, among other short-term complications

3.11 Caesarean section has been associated in the long term with an increased risk of asthma and obesity in children, and complications in subsequent pregnancies, such as uterine rupture, placenta accreta, placenta praevia, ectopic pregnancy, infertility, hysterectomy and intraabdominal adhesions, with the risk of these morbidities progressively increasing as the number of previous caesarean deliveries increases

4 EVIDENCE BASED INTERVENTIONS PANEL APPLICATION PROCESS

4.1 Patients who are not eligible for treatment under this policy may be considered on an individual basis where their Consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy

4.2 Completion of a **Generic EBI Application Form** by a **Consultant** may be put forward

4.3 Applications cannot be considered from patients personally

4.4 It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBIP. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context

4.5 EBI applications are reviewed and considered for clinical exceptionality

For further information on 'clinical exceptionality' please refer to the NHS England IFR policy
https://www.england.nhs.uk/wp-content/uploads/2017/11/comm-policy-indivdual-funding-requests.pdf

4.6 An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question

- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

5 ACCESS TO POLICY

5.1 If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and

Liaison Service on Telephone number: 08000 851067

5.2 **Or write to us**: NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somccg.pals@nhs.net

6 REFERENCES

The following sources have been considered when drafting this policy

6.1 https://www.nice.org.uk/guidance/CG132

6.2 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31930-5/fulltext

6.3 http://apps.who.int/iris/bitstream/handle/10665/275377/9789241550338-eng.pdf?ua=1

6.4 nice.org.uk/guidance/qs32
https://www.nice.org.uk/guidance/cg132/evidence/appendix-a-summary-of-new-evidence-pdf-2736386032

6.5 Long-term risks and benefits associated with caesarean delivery for mother, baby, and subsequent pregnancies: Systematic review and meta-analysis
https://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002494