

94/165 (60%) respondents had their own children (201 children). Mode of delivery for first born child; normal vaginal 48%, caesarean section 26.5% (elective 8.5%, emergency 18%), instrumental 24.5% and vaginal breech 1%. Elective caesarean was performed in 8.5%. Only one chose an elective caesarean for maternal request. SW obstetricians statistically have the same overall actual modes of birth (Kruskal-Wallis  $p = 0.932$ ).

**Conclusions** 10% report they would request caesarean section for themselves/their partner, which is the lowest rate reported within UK studies. Only 1% had a caesarean solely for maternal choice. SW Obstetricians would choose non interventional delivery if possible. They currently have modes of delivery that are not statistically different from the general population. These results challenge long held misconceptions about birth choices made by obstetricians.

**PL.16 DOES THE USE OF CARBETOCIN REDUCE RECOVERY TIMES AT CAESAREAN SECTION? AN AUDIT OF OUTCOMES FOLLOWING ROUTINE INTRODUCTION OF CARBETOCIN AT SOUTHMEAD HOSPITAL**

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**Objectives**

1. To investigate time in theatre recovery for women who received carbetocin at Caesarean Section (CS) compared with a historical cohort.
2. To compare costs per patient, from a health sector perspective, between the two cohorts.

**Methods** We evaluated outcomes for all women (elective and emergency) undergoing CS, after the introduction of carbetocin in April 2012. The controls comprised every 3<sup>rd</sup> patient undergoing CS in January 2012 (pre-carbetocin).

**Main outcome measure** Difference in time in theatre recovery between the two groups.

**Results** Women who received carbetocin ( $n = 265$ ) spent less time in recovery than the historical cohort ( $n = 33$ ) (carbetocin 170 min, syntocinon 271 min; difference:  $-101.3023$  minutes, 95% CI:  $-175.8518$ ;  $-26.75276$ ,  $p < 0.01$ ).

Additionally there was reduced need for additional 3<sup>rd</sup> stage uterotonics (carbetocin 16%, syntocinon 60%; mean difference in proportion:  $-0.294$ , 95% CI:  $-0.1183$ ;  $-0.4697$ ). This is consistent with findings from RCTs.

Using financial modelling (Abstract No: PL.19) drug cost per patient when all 3<sup>rd</sup> stage requirements are included is carbetocin £7.78 v syntocinon £6.37. In addition, reduced theatre recovery time has potential midwifery staffing cost efficiencies of up to £189,000 pa.

**Conclusion** Carbetocin decreases time spent in recovery post-CS, and reduces the need for additional 3<sup>rd</sup> stage management.

**Discussion** Introducing carbetocin routinely for all CS will reduce recovery times and potentially constitutes a cost saving. There are likely to be additional important staffing and theatre efficiencies.

**PL.17 TESTING FOR LIKELIHOOD OF PRE-TERM LABOUR – A DESCRIPTIVE STUDY OF ENGLISH MATERNITY UNITS 2011–2012**

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**Introduction** Prematurity is a leading cause of neonatal morbidity and mortality. Tests are available to help predict the likelihood of pre-term labour (PTL), although optimal protocols remain uncertain. We assessed the changing pattern of testing in English maternity units.

**Methods** 163 maternity units were surveyed online in Sept/Oct 2011, and again in Sept/Oct 2012. In 2012, non-responders were followed up by telephone contact. The overall response rate improved from 32.5% (54 units) in 2011 to 73% (119 units) in 2012. Data were analysed quantitatively using contingency tables, and spatially using Geomapping software.

**Results** In 2012, 87% (CI; 80–92%) of units used biochemical testing to predict PTL, a significant ( $p < 0.05$ ) increase from 2011 (76%, CI; 63–85%). For units where data were available for both years, 33% altered their method of PTL testing between 2011–2012, with 40% of these initiating biochemical testing. 14 units did not test for pre-term labour (11%, CI; 7–18%). The most commonly cited barriers to testing were cost and inexperience of operators, each cited by 16% of units (CI; 10–24%). On the basis of test results, 94% (CI; 87–97) of units gave steroids, but only 77% (CI; 67–84) discharged home and 82% (CI; 73–88%) arranged *in utero* transfer.

**Conclusions** Our results suggest a heterogeneous pattern of test utilisation. The high proportion of units changing methods within a year implies confusion regarding optimal strategies for PTL prediction. There is an urgent need for further research and clearer guidance in this area. Heterogeneity in protocols could lead to suboptimal allocation of valuable neonatal network resources.

**PL.18 VALIDATION OF A SKILL LIST OF NON-TECHNICAL SKILLS FOR OBSTETRICIANS WHEN PERFORMING AN OPERATIVE VAGINAL DELIVERY**

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**Background** Non-technical skills for obstetricians play a vital role in adequate patient care and combine social and cognitive elements that are separate from the practical skills involved in obstetric care. Categories of non-technical skills for operative vaginal delivery have been postulated from healthcare professionals to provide a framework of good practise.

**Aim of this study** To validate the social non-technical skills defined by obstetricians and midwives.

**Method** Women who had an operative vaginal delivery of a term baby underwent a semi structured interview 6–8 weeks postnatal. The interview recordings were transcribed verbatim. Thematic coding of data was carried out. Consistency of interpretation was ascertained by two researchers. Data was analysed to compare and contrast the emerging themes to the elements and categories previously identified.

**Results** 16 interviews were transcribed and analysed for this study. Social categories of non-technical skills, namely professional relationship, behaviour, teamwork and communication, suggested by obstetricians and midwives were common themes from all participants. New themes emerged such as 'importance of understanding preconception of what operative vaginal delivery would involve'.

**Conclusion** The non-technical skills developed by obstetricians and midwives in operative vaginal delivery have been validated by women. Furthermore new themes emerged that need to be embedded into the pre-existing categories. This validated framework of non technical skills is vital to ensure an operative vaginal delivery occurs in an environment that is positive and respects the unique event of a birth of a child. Additionally the framework can be used as a tool for training and feedback.

**PL.19 COST COMPARISON OF ROUTINE CARBETOCIN USE AT CAESAREAN SECTION**

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