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Royal Cornwall Hospitals NHS Trust

Vaginal Birth After Caesarean Section (VBAC) Clinical Guideline

V3.0

September 2022

1. Aim/Purpose of this Guideline

1.1. Due to a rise in the caesarean section rate, there are increasing numbers of pregnant women who have had a prior caesarean section. These women should all receive a referral to an obstetric consultant clinic where they should receive counselling and discussion about their options for delivery so that they are aware of the risks and benefits of both elective Caesarean section and vaginal birth.

1.2. This guideline informs obstetrics and midwives on the management of a woman who has had a previous caesarean section during pregnancy and labour.

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

1.4. 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.

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

The Trust has a duty under the Data Protection Act 2018 and 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 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 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. Patient Suitability for VBAC

2.1.1. Women who have had one uncomplicated lower section caesarean section (LSCS) and have an otherwise uncomplicated pregnancy should be encouraged to attempt a VBAC. The success rate is between 72 to 75 % if the woman has never had a vaginal birth and 85 to 90% if she has.

2.1.2. VBAC may also be suitable for other women after consideration and discussion of the risks.

2.1.3. Women admitted in preterm labour with a history of previous LSCS have a similar success rate to those who labour at term but a lower risk of uterine rupture1 and therefore should be counselled about regarding these changes and the impact to their baby.

2.1.4. The woman's preferences need to be supported throughout all discussions and decision making. (NEW 2022)

2.2. **Situations in which further considerations are needed (NEW 2022):**

- Women with a complicated pregnancy or difficulties at previous CS
- Two or more caesarean sections (these women need to be fully counselled by a senior obstetrician)
- Women requiring induction of labour

2.3. **Contraindications:**

- Previous uterine rupture
- Previous classical caesarean section
- Absolute contraindication to vaginal birth (placenta praevia, footling Breech)

2.4. **Antenatal Counselling and Management:**

2.4.1. A VBAC leaflet should be given or signposted to in their electronic health record to the woman by the community midwife at the time of booking and this should be documented in the woman's handheld notes and on the electronic health records. The woman should be encouraged to read this prior to attending the consultant clinic.

2.4.2. The woman should be seen in the obstetric clinic before 24 weeks gestation. Any requirements for additional obstetric clinic appointments should be individualised.

2.4.3. At the clinic suitability for VBAC should be considered. If there are any concerns regarding the suitability this should be discussed with the consultant.

2.4.4. Women should be informed that if they are admitted in preterm labour the success rate of VBAC is similar to that at term however there is a lower risk of uterine rupture.

2.4.5. 72-75% of those planning a VBAC will have a vaginal birth. This may be lower depending on individual risk factors such as:

- Induction of Labour
- No previous vaginal birth
- BMI greater than 30

- Previous section for dystocia
- Greater than 41 weeks gestation
- Less than 2 years from previous caesarean
- Maternal age over 40

2.5. **Risks of VBAC should be discussed with the woman and include:**

- 0.5 % risk of uterine rupture, which can be associated with significant maternal and perinatal morbidity/mortality
- 4/10,000 risk of delivery related perinatal mortality which is no different to the risk for women having their first birth
- <1 in 1000 risk of neonate developing hypoxic ischemic encephalopathy (which has variable outcomes)
- 1% additional risk haemorrhage requiring a blood transfusion

2.6. **Benefits of VBAC should also be discussed and should include:**

- Reduces the risk of neonate having respiratory problems such as transient tachypnoea or respiratory distress syndrome after birth – risk is 2-3% with VBAC and 4-5% with elective LSCS
- Further caesarean increases risks in future pregnancies e.g., placenta praevia and accreta and hence caesarean hysterectomy, complications of adhesions during surgery and bladder and bowel trauma.
- Quicker recovery period. Able to return to normal activities such as lifting and driving sooner than with a CS.
- Potential of avoiding major surgery and the associated complications.

2.6.1. The antenatal counselling should be documented using the Discussion Form (appendix 3). The woman should be asked to sign it and it should be filed in the woman's handheld notes.

2.6.2. A plan in the event of labour starting prior to the scheduled CS date should be discussed with the woman and documented on the Discussion Form.

2.6.3. A plan should labour not commence spontaneously by term +12 should be discussed with the woman and documented on the Discussion Form.

2.6.4. Induction of labour should not be commenced with Propess and instead a balloon catheter +/- artificial rupture of membranes and oxytocin infusion. (NEW 2022) (see induction of labour guideline)

2.7. **Intrapartum Management**

2.7.1 Women should be advised to deliver at Consultant Unit.

2.7.2 Women who present in labour who have had a previous CS should be assessed as high risk and require an obstetric review within 30 minutes of arrival on delivery suite. This review must be documented in the notes. If the obstetric team are unavailable, it must be clearly documented in the notes why and when a review is expected. The coordinator should review the patient to assess the urgency. If an obstetric review is required urgently, immediate escalation to the Obstetric Consultant on call should take place. Until the review happens the coordinator should be kept up to date with any changes

2.7.3 All women who are assessed as high risk must be reviewed by an obstetrician a minimum of 6 hourly and this must be documented by them in the notes. If this timeframe cannot be achieved, the reason why must be documented in the notes and the coordinator informed

2.7.4 IV access is not routinely required and the need for a cannula should be based on other risk factors and the woman's wishes. If a decision is made for a cannula, then full blood count (FBC) and group and save (G&S) should be sent

2.7.5 Women who have opted for an elective repeat CS but who present in labour should have a discussion with an experienced obstetrician to re discuss mode of delivery considering the woman's wishes, stage of labour and overall risk factors (NEW 2022)

2.7.6 There is no contraindication to epidural.

2.7.7 Continuous fetal monitoring via Cardiotocograph is recommended for all women attempting a VBAC once labour is established.

2.7.8 Maternal monitoring – hourly blood pressure (BP) and pulse

Watchful of signs of uterine rupture:

- Abnormal CTG
- Severe abdominal pain- persisting through contractions
- Chest pain/shoulder tip pain, shortness of breath
- Acute onset scar tenderness
- Abnormal vaginal bleeding/haematuria
- Cessation of previously good contractions
- Signs of maternal shock
- Loss of station of the presentation part
- Sudden loss of effectiveness of previously good working epidural

2.8. **Women requesting Delivery in the Birthing Centres or Home**

Women should be advised that the NICE guidance and the RCOG guidance is for continuous monitoring in labour from the onset of regular contractions and this cannot be provided in any of the low risk settings and therefore we would advise against this.

2.8.1. Women who still request delivery in the low risk settings should be referred to the Consultant clinic for discussion and a clear record of the discussion and outcome made in the woman's record. They should be advised that;

- Continuous monitoring cannot be provided in the low risk settings and the lack of this may be associated with a higher risk of uterine rupture as the safety data is based on deliveries in consultant led units with continuous monitoring.
- If uterine rupture were to occur in a low risk setting then there would be a delay in transferring to the consultant unit which may result in increased fetal and maternal morbidity and potentially mortality.
- The Truro Birth Centre, even though it is closer to the delivery suite is not staffed by doctors and is not located on delivery suite and if a complication were to arise a transfer would be required which would lead to a delay in treatment or delivery.

2.8.2. If a woman requests delivery in the low risk setting, despite this advice, then she should be informed that she may use the Truro Birth Centre, against medical advice.

2.8.3. Women will need to follow the birth options pathway if they have had 2 or more LSCS, and wish to birth on TRBC factors or chose to deliver in a stand alone birth Centre or a home birth following any uterine scar.

2.8.4. Women should be advised not to use the Truro Birth Centre due to the uncertainty about the safety and efficacy of planned VBAC in this group in the following circumstances:

- More than 1 CS
- >T+12
- Estimated fetal growth >90th centile

2.8.5. When a woman is admitted to the Truro Birth Centre for a VBAC the coordinator on delivery suite should be informed and inform the SpR on delivery suite.

2.8.6. Any woman who has opted to use Truro Birth Centre should be advised to transfer to delivery suite if there is **suspected** delay, if the need for an amniotomy arises, any concern with the fetal heart rate, any scar pain or any maternal tachycardia or any other concern the midwife or woman has.

2.9. **Induction and Augmentation**

2.9.1. There is a 2-3 times increase risk of uterine rupture with induction of labour (IOL) or augmentation of labour

2.9.2. There is in addition a 1.5 x increase in need for LSCS with IOL/augmentation

2.9.3. The decision to induce, and method used should be made by a senior obstetrician and the plan clearly documented in the woman's notes. A routine post-date's induction must not be booked by a midwife without seeking the advice of an obstetrician

2.9.4. Propess should not be used for the induction of labour of VBAC's. A cervical catheter should be used if an artificial rupture of membranes is not possible (NEW 2022)

2.9.5. If the labour deviates from expected time frames then the woman should be reviewed by the SpR or consultant obstetrician and a clear plan for the management of the continuing labour must be documented in the notes.

2.9.6. Oxytocin should not be used for augmentation of established labour unless the woman has been reviewed by an SpR or Consultant Obstetrician and evidence of obstructed labour or signs of scar rupture have been excluded and documented by the reviewing doctor

2.9.7. If oxytocin is used it should be titrated carefully so that the woman is not contracting more than 4 in 10 minutes.

2.9.8. Oxytocin should not be used in the second stage of labour in a woman attempting a VBAC unless a full assessment (including a vaginal examination) has been made by a senior obstetrician and they have sought agreement from a consultant

2.9.9. Any woman being induced or having their labour augmented should be informed of the risks and this should be documented on the induction of labour consent form and filed in the handheld notes.

2. 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 and midwives • The results will be inputted onto an excel spreadsheet • The audit will be registered with the Trust's audit department
Lead	Audit midwives

Information Category	Detail of process and methodology for monitoring compliance
Tool	• Is it documented that the VBAC information sheet was given to the woman at the time of booking • Was the woman seen in the consultant clinic before 24 weeks gestation • Was the antenatal counselling documented using the Discussion Form • Was there an individual management plan written for the woman when she presented in labour • Was the intended method of fetal heart monitoring documented when the woman presented in labour
Frequency	1% or 10 sets, whichever is the greater, of all health records of women who have had a vaginal birth after caesarean section, will be audited over a 12 month period
Reporting arrangements	• A formal report of the results will be received annually at the maternity risk management and clinical audit forum, as per the audit plan • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed.
Acting on recommendations and Lead(s)	• Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum and an action plan developed • Action leads will be identified and a time frame for the action to be completed by • The action plan will be monitored by the maternity risk management and clinical audit forum until all actions complete
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within a time frame agreed on the action plan • A lead member of the forum will be identified to take each change forward where appropriate. • The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan

3. 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, Inclusion & Human Rights 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:	Vaginal Birth After Caesarean Section (VBAC) Clinical Guideline V3.0
This document replaces (exact title of previous version):	Vaginal birth after Caesarean Section VBAC Guideline V2.1
Date Issued/Approved:	August 2022
Date Valid From:	September 2022
Date Valid To:	September 2025
Directorate / Department responsible (author/owner):	Sophie Haynes Consultant Obstetrician
Contact details:	01872 252729
Brief summary of contents:	This guideline informs obstetrics and midwives on the management of a woman who has had a previous caesarean section during pregnancy and labour and who is requesting a vaginal birth.
Suggested Keywords:	VBAC, vaginal birth after caesarean section
Target Audience:	RCHT: Yes CFT: No KCCG: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group Care Group Board
General Manager confirming approval processes:	Caroline Chappell, Care Group Manager
Name of Governance Lead confirming approval by specialty and care group management meetings:	Caroline Amukusana
Links to key external standards:	CNST 4.0
Related Documents:	1. RCOG Green Top Guideline No. 45,.Birth after Previous Caesarean Birth, Feb 2007

Information Category	Detailed Information
	2. Bujold E, Blackwell SC, Gauthier RJ. Cervical ripening with transcervical foley catheter and the risk of uterine rupture. Obstet Gynecol 2004:103;18-23 3. Birth After Previous Caesarean Birth, RCOG, Green top guideline No.45 October 2015 NICE Guideline Inducing Labour, November 2021
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
December 2009	V1.0	Initial version	Karen Watkins Consultant obstetrician
November 2010	V1.1	Reviewed and compliance monitoring tool added	Karen Watkins Consultant obstetrician
September 2012	V1.2	Reviewed, no changes to clinical content. Changes to compliance monitoring tool only	Karen Watkins Consultant obstetrician
June 2019	V2.0	Full review. Addition to the contraindications in 2.3. 2.7.2 IV access requirements. Section 2.8 re place of delivery and section 2.6.	Karen Watkins Consultant obstetrician
May 2020	V2.1	Addition of inclusion statement (1.5) Addition of review within 30 minutes of transfer to DS (2.7.2.) Addition of review a minimum of 6 hourly whilst in labour (2.7.3.)	Julie Walton Audit Midwife
September 2022	V3.0	Review of document with addition of induction of labour by balloon catheter and/or ARM and not Propess.	Sophie Haynes Obstetric Consultant

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

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). 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 & Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Vaginal Birth after Caesarean Section (VBAC) Clinical Guideline V3.0
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):	01872 252729
Contact details:	Leann Morris, Practice Development Midwife

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)	This guideline informs obstetrics and midwives on the management of a woman who has had a previous caesarean section during pregnancy and labour and who is requesting a vaginal birth
2. Policy Objectives	Ensure current evidenced based management of a woman having a vaginal birth following a caesarean section
3. Policy Intended Outcomes	Safe outcome for woman and baby
4. How will you measure each outcome?	Compliance monitoring tool
5. Who is intended to benefit from the policy?	Pregnant women and their babies

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 Care Group Board
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:**

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:

Leann Morris, 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. CHA4321: Vaginal Birth after Caesarean Section (VBAC) Discussion Form

Name: _____
Address: _____
_____
Date of birth: _____
CR number: _____
NHS number: _____

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Vaginal Birth after Caesarean Section (VBAC) Discussion Form

(This form is to be completed by the doctor with the woman)

Date of Discussion		Gestation		Obstetrician	

- 72-75% of pregnant people opting for a VBAC will have a vaginal birth (85-90% if previous vaginal delivery)
- Risk of the scar in the uterus opening is 1 chance in 200 (0.5%) + the complications of this
- Risk of blood transfusion with VBAC 2%
- Risk to baby similar to woman having her first baby, but higher than with a planned CS
- VBAC less likely if induced labour, no previous vaginal delivery, BMI > 30 and previous CS for labour dystocia.
- Induction of labour will increase the risk of the scar opening and associated complications by 2 – 3 times. Propess is not recommended for birthing people that have has a previous Caesarean section.
- It is recommended to deliver in Consultant Led Unit / Delivery Suite
- It is recommended for continuous electronic fetal monitoring
- It is not recommended to have a VBAC on the birth centre however if you chose to:
  - We cannot offer continuous monitoring of you baby's heart beat in line with national guidance.
  - Transfer time to delivery suite may result in a worse outcome for you and baby in the event of scar rupture.
  - If there is suspected delay in labour or any concerns you will be transferred to Consultant Led Unit / Delivery Suite

Intended mode of delivery	**VBAC** ☐	**Elective CS** ☐	**Undecided** ☐
If labours prior to Elective CS	VBAC ☐	Emergency CS ☐	To re-discuss at the time ☐
If not laboured by T+12	ANC at T+3-10 ☐ Cervical catheter ☐	Elective CS ☐	ARM + Syntocinon ☐
Elective Caesarean Section	Date _____ Gestation _____ Steroids required YES ☐ NO ☐		
Pre-op Assessment in DAU	Date _____ Time _____		

The above points have been discussed with me and I have had the opportunity to ask questions. I have received the VBAC Information Sheet.

Patient's Signature _____ **Print** _____ **Date** _____

Doctor's Signature _____ **Print** _____ **Date** _____

Women, Children & Sexual Health

CHA4321 V3 Printed 08/2022
Review due 2025

Appendix 3. Vaginal Birth after Caesarean Section (VBAC) Discussion Form

Royal Cornwall Hospitals NHS
NHS Trust

Vaginal Birth after Caesarean Section (VBAC) Discussion Form (This form is to be completed by the doctor with the woman)

Patient's Details	Date of Discussion…… Gestation…… Obstetrician……..

- Success rate of VBAC is 72 – 75% (85-90% if previous vaginal delivery)
- Risk of the scar in the uterus opening is 1 chance in 200 (0.5%) + the complications of this
- Risk of blood transfusion with VBAC 2%
- Risk to baby similar to woman having her first baby, but higher than with a planned CS
- VBAC less likelyif induced labour, no previous vaginal delivery, BMI > 30 and previous CS for labour dystocia.
- Induction of labour will increase the risk of the scar opening and associated complications by 2 – 3 times. Propess® is not licensed but the use of prostaglandins for IOL is supported by NICE.
- Need to deliver in Consultant Unit
- Need for continuous electronic fetal monitoring
- Need for intravenous access

Intended mode of delivery	**VBAC / Elective CS / undecided**		
If labours prior to Elective CS	VBAC / Emergency CS / to re-discuss at the time		
If not laboured by T^{+12}	ANC at T^{+3-10} / Propess® / ARM + Synto® / Cervical catheter / Elective CS		
Elective Caesarean Section	Date	Gestation	Steroids yes/no
Pre-op Assessment in DAU	Date	Time	

The above points have been discussed with me and I have had the opportunity to ask questions. I have received the VBAC Information Sheet.

Patient's Signature_____**Print**_____**Date** _____

Doctor's Signature_____**Print**_____**Date** _____

VBAC guideline/September 12/review September 15

Appendix 4. Risk factors for unsuccessful VBAC:

- Induction of Labour
- No previous vaginal birth
- BMI greater than 30
- Previous section for dystocia
- Greater than 41 weeks gestation
- Less than 2 years from previous caesarean
- Advanced maternal age