Vaginal Birth
After Caesarean Section (VBAC)
Clinical Guideline

V2.1

June 2020
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 DPA18 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.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the Information Use Framework Policy or contact the Information Governance Team 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 has¹.

2.1.2. VBAC may also be suitable for other women after consideration and discussion of the risks
2.1.3. The success rate for women who have had a previous vaginal birth and who had a LSCS for fetal reasons is extremely good and these women in particular should be encouraged and supported to attempt a VBAC.

2.1.4. 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 rupture\(^1\) and therefore should be encouraged to reconsider a VBAC even though they may have originally requested an elective LSCS.

2.2. Situations in which further discussion with a consultant is needed:
- 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 Information Sheet (appendix 3) should be given to the woman by the community midwife at the time of booking and this should be documented in the woman’s hand held notes and on Euroking. The woman should be encouraged to read this prior to attending the consultant clinic.

2.4.2. The woman should be seen in the consultant 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. An overall success rate for planned VBAC of 72-76\% should be given (87\%-90\% if previous vaginal birth)\(^1\). This will be influenced by the risk factors for unsuccessful VBAC (appendix 5)\(^1\). The success is similar after two previous CS’s.

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.\(^1\) The risk is lower if previous vaginal birth has occurred. The risk is no higher after two or more previous CS’s\(^1\).
4/10,000 risk of delivery related perinatal mortality which is no different to the risk for women having their first birth.¹

<1 in 1000 risk of neonate developing hypoxic ischemic encephalopathy (which has variable outcomes)¹.

1% additional risk haemorrhage requiring a blood transfusion¹

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 LSCS¹

- 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 hand held 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.

2.7. 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. (NEW 2020).

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 the reason why must be documented in the notes and the coordinator informed. (NEW 2020)
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 (NEW 2019)

2.7.5 The SpR on call for delivery suite should be informed of the admission.

2.7.6 Women who have opted for an elective repeat CS but who present in labour should have a discussion with an experienced obstetrician to explore the possibility of VBAC.

2.7.7 There is no contraindication to epidural.

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

2.7.9 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 (NEW 2019)
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 still 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. We do not advise homebirth or standalone birth centres for women choosing VBAC.

2.8.3. The woman should be informed that if an amniotomy is required or if there is suspected delay in her labour then she will be transferred to the consultant led unit for continuous monitoring of the fetal heart. There should be a documented discussion regarding augmentation if delay is confirmed.

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 (RCOG) (NEW 2019);

- More than 1 CS
- >T+12
- Estimated fetal growth >90\textsuperscript{th} centile
- Maternal age >40 years

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 transferred 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) with prostaglandins or augmentation of labour\textsuperscript{1}

2.9.2. There is in addition a 1.5 x increase in need for LSCS with IOL/augmentation\textsuperscript{1}.

2.9.3. The decision to induce, and method used should be made by a consultant 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 a consultant obstetrician.

2.9.4. Prostaglandins are not licensed for use in women who have had a previous LSCS and this fact should be discussed with the woman and documented. A cervical ripening balloon/foley’s catheter is an alternative to prostaglandins for cervical ripening, and there is some evidence that it is not associated with the increase risk of uterine rupture seen with prostaglandin use. The fact that Propess it is not licensed for use with a previous LSCS should be discussed with the woman and documented in the hand held notes.

Vaginal Birth after Caesarean Section (VBAC) V2.1
2.9.5. If the labour deviates from normal 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 (NEW 2019).

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 in the hand held notes.

3. Monitoring compliance and effectiveness

| 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 |
| Tool | Is it documented that the VBAC information sheet was given to the woman at the time of booking with the obstetrician  
| | Was the woman seen in the consultant clinic before 36 weeks gestation  
| | Was the antenatal counselling documented using the Discussion Form  
| | Is there an individual plan in the event of labour starting prior to the scheduled date  
| | Is there an individual plan should labour not commence spontaneously  
| | Is the need for continuous electronic fetal monitoring identified on the discussion sheet  
| | 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. |

<table>
<thead>
<tr>
<th>Acting on recommendations and Lead(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum and an action plan developed</td>
</tr>
<tr>
<td>• Action leads will be identified and a time frame for the action to be completed by</td>
</tr>
<tr>
<td>• The action plan will be monitored by the maternity risk management and clinical audit forum until all actions complete</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change in practice and lessons to be shared</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Required changes to practice will be identified and actioned within a time frame agreed on the action plan</td>
</tr>
<tr>
<td>• A lead member of the forum will be identified to take each change forward where appropriate.</td>
</tr>
<tr>
<td>• The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan</td>
</tr>
</tbody>
</table>

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, 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

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Vaginal Birth after Caesarean Section V2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical guideline for vaginal birth after caesarean section (VBAB) V2.0</td>
</tr>
<tr>
<td>Date Issued/Approved:</td>
<td>May 2020</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>June 2020</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>6th June 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Karen Watkins  Consultant obstetrician  Obstetrics and Gynaecology Directorate</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252729</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>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</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>VBAC, vaginal birth after caesarean section</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT CFT KCCG</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Approval route for consultation and ratification:</td>
<td>Maternity Guidelines Group  Care Group Board  Policy Review Group</td>
</tr>
<tr>
<td>General Manager confirming approval processes</td>
<td>Debra Shields, Care Group Manager.</td>
</tr>
<tr>
<td>Name of Governance Lead confirming approval by specialty and care group management meetings</td>
<td>Caroline Amukusana</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>CNST 2.10</td>
</tr>
</tbody>
</table>
Training Need Identified?  No

Publication Location (refer to Policy on Policies – Approvals and Ratification): Internet & Intranet ✔ Intranet Only

Document Library Folder/Sub Folder  Clinical / Midwifery and obstetrics

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>December 2009</td>
<td>V1.0</td>
<td>Initial version</td>
<td>Karen Watkins Consultant obstetrician</td>
</tr>
<tr>
<td>November 2010</td>
<td>V1.1</td>
<td>Reviewed and compliance monitoring tool added</td>
<td>Karen Watkins Consultant obstetrician</td>
</tr>
<tr>
<td>September 2012</td>
<td>V1.2</td>
<td>Reviewed, no changes to clinical content. Changes to compliance monitoring tool only</td>
<td>Karen Watkins Consultant obstetrician</td>
</tr>
<tr>
<td>June 2019</td>
<td>V2.0</td>
<td>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.</td>
<td>Karen Watkins Consultant obstetrician</td>
</tr>
<tr>
<td>May 2020</td>
<td>V2.1</td>
<td>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.)</td>
<td>Julie Walton Audit Midwife</td>
</tr>
</tbody>
</table>

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 Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Vaginal Birth after Caesarean Section (VBAC) V2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate and service area:</td>
<td>Obstetrics and Gynaecology</td>
</tr>
<tr>
<td>Name of individual/group completing EIA</td>
<td>Karen Watkins, Obstetric Consultant</td>
</tr>
<tr>
<td>Is this a new or existing Policy?</td>
<td>Existing</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252729</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   Who is the strategy / policy / proposal / service function aimed at?

   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 the outcome?**
   Compliance monitoring tool.

5. **Who is intended to benefit from the policy?**
   Pregnant women and their babies.

6a). Who did you consult with?
   Workforce
   Patients
   Local groups
   External organisations
   Other

   X

b). Please list any groups who have been consulted about this procedure.
   Please record specific names of groups:
   Maternity Guidelines Group
   Care Group Board

c). What was the outcome of the consultation?
   Guideline agreed
7. The Impact
Please complete the following table. If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.

Are there concerns that the policy could have a positive/negative impact on:

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female non-binary, asexual etc.)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender reassignment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability (learning disability, physical disability, sensory impairment, mental health problems and some long term health conditions)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion/other beliefs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual orientation (bisexual, gay, heterosexual, lesbian)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If all characteristics are ticked ‘no’, and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

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: Karen Watkins, Obstetric Consultant

If you have ticked ‘yes’ to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here: Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead debby.lewis@nhs.net
Vaginal Birth after Caesarean Section (VBAC) Discussion Form (This form is to be completed by the doctor with the woman)

<table>
<thead>
<tr>
<th>Patient's Details</th>
</tr>
</thead>
</table>

- 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 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 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

<table>
<thead>
<tr>
<th>Intended mode of delivery</th>
<th>VBAC / Elective CS / undecided</th>
</tr>
</thead>
<tbody>
<tr>
<td>If labours prior to Elective CS</td>
<td>VBAC / Emergency CS / to re-discuss at the time</td>
</tr>
<tr>
<td>If not laboured by T-12</td>
<td>ANC at T+10 / Propess® / ARM + Synto® / Cervical catheter / Elective CS</td>
</tr>
<tr>
<td>Elective Caesarean Section</td>
<td>Date Gestation Steroids yes/no</td>
</tr>
<tr>
<td>Pre-op Assessment in DAU</td>
<td>Date Time</td>
</tr>
</tbody>
</table>

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