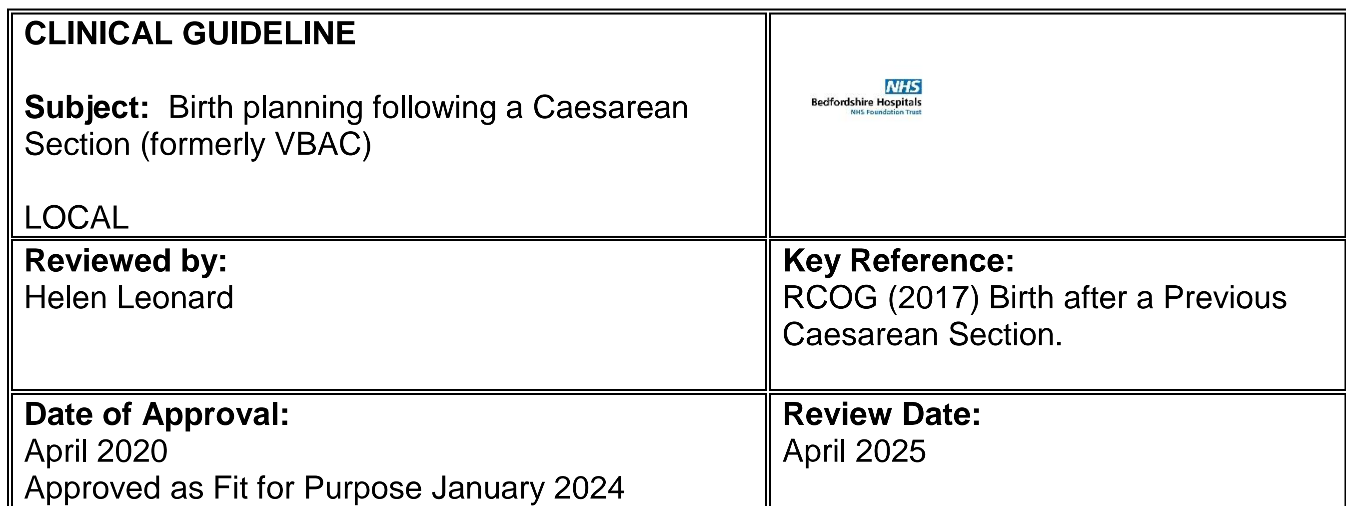

CLINICAL GUIDELINE **Subject:** Birth planning following a Caesarean Section (formerly VBAC) LOCAL	NHS Bedfordshire Hospitals NHS Foundation Trust
Reviewed by: Helen Leonard	**Key Reference:** RCOG (2017) Birth after a Previous Caesarean Section.
Date of Approval: April 2020 Approved as Fit for Purpose January 2024	**Review Date:** April 2025

<table>
<tr><td>Purpose</td><td>To outline the antenatal and intrapartum management of women with a previous uterine scar.</td></tr>
<tr><td>Objectives</td><td>To facilitate safe & effective birth planning by minimising the risk of uterine scar rupture</td></tr>
<tr><td>For Use By</td><td>All medical staff and midwifery staff</td></tr>
<tr><td>Related Policies
Any policies or guidelines that directly impact or are impacted by this Guideline</td><td>Emergency and Urgent Caesarean Section
Fetal Heart Monitoring
Care of Women in Labour in all Settings
Care planning for women who request care outside of local and national guidance.
Water Birth</td></tr>
<tr><td>Definitions
Any Acronyms or Abbreviations used in Guideline</td><td>Planned vaginal birth after previous caesarean section (VBAC) refers to any woman who has experienced a prior caesarean birth who plans to deliver vaginally rather than by elective repeat caesarean section (RCOG 2007).

ERCS- Elective Repeat Caesarean Section
IOL – Induction of labour
CTG – Continuous toccography
BGH – Bedford General Hospital
LSCS – Lower segment caesarean section
EMCS – Emergency caesarean section
ELCS – Elective lower segment caesarean section.
BMI – Body Mass Index</td></tr>
<tr><td>Status / Version Control
Previous versions of the Guideline should be stated here with former name if changed along with dates when they were approved.</td><td>
<table>
<tr><th>Version</th><th>Guideline</th><th>Date Passed</th></tr>
<tr><td>01</td><td>Vaginal Birth after Caesarean Section</td><td>Nov-2000</td></tr>
<tr><td>02</td><td>Vaginal Birth after Caesarean Section</td><td>Jun-2003</td></tr>
<tr><td>03</td><td>Vaginal Birth after Caesarean Section</td><td>Sep-2004</td></tr>
<tr><td>04</td><td>Vaginal Birth after Caesarean Section</td><td>Jun-2007</td></tr>
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08</td><td>Vaginal Birth after a previous Caesarean Section
Vaginal Birth after a previous Caesarean Section
Vaginal Birth after a previous Caesarean Section
Birth planning after a previous Caesarean section</td><td>Jul-2009

Sept- 2012
Sept-2014
Dec 2018</td></tr>
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ANTENATAL CARE

Every woman should develop a personalised care plan where unbiased information should be made available to all women to help them make their decisions and develop their care plan (Better Births 2017).

Women who have had one LSCS and have no other risk factors identified at booking may follow a midwife-led antenatal care pathway and can have all antenatal care provided by their case loading/community midwife, unless other clinical factors necessitate allocation to a Consultant e.g. diabetes. In the absence of any other risk factors apart from the previous CS, the woman may continue with midwifery-led antenatal care. A consultant obstetrician will be allocated when the woman is in labour. See clinical care pathway on page 5.

Women who have undergone more than one previous caesarean section, have additional risk factors or other uterine surgery represent a 'High obstetric' risk group in both pregnancy and the intrapartum period and should be booked for Consultant- led care and will have combined care with her case loading midwife.

Key Message

A discussion should take place with all women at 16 weeks and should include information on:

- The option of VBAC or elective caesarean section
- The risk and benefits of planned, and successful, VBAC vs. elective caesarean section.
- Likelihood of VBAC success (72-75% or 85-90% if previous vaginal birth)
- The incidence of scar rupture is:-
  - 2 per 10,000 **(0.02%)** in women who plan to have an Elective Repeat Caesarean Section (ERCS) and do not go into labour.
  - 5 per 10,000 **(0.5%)** in women who labour spontaneously
  - 0.29 per 10 000 **(0.29%)** in women who are induced without the use of prostaglandins (ARM). This is associated with a lower risk of scar rupture compared to induction with prostin.
  - **1.2%** in women who are induced using prostaglandins
  - **1.1%** in women who are augmented in labour (RCOG 2017)
- The recommendations for:-
  - Mode of delivery
  - Place of birth
  - Fetal heart monitoring in labour

And from 36 weeks the:

- Plan for labour, including if labour should commence early
- Plan for labour, should this not commence as planned
- Options if pregnancy goes past term >40 weeks

Women should also be informed that:

- Successful VBAC has the fewest complications, therefore the chance of VBAC success is an important consideration when choosing mode of delivery
- As with any emergency caesarean section in labour the greatest risk of adverse outcome occurs in a trial of labour resulting in an emergency caesarean section. The absolute risk of birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for a nulliparous woman in labour

- That planned elective caesarean section is associated with a small increased risk of placenta praevia and/or accreta in future pregnancies and of pelvic adhesions complicating any future abdominopelvic surgery
- Whilst the risk of perinatal death is extremely low, there is a small increase in neonatal morbidity when caesarean section is performed before 39 weeks.
- Planning 3 or more caesarean sections increases the risk for future pregnancies and to the mother from delivery if the woman chooses caesarean section

Factors that increase, or decrease, the chances of VBAC success (see appendix 1) should be discussed, as appropriate, where relevant to the woman's circumstances (see table below) to enable the best-informed choice.

- The midwife who undertakes the booking is responsible for ensuring that the woman is given the patient information leaflet about Birth Options after a Caesarean Section at booking.

- Following the booking appointment. Weekly risk assessment meetings will be undertaken after each woman's nuchal uss with consultant obstetrician Ms Thanga Katimada and attended by a midwife from the Birth Choices clinic. Woman will follow either midwife led or obstetric led pathway and a recommendation will be made between consultant and midwife for VBAC OR LSCS.

- Women who have additional risk factors will have appointments made in the obstetric antenatal clinic. If the woman has not had her baby at Bedford then a letter requesting a summary of the birth details and any complications will be requested from the hospital she gave birth at. This will be done during the risk assessment meeting. Women requiring consultant care will be allocated any obstetric consultant.

- As soon after the nuchal uss but before 20 weeks gestation an appointment will be booked for the Birth Choices clinic At this appointment a discussion will take place around the options regarding mode of delivery including the risks and benefits of VBAC vs elective CS to promote shared decision-making. The Birth after Caesarean discussion form is initiated at this stage (appendix 1), and that, if required, referrals are made according to the flow-chart on page 5.

- For women who live on the Bedfordshire Borders and book to have their baby at other maternity units, please follow the clinical guideline relevant to the Hospital they are booked at (see appendix 5, 6 & 7). These women will continue to receive care by their community midwives in their geographical area.

- If a woman and/or her partner presents with symptoms of depression, anxiety, panic, feeling unable to cope or traumatised from her birth experience then she should be signposted to the Bedfordshire wellbeing service https://bedfordshirewellbeingservice.nhs.uk/.
  Women can self-refer via the website or call 01234 880400 for access to psychological therapies. If a woman discloses thought of self-harm or harm to others then urgent help should be sought via the Psychiatric liaison service (PLS) and the Maternal Mental Health Pathway should be followed. A routine enquiry about domestic abuse should be made at least once in pregnancy (refer to Domestic Abuse Recognition and Management guideline).

- There should be a discussion on a case by case basis as to which team should lead the case loading for women who meet the criteria for the Vulnerable Family's midwives team and also.

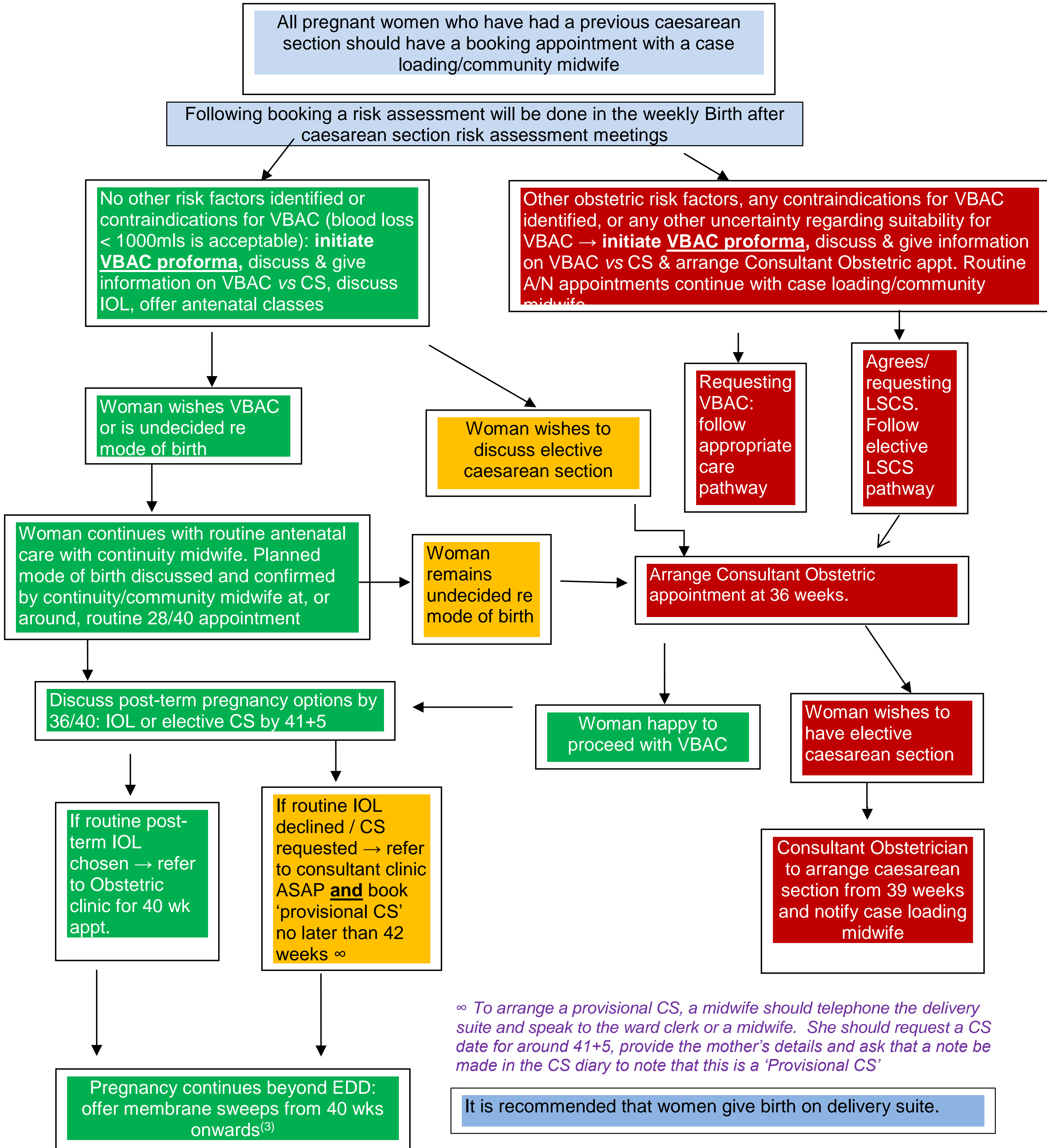
Midwife Antenatal Pathway

- Where women are on a **midwife-led antenatal** birth after caesarean section (BAC) care pathway:
  - Her case loading/community midwife is responsible for ensuring that that the woman has a decision and plan regarding mode of birth recorded in her hand-held antenatal notes at, or around, 28 weeks of pregnancy. In addition an outline of the plan in the 'green' handheld notes –on 'management plan page'
  - The case loading/community midwife, is responsible for referring to a Consultant Obstetrician if complications arise in pregnancy or to discuss post-term pregnancy options after 40 weeks. The case loading midwife should discuss post-term pregnancy options **by 36 weeks.**
  - If a caesarean section is requested by the woman or she is undecided, the woman should have an appointment made in the Consultant Obstetric antenatal clinic at the earliest opportunity.

Obstetric Led Antenatal Pathway

- Where woman are on a **Obstetric led antenatal** birth after caesarean section (BAC) care pathway:
  - Women will continue to have combined care with their case loading/community midwives and will be booked into the Birth Choices clinic to have a debrief of their previous birth experience (if delivered at Bedford).
  - A discussion about the risk & benefits of VBAC & repeat Caesarean will take place and be recorded on the decision tool (appendix 1). The aim is to enable the woman to make an informed choice.

BEDFORD HOSPITAL CLINICAL CARE PATHWAY FOR WOMEN WHO HAVE HAD A PREVIOUS CAESAREAN SECTION



Factors associated with increased chances of VBAC success

Table 1: Factors associated with increased chances of VBAC success

- Previous vaginal birth (increases success to 85-90%)
- Greater maternal height
- Maternal age < 40yrs
- BMI < 30
- Gestation < 40wks
- Infant birth weight < 4kg (or similar/lower than that of the previous CS birth weight)
- Spontaneous labour
- Cephalic presentation with head engaged, or at a low station
- Favourable cervix on admission
- Previous CS performed for fetal presentation (eg breech) (84% success) compared to previous CS for labour dystocia (64%), fetal distress (73%) or unsuccessful IOL. Previous unsuccessful instrumental birth led to a success rate in one study of 61% (but was reduced if the indication for the instrumental birth was OP position and prolonged 2nd stage)
- Previous labour dystocia performed after ≥ 8cms compared to < 8cms (but inconsistent data).

Contraindications for VBAC are:

- Previous CS with classical CS, Inverted T or J incision
- Previous uterine rupture
- 5 or more previous C/S
- Presence of contraindication to labour; such as placenta praevia or malpresentation.

A cautious approach is advised, due to uncertainty about the safety and efficacy of planned VBAC in pregnancies complicated by:

- Significant inadvertent uterine extension at time of primary CS
- Previous myomectomy or perforation at the time of intra-uterine instrumentation e.g. termination of pregnancy or evacuation of retained products, and should be discussed with the Consultant Obstetrician on an individual basis.
- Twin gestation
- Fetal macrosomia
- Short inter delivery interval (< 12-24 months from previous C/S)
- Maternal age > 40years
- Post-term pregnancy
- Antepartum stillbirth.

Women with special circumstances (2 or more Caesareans)

Women who have had 2-4 caesarean sections who request a VBAC will have an appointment with the Consultant obstetrician to review the plan with the woman and wherever possible will be attended by the woman's case loading midwife.

Research into outcomes following 2 or more Caesarean sections is conflicting. A systematic review by Tahseen & Griffiths (2010) has suggested women should be informed of the uterine rupture rate (1.36%) and the comparable maternal morbidity to the CS option. In this review, rates of hysterectomy and blood transfusion were increased in women undergoing VBAC after 2 previous CSs, compared with one previous CS. However Landon et al (2006) found no significant difference in the rates of uterine rupture in VBAC with 2 or more previous CS births compared with a single previous CS. Providing

women have been informed by a senior obstetrician of the increased risks and a comprehensive individualised risk assessment has been undertaken of the indication for and the nature of their previous CS births, then planned VBAC may be supported in women with 2 or more previous CS births (RCOG 2017).

Induction of Labour with VBAC

1. Women should be offered a cervical sweep from 40 weeks gestation if VBAC is planned and labour has not occurred and this may be repeated, if desired, every 2-3 days (De Miranda (2007).
2. IOL should be discussed with all women planning VBAC by 36 weeks gestation initially by a midwife and followed up by an Obstetrician at 41 weeks. Women who are planning a VBAC may be offered induction of labour at 40+12

3. Women should be informed of the 2-3-fold increased risk of uterine rupture with induction of labour compared with spontaneous labour (140-240/10,000 if Prostaglandins are used and 80/10,000 if non-Prostaglandins are used) and 1.5-fold increased risk of CS in induced or augmented labours compared to spontaneous labours.

4. If the woman wishes to proceed with post-term IOL, she should be referred to a consultant obstetrician at 41 weeks who should discuss a plan for Induction, Elective LSCS or wait for spontaneous labour as detailed in pathway. The decision to induce labour, proposed method, augmentation with syntocinon, time intervals between serial VEs and the selected parameters of progress that would lead to a recommendation for CS and discontinuation of VBAC should also be discussed (RCOG 2017).

An individual management plan for labour must be documented in the 'yellow' birth notes.
The management plan for labour should include the provision for management of a preterm labour/delivery. Up to 10% of women scheduled for Elective LSCS go into labour before the 39th week of pregnancy (RCOG 2017).

Methods of induction of labour:

a) Amniotomy preferable.
b) Not more than one prostaglandin pessary should be used.
c) Judicial use of oxytocin, with extra vigilance.
d) Use of prostaglandin and oxytocin together preferably avoided.

Induction of labour using mechanical methods (amniotomy or Foley catheter) is associated with a lower risk of uterine scar rupture compared with induction using prostaglandins (RCOG 2017).

There should be serial cervical assessments, preferably by the same person, to ensure adequate cervical dilatation. If progress deviates from these parameters for review by duty Registrar

OXYTOCIN
Oxytocin is associated with an increased risk of scar rupture. 1.1% in women who are augmented in labour (RCOG 2017)

- The use of oxytocin must be discussed and agreed with the duty Consultant
- Oxytocin may be used if amniotomy alone is ineffective or cervical dilatation is less than 1cm per hour in established labour but ensure that;
- No more than 4 contractions are occurring in a 10-minute period
- The uterus returns to normal resting tone between contractions

Refer to Augmentation of Labour guideline

Uterine Hyperstimulation
This is defined as a period of more than 5 contractions in a ten-minute period occurring for a period of at least 10 minutes or a contraction lasting at least 2 minutes (NICE, 2001), with or without fetal heart rate changes. If this occurs discontinue the oxytocin and administer Subcutaneous Terbutaline 0.25 milligrams (NICE 2001) inform Registar or consultant Obstetrician.

Recommendations for the mother include

- Plan to deliver in a hospital where there is immediate access to facilities for emergency caesarean and neonatal resuscitation equipment.

- Continuous fetal heart monitoring (telemetry to promote mobility) to aid possible early detection of scar rupture (refer to Fetal Heart monitoring guideline). It is uncertain whether continuous cardiotocography in VBACs allows risks to be identified sooner than if intermittent auscultation is used (NICE 2019). Therefore if a woman requests intermittent ausculatation of the fetal heart it should be undertaken.

- Intravenous access for urgent blood transfusion **is no longer recommended as the risk is unlikely to be higher in these women** (NICE 2019).

- 4 hourly assessment of cervical dilatation in established labour to ensure adequate progress is being made.

- Routine amniotomy in women in labour with previous caesarean section **should not be offered** (NICE 2019).

Water birth- Women in spontaneous labour have a lower risk of uterine rupture and can be offered the 'VBAC in water pathway' with telemetry CTG monitoring. There is no evidence that the use of the birthing pool for pain relief is contraindicated for these women (NICE 2019).
Women who are being induced or have other risk factors in pregnancy may use the birthing pool after a risk assessment using the water birth for women with risk factors management plan with the senior Midwife in charge or Obstetrician.
Telemetry CTG monitoring should be offered for the water birth pathway unless declined by the woman (see Birthing pool guideline). The risk and benefits of her choices must be explained to her, escalated to the senior midwife in charge and senior obstetrician. These discussions must be documented including the woman's responses.

WOMEN WHO REQUEST HOME BIRTH

Home birth, some mothers may choose to give birth at home however this should not be recommended (RCOG 2017).
The case loading midwife must provide information to enable an informed choice to be made and counsel women about the risks of scar rupture and the consequences of delay in treatment should this happen.

An appointment should be made with the consultant obstetrician to discuss the woman's preferences, where ever possible the woman's case loading midwife should also attend (Refer to Care planning for women requesting maternity care outside of local and national guidance).

Foster a supportive enabling relationship.

In the event that a woman continues in her wish for a home birth seek advice and support from the Community Matron, Professional Midwifery Advocates (PMA) and Home birth continuity team.

Ensure that accurate records are maintained including the content and results of all discussions and decisions made.

Practice point – Abnormalities in the fetal heart rate including prolonged fetal heart decelerations, variable decelerations and bradycardia and/or abrupt cessation of uterine contractions may be among the first signs of scar rupture and is why continuous electronic monitoring is recommended. (Refer to 'Home Birth' and 'Fetal Heart Monitoring' guidelines).

INTRAPARTUM CARE: VBAC

1. Spontaneous onset of labour is desirable. All women admitted in labour should be allocated an consultant obstetrician if they do not already have one. The Obstetrician on call should be made aware of all women admitted in labour who plan for a VBAC.

2. All women will receive continuous 1:1 care in labour as outlined in the clinical guideline 'Care of Women in Labour'. Continuous care in labour is important to enable prompt identification and management of uterine scar rupture. Water or isotonic drinks can be given in labour and Ranitidine 150 mgs should be administered orally every six hours.

3. Continuous CTG is recommended in established labour with the onset of regular uterine contractions. An abnormal CTG is the most consistent finding in uterine rupture and is present in 66-76% of events (RCOG 2017). NICE (2019) have concluded that it is uncertain whether continuous cardiotocography in these circumstances allows risk to be identified sooner than if intermittent auscultation is used. Therefore if a woman requests intermittent auscultation of the fetal heart it should be undertaken as per the fetal monitoring guideline and the discussion and the woman's decision documented in the maternity notes. The co-ordinating midwife and obstetric registrar & consultant should be informed of the woman's choice.

4. Women should be encouraged to mobilise and remain in upright positions during labour. They should be encouraged to use the birthing pool with fetal heart monitoring using telemetry, if they so wish. The benefits of immersion in water should be discussed and women should be informed that the normal birth rate on the water birth pathway with risk factors is 75% (Leonard 2018)

5. Intravenous access for urgent blood transfusion **is no longer recommended as the risk is unlikely to be higher in these women** (NICE 2019).

6. Assessment of cervical dilatation should be undertaken no more frequently than 4 hourly in established labour, preferably by the same person, to ensure there is adequate progress of cervical dilatation RCOG (2017)

7. If augmentation of labour is required in spontaneous labour, a senior obstetrician should discuss the following with the woman: the decision to augment labour with oxytocin, the time intervals for serial vaginal examination and the selected parameters of progress that would necessitate discontinuing VBAC (RCOG 2017). Adequate progress should be made within 8 hours of established labour (4cms) or from commencement of syntocinon.

8. If a fetal blood sample (FBS) is required, this should be discussed with a consultant. There should be documented evidence of assessment for signs of scar dehiscence and if an FBS is not undertaken, reasons for this should be clearly documented in the woman's notes.

9. An epidural is not contra-indicated but women should be informed that an epidural increases delay in 2nd stage and instrumental birth. **An increased need for pain relief in labour or breakthrough pain with an epidural should raise awareness of the possibility of impending scar rupture.**

10. The Obstetric Registrar should be informed and should review the woman if birth has not occurred following one hour of active pushing and assess suitability for vaginal delivery or Caesarean section.

Signs of scar dehiscence or uterine rupture
There is no single clinical feature that is indicative of uterine rupture and the presence of any of the following peripartum should raise the concern of the possibility of the scar rupturing and the Registrar must be informed immediately if:

1. CTG abnormalities in labour - occurs in 66-76% of cases (RCOG 2017)
2. Meconium stained liquor
3. Severe abdominal pain especially if persisting between contractions
4. Abdominal pain breaking through a previously effective epidural
5. Chest pain or shoulder tip pain, sudden onset of shortness of breath
6. Acute scar tenderness
7. Abnormal vaginal bleeding or haematuria
8. Cessation of previously efficient uterine activity
9. Maternal tachycardia, hypotension or shock
10. Presenting part seems to 'retreat' into abdomen, loss of station of the presenting part.
11. Easy palpation of fetal parts
12. Change in the abdominal shape and inability to pick up the fetal heart rate.

If any of the above signs or symptoms are detected the midwife must request an urgent obstetric review.
Syntocinon infusion must be stopped immediately if in use.

INDICATIONS FOR EMERGENCY LSCS:

Evidence of scar rupture, proceed to delivery of the fetus within **30** minutes (NICE 2019) where there is evidence suggestive of scar rupture but within **15** minutes whenever possible. **Stop Oxytocin**

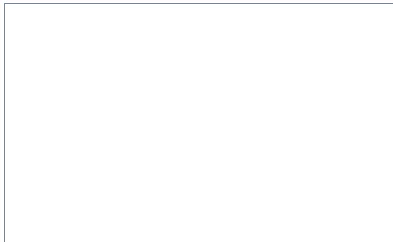
References i.e. NICE guidance, externally recognised reports or research	RCOG (2017) Birth after a Previous Caesarean Section (Green-Top Guideline No. 45), London: RCOG. Available at: www.rcog.org.uk NICE (2019) Intrapartum care for women with obstetric complications overview. NICE guideline [NG121] NICE (2004) Caesarean Section Clinical Guideline 13 Available at: www.nice.org.uk/cg13 NICE (2011) Caesarean Guideline CG13 Available at www.nice.org.uk/cg13
Staff Involved In Development	Version 8 VBAC Team-, Helen Leonard,(Midwifery Team Manager, VBAC lead & Professional Midwifery Advocate) Version 7 –June 2013- Miss Katimada (Consultant Obstetrics and Gynaecology). Claire Angell- Quality and Governance Midwife, VBAC Team

Monitoring / Audit Criteria

Aspect	Method	Frequency	Responsibility	Reporting Arrangements
retrospective case note review as follows	Evidence in notes of:- Management plan will be documented in the obstetric care plan. Documented discussion of the risks and benefits of VBAC and ERCS Use of Continuous fetal monitoring during VBAC labour Decision to induce or augment labour will be made after discussion with the Consultant and the plan for managing progress of labour will be documented	Annual	VBAC/LSCS Case loading Midwifery Team	The Maternity Service measures compliance with the guideline through annual audit. Results from the annual audit will be presented and discussed at the Multidisciplinary Clinical Audit Meeting and/or the Quality Committee Maternity, Paediatric and Sexual Health. Where audit has identified any non-compliance an action plan will be developed to address this, a lead person identified to ensure the actions are carried out and all action plans will be monitored by the Consultant Obstetrician – Audit Lead.

Appendix 1 Shared Woman-Doctor/ Midwife Decision Tool

Patient sticker



Congratulations on your pregnancy. The aim of this tool is to advise you about your birth choices after a caesarean delivery and to discuss the benefits and potential risks of having a vaginal birth after a caesarean section (VBAC) compared to an elective repeat caesarean section. We aim to assist you to make an informed decision about how you would like to give birth this time.

The reason for your previous caesarean section was ....,
Research has shown that in most cases VBAC would appear safer for a mother and baby than an elective repeat caesarean section (RCOG 2017).

During the consultation, the tool will be used to discuss how any factors may or may not affect you and answer any questions that you may have. A copy of this will be filed in your notes for future reference.

Factors for successful VBAC based on previous and current pregnancies

Positive	Negative
Previous VBAC	Induced labour
Previous vaginal birth	Short stature under 152cms
Age < 40 years of age	Birth weight > 4kgs
>4cm on admission in labour	BMI > 30 at booking
Previous caesarean for malpresentaion	Previous caesarean for labour dystocia
Spontaneous Labour	>41 weeks gestation

Due to these risk factors it is recommended that you:

- Plan to deliver in a hospital which has immediate access to facilities for emergency caesarean and neonatal resuscitation equipment.
- Continuous fetal monitoring – telemetry in birthing pool
- Can use the birthing pool in most circumstances
- Assessment of cervical dilatation performed at least 4 hourly in established labour to ensure adequate progress is being made.

Did the woman previously give birth at BGH? □Yes □No

Date previous birth summary has been requested………………… Hospital…………………

□ Midwife led pathway A/N □ Combined Obstetric/Midwife led pathway A/N

Likelihood of: Tick & sign when discussed		**Overall**	
Successful VBAC (one previous caesarean delivery, no previous vaginal birth)		3 out of 4 or 72-75%	☐
Successful VBAC (one previous delivery, at least one previous vaginal birth)		Almost 9 out of 10 or up to 85-90%	☐
Unsuccessful VBAC more likely in: Induced labour, no previous vaginal delivery, body mass index (BMI) greater than 30 and previous caesarean for labour dystocia. If all of these factors are present, successful VBAC is achieved in 40%			☐
Likelihood of:	**VBAC**	**Elective Repeat Caesarean Section (ERCS)**	
	Maternal		
Uterine rupture	5 per 1000/0.5% (x1 C/S (1.36%) ↑2 C/S	2 per 1000/0.2%	☐
Blood transfusion	2 per 100/2%	1 per 100/1%	☐
Endometriosis	No significant difference in risk		☐
Significant complications In future pregnancies:	Not applicable if successful VBAC	Increased likelihood of placenta praevia/ morbidity adherent placenta	☐
Maternal mortality	4 per 100,000/0.004%	13 per	☐
100,000/0.013%		Longer & more difficult procedure, ↑blood clots. Scar tissue resulting in bladder/bowel damage, Longer recovery time	
	Fetal/newborn		
Transient respiratory Morbidity	2-3 per 100/2-3%	4-6 per 100/4-6% (risk reduced with corticosteroids, but there are concerns about potential long-term adverse effect(s)	☐
Antepartum stillbirth beyond 39^{+0}weeks while waiting spontaneous labour	10 per 100,000/0.1%	Not applicable	☐
Hypoxic ischaemic Encephalopathy (HIE)	8 per 10,000/0.08%	<1 per 10,000/<0.01%	☐

Information leaflet(s) provided: VBAC ☐ ERCS ☐ Water Birth ☐

Discussed:

Continuous electronic fetal monitoring at the onset of regular uterine contractions ☐

Birth on the obstetric unit (Delivery Suite) ☐

Management plan in the event of			
	Discussed at 16/40	**Discussed at 36/40**	**Discussed at 40/40**
Preterm Labour	VBAC / EMCS	VBAC / EMCS	VBAC / EMCS
Spontaneous labour before date of ELCS	VBAC/EMCS Depends of stage of labour -	VBAC/EMCS Depends of stage of labour -	VBAC/EMCS Depends of stage of labour -
No spontaneous labour after 41 weeks	Sweep/ IOL/ELCS	Sweep/ IOL/ELCS	Sweep/ IOL/ELCS

For obstetric discussion (if applicable):

Sweep ☐

Induction of labour (give details of agreed plan below) ☐

No spontaneous labour after 41 weeks – discussed with Obstetrician ERCS ☐

Use of oxytocin in labour- discussed with Obstetrician ☐

Risks of IOL discussed with mother:

- 5 per 10,000 **(0.5%)** in women who labour spontaneously
- 0.29 per 10 000 **(0.29%)** in women who are induced without the use of prostaglandins (ARM).
- This is associated with a lower risk of scar rupture compared to induction with prostin.
- **1.2%** in women who are induced using prostaglandins
- **1.1%** in women who are augmented in labour (RCOG 2017)

If previous CS, stillbirth risk after 39wks is 1.5-2 fold higher (0.11% *vs* 0.05%) compared to risk with no previous CS ☐

Woman's preferences:

Details of induction of labour: (eg preferred options: prostin, ARM & Syntocinon)

ERCS booking details:

Additional comments:

Signature: …………………………………… Name & designation: …………………………………………………. Date: ……………………

Appendix 2

NHS
Bedfordshire Hospitals
NHS Foundation Trust

South Wing
Kempston Road
Bedford
MK42 9DJ
Telephone: Bedford (01234) 355122
Fax No: Bedford (01234) 795782

Re: **Hospital/NHS No…………..**
Date…………………..

Dear Colleague,

I am writing to you regarding the Caesarean Section performed at your hospital on _ _ / _ _ /_ _ _ _ .

Currently this woman is booked with us for her subsequent pregnancy. We would be grateful if you could forward her caesarean section summary, as this will help formulate her future management plan.

Yours sincerely

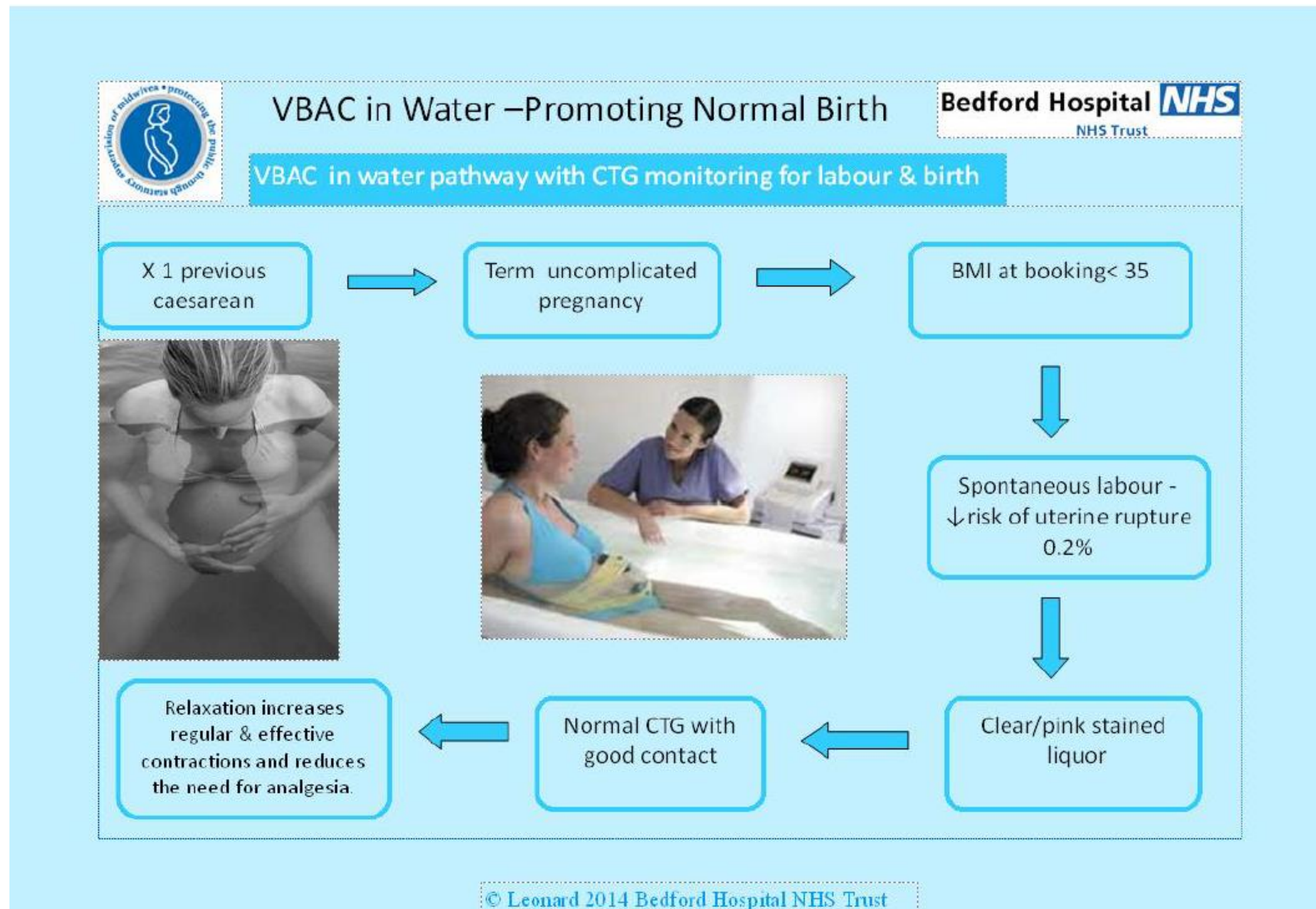
Obstetric Team
Bedford Hospital NHS Trust

To be forwarded to Bedford Hospital Antenatal Clinic secretarial department

Appendix 3 Birth after LSCS patient information leaflet

Vaginal Birth After Caesarean Section - 2019.pub

Appendix 4 - VBAC in water pathway/criteria for exiting VBAC in water pathway



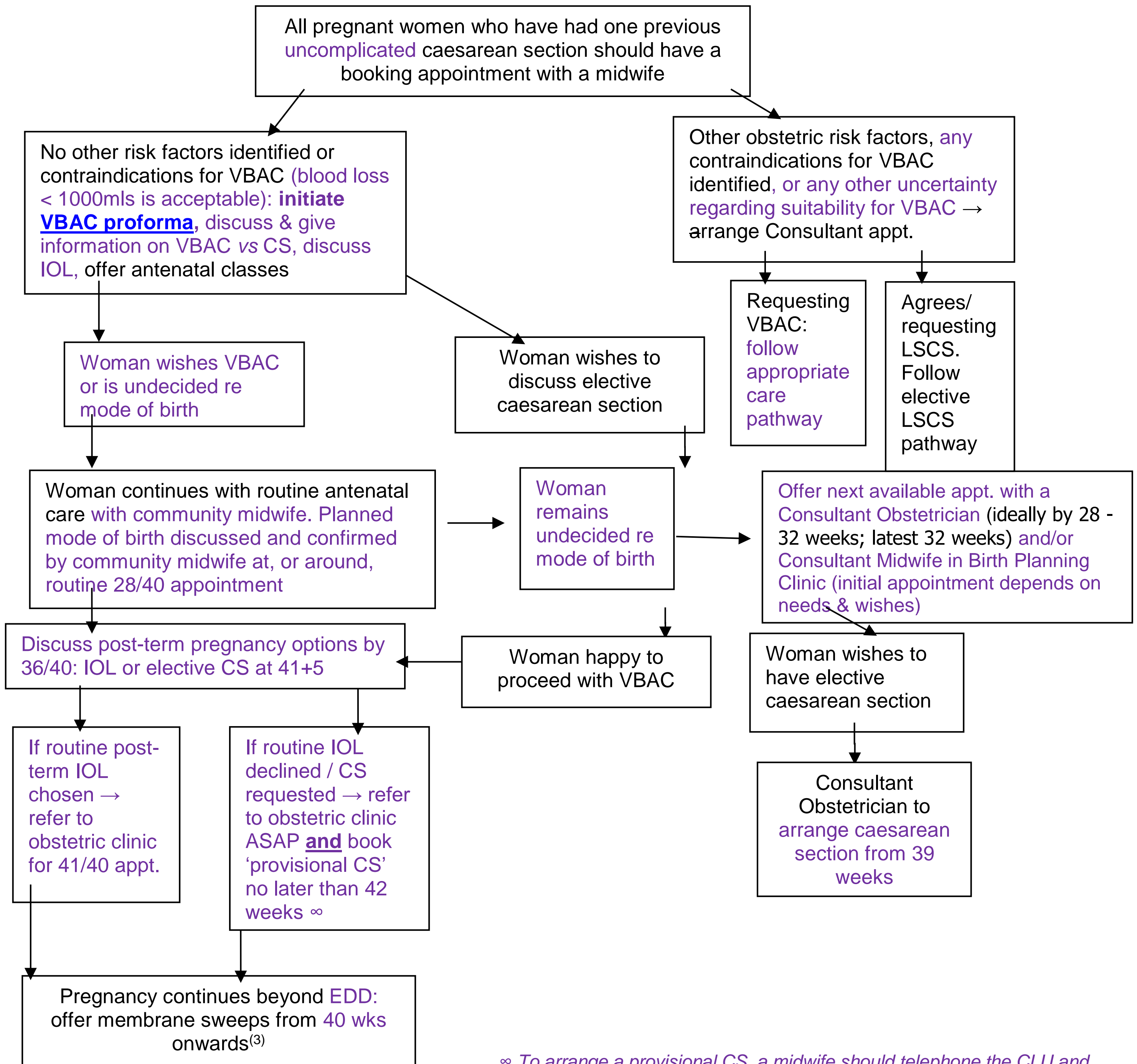
Water birth for women with risk factors pathway **Date:**	Consultant
Risk factors in pregnancy	
Risk factors in labour	
Fetal monitoring in labour	Telemetry CTG Yes/No Intermittent auscultation Yes/NO
Labour in Pool	Yes/No
Birth in pool	Yes/No
Venflon required? (not routinely recommended)	Yes/No
Syntocinon in pool	Yes/No
3rd stage	Active/ Physiological
Reasons for exiting pool discussed	Yes/No
Signature of Reviewing senior Mw/Dr	

Criteria For Exiting Pathway

- An abnormal cardiotocograph (CTG) is the most consistent finding in uterine rupture and is present in 55–87% of these events.
- Severe abdominal pain, especially if persisting between contractions
- Chest pain or shoulder tip pain, sudden onset of shortness of breath
- Acute onset scar tenderness
- Abnormal vaginal bleeding or haematuria
- Cessation of previously efficient uterine activity
- Maternal tachycardia, hypotension or shock
- Loss of station of the presenting part.
- Failure to progress in labour.

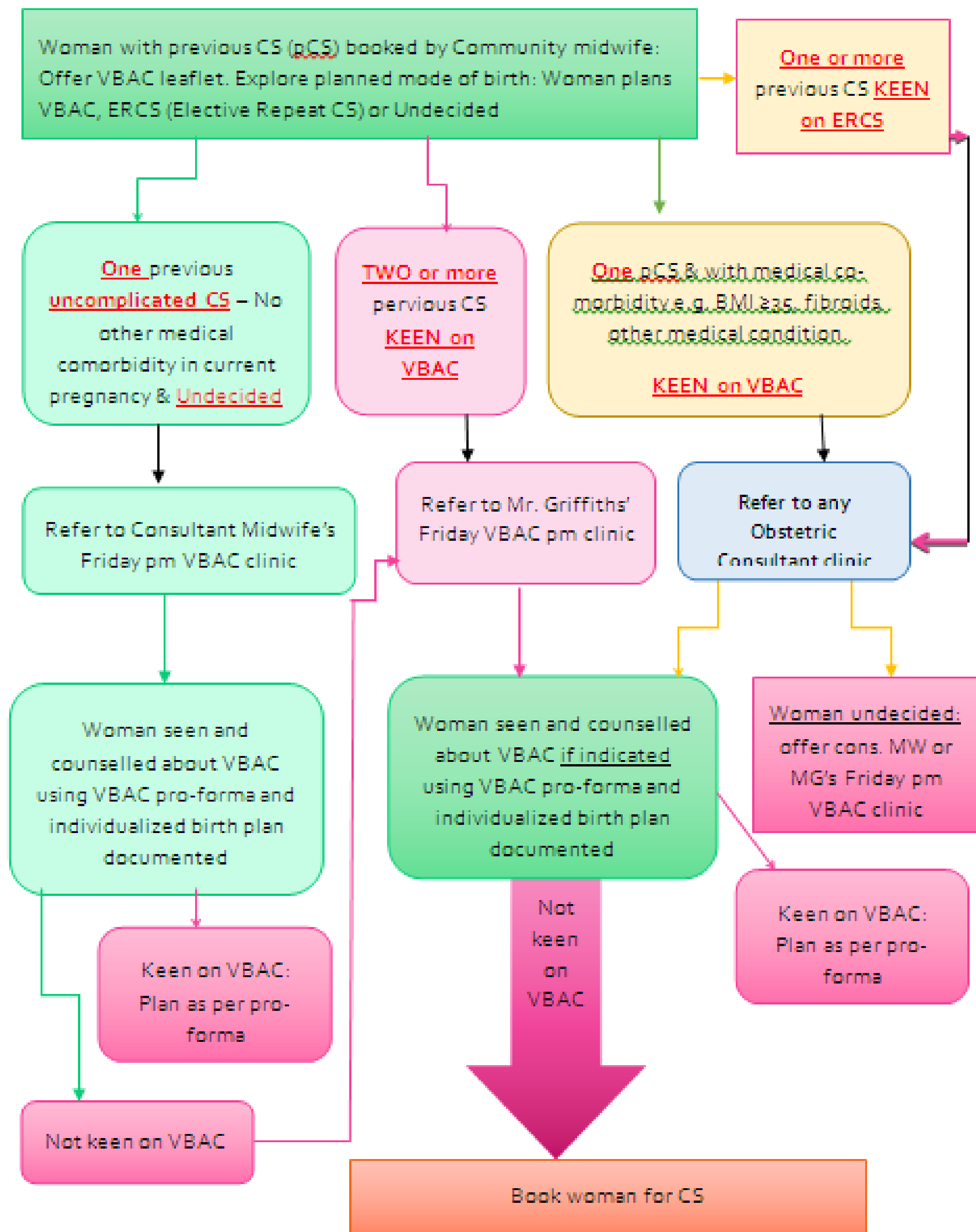
RCOG Green Top Guideline no 45 (2007) Birth After Previous Caesarean Section

Appendix 5 CLINICAL CARE PATHWAY FOR WOMEN WHO HAVE HAD ONE PREVIOUS CAESAREAN SECTION BOOKED AT LISTER HOSPITAL



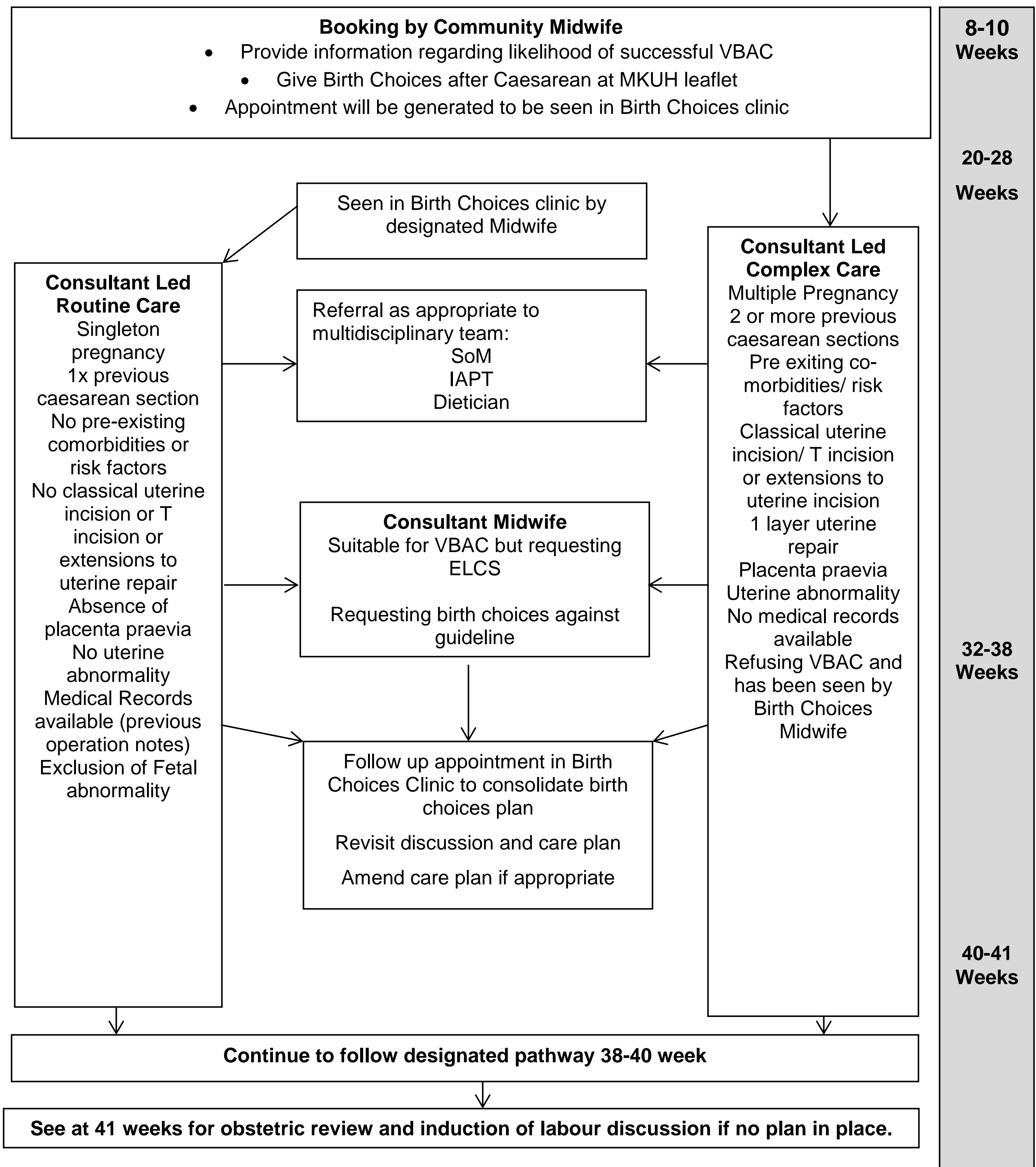
∞ To arrange a provisional CS, a midwife should telephone the CLU and speak to the ward clerk or a midwife. She should request a CS date for around 41+5, provide the mother's details and ask that a note be made in the CS diary to note that this is a 'Provisional CS'

Appendix 6 CLINICAL CARE PATHWAY FOR WOMEN WHO HAVE HAD ONE PREVIOUS CAESAREAN SECTION BOOKED AT LUTON & DUNSTABLE HOSPITAL.



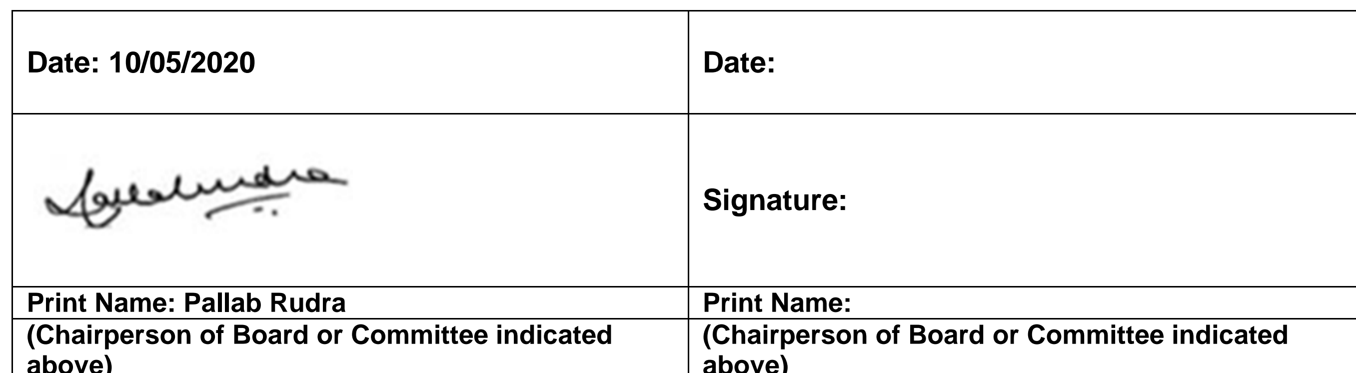
Mr. Bright Gyampoh, Stella Roberts, Mr Malcolm Griffiths (July 2016) Version 2

Appendix 7 CLINICAL CARE PATHWAY FOR WOMEN WHO HAVE HAD ONE PREVIOUS CAESAREAN SECTION BOOKED AT MILTON KEYNES HOSPITAL.



Approving Signatories

Name of Leading Sub-Committee / Business Division Approving this Guideline: **Women and Children's**

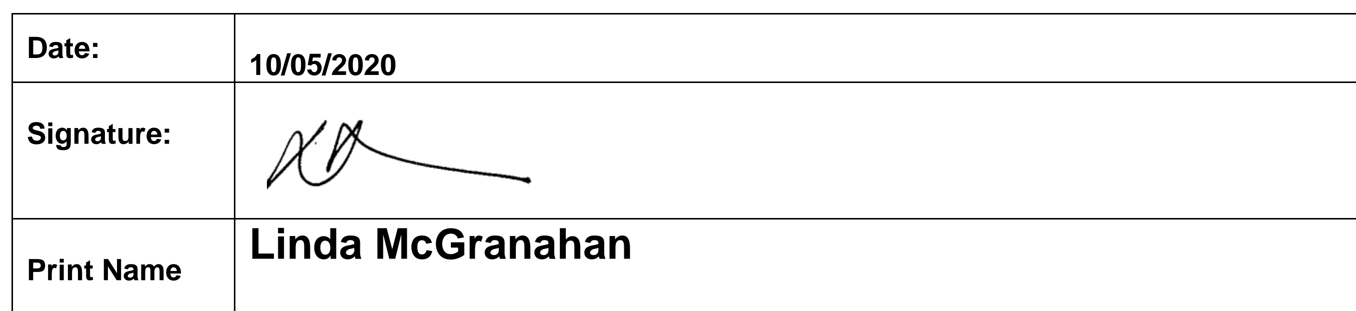


Date: 10/05/2020	Date:
	Signature:
Print Name: Pallab Rudra	Print Name:
(Chairperson of Board or Committee indicated above)	(Chairperson of Board or Committee indicated above)

Name of Other Sub-Committee / Business Division involved in Approval of Guideline: ____________________

Date:	Date:
Signature:	Signature:
Print Name:	Print Name:
(Chairperson of Board or Committee indicated above)	(Chairperson of Board or Committee indicated above)

Ratification Signature
Approved by Associate Director of Operations – W&C



Date:	10/05/2020
Signature:	
Print Name	Linda McGranahan

Consultation List A completed list should accompany **every** guideline/policy (This gives evidence on who has seen this Guideline and any comments made)		NHS Bedfordshire Hospitals NHS Foundation Trust
Name of Person	**Department or Committee**	**Comments**
Lilianna Grosu	Consultant Obstetrician	Comments included
Mary Esymot	Consultant Obstetrician	No comments received
Thanga Katimada	Consultant Obstetrician	Comments included
Karl Hattotuwa	Consultant Obstetrician (Labour Ward Lead)	Comments included
Sarah Reynolds	Consultant Obstetrician	Comments included
Dilip Patil	Consultant Obstetrician	No comments received
Pallab Rudra	Consultant Anaesthetist	No comments received
Amanda Pachulski	Better Births Project Midwife	Comments included
Claire Garett	Matron – Community & ANC	Comments included
Oonagh Purdy	Matron – Maternity Risk	No comments received
Shirley Jones	Head of Midwifery	No comments received
Team managers, Midwives	Team Leads Delivery Suite and Midwives	Comments included
Linda McGranahan	Director of Operations CBU Obstetrics, Gynaecology and Sexual Health	No comments received
S Prince	Matron Inpatients	No comments received
Suzi Adacen	Ward Manager Delivery Suite	No comments received
M Reid, K Nelson, C Johnson, T McCann	Professional Midwifery Advocates (PMA's)	No comments received
L Church, J Shields, Rebecca Burrows, E Davis, P Mason, S Norris & N Robinson	Bluebelles case loading midwives	No comments received
Service users	NCT, Maternity Voices Partnership	Comments added