(BIRTH AFTER CAESAREAN (BAC)

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Target Audience:

People who need to know about this document in detail	All obstetric and midwifery staff including locum and agency staff working in CTM UHB
People who need to have a broad understanding of this document	As Above
People who need to know that this document exists	All Obstetric and Midwifery staff

Integrated Impact Assessment:

Equality Impact Assessment Date & Outcome	**Date: December 2024**
	Outcome: There is no negative impact
Welsh Language Standard	Choose an item.
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Aligns to the following Wellbeing of Future Generation Act Objective	Choose an item.

Disclaimer:
If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Contents

Guidelines Definition

Clinical guidelines are systemically developed statements that assist healthcare provider and patients in determining the most suitable course of action for medical conditions. They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Introduction

With rising prevalence of caesarean births, more women require counselling during subsequent pregnancies to support informed decisions regarding their mode of birth.

For the majority of women with a single previous lower segment caesarean section (LSCS), planning a vaginal birth is a clinically safe option for mother and baby. A successful vaginal birth after caesarean section (VBAC) reduces the overall chance of adverse outcome when compared to an elective repeat caesarean section (ERCS).

Of the women in CTM UHB who attempt VBAC in 2023, 43% progressed to a vaginal birth. This sits lower than 72-75% of women cited by RCOG (2015).

Purpose and Scope

This is a woman-centred pathway, ensuring that women receive current evidence based information and have the opportunity to discuss their options in order to make the right choices for themselves and their families.

The guideline will support maternity teams, particularly midwives and obstetricians, and when discussing and planning births with women who have had a previous caesarean birth, with a focus on promoting individualised care and choice, and reducing maternal morbidity linked with multiple caesarean births.

Definitions

- Vaginal Birth after Caesarean (VBAC)
  VBAC stands for 'vaginal birth after Caesarean'. It is the term used when a woman gives birth vaginally after having a caesarean birth in the past.
- Elective Repeat Caesarean Section (ERCS)
  An elective repeat caesarean birth is a planned caesarean birth which is usually scheduled from 39 weeks gestation.

Objectives

- Standardise the antenatal counselling and information provided to women who have had a previous caesarean birth.
- Support and facilitate informed decision making for women who have had a previous caesarean birth.
- Standardise the antenatal care and birth planning provided to women who have had a previous caesarean birth.

Equality Impact Assessment Statement

- This Procedure has been subject to a full equality assessment and no impact has been identified.

Related Guidelines:

- Fetal Monitoring Guideline (CTMUHB) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/fetal-monitoring-guideline/
- Induction of Labour (including arrest of labour) Guideline (CTMUHB) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/induction-of-labour-guideline-including-arrest-of-labour/
- Management of Intrapartum Care Guideline (CTMUHB) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/intrapartum-care-guidelines/
- Royal College of Obstetricians & Gynaecologists (RCOG) *'Birth options after previous caesarean section'* information leaflet pi-birth-options-after-previous-caesarean-section.pdf (rcog.org.uk)
- CTMUHB *'Steroids before planned elective caesarean birth'* information leaflet wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/steroids-before-planned-elective-caesarean-birth-patient-information-leaflet/
- National Institute for Health and Care Excellence (NICE) Shared decision making guideline Shared decision making (nice.org.uk)
- National Institute for Health and Care Excellence (NICE) Intrapartum Care guideline Intrapartum care (nice.org.uk)
- Management of SROM at term Guideline (CTMUHB) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/management-of-pre-labour-spontaneous-rupture-of-membranes-srom-at-term-37-0-gestation/
- Water Immersion Guideline (CTMUHB) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/water-immersion-for-labour-and-birth/
- Management of Uterine Rupture Guideline (CTMUHB) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/uterine-rupture-management-guideline/

Antenatal care and schedule for women with previous caesarean birth

1) At the initial pregnancy booking appointment, the community midwife should discuss the recommended care pathway for women who have had a previous caesarean birth, and provide the woman with the RCOG information leaflet 'Birth Options after Caesarean Section' (Appendix 1).
2) In addition to the routine schedule of antenatal midwifery care, women who have had a previous caesarean birth should be referred to a consultant obstetrician, with an appointment scheduled between 21-28 weeks gestation.
3) It is recommended that women have shared-care (between the named community midwife/team, and the named consultant obstetrician) during the antenatal and intrapartum care.

Gestational Age	Place	Action
12 weeks	Community midwife/ Antenatal clinic midwife	Review obstetric risk factors. If previous caesarean birth, refer to general antenatal clinic using routine referral pathways
20 weeks	Anomaly scan	If a low-lying placenta is identified, please follow the Placenta Praevia guideline
21 - 28 weeks	Consultant-led antenatal clinic	Review previous labour and birth notes. If the birth occurred in another Health Board/Trust, request information by letter. Assess individual risks and benefits for VBAC and ERCS. Fully discuss birth options with woman. The woman's wishes should be explored and respected. Document this discussion on the birth after Caesarean (BAC) checklist proforma, which should be filed in the handheld maternity notes. Provide RCOG VBAC information leaflet (if this has not already been provided). Women should be made aware that if opting for VBAC, the recommended care pathway includes birth on an obstetric-led unit and continuous fetal monitoring during labour. All women requesting birth outside of the obstetric unit (including home, freestanding midwife-led unit or alongside-led unit) should be referred to the consultant midwife. Discuss: • Counselling around birth options - It is woman's choice if she chooses elective caesarean birth and discussion should include if spontaneous labour occurs before the planned date of caesarean. • 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), and their preference for mode of birth if pre-term labour commences

		• Mode of birth if spontaneous labour commences before the ERCS date • Considerations regarding induction of labour (including the increased risks associated with induction or augmentation of labour with previous caesarean birth). • Discuss postnatal contraception, and if opting for ERCS, discuss sterilisation/ insertion of contraception coil at the time of caesarean section if this appropriate. If the woman is unsure regarding mode of birth, after a discussion with their obstetrician and named community midwife, offer referral to the consultant midwife clinic for further discussion and support. If the woman chooses to plan for VBAC, and there is no other indication for consultant-led antenatal care then: • The woman should receive routine scheduled midwifery antenatal appointments • The woman should be offered an appointment in the obstetric antenatal clinic for 40+ weeks to discuss an ongoing plan of care.
36 weeks	Consultant-led antenatal clinic	Required for women requesting ERCS or unsure of mode of birth at the 21-28 weeks appointment. Discuss risks and benefits of each birth option and agree a plan regarding mode of birth. If requesting ERCS, book and consent for ERCS from >39 weeks gestation, unless indicated otherwise. Discuss possibility of spontaneous labour prior to scheduled ERCS date, and document decision regarding mode of birth in this situation (emergency caesarean section vs VBAC). Discuss postnatal contraception options and provide postnatal contraception leaflet. Clearly document the decision and plan in woman's handheld records.
39-40 weeks	Consultant-led antenatal clinic	Required for women wishing to have VBAC. A senior Obstetrician should assess individual risks for induction of labour. Discuss the risks, which increase with induction of labour or augmentation of labour. Offer membrane sweep and perform if accepted. Clearly document Bishop score in the maternity notes. If woman chooses induction of labour, the timing of induction should be discussed and agreed between the woman and the consultant obstetrician or senior obstetric registrar, taking into account her preferences and priorities for birth.

		If woman declines induction of labour and requests a caesarean birth providing the woman has been counselled and is making an informed decision this can be booked. If the woman declines induction of labour and wants her pregnancy to go over 40+12 weeks to await spontaneous labour a senior obstetric review and individualised management plan will be required. Discuss post-dates caesarean section to allow every opportunity for spontaneous labour to commence. Timing of planned caesarean birth should be discussed and agreed between the woman and the consultant obstetrician or senior obstetric registrar.
Labour and Birth	Consultant-Led Unit	When in established labour women undergoing VBAC should be recommended: • Intravenous access with FBC and Group & Save, confirming suitability for Electronic Issue (EI) • Continuous FHR monitoring via cardiotocograph (CTG) or wireless telemetry
Labour and Birth	Midwife-Led Setting	Will be require an 'Individualised Outside of Recommended Guidance' plan via SBAR format (Appendix 3)

Informed Decision Making

The following principles around informed decision making Shared decision making (nice.org.uk) should be used during counselling, including:

- Encouraging people to talk about what is important to them
- Communicating with people in a way they can understand
- Using clear language, avoiding jargon and explaining technical terms
- Sharing and discussing the information needed to make informed decisions
- Making sure that the woman understands the choices available to her (including the choice of doing nothing or not changing her current plan)
- Accept and acknowledge that people may vary in their views about the balance of risks, benefits and consequences of treatments, and that they may differ from those of their healthcare professionals.

Explore risks/benefits/alternatives using the B.R.A.I.N pneumonic

Benefits - What are the benefits of the proposed plan?

Risks - What are the risks of the proposed plan?

Alternatives - What are the alternatives to the proposed plan?

Intuition - What does the woman feel about what is right for her, knowing her body and any previous birth experience?

Nothing - What could happen if the woman does nothing, or says 'not now' and takes some time to think?

Antenatal Counselling and Discussing Birth Choices

Information regarding the benefits and risks of VBAC compared with Elective Repeat Caesarean Section (ERCS) are detailed on the VBAC Counselling Proforma (Appendix 2).

An individual assessment should be performed at the initial consultant antenatal clinic appointment, to:

- Assess the individual likelihood of success about VBAC for each woman;
- Identify and discuss any contraindications for VBAC;

This assessment should be clearly documented on the BAC counselling proforma (Appendix 2), and filed within the handheld records.

Planned vaginal birth after caesarean	Planned caesarean section
Between 72-75 in 100 women (72% - 75%) who plan a vaginal birth after a caesarean section are able to have one. This is the same chance as a woman who has not had a baby before. If a woman has also had a previous vaginal birth, the chance of having another vaginal birth is around 9 out of 10 (90%). Previous vaginal birth is independently associated with a reduced risk of uterine rupture. Previous caesarean birth due to Malpresentation (breech presentation), success rate can be up to 84%. Difficulties with the pregnancy or during labour might mean that a woman needs to have a caesarean section The rate of births assisted with forceps/ventouse is increased with VBAC (This can be up to 39%) There is a reduced chance of having a vaginal birth with the following factors: • a woman has a raised Body Mass Index (≥30); • aged >40yrs • labour is induced; • a woman has never had a vaginal birth, • if there was previous labour dystocia – which means the cervix stopped dilating past a certain point (particularly <8cm cervical dilatation). The presence of these factors does not contraindicate VBAC, but may be considered in	About 98 in 100 (98%) women who plan a repeat caesarean section are able to have one. There is the ability to plan birth date however this may change due to clinical circumstances, and acuity/activity of the obstetric unit Small increased risk of placenta previa/accreta and adhesions with successive caesarean /abdominal surgery Virtually avoids risk of ruptured uterus (0.02%) Reduces risk of pelvic organ prolapse and urinary incontinence in short term Option for sterilisation if fertility no longer required. **However, this should not be a determining factor for caesarean section**. Risk of bladder ureteric /bowel damage (1/1000) There is no risk of obstetric anal sphincter injury with ERCS If a woman goes into labour before her caesarean section date, and labour is advanced by the time she reaches the hospital, it may be safer for the woman and her baby to continue with a vaginal birth Around 10 in 100 (10%) women who plan a repeat caesarean section go into labour before their scheduled caesarean section date. Unless a woman is in advanced labour, she should still be able to have a caesarean section if she wishes.

the decision-making process, especially if considering induction or augmentation of labour. 1 in 200 (0.2-0.5%) chance of having uterine rupture. This risk increases 2 - 3 times if labour induced If VBAC is successful , this is associated with a shorter recovery period Risk of anal sphincter injury 3rd/4th degree tear 5 in 100 (5%) with birth weight the strongest predictor of this Reduced risk of venous thrombosis Risk of maternal death 4 in 100,000 Successful VBAC has the fewest complications and increases likelihood of future vaginal births Unsuccessful VBAC resulting in emergency caesarean section has the greatest adverse outcomes associated Around 25 in 100 women (25%) who choose a vaginal birth will have an unplanned caesarean section during labour (this is much lower for women with uncomplicated pregnancy planning birth in a midwife-led setting). A caesarean section will be recommended if there is any immediate risk to a woman or her baby, or if labour is not progressing.	There is a longer hospital stay and recovery period following ERCS. Risk of maternal death with ERCS 13 in 100,000 If BMI is raised there is an increased risk of surgical/venous thromboembolic complications
Respiratory distress syndrome. A temporary breathing problem occurring in some mature babies (born after 37 weeks) happens to less than 1 in 1000 babies born by vaginal births after caesarean section	Respiratory distress syndrome. A temporary breathing problem occurring in some mature babies (born after 37 weeks) happens to around 4 – 6 in 1000 babies born by repeat caesarean section and is limited by ensuring the caesarean section is booked for no earlier than the 39 weeks gestation
Planned VBAC associated with 10 in 10,000 prospective risk of antepartum still birth beyond 39+0 weeks (this chance is the same as any other woman with the ongoing pregnancy >39 weeks gestation) 4 in 10,000 (0.04%) risk of birth-related perinatal death (this risk is comparable to the risk of nulliparous woman in labour).	

8 in 10,000 (0.08%) risk of Hypoxic Ischaemic Encephalopathy (HIE), which can be explained to women as 'a brain injury of varying severity caused by low oxygen to baby's brain in labour'. Absolute risk is minimal.	1 in 10,000 (0.01%) risk Hypoxic Ischaemic Encephalopathy (HIE), which can be explained to women as 'a brain injury of varying severity caused by low oxygen to baby's brain in labour'. Absolute risk is minimal.
This is a condition where the baby breathes abnormally fast. It may happen if the baby is born <39 weeks gestation, and is often treated by giving the baby oxygen or antibiotics. It is not life threatening and usually stops after a day or two. Babies with transient tachypnoea may need a short stay in a neonatal unit (NNU) for observation Occurs in about 26 in 1000 babies born vaginally	This is a condition where the baby breathes abnormally fast. It may happen if the baby is born <39 weeks gestation, and is often treated by giving the baby oxygen or antibiotics. It is not life threatening and usually stops after a day or two. Babies with transient tachypnoea may need a short stay in a neonatal unit (NNU) for observation Occurs in about 36 in 1000 babies born by caesarean section
	7 – 31 in 1000 babies (around 2%) are accidentally cut by the doctor during caesarean birth. This is more likely during an unplanned caesarean section (when the waters have gone) than a planned caesarean section. The cuts can occasionally leave scars.
Women who choose a vaginal birth are to choose either another vaginal birth or a planned caesarean section in future pregnancies If a woman has a successful vaginal birth this time, her chance of having a successful vaginal birth in the future with a straightforward recovery will be higher. About 94 in 100 (94%) women who have a successful vaginal birth after a caesarean section, have a successful second vaginal birth. If a woman has an assisted vaginal birth (with forceps or ventouse), the chance that she will need an assisted birth next time will be much lower.	Women who have an unplanned caesarean section or where their plan changes to an elective caesarean section, may affect a woman's chances of having a vaginal birth next time. Having multiple caesarean section increases the risks of morbidly adherent placenta (placenta praevia/acreta/adhesions) and increases the likelihood of further caesarean section, and increases risk to the woman during this birth (including postpartum haemorrhage and hysterectomy).

Planned VBAC in special circumstances

- VBAC can be offered as an option to women undergoing pre-term birth, with a history of prior caesarean birth. Women undergoing a pre-term VBAC should be informed that rates of success are similar to VBAC at term, and the chance of uterine rupture is substantially less (34 in 10,000 compared to 74 in 10,000), and the same perinatal outcomes.

- Women who have had two previous lower segment caesarean births may be offered VBAC after counselling by a consultant obstetrician. This should include the risk of uterine rupture (1.36% in women with two previous caesarean births) and maternal morbidity, and the individual likelihood of successful VBAC (e.g. given a history of prior vaginal delivery), and the woman's decision should be supported following review of the previous births and discussion of the risks and benefits.

- For women preferring to plan VBAC with three or more previous caesarean births, antenatal counselling should be supported by a consultant obstetrician. Counselling should include discussion and documentation around the limitations o the evidence base, an opinion around risk of scar rupture considering current and previous obstetric history, and comprehensive plan for the intrapartum period, to include expected progress of labour, and cervical dilatation and plan in case of primary or secondary labour dystocia.

Contraindications

Previous Uterine Rupture

There is limited observational data, but a higher uterine rupture risk (5% or higher) of recurrent uterine rupture with labour is reported. Repeat elective caesarean section is recommended.

Previous inverted T or J incisions, low vertical uterine incisions, or significant inadvertent uterine extension at the time of primary caesarean

There is insufficient evidence to support the safety of VBAC in these circumstances. Repeat elective caesarean section is recommended.

Women who have complicated uterine scars should be reviewed by a consultant obstetrician.

Previous classical uterine incision (high vertical)

VBAC is contraindicated due to the high risk of uterine rupture. Elective repeat elective caesarean section (ERCS) is recommended.

Previous uterine surgery

There is uncertainty if women are at an increased risk of uterine rupture where a woman has had previous uterine surgery, for example, laparoscopic or abdominal myomectomy.

Women who have such uterine surgery should be considered to have risks at least equivalent to those of women with one previous caesarean birth, and managed similarly in labour.

In cases where the uterine cavity has been breached, elective repeat caesarean section is recommended.

Post-Dates Care

Post-dates care will need to be individualised and tailored to individual clinical circumstances, and the woman's plans and preferences:

- A membrane sweep may be offered >39 weeks gestation for those planning VBAC. The woman should be supported with a discussion about what a membrane sweep is, and advised that this may make it more likely that spontaneous labour will start without the need for pharmacological or mechanical methods of induction. The woman should also be supported to discuss and agree an ongoing plan after an initial membrane sweep.

- Where a woman's pregnancy is progressing normally, induction of labour should be offered between 41+0-41+5 weeks gestation, to maximise the opportunity for spontaneous labour to commence. Timing of induction of labour will be dependent upon the clinical circumstances and will be after discussion with the woman regarding the risks and benefits.

- Where spontaneous labour has not commenced, and the woman declines induction of labour; she should be offered ERCS, which should be scheduled for 41+0 - 41+5, with discussion with the woman regarding the risks and benefits.

- Where spontaneous rupture of membranes has occurred ≥37+0 weeks gestation, in the absence of contractions, or clinical concerns, intermittent auscultation can be used to assess fetal wellbeing. Women presenting with pre-labour rupture of membranes should be offered the same primary management as a woman with no history of prior caesarean section wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/management-of-pre-labour-spontaneous-rupture-of-membranes-srom-at-term-37-0-gestation/

- Where a woman attends with spontaneous rupture of membranes and/or query labour assessment, with uterine contractions, the assessment should include a cardiotocograph (CTG) monitoring.

Induction of Labour/Augmentation of Labour in women with previous caesarean birth

- The decision to induce labour in women with previous caesarean birth should be made between the woman and a consultant obstetrician.

- A plan should be discussed and documented, to include proposed methods for induction, the time intervals of cervical assessment during labour and any parameters of cervical progress that would indicate discontinuing VBAC attempt.

- 33-4Women undergoing VBAC are not suitable for outpatient induction of labour.

- Mechanical induction with ARM, Foley's catheter or Dilapan is the preferred method of induction in this cohort of women as they are associated with a lower incidence of uterine scar rupture compared to prostaglandins/oxytocin. Propess 10mg for 24 hours may be used, if agreed by the consultant booking the induction of labour.

- The woman should be informed of the increased chance of uterine rupture with the use of prostaglandins/oxytocin (2 to 3 fold increase, therefore 2 to 3 in 200 women).

- The woman should be informed of the increased chance of emergency caesarean birth with induction of labour which is 33-41 in 100 women, and after augmentation of labour 28-36 in 100 women which is approximately 1.5 fold increase from the 25-28 women in 100 if spontaneous labour.

- Induction of labour should not be recommended to women who have had two previous caesarean births. If the woman wishes to have induction of labour, this should be made in conjunction with a consultant obstetrician.

Intrapartum Care during planned VBAC

- Women should be advised that planned VBAC is recommended in an obstetric unit, with continuous intrapartum fetal heart rate monitoring, and resources available for immediate caesarean section and advanced neonatal resuscitation.

- Initial assessment of labour, when the woman is experiencing contractions should be undertaken with continuous fetal heart rate monitoring included as part of this assessment.

- In the latent phase of labour, when contractions are irregular, both maternal and fetal wellbeing have been confirmed and the woman is coping, then she may be encouraged to return home to await events, with relevant advice.

- A senior obstetric review should be advised on a second or subsequent admission where the woman remains I the latent phase of labour.

- When in established labour, the woman should be admitted to the obstetric unit with one-to-one midwifery care.

- A full blood count (FBC) and Group & Save should be offered on admission to the labour ward for all women planning VBAC.

- The need for intravenous (IV) access should be assessed on admission to the labour ward and documented in the maternal records.

- Early cannulation should be recommended if it is predicted to be difficult (for example, women with raised BMI) or where there are any additional fetal or maternal concerns.

- The physiology of labour and birth should be supported in all environments, to optimise the likelihood of successful VBAC, including: maternal positioning and mobilisation, bladder care and hydration with water and isotonic drinks.

- Maternal observations during labour and birth should align with current National Institute for Health and Care Excellence (NICE) 2023 guidance: Intrapartum care (nice.org.uk)

- Assessment of progress during the first stage of labour should be recommended by abdominal palpation and vaginal assessment four hourly.
- Assessment of progress during the second stage of labour should be recommended by abdominal palpation and vaginal assessment hourly.

- Obstetric review is recommended after one hour of active pushing if birth is not imminent.

- If after one hour of active pushing, there is found to be slow progress, this should be discussed with the obstetric registrar and consultant obstetrician on-call.

- Telemetry is available in POWH and PCH, and should be utilised wherever possible to support maternal positioning and mobility during labour and birth.

- Water birth facilities are available in POWH and PCH labour wards; VBAC is not a contraindication to using the birth pool for labour and birth as long as labour is progressing normally and there is no evidence of fetal or maternal concerns. The woman should be independently able to mobilise in to, and out of the pool. See water immersion guideline: wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/water-immersion-for-labour-and-birth/

- All options for pharmacological analgesia are available and suitable for women during a planned VBAC.

- Early diagnosis of uterine rupture followed by expeditious laparotomy and resuscitation is essential to reduce the associated morbidity and mortality in mother and infant.

- Health care professionals should be knowledgeable about indicators of uterine rupture. There is no single pathognomonic clinical feature that is indicative of uterine rupture but the presence of any of the following should raise the concern of the possibility of this event
  Abnormal CTG (present in 55-87% of uterine rupture)
  Severe abdominal plain, especially if persisting between contractions
  Chest pain or shoulder tip pain
  Sudden onset shortness of breath
  Acute onset scar tenderness or pain
  Haematuria
  Abnormal vaginal bleeding
  Cessation of previously efficient uterine activity
  Maternal tachycardia, hypotension, fainting or shock
  Loss of station of the presenting part

- The diagnosis is ultimately confirmed at emergency caesarean section or postpartum laparotomy.

- Where uterine rupture is suspected follow the Uterine Rupture guideline and Prompt algorithm: wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/uterine-rupture-management-guideline/

Care for women planning labour and birth in a midwife-led setting outside of clinical recommendations

Where women decline to give birth in an obstetric unit, or choose a package of care outside of clinical recommendations, the woman should be supported through a process of informed decision making to include:

- Offering thorough and detailed counselling and discussion of the risks, benefits and alternatives available to the woman, particularly the differences to the care and management available in obstetric led settings, and midwife led settings.

- Counselling should be provided jointly between the consultant obstetrician and the consultant midwife.

- Where the woman plans birth in a midwife-led setting, the consultant midwife should support counselling and care planning.

- Where a woman declines consultation with a consultant obstetrician, it is recommended that care is handed over to the consultant midwife (who will still utilise the support of the named consultant obstetrician to provide support and obstetric advice).

- The woman's decisions and choices should be respected.

- Robust documentation of the discussion and informed-decision making process.

- A detailed plan should be developed in conjunction with the woman, with this plan documented in SBAR format (see Appendix x).

- The individualised outside of recommended care SBAR plan should be filed within the handheld notes, and shared with the community midwife/team, labour ward coordinator, lead midwife for community services and the named consultant obstetrician.

- Where midwives are providing care for a women who is choosing a package of care or birth setting outside of clinical recommendations, they should be offered support via the labour ward coordinator and/or the senior midwifery manager. Outside of normal working hours, the senior midwifery manager on-call can provide additional professional support (contactable via hospital switchboard).

Elective Repeat Caesarean Section (ERCS)

- An elective caesarean birth may be offered to any woman who has had one or more previous caesarean births. The risk of uterine rupture with repeat planned caesarean birth is very low (less than 0.02%).
- Previous operation notes should be reviewed to identify surgical risks associated with repeat caesarean section. These will be specific to each individual.
- Where the previous caesarean section was anything other than uncomplicated, a copy of the operation note should be made and placed in the woman's handheld records.
- Women should be made aware that the increasing number of caesarean births increase surgical risks in the future, including an increased risk of adhesions, organ damage and hysterectomy.
- The risk of placenta praevia and accrete also increases with repeat caesarean sections. Considerate and sensitive exploration of a woman's planned family size should take place, and VBAC should be considered for those wishing to have multiple future pregnancies.
- ERCS is recommended if there are three or more previous caesarean births.

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Appendix 1

Royal College of Obstetricians & Gynaecologists 'Birth options after previous caesarean section' information leaflet

pi-birth-options-after
-previous-caesarean-s

Appendix 2

Birth after previous caesarean counselling proforma

(To be completed at 21 – 28 weeks)

Likelihood of:	Overall	Tick when discussed
Successful VBAC (one previous caesarean delivery, no previous vaginal birth)	3 out of 4 or 72–75%	
Successful VBAC (one previous caesarean delivery, at least one previous vaginal birth	Almost 9 out of 10 or up to 85–90%	
Successful VBAC more likely in: spontaneous labour, previous vaginal delivery (particularly previous VBAC), greater maternal height, maternal age less than 40 years, BMI less than 30, previous caesarean for fetal malpresentation, gestation of less than 40 weeks and infant birthweight less than 4 kg (or similar/lower birthweight to/than index caesarean delivery) Unsuccessful VBAC more likely in: induced labour, no previous vaginal delivery, BMI greater than 30 and previous caesarean for labour dystocia. If all of these factors are present, successful VBAC is achieved in 40% of cases.		

Risk of:	VBAC	ERCS	Tick when discussed
Uterine rupture	Overall 5 per 1000/0.5% (Spontaneous labour (0.15– 0.4%), induced (0.54–1.4%) or augmented (0.9–1.91%)	< 2 per 10000/< 0.02%	
Blood transfusion	2 per 100/2%	1 per 100/1%	
Endometritis	No significant difference in risk	No significant difference in risk	
Serious complications in future pregnancies	Not applicable if successful VBAC	Increased likelihood of placenta praevia/ morbidly adherent placenta	
Maternal mortality	4 per 100000/0.004%	13 per 100000/0.013%	
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 effects)	
Antepartum stillbirth beyond 39+0 weeks while awaiting spontaneous labour	10 per 10000/0.1%	Not applicable	
Hypoxic ischaemic encephalopathy (HIE)		< 1 per 10000/< 0.01%	

Consideration of woman's future reproductive plans		
Woman's preference for deliver	VBAC	
	ERCS	
	Undecided	

Info leaflet provided	Birth options after previous caesarean section (RCOG)	
Intrapartum care for VBAC	Tick when discussed	
Birth on the consultant delivery suite		
Continuous electronic fetal monitoring at the onset of regular uterine contractions		
Need for intravenous (IV) access in labour		
Management plan in the event of:		
Preterm labour <37 weeks	VBAC	
	Em CS	
Spontaneous labour before ERCS date	VBAC	
	Em CS	
	Dependent on stage of labour – see comments	
No spontaneous labour after 41 weeks – review by senior obstetrician	Sweep	
	IOL	
	ERCS	
	Expectant Mx	
Senior obstetrician plan re use of oxytocin in labour	As per CTMUHB protocol	
	Other	
Senior obstetrician plan for IOL	As per CTMUHB IOL guideline	
	Other	
ERCS booking details	ERCS date (39+weeks)	
	Preadmission date	
	date Steroids if indication for ERCS < 39 weeks	
Additional comment		

Counselling at first antenatal clinic appointment

Patient Addressograph

VBAC		
Successful VBAC (1 previous caesarean delivery, no previous vaginal birth)	72-75%	□
If at least one previous vaginal birth	85-90%	□
Risk of uterine rupture	0.5%	□
Blood transfusion	2%	□
Third or fourth degree tears	5%	□
Transient breathing problems for baby	2-3%	□
Hypoxic ischaemic encephalopathy (HIE), usually associated with uterine rupture - RARE.	0.08%	□
Antepartum stillbirth beyond 39+0 weeks while awaiting spontaneous labour	10 per 10000/0.1%	□
Maternal mortality 4 per 10,000/0.04%		□
Delivery on Consultant Led Unit (CLU)		□
Continuous electronic fetal monitoring in labour Need for intravenous (IV) access in labour		□
Repeat ERCS		
Longer procedure, with increased risk of organ damage, due to previous scarring		□
Longer recovery compared with successful VBAC		□
Increased likelihood of placenta praevia/morbidly adherent placenta in future pregnancies		□
Blood transfusion	1%	□
Transient breathing problems for baby	4-6%	□
Hypoxic ischaemic encephalopathy (HIE) Rare		□
RCOG VBAC Information Leaflet Provided		□
Contraception discussed/sterilisation or coil		□
Planned mode of delivery:		
VBAC		□
Repeat ERCS		□
Undecided		□
Preterm labour or spontaneous labour prior to Repeat ElCS:		
VBAC		□
Emergency caesarean section		□
Depends on stage of labour (document in comments below)		□
Comments		

Review 36-37 weeks

VBAC □
Postnatal Contraception Discussed □

Induction of labour if does not labour spontaneously.
2- to 3-fold increase in risk of uterine rupture □
1.5-fold increased risk of emergency caesarean section □
Stretch and sweep offered □
Vaginal examination findings:

Gestational Age at IOL:

IOL discussed with consultant/senior registrar □
IOL booked □
IOL information leaflet provided □
Instructions for prostaglandins/oxytocin: As per CTMUHB protocol

	Yes	**No**
For Propess	□	

For mechanical induction (ARM, Foley catheter or Dilapan, please specify)
ARM □ Foley catheter □ Dilapan □ For oxytocin following ARM □
Comments:

Repeat ERCS
Elective caesarean booked at 39+ weeks gestation □ I
Preadmission date given □
If planned caesarean prior to 39 weeks, antenatal corticosteroids considered (PIL) □
Postnatal contraception discussed/sterilization □

Appendix 3

Outside-of-Guidance/ Complex Birth Planning SBAR Vaginal Birth After Caesarean Section

This template is for guidance only and is not exhaustive. All discussions should be tailored to individual needs and wishes and documented accordingly

Please circulate to the named community midwife/team, consultant obstetrician and consultant midwife

Individual Plan for:	Name: Hospital Number: DOB: Address: Named Consultant Obstetrician: Named community midwife:
Situation	Planning birth in a midwife-led setting (home, stand alone midwifery led unit, along side midwifery led unit): outside of recommended guidance due to VBAC.
Background	EDD Gravida Para

Assessment

Vaginal Birth after Caesarean	Initial Discussed
A planned VBAC is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture.	
The absolute risk of birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for nulliparous women in labour 4 in 10,000 (0.04%).	
The success rate of planned VBAC is nationally recognised as around 72–75%, and highest for those women who have a history of vaginal birth previously (85-90%).	
It is recommended that planned VBAC should take place in an obstetric unit with continuous intrapartum care with resources available for immediate caesarean section and advanced neonatal resuscitation.	
Women undergoing VBAC are advised to have continuous electronic fetal monitoring during labour. In some cases (55-87% of uterine rupture), earlier signs of uterine rupture/concern regarding fetal wellbeing will be associated with changes and abnormalities in the fetal heart rate.	
Continuous CTG is not available in a midwife-led setting; we can offer intermittent auscultation every 15 minutes during first stage and every 5 minutes during second stage (according to NICE Intrapartum Care guidance).	
Immediate threat to maternal and fetal life in the event of a uterine rupture in an out-of-hospital setting, in addition to fetal hypoxia, and maternal haemorrhage.	
Discussed the signs and symptoms of uterine rupture or dehiscence:	

	○ Severe abdominal plain, especially if persisting between contractions ○ Chest pain or shoulder tip pain ○ Sudden onset shortness of breath ○ Acute onset scar tenderness or pain ○ Haematuria ○ Abnormal vaginal bleeding ○ Cessation of previously efficient uterine activity ○ Maternal tachycardia, hypotension, fainting or shock ○ Loss of station of the presenting part		
	In accordance with Obs Cymru stage 1 risk assessment we would offer cannulation during labour (due to previous uterine surgery), however NICE (2019) recommends cannulation is only required where there are additional concerns for mum or baby, or suspicion of difficult cannulation. IV access is recommended in the event of a mum requiring IV fluids or blood products, or requiring emergency birth. IV access will not be routinely secured in a birth centre environment. In the event of abnormal bleeding, cannulation may become more challenging to secure.		
	Antacids are offered during active labour to reduce acidity of stomach contents, and may reduce the risk associated with general anaesthetic (in case of emergency delivery being necessitated). Antacid medication will not be administered in a midwifery led setting.		

Midwife-led Intrapartum Care	
Care during labour and birth in a midwife-led setting will be provided in line with NICE guidance (Intrapartum Care, 2023) and the All Wales Clinical Pathway for Normal Labour (AWCPNL).	
Fetal monitoring during labour is offered with a Doppler (as above).	
Transfer would be recommended if deviations or concerns were picked up during intrapartum care.	

Transfer Arrangements	
Transfer rates from a midwife led setting, according to national data (The Birthplace cohort study suggests a peripartum transfer rate as follows: Multiparous women experiencing a straightforward pregnancy and planning homebirth (12%), alongside midwife-led unit (AMU) (13%), and freestanding midwife-led unit (FMU) (9%), but likely to be higher where pre-existing complexity exists.	
Ambulance services aim for a response time for emergency 'Red' calls within 8 minutes. Transfer times will differ depending on factors including ambulance service acuity/activity and location of the person from the hospital environment and could exceed 60 minutes.	
The length of completed transfer depends on proximity to the nearest Obstetric Unit. Any inevitable transfer time will delay treatment, and could increase the likelihood of maternal, fetal/neonatal morbidity and mortality during an emergency event.	

Recommendations	I believe that the following discussion, add woman's name has been given appropriate information and discussion to support informed decision making to plan birth outside of recommendations. **Plan**

Birth plan discussion facilitated by:

Sign: