Private Midwives™

Policy: 17 - Vaginal Birth After Caesarean – VBAC Policy

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NAME AND DESIGNATION OF GUIDELINE AUTHOR(S):	Linda Bryceland, Head of Midwifery

All policies and guidelines will be circulated to appropriate staff for a two-week consultation prior to being finalised. The date of issue reflects the date finalised after this consultation has taken place.

MONITORING COMPLIANCE WITH THE GUIDELINE	
Process for monitoring	Audit of Guideline
Frequency of monitoring	3 yearly
Responsible individual development of action plan	Head of Midwifery

NATIONAL GUIDANCE RELATING TO THIS GUIDELINE (E.G. NIHCE, NATIONAL INSTITUTE FR HEALTH AND CLINICAL EXCELLENCE)
• RCOG Green Top Guidelines No 45 published 2015

DOCUMENT REVIEW HISTORY			
Version	**Review Date**	**Reviewed by**	
1.	June 2016	Linda Bryceland, Head of Midwifery	No changes made
2.	June 2018	Trish Nolan Melfi	Updated signs of uterine rupture
3.	November 2018	Linda Bryceland	Introduction of risk categories, management guidance and escalation criteria
4.	Feb 2020	Linda Bryceland	Condensed and clarification. Revision of risk assessment in labour guidance.
5.	Feb 2023	Linda Bryceland	Updated risk assessment to remove “pregnant within 2yrs” updated references. Revised wording on the introduction. Removal of notes review by PM obstetrician.

AUDITABLE STANDARDS	
1.	Management is in line with this guidance when individual case reviews are completed. Audits of VBAC cases will be completed in line with the audit plan. The whole case and care will be reviewed for compliance with this guideline.

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Introduction

Private Midwives is committed to promoting safe birth, positive birth experience and a woman's choice on how she wants her birth to be supported by health professionals. This policy is aimed to give information and guidance to women and to their midwives, on how this can be best achieved for those who have had a previous caesarean section. We fully respect the individual preferences of women and the clinical expertise of the midwife caring for them. This policy does not undermine this but aims to support it.

There is a general consensus amongst professional bodies that planned VBAC is clinically safe for the vast majority of women (RCOG[1], NICE[2], ACOG[3 4 5]) with success rates 72-75% (Private Midwives VBAC success rate is consistently above 85%). However, these recommendations do advise a birth in an obstetric unit with intravenous access and continuous electronic fetal monitoring due to the very small risk of uterine rupture. This approach does restrict and medicalise a large number of women to mitigate a risk that in reality impacts on very few. However, the consequences of uterine rupture for mother and/or baby could be fatal.

- It is for the individual to weigh up all the information, consider this in the context of their personal medical history, balance this with their informed choices and come to a decision on where and how they want to plan to birth their baby.
- The midwives role is to ensure all information and evidence is presented and understood. To assist the client in exploring the risks on an individual level based on history and personal circumstances, and to work with the client to mitigate the risks with careful planning and continual reassessment.

It is well known that having continued care and support from a skilled midwife who is known to the woman, with minimal medical intervention unless clinically indicated, increased the success of VBAC and maximises maternal and fetal well-being[8]. This positive birth experience can be a "healing" experience and help in addressing any previous birth trauma. For this reason, Private Midwives will support women who make an informed decision to opt for a VBAC at home with intermittent fetal monitoring and without IV access. This policy provides a basis for the care we recommend and is a fundamental part of care planning and informed choice discussions with the woman.

Contraindications to VBAC

Whilst we fully respect individual choice, we do not wish to provide care at home to clients in the following circumstances:

- Previous uterine rupture
- Previous classical Caesarean Section
- Obstetric complication preventing vaginal birth, for example placenta praevia

Requirement for Obstetric Review

In all cases, a full review of history and previous birth notes should take place. This is to ensure that any risk factors are identified that may increase the risk of uterine rupture in a subsequent pregnancy. Identifying these risk factors and exploring their implication

is a key component of informed consent for the woman. The woman may be unaware of previous surgical complications, incision extensions or problems that may impact on her informed decisions for this pregnancy, so having sight of previous surgical notes is vital. Putting a plan in place in conjunction with the woman, to mitigate the risk factors is a fundamental component of the midwives' role.

In most cases, a woman (and her previous surgical notes) will be reviewed by her own obstetrician (or nominated representative, such as a Consultant Midwife) and as long as vaginal birth is not contra-indicated, and the notes reflect that a vaginal birth is the preferred plan for birth, then Private Midwives will support her decision to book either a home or hospital VBAC according to her choice. So if the notes state *"planned VBAC"* or *"suitable for VBAC"* and this is signed by an obstetrician or Consultant Midwife, this will suffice.

If the woman does not wish to engage a local obstetrician, or this is not possible, the Private Midwives Senior Clinical Team can undertake a notes review. The woman will need to supply a copy of previous clinical notes, including the surgical procedure. There is a charge for this review.

Initial Consultation

- Discuss previous births and hopes for this birth
- Identify any other risk factors – if possible view previous notes. The midwife should advise the woman how she can access her previous notes.
- Discuss options and choices – ensure the woman is aware of the national recommendations stated above, any limitations and benefits that her birth choices present.
- Identify if obstetric review has taken place, if not see notes above
- **Give client a copy of this policy and encourage them to read it at their convenience – discuss this at your next appointment and document the details of the discussion in the notes**

Following the initial consultation, if the midwife is not confident is caring for the client, she should notify Head Office at once.

Antenatal Care

- **PRINT THIS POLICY ask the client to sign the "informed consent" section. Also, complete Appendix A & B and put everything in the clinical notes.**
- Use this policy as a reference tool throughout care.

The lead midwife must discuss the information contained within this policy with the client and ensure that the client understands their options and has an opportunity to ask questions. Details of discussions must be documented in full in the clinical notes. Medical terms used in this guideline should be explained in a language the woman can understand. **It is recommended that women who want a VBAC book as early as possible in their pregnancy, so that their lead midwife can work with them to address any**

concerns, fears, anxieties etc. Also, so that the midwife can advise on optimal fetal positioning to promote baby adopting a favourable position for birth. Bookings are not normally accepted for packages of care starting late in pregnancy.

Table One: Risks and Benefits of VBAC

Risks and benefits are summarised below. Data should be viewed in context as the table includes all births, including those where labour is induced or augmented, and where a midwife who may not be in continuous attendance provides care. Data is also based on labour where continuous EFM was in place.

Table 1. Risks and benefits of opting for VBAC versus ERCS from 39+0 weeks of gestation[1]

	Planned VBAC	**Elective repeat caesarean from 39+0 weeks**
Maternal outcomes	• 72–75% chance of successful VBAC. If successful, shorter hospital stay and recovery.	• Able to plan a known delivery date in select patients. This may however change based on circumstances surrounding maternal and fetal wellbeing in the antenatal period.
	• Approximately 0.5% risk of uterine scar rupture. If occurs, associated with maternal morbidity and fetal morbidity/mortality.	• Virtually avoids the risk of uterine rupture (actual risk is extremely low: less than 0.02%).
		• Longer recovery.
		• Reduces the risk of pelvic organ prolapse and urinary incontinence in comparison with number of vaginal births (dose– response effect) at least in the short term.
	• Increases likelihood of future vaginal birth.	• Future pregnancies – likely to require caesarean delivery, increased risk of placenta praevia/accreta and adhesions with successive caesarean deliveries/ abdominal surgery.
	• Risk of anal sphincter injury in women undergoing VBAC is 5% and birthweight is the strongest predictor of this. The rate of instrumental delivery is also increased up to 39%.	
	• Risk of maternal death with planned VBAC of 4/100 000 (95% CI 1/100 000 to 16/100 000).	• Risk of maternal death with ERCS of 13/100 000 (95% CI 4/100 000 to 42/100 000).
	• Risk of transient respiratory morbidity of 2–3%.	• Risk of transient respiratory morbidity of 4–5% (6% risk if delivery performed at 38 instead of 39 weeks). The risk is reduced with antenatal corticosteroids, but there are concerns about potential long-term adverse effects.
Infant outcomes	• 10 per 10 000 (0.1%) prospective risk of antepartum stillbirth beyond 39+0 weeks while awaiting spontaneous labour (similar to nulliparous women).	
	• 8 per 10 000 (0.08%) risk of hypoxic ischaemic encephalopathy (HIE).	• < 1 per 10 000 (< 0.01%) risk of delivery- related perinatal death or HIE.
	• 4 per 10 000 (0.04%) risk of delivery-related perinatal death. This is comparable to the risk for nulliparous women in labour.	

The estimates of risk for adverse maternal or fetal events in VBAC are based on women receiving continuous electronic monitoring during their labour.

Risk of scar rupture in simple terms

Studies looking at scar rupture vary in their results and this is largely because the incidence is so low. In simplified terms, risks of scar rupture in planned VBAC deliveries:

Induction of labour	just over 1%	(1.02%)
Augmentation of labour	under 1%	(0.87%)
Spontaneous labour	0.1%[12]	

Risk of uterine rupture when there is no scar on the uterus*: 0.02%
(*whether labour is spontaneous, induced or augmented)

Latent phase

An unusually prolonged latent phase, particularly in a woman who has laboured previously, should alert the midwife to a possibility of a problem. Abdominal palpation, review of fetal position, review of GROW chart, placental position and any scan results should be reviewed.

Intrapartum Care

The following care is recommended to promote the best outcomes for client and baby if midwifery led care is chosen. If care deviates from this, the reason must be documented within the client notes:

- Individualised care from an experienced midwife who the woman knows and trusts.
- Intermittent auscultation of the fetal heart rate every 15 minutes in the first stage of labour and at least every 5 minutes during the second stage, after a contraction, for one full minute
- Maternal observations throughout labour – pulse every hour, BP and Resps every 4hrs in the first stage. In the second stage, BP and Resps hourly and pulse every 1/4hr.
- Full holistic assessment within an hour of the midwife arriving at home, every 4hrs in the first stage of labour and every hour in the second stage of labour.[a]
- Urinalysis at least 4hrly. If the woman does not pass urine for 6hrs, the midwife should consider fluid intake and if a urinary catheter is required.[b]
- Vaginal examination 4hrly – the notes should reflect full cervical assessment and make reference to the station and position of the presenting part.[c]

[a] If the midwife arrives before labour is established a vaginal examination may not be clinically appropriate.
[b] If birth is imminent, an "in/out" catheter should be used. However, if birth is expected to be several hours away, a foleys catheter should be used. Maintaining fluid balance in labour is good practice and should be commenced once labour is established.
[c] The recommendation for regular vaginal examinations in labour to determine not only progress but the absence of uterine rupture should be explained to the client during antenatal discussions. If examinations are declined the midwife should refer to the informed consent policy. The on call manager is available for advice and support.

Holistic assessment

A full holistic assessment should inform discussions on a plan of care going forward. This should include the details below. Use the headings below to record your clinical findings.

- Review of **background**, length if labour, progress so far
- **Maternal assessment** – general appearance and coping ability, palpation, contraction strength – duration – frequency, any scar tenderness, fluid balance, urinalysis, temp, pulse, BP, Resps
- Vaginal examination – cervical dilatation, presenting part, position, station, moulding, caput, liquor
- **Fetal assessment** – FH now – any change over time
- **Reflect on findings** in the context of risk assessment – see Appendix C
- **Conclusion** – assess progress, is the woman coping? is baby coping? Is there any indication that things are not going well? If cervical dilatation is slower than expected, consider if rotation and descent of presenting part has taken place.
- **Plan** – discuss the findings and options with woman and record the agreed plan of care in the notes. Some examples are given below:
    - *"Making great progress, coping well, plan: continue and reassess in 4hrs"*
    - *"No progress in past 4hrs, mum is tired and exhausted. Mobilising has not been effective. Plan: opted for transfer to hospital, ambulance called at …."*
    - *"Progress is slow but mum and baby coping well. Some rotation and descent has taken place. Discussed options, Plan: change position and reassess in an hour"*

Please use Appendix C to guide you during intrapartum care.

Signs of uterine rupture requiring immediate, emergency transfer to hospital

If any of these signs are present, immediate transfer to hospital is vital. The optimum interval from onset of these factors to birth of baby is 18 minutes. [1] Whilst waiting for the ambulance, the midwife should consider advising cannulation and IV fluids.

- **Abnormal fetal heart rate or rhythm or significant change to the baseline is normally the first indicator of a problem such as scar rupture**
- **Severe pain, particularly between contractions. However, in a significant number of cases there will be no pain at all**
- **Acute onset of scar tenderness may or may not be present but should always be acted upon**
- **Vaginal bleeding other than a mucoid show**
- **Haematuria**
- **Reduced uterine activity – in some cases contractions may stop but reduced frequency, duration or strength are also significant factors**
- **Abnormal maternal observations (tachycardia, hypotension, fainting, shock)**
- **Loss of station of presenting part – this is one reason why regular vaginal examinations are recommended**
- **Maternal gut feeling or instinct that something is wrong, should be considered.**
- **Change in palpation – uterus feels different and presenting part has moved**

Postnatal care

Postnatal care should include a debriefing and discussion of birth events with advice on any implications for future pregnancies. This may be done in hospital if a repeat caesarean has taken place. The midwife should include this discussion as part of routine postnatal care.

Informed Consent

It is accepted that on occasion, care may deviate from this guideline. In such circumstances, a full and detailed explanation must be recorded in the clinical notes.
Women who choose a VBAC with Private Midwives must receive a copy of this guideline and have an opportunity to discuss it. Should their wishes differ, this should be discussed at the earliest opportunity, ideally before booking. Details of this discussion must be recorded in the clinical notes. The on call manager must also be informed so that an agreed plan of care can be put in place to support the woman's wishes and support the midwife.[d]

I have received a copy of this guideline and had an opportunity to discuss it with my Lead Midwife. I have asked questions relating to my specific circumstances and had the clinical terms, risks and benefits explained to me. I fully understand my options and any risks and benefits associated with the choices I may make. I agree to the care recommended within this guideline.

Sign & print name (Client) ____

Sign & print name (Partner/other person present) ______________________________

Sign & print name (Midwife) ____

Date ____

[d] On rare occasions, care may be declined if it is believe that choices of the woman put the woman, baby, midwife and organisation at significant risk. One example would be the presence of a condition listed above under "contraindications to VBAC"

References

[1] RCOG green top guideline 2015 Birth After Previous Caesarean Birth
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf

[2] National Institute for Health and Clinical Excellence. Caesarean section. NICE clinical guideline 192. Manchester: NICE; 2021.

[3]American College of Obstetricians and Gynaecologists. ACOG Practice bulletin no. 115: Vaginal birth after previous caesarean delivery. Obstet Gynaecol 2019.

[4] Cunningham FG, Bangdiwala SI, Brown SS, Dean TM, Frederiksen M, Rowland Hogue CJ, et al. NIH consensus development conference draft statement on vaginal birth after caesarean: new insights. NIH Consens State Sci Statements 2010;27(3):1–42.

[5] Guise JM, Eden K, Emeis C, Denman MA, Marshall N, Fu R, et al. Vaginal Birth After Caesarean: New Insights. Evidence Reports/Technology Assessments, No. 191. Rockville, Maryland: Agency for Healthcare Research and Quality; 2010.

[6] Guise JM, Berlin M, McDonagh M, Osterweil P, Chan B, Helfand M. Safety of vaginal birth after cesarean: a systematic review. Obstet Gynecol 2004;103:420–9.

[7] Mozurkewich EL, Hutton EK. Elective repeat cesarean delivery versus trial of labor: a meta-analysis of the literature from 1989 to 1999. Am J Obstet Gynecol 2000;183:1187–97.

[8] Tieying Zhang and Chunna Liu Comparison between continuing midwifery care and standard maternity care in vaginal birth after caesarean PMCID: PMC4928428
PMID: 27375719 Pak J Med Sci. 2016 May-Jun; 32(3): 711–714. doi: [10.12669/pjms.323.9546]

[9] Thomas P. Sartwelle, BBA, LLB James C. Johnston, MD, JD Continuous Electronic Fetal Monitoring during Labor: A Critique and a Reply to Contemporary Proponents
Surg J 2018;4:e23–e28.

[10] Wilson E. Rates of vaginal birth after caesarean section: What chance do obese women have?
First published: 18 June 2019
https://doi.org/10.1111/ajo.13003

[11] https://www.npeu.ox.ac.uk/research/ukoss-uterine-rupture-142?fbclid=IwAR0AI-m0yn-5M2oi0-nAiO6Yt7TtzLdzTSlfNPocYnssBuvliWr8nYCxIJk

[12]https://www.researchgate.net/publication/339748993_OptiBIRTH_a_cluster_randomised_trial_of_a_complex_intervention_to_increase_vaginal_birth_after_caesarean_section

Appendix A – BOOKING RISK ASSESSMENT

Commence at Initial Consultation, build on discussions at booking and complete before 20 weeks gestation (or at first appointment if after 20/40)

Client name: ____

Summary of previous obstetric history

____

____

____

	Yes	No	Notes
An obstetrician (or VBAC clinic, consultant midwife etc) has documented that this client is suitable for VBAC Plan:			If no, see notes above and record agreed plan
A risk assessment has taken place at initial consultation and/or booking? Use table below for guidance.			If no, do it now
A copy of this guideline has been given to the client and the recommended pathway of care explained			If no, do it now
Once completed, this guideline is filed in the client notes			If no, do it by 20 weeks gestation
The client agrees to on-going holistic assessment in line with the recommendations contained here Deviation:			If no, please record specific details and discuss ICP
The midwife has discussed reasons for possible transfer in labour at consultation and booking. This must be in the context of travel times and implications for delay in the case of uterine rupture.			If no, do it now
Approx transfer time to the nearest hospital in an emergency has been established. Transfer time is …….			If not, do it now.

Once you have completed this form, go to the risk assessment chart on the next page and circle ALL factors that are applicable. This assessment should be completed by 20 weeks gestation ideally, or on the first booking appointment if gestation if after 20 weeks.

Appendix B: ANTENATAL RISK ASSESSMENT

Based on client history and the table above, circle all factors below which are applicable and follow the actions accordingly.

MINIMAL CONCERNS	SOME CONCERNS	SIGNIFICANT CONCERNS/ contraindications
Previous Caesarean birth more than 12 months since becoming pregnant with this baby Booking before 34 weeks of pregnancy	Pregnant within 12 months of last birth Previous board ligament hematoma previously Client is declining ultrasound scan More than one previous CS with no vaginal births – review reasons Client wishes to deviate from the recommendations in this guideline – complete ICP BMI>35 Previous caesarean for CPD / dystocia Maternal age >40yrs Previous baby >4.5KG Booking after 34 weeks of pregnancy but before 37 weeks Hospital transfer time more than 20 minutes but less than 40 mins	Classical uterine incision T or J shaped incision Multiple pregnancy Low lying placenta Previous uterine rupture Booking after 37 weeks of pregnancy Breech presentation Fetal head not engaged by 38 weeks of pregnancy Previous uterine surgery other than caesarean Hospital transfer time more than 40 mins BMI >40 Estimated fetal weight for this baby >5kgs
Document all discussions and plans of care in the notes.	**If any of these factors present, discuss with HoM/Deputy** **Agree plan of care and document in notes**	**If any of these factors present, discuss with HoM/Deputy**

Completed by Midwife (name) ………………………………………………………

Date of completion …………………………………

Gestation at completion ……………………………

Appendix C – INTRAPARTUM RISK ASSESSMENT

Specific guidance for care during labour for women having VBAC – Use as part of continued holistic assessment – circle all factors as they arise and follow the actions below accordingly.

Please consider hospital transfer time when using the chart below. If transfer time is excessive the midwife should use her judgement to determine if actions needs to be advised earlier than the time frames used here.

MINIMAL CONCERNS - REASSURING	SOME CONCERNS	SIGNIFICANT CONCERNS
Previous elective / pre-labour caesarean and progress is as you would expect for a woman in her first labour Previous caesarean in labour and progress is as you would expect for a woman who has laboured before Previous VBAC and progress is as you would expect for a woman who has laboured and birthed vaginally before Previous vaginal birth followed by a caesarean – this is the first labour after the caesarean. Midwife is reassured by holistic assessment. Progress is as expected for a woman who has laboured before All maternal and fetal observations are satisfactory Urinalysis shows NO haematuria	Unusually prolonged latent phase of labour Progress in the first stage is a little slower than expected. However, progress is being made. Mum and baby are well. Progress in the second stage is a little slower than expected. However, progress is being made. Mum and baby are well.	Head is not presenting – previously thought to be cephalic Head is not engaged Fresh vaginal bleeding Haematuria present Scar tenderness Loss of presenting part on VE FH abnormality or significant change Concerns for maternal or fetal condition Uterine activity significantly diminished 1st stage: Baby is OA position, no increase in cervical dilatation in past 4hrs 1st stage of labour is protracted with very slow progress In 2nd stage for 2hrs or more and birth not imminent
Continue to support client in line with this guideline	**Everything may be OK and just taking a little longer, however this could be the early signs that things are not going well.** **Make a full holistic assessment, discuss findings with woman and agree a plan of care.** **Agree a time for earlier re-assessment – ideally in an hour for 2nd stage concerns and 2hrs for first stage concerns.** **Use on call manager or senior team for advice and support.**	**Advise immediate transfer to hospital.** **Call emergency ambulance NOW.** **Stay with woman and continue to monitor her and baby.** **Phone hospital and inform them of transfer and reason why.** **Consider IV fluids if scar rupture suspected.** **When able to do so, notify Private Midwives manager on call**

Discussion notes

Use this page to record any specific discussions between the midwife and client at the initial consultation, any questions that need further discussion and any points that need clarification. All of this policy should be filed with the clinical notes.