University Hospitals of North Midlands NHS

Achieving Sustainable Quality in Maternity Services

ASQUAM Guideline for Midwife-Led VBAC Clinic

(Vaginal Birth After Caesarean)

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VERSION CONTROL SCHEDULE

Version	Date	Author	Comments
1	2016 (March)	Deborah Tomlinson Deputy Antenatal Clinic Manager Helen Hinchliffe Antenatal Clinic Manager	New guideline
2	2016 (June)	As above	Appendix 2 updated as follows: **Removed:** Shorter hospital stay Reduction in the need for blood transfusion Increased risk of blood transfusion **Included:** Increase chance of uncomplicated normal birth in the future Virtually no risk of scar rupture Associated with an increased risk of transient tachypnoea of the newborn: 11.4% at 37/40 6.2% at 38/40 1.5% at 39/40 Decision for VBAC – Yes / No **Moved:** Increased risk of repeat c/s for subsequent delivery (VBAC not discussed at Midwife-led VBAC clinic for greater than one previous LSCS) -to the right hand side comments box under heading C/S Risks

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1. PURPOSE OF GUIDELINE

The purpose of the guideline is to provide up to date information for midwifery staff to ensure the provision of consistent, high quality evidence based care for women who may be suitable for a trial of Vaginal Birth after Caesarean section (VBAC) at the University Hospitals of North Midlands.

This guideline will address the following issues:

a) Criteria for referral

b) Antenatal counselling by Midwife for VBAC

c) Management.

2. BACKGROUND

Over the last 22 years, Caesarean Section (CS) rates have risen worldwide. In many developed countries the overall CS rates range from between 15% and 25%.

56% of women attempt vaginal birth after one caesarean section, with 66.7% of them succeeding.

In the UK, this means that only 33% of women who have had a previous caesarean section achieve a vaginal delivery.[1]

3. DEFINITION

VBAC refers to any woman who has experienced a previous Caesarean Section and who plans to deliver a subsequent baby vaginally rather than by a repeat Caesarean Section.

4. AIMS

- The RCOG recommends that a trial of labour should be considered in all women with a history of one previous LSCS.

- The aim of the VBAC/Birth Options clinic is to provide women with a high standard of evidence based care to enable them to make an informed choice regarding mode of delivery.

5. INCLUSION CRITERIA

Criteria for referral to midwife-led Birth Options/ VBAC clinic. (Appendix: To be completed at booking by Community Midwife)

- Any woman who has had a maximum of 1 previous Caesarean Sections with no other risk factors
- Any woman who has had 1 previous Caesarean Section and is requesting to have an Elective LSCS in the current pregnancy.

  (N.B Support can be sought from a Supervisor of Midwives.)

  If the woman's exclusion criteria category changes at any time, appropriate referral must be made.

6. EXCLUSION CRITERIA

Exclusion Criteria for midwife-led Birth Options/VBAC Clinic

- More than 1 previous Caesarean Sections
- Pre-existing co-morbidities/risk factors
- A classical uterine incision or T incision
- Placenta Praevia

The above women should be referred to a consultant-led antenatal clinic for an individualised plan of care.

7. BENEFITS

Benefits to discuss

- The chances of successful VBAC 72-76%; increasing to 87-90% for previous spontaneous vaginal delivery (SVD)/VBAC

- Women who successfully achieve vaginal birth after a Caesarean Section may have a more positive birth experience

- An increase in breastfeeding rates amongst women who achieve VBAC

- The recovery period is less for VBAC

- Reduced inpatient episode

- Vaginal birth significantly reduces the risk of transient tachypnoea of the newborn which is associated with pre-labour Caesarean Section.

- The risk of birth related perinatal death with VBAC is comparable to that for nulliparous women.

- If the woman has already had a successful VBAC, the likelihood of scar rupture is significantly reduced.

- Reduced complications from surgery and anaesthetics

- Reduction in the need for blood transfusion

8. RISKS

Risks of vaginal birth after caesarean birth

- Uterine rupture is a rare occurrence (1:200 or 0.5%) but it does present a risk to mother and baby

- Success rate of VBAC following 2 previous Caesarean Sections is 62-75%

- There is no significant difference in the rate of uterine rupture in VBAC with 2 or more Caesarean Sections

- The risk of maternal death with VBAC is less than 1:1000

Important points to consider:

- 2-3 fold increase in uterine rupture where there is a short delivery interval <12 – 24 months

- Maternal obesity, Induction of Labour and previous Caesarean Section due to labour dystocia reduce the rate to 40%

9. REFERRAL

When to refer

Women can be given an appointment to be seen in the midwife-led VBAC/ Birth Options clinic once they have had a dating Ultrasound Scan.
Ideally between 12 and 16 weeks gestation.

A referral criteria form **(see Appendix 1)** should be attached to the ANC referral sheet and forwarded to the Antenatal Clinic at the Royal Stoke University Hospital.

Following receipt of this an appointment will be generated.

The initial appointment will be for 30 minutes; this will allow sufficient time to discuss past delivery, utilise the medical notes and to consider referral to Birth Afterthoughts and/or PEACH, if applicable.

A management plan will be outlined, allowing adequate time for a follow-up appointment, if required.

For women who are non-English speaking, an interpreter will be booked to attend.

10. DISCUSSION

- In order to make an informed decision, women must be given unbiased, accurate information.

- The risks and benefits of a planned VBAC, including the risk of unplanned Caesarean Section should be discussed and the VBAC proforma **(see Appendix 2)** completed and filed within the woman's Hand Held Pregnancy Notes.

- The risks and benefits of a repeat Caesarean Section should also be discussed and documented.

- Women should be given a copy of UHNM VBAC patient information leaflet when first attending the Midwife-Led VBAC Clinic.

- Discussion regarding the mode of delivery must reflect maternal preference and priorities.

11. INDIVIDUAL MANAGEMENT PLAN

Women should be informed that the best chance of labour being straight forward is when labour commences spontaneously.

Place of birth should be discussed.

NICE recommend that women who have had one or more previous Caesarean Sections should plan to deliver in a hospital obstetric unit.

If the woman wishes to explore the option of a midwife-led delivery on a Midwife Birth Centre or at home, then she should be encouraged to attend a consultant appointment to discuss this further, and seek advice/input from a Supervisor of Midwives.

NICE recommend continuous electronic fetal monitoring during established labour when women have had one or more previous Caesarean Sections.

The use of telemetry should be advocated.

Pain relief should be discussed with women planning VBAC.

Hydrotherapy should be advocated.

The philosophy of normal birth should be emphasised including adaptation of the birth environment. The use of birthing balls, beanbags and upright birthing positions should be advocated to maximise the chance of normal birth.

12. MONITORING AND AUDIT

The need to monitor/audit the standards set out below will be considered alongside other Directorate requirements and prioritised accordingly. The Directorate Clinical Audit programme is drafted by the Directorate Clinical auditor, in liaison with clinical staff, and approved by the Directorate.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
Guideline content	Guideline Co-ordinator	Guideline Review	Every three years	Labour Ward Forum Subgroup: Guideline Meeting	Required changes to practice will be identified and actioned with the release of the updated guideline.	Required changes to practice will be identified and actioned with the release of the updated guideline.
Clinical standards within guideline	Directorate Clinical Auditor	Clinical Audit	As required in relation to other Directorate priorities	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.

13. REFERENCES

1. Thomas J, Paranjothy S. Royal College of Obstetricians and Gynaecologists Clinical Support Unit. In: *National Sentinel Caesarean Section Audit Report*. London: RCOG Press; 2001Landon MB, Hauth JC, Leveno KJ, Spong CY, Leindecker S,

Appendix 1: Referral Criteria for Midwife-Led VBAC/ birth Options Clinic

Name……

Unit Number/NHS…….

EDD……. **Parity**……

Referring Midwife……..

Refer to VBAC/ Birth Options Clinic		Exclusion Criteria
Women who have had one previous uncomplicated lower segment Caesarean section ☐		Two or more previous Caesarean Sections ☐
Maternal request for an elective caesarean section without indication ☐		Pre-existing co-morbidities/risk factors ☐
Other reasons for referral ☐ ……. …… …….		A previous classical uterine incision or T incision ☐
		Placenta Praevia ☐

Appendix 2: VBAC/Birth options Counselling discussion

Name……
Unit
Number/NHS……EDD……

VBAC Benefits if successful:		**VBAC Risks**	
Chance of successful VBAC 72-76%, increasing to 87-90% for previous NVD/VBAC		0.5% risk of uterine rupture	
More positive birth experience		Risk of repeat emergency c/s	
Increases chance of successful breastfeeding			
Shorter recovery period			
Reduced complications from surgery/anaesthetics			
Increase chance of uncomplicated normal birth in the future			

Elective C/S Benefits		**C/S Risks**	
Planned date of delivery		Increased risk of bladder and other organ damage	
		Scar tissue can cause long term pain/ adhesions and sub-fertility	
		Increased risk of repeat c/s for subsequent delivery (VBAC not discussed at Midwife-led VBAC clinic for greater than one previous LSCS)	
		Virtually no risk of scar rupture	
		Increased risk of infection	
		Increased risk of placenta accreta	
		Increased risk of thrombosis	
		Associated with an increased risk of transient tachypnoea of the newborn: 11.4% at 37/40 6.2% at 38/40 1.5% at 39/40	

Decision for VBAC:

Yes ☐

No ☐

Midwife

Name……Signature……

Date……..

Appendix 3 – Patient Information Leaflet

University Hospitals of North Midlands NHS NHS Trust	**Patient Details**
Patient Information Leaflet **Giving birth vaginally after a previous Caesarean section (VBAC)**	

The aim of this information leaflet is to help you to understand the risks and benefits of having a Vaginal Birth after having had a previous Caesarean Section and to answer any questions you may have.

Making a Choice…….. There is no right or wrong choice.

What is VBAC?

VBAC is an abbreviation of Vaginal Birth After Caesarean.

The term Vaginal Birth will also include having an assisted vaginal delivery, including Ventouse suction or a Forceps delivery.

60-70% of women will achieve a Vaginal Delivery following a previous Caesarean Section.

What are the benefits of VBAC?

- Women who achieve a Vaginal Birth after a previous Caesarean Section may have a more positive birth experience.
- It allows women the opportunity to have a more natural approach to Labour and Birth.
- Avoidance of surgery, allowing a more speedy return to everyday activities.
- Reduced complications by avoidance of surgery, leading to less chance of infection, thrombosis (Blood Clots) and Blood Transfusion.
- Babies born vaginally have a reduced risk of breathing problems compared to babies born by Caesarean Section.

What are the Risks of VBAC?

- There is a small risk of scar complications. The scar from your previous Caesarean may begin to rupture during labour and an Emergency Caesarean Section would be required.
- The risk of scar/Uterine rupture is 0.5%. However, having an Induction of Labour, when you have had a previous Caesarean Section may increase the risk of Uterine rupture three-fold.
- Scar rupture may increase the risk of a Hysterectomy following birth. This happens to 3 in 10,000 women who attempt VBAC (0.03%

What choices do you have?

VBAC is a very realistic choice for most women, but some will have a valid reason for choosing a planned Caesarean Section.

There is a 72-76% chance of achieving a successful VBAC.

Increasing to 87-90% for women who have had previous VBAC and/or any woman who has had a previous normal delivery

You may have an invitation to attend the Midwife-Led birth options clinic if you have had a single previous Caesarean Section, where a Midwife will discuss your previous delivery and Birth choices for your current pregnancy**.**

Alternatively, some women will have an appointment with an Obstetrician to discuss Birth Options.

Points to Consider:

- The reason why you had a previous Caesarean Section
- How many babies are you planning to have?

Place of Delivery:

If you decide to opt for VBAC Delivery, it is advisable to have a Hospital birth on the Consultant-Led Delivery Suite with appropriate facilities if complications arise in relation to the labour and delivery.

Your care will be given by a Midwife during the Labour and Birth.

However, if you wish to explore the option of a Home Birth or delivery on the Midwife Birth Centre, you can discuss this with the Obstetrician and Midwife.

Monitoring:

For women agreeable to VBAC, it is advisable that the Baby's Heart Rate is monitored continuously throughout labour.

If you wish to be mobile in labour, or to use hydrotherapy during the first stage of labour, we have access to Telemetry (Mobile Continuous Monitoring)

Communication:

You will be asked to confirm that you understand the purpose and outcome of the consultation and a management plan will be documented in your Hand Held Pregnancy Notes regarding your birth choices, including a care plan in case you do not labour spontaneously.

Interpreters will be used, as per Trust Policy, for all women for whom English is not their first language. Please let staff know if you need an interpreter.

Further Information:

If you have any questions or concerns regarding your pregnancy, or for any further information, please contact your G.P. or Community Midwife.

The Patient Advice and Liaison Service (PALS) offer a confidential advice and support service if you have any concerns.

PALS can be contacted on: 01782 676450 or email: patient.advice@uhns.nhs.uk