2.11 VAGINAL DELIVERY AFTER CAESAREAN SECTION (VBAC)

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1			Updated in preparation for CNST		14 September 2012
2			Amended in light of VBAC audit and need to refine process for obtaining details of previous CS		12 February 2020
3			Changes to the VBAC pathway		9 December 2016
4			Change to name of VBAC clinic to birth options		22 September 2017
5	NWAFT Guideline Committee	5th October 2020	Merged guideline NWAFT	Performance and Governance Management Committee Meeting	19th August 2020

Summary of key points in this document:

- Contraindications for VBAC
- Factors which may reduce the chance of successful VBAC
- Risks and benefits of opting for VBAC or ERCS
- Midwife led birth options clinic
- Planning for labour and IOL

Contents

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2.11 VAGINAL DELIVERY AFTER CAESAREAN SECTION (VBAC)

1. INTRODUCTION

There are two options following caesarean section (CS) elective repeat caesarean section (ERCS) or vaginal birth after caesarean section (VBAC). There is a consensus from NICE and the RCOG that planned VBAC is a clinically safe choice for the majority of women with a single previous lower segment caesarean delivery and can be considered after two. Studies suggest a success rate of 75% achieving a vaginal birth following one CS, if the woman goes into spontaneous labour.

2. PURPOSE

To provide guidance in managing the pregnancy and delivery of all pregnant women who have had a previous caesarean section and to ensure evidence based effective care is provided in line with the recommendations from NICE and RCOG guidelines. The guideline and K2 proforma aims to personalise this care and support women with their decision.

3. SCOPE

Women who have had one or more previous caesarean sections and no contraindications to vaginal birth.

4. CONTRAINDICATIONS

1. Any contraindication to vaginal births e.g. placenta praevia
2. Previous uterine rupture – 5% or more increased risk of repeat uterine scar rupture with labour
3. Previous classical caesarean section
4. Three or more previous caesarean sections
5. In women with complicated uterine scars, caution should be exercised and decisions should be made on a case-by-case basis by a senior obstetrician with access to the details of previous surgery
6. Any complication of current pregnancy which requires urgent delivery without induction.
7. An individualised assessment of the suitability for VBAC should be made in women with factors that increase the risk of uterine rupture.

5. FACTORS WHICH MAY REDUCE THE CHANCE OF A SUCCESSFUL OF VBAC INCLUDE:

- Induced labour
- No previous vaginal birth
- BMI >30

- Previous CS for failure to progress
- Gestation > 41 weeks
- Birth weight > 4000g
- Previous preterm CS
- Cervical dilatation on admission <4cm
- Advanced maternal age
- Non-white ethnicity
- Short stature

The more of these factors that are present the lower the chances of successful VBAC. For example; a woman who is being induced with an increased BMI and last caesarean for failure to progress has a 40% chance of achieving a vaginal birth.

There are positive predictors for a successful vaginal birth i.e. any previous vaginal birth (85-90% success rate), increased maternal height, previous LSCS for malpresentation (84% success rate).

6. RISKS AND BENEFITS OF OPTING FOR VBAC or ERCS

- Women should be made aware that successful VBAC has the fewest complications and therefore the chance of VBAC success or failure is an important consideration when choosing the mode of delivery
- Women should be made aware that the greatest risk of adverse outcome occurs in a trial of VBAC resulting in emergency caesarean delivery
- Women should be informed that planned VBAC is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture. UKOSS quoted a risk of 1:500 (0.2%)
- Women should be informed that the absolute risk of birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for nulliparous women in labour.
- Women should be informed that ERCS is associated with an increased risk of placenta praevia and/or accreta in future pregnancies and of pelvic adhesions complicating any future abdominopelvic surgery.
- The risk of perinatal death with ERCS is extremely low, but there is a small increase in neonatal respiratory morbidity when ERCS is performed before 39+0 weeks of gestation. The risk of respiratory morbidity can be reduced with a preoperative course of antenatal corticosteroids.

	Planned VBAC	ERCS 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.
		Option for sterilisation if fertility is no longer desired. Evidence suggests that the regret rate is higher and that the failure rate from sterilisation associated with pregnancy may be higher than that from an interval procedure. If sterilisation is to be performed at the same time as a caesarean delivery, counselling and agreement should have been given at least 2weeks prior to the procedure.
	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).
Infant outcomes	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.
	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		

7. RUPTURE OF THE SCARRED UTERUS IN PREGNANCY AND LABOUR, (SEE 3.05 RUPTURED UTERUS GUIDELINE

7.1 Risk of Uterine Rupture

- After previous classical CS = 2-9%
- After previous T-or J-shaped incisions = 2%
- After previous low vertical incision (De Lee Incision) = 2%
- After previous lower segment transverse incision = 0.2%
- After augmented VBAC = 0.86%
- After induced VBAC labour = 1%, increases with prostaglandin use

7.2 Signs and Symptoms

- CTG abnormalities
- Severe abdominal pain – persisting between contractions
- Loss of presenting part on VE
- Cessation of uterine contractions
- Maternal tachycardia and hypotension
- abnormal vaginal bleeding

8. RESPONSIBILITIES OF STAFF

8.1 Community Midwife

- The community midwife who undertakes booking is responsible for initiating the discussion regarding mode of delivery in women who have previously undergone a caesarean section. The K2 VBAC wizard can be started.
- All women who have had a previous LSCS must be referred for consultant led care. If the woman fulfils the criteria for the referral for the Birth after Caesarean clinic this should be identified on the booking form and **immediate referral** to the VBAC clinic can be made. Women **do not need to see a Cons unless there is a contraindication for a vaginal birth** when a direct consultant referral needs to take place.
- Antenatal discussion should be clearly documented in the VBAC wizard on K2 , using the RCOG checklist to ensure all risks are discussed. Community midwives should refer to the birth options clinic based on the referral guidelines or consultant led clinic if there are other concerns.
- Community Midwives should provide the woman with the RCOG VBAC information leaflet https://www.rcog.org.uk/en/patients/patient-leaflets/birth-after-previous-caesarean/
- The midwife should refrain from making any negative comments which may influence the woman adversely in her decision-making.
- In a randomised, controlled trial of a prenatal 'vaginal birth after caesarean' (VBAC) education and support program, the most frequent reasons reported for choosing elective repeat caesarean section were the fear of failed trial of labour, concerns about the dangers of vaginal birth, the fear of pain, and the convenience of scheduling. Every effort should be made in the antenatal period to address

these issues where appropriate. An appointment to meet an obstetric anaesthetist can be arranged if necessary.

- Community midwives should re-refer patients to the birth options clinic if they are unsure about their mode of delivery later on in pregnancy and before 36 weeks if possible.

8.2 Midwifery–led Birth Options Clinic

- This clinic is held weekly in the antenatal clinic, 30 minute slots. The appointment is for discussion only and does not include a physical antenatal assessment. Women are seen by a senior clinical midwife who will discuss the previous experience, the woman's expectations and wishes and her options for labour this time.
- Women will be seen in the clinic as soon as possible after their 20-week anomaly scan.
- Before the clinic efforts should be made to review the woman's notes and her past delivery and assess suitability for VBAC. Previous CS operation notes should be accessed, or requested from other hospitals as required, to ensure that any complications such as an inverted 'T' incision did not occur
- At the appointment the midwife will open the consultation wizard and complete the K2 VBAC proforma located in 'specialisms', along with a personalised success rate.
- The decision regarding the mode of delivery must take into consideration maternal preferences and priorities.
- If a woman is unsure of her decision she should be offered a second VBAC appointment before 32-weeks.
- If a woman requests an elective caesarean or has medical problems, she should be referred to a consultant clinic as soon as possible and before 32 weeks.
- If a woman request CS because she has concerns and anxiety about childbirth, offer
  - referral to a health care professional with expertise in proving perinatal mental health support (PMHS) via tocophobia clinic
  - Counsellor
  - Birth Afterthoughts
- The decision regarding mode of delivery should be in place by 36 weeks gestation and this must be documented in the patient notes.
- If a woman opts for an ERCS, this booked from 39 weeks onwards, after review in the consultant clinic.
- Women who are very keen for VBAC may be offered sweeps from 38-39 weeks if they wish
- Her care plan must include details on mode of delivery should she labour spontaneously prior to the planned caesarean section, as up to 10% of women who opt for an ERCS go into labour spontaneously before 39 weeks.
- If a woman does not spontaneously labour, she should have a consultant appointment at term (40 weeks) to discuss induction of labour.
- Local maternity services (LMS) run a VBAC support group to discuss issues related to VBAC and women's choices.

8.3 Obstetrician

- The obstetrician will review woman antenatally if they do not fulfil the criteria for the midwife led birth options clinic.
- Once the obstetrician has reviewed the patient they may refer her back to the VBAC clinic for further counselling about her mode of delivery.
- The obstetrician sees the woman at 40 weeks to discuss induction and its associated risks. The induction can be left as normal until T+12
- Women declining induction but still keen on VBAC can have their elective caesarean booked at T+12
- The obstetric registrar must be informed when a woman with a previous caesarean section is in labour and will be involved in reviewing her care in labour and whenever requested by the midwifery staff.
- The obstetric registrar will inform the on-call consultant of any deviation from expected progress.
- Induction and/or augmentation of labour must be a consultant decision after discussion and documentation of the risks.

8.4 Labour Ward Midwife

- The midwife on labour ward must inform the obstetric registrar when a woman who has had a previous caesarean section is admitted in labour.
- The midwife should review the management plan on K2 and complete the birth plan review with the woman.
- The midwife must refer any deviation from normal to the obstetric registrar, informing the core midwife.

8.5 Delivery Suite Coordinator

- The coordinator must be aware of women on the delivery suite who are high risk, this includes women who have had a previous caesarean section.
- The core midwife should ensure that the appropriate plan of care is in place and that the midwife caring for the woman is aware of this guideline.
- The core midwife must ensure she is aware of the progress of the high-risk women on the delivery suite and communicate with the allocated midwife and the obstetric, theatre anaesthetic teams as required, ensuring that they are aware of the potential need for operative intervention.
- Any clinical concerns will be escalated to the on-call consultant if not dealt with appropriately by the registrar.

9. WHEN TO RECOMMEND ERCS

It is generally considered appropriate to offer repeat CS after a previous classical caesarean section or one where there has been a previous “inverted-T” incision (see above). VBAC may be undertaken in cases of two previous CS, provided no absolute contraindications exist, and it is the woman’s wish, taking into account

the above factors. They should be reviewed by a consultant before this decision is made. Consent is essential before surgery and so if a patient with two or more previous CS declines a further CS she cannot be compelled to have one, but the decision should be carefully documented including the explanation of the risks. Oxytocic drugs and induction would generally be avoided, or kept to an absolute minimum.

VBAC is contraindicated in cases of:

- Previous rupture
- Previous classical incision
- Three or more previous CS

However, in cases of miscarriage or intrauterine fetal death, a value judgement may be made by a consultant obstetrician to allow vaginal delivery, particularly in earlier gestations.

10. PLANNING FOR LABOUR

- Women who have had a previous CS should be encouraged to deliver in a consultant-led unit which has access to perform immediate CS if required and blood transfusion facilities. Home births are not encouraged.(see Birth Choices guideline) . The plan of care, is then documented on K2.
- If the previous CS was performed elsewhere in the UK, then a letter requesting details of the surgery should be sent to the hospital. This may highlight whether there were any particular complications, such as a different type of uterine incision, which may affect the relative risks of ECS or VBAC. When the CMW completes the antenatal booking referral form, she should indicate this if the previous CS was performed outside Peterborough. This will prompt a consultant appointment during which a letter to the other hospital requesting details will be dictated.
- If the previous CS was performed NWAFT and the notes/K2 records are available, the operation notes should be scrutinised. If these indicate that there were uterine lacerations, an extension of the uterine incision, a J-shaped or inverted 'T' incision, or any other complications, the woman needs to have a discussion with a consultant.
- An individual management plan should be documented in the antenatal handheld notes, including place of labour and method of continuous fetal monitoring and whether this plan should differ if labour commences early. The woman should be provided with a patient information leaflet. Where she wishes to have a repeat elective caesarean section, a consultant referral should be made for no later than 32-34 weeks to discuss this further.

10.1 Induction of Labour Following Previous Caesarean Section

- A clear plan for timing and method for induction of labour must be documented in the woman's maternity notes by the consultant whose care the patient is booked. The information must be backed by the Trust information leaflet.

- The woman must be thoroughly counselled regarding the risks of IOL. The risk of scar rupture increases 2 to 3 fold if the labour is induced (but still may only be as low as <1%)
- If the woman does not spontaneously labour, a consultant clinic follow up at 40 weeks must be arranged to assess suitability for induction of labour or the option of ERCS, as appropriate. The plan for induction of labour with the prostaglandin and oxytocic of choice must be clearly documented in the maternity notes. Oxytocic drugs would generally be avoided totally after two or more previous CS.
- Induction of labour is usually planned for 42 weeks
- Cervical sweeps can be arranged from 39 weeks up to twice weekly. These can be performed in the community.
- Induction of labour must be in the consultant led unit on delivery suite.
- During the induction process, electronic fetal monitoring is commenced prior to insertion of prostaglandins (Prostin® or Propess®) or mechanical methods like Dilapan/catheter and continued for at least 30minutes following the procedure. If the electronic fetal monitoring is normal and there are no other risks, the tracing is repeated every four hours as per the Trust guidelines.

10.2 Intrapartum Care

- One-to-one care in established labour is necessary to increase the likelihood of the woman achieving a VBAC and enables prompt identification and agreement of uterine scar rupture and other obstetric emergencies should they occur.
- On admission to labour ward the management plan must be reviewed by the midwife providing the care to the woman.
- The insertion of an intravenous cannula routinely is not recommended for women in labour who have had a previous caesarean section (NICE 2019). Discussion with the on-call consultant obstetrician is recommended.
  When here an intravenous cannula is required blood should be taken and sent to the path lab for full blood count and group and save.
- An admission cardiotocograph (CTG) must be performed
- Women can have a waterbirth with telemetry if they meet the criteria (see 2.15 Waterbirth guideline)
- Once in established labour (cervix 3-4cms or more with regular, painful contractions) continuous electronic fetal monitoring (CEFM) should be offered and is recommended by RCOG guideline. Fetal heart rate (FH) abnormalities are seen in 50-70% of cases of uterine rupture. The use of CEFM means that this can be recognised as early as possible. This may be achieved using telemetry to encourage mobility.
- Cervical assessments should be conducted preferably by the same person to ensure there is adequate cervical progress. If there is no adequate cervical progress in four hourly intervals (or sooner if clinically indicated) then the woman will need to be reviewed by the obstetric registrar and/or consultant. The partogram must be completed and adequate progress must be monitored during the first and second stages of labour. Any deviations must be cascaded to the senior midwife and obstetric registrar.
- If progress is inadequate, there should be a discussion with a consultant about the need for CS. A CS at this stage will be a category 2 (maternal or fetal

compromise which is not immediately life threatening (or category 1 if there is immediate threat to life of woman or fetus.

- Women will be supported to achieve the birth experience that they want, including options for pain relief. An epidural may also be used for pain relief if the woman wants one.
- The woman may use water for analgesia and birth if she requests, CEFM in the pool is recommended using telemetry.
- Oxytocin augmentation for slow progress in the first or second stages of labour may only be used after discussion with the Consultant on-call. Contraction frequency should not exceed 4 in 10 minutes. As the use of oxytocin for augmentation increases the risk of scar rupture, these risks must be discussed with the woman and be agreed by the on-call consultant. Oxytocin can only be considered in women who are prepared to accept CEFM. One-to-one care in labour must be provided.
- Even greater caution should be used when other oxytocic drugs e.g. prostaglandins have been used to induce labour, since the effect is cumulative and the risk of rupture is proportional to the total dose of oxytocic administered.
- Women with a previous caesarean section are recommended to deliver on the consultant led birthing unit where access to continuous fetal monitoring, emergency surgery, and neonatal resuscitation facilities available.
- The obstetric and anaesthetic registrar must be informed when a woman with a previous caesarean section is in labour.
- The midwife providing care in labour must keep the labour ward co-ordinator informed of the woman's progress.
- Women can eat a light diet in early labour
- The partogram is an important tool to access progress in labour and should be used in al labouring women
- Antacid prophylaxis should be given throughout labour i.e. 150mg Ranitidine orally six hourly 30 mls of 0.3M Sodium Citrate Solution orally in theatre prior to surgery.
- Maternal vital parameters must be documented using standardised charts e.g. MEOWS chart.
- Staff caring for a labouring woman with a scarred uterus must be vigilant about the symptoms and signs of scar dehiscence (see section 8.3).Any of the above warrants urgent consultant/registrar review.

11. AUDITABLE STANDARDS AND MONITORING OF COMPLIANCE

Monitoring of compliance with this guideline will be by an audit according to the departmental annual forward audit plan

- Evidence that previous CS details have been obtained
- Documentation of risk of uterine rupture for women planning VBAC

Audit findings and recommendations will be presented in a rolling monthly clinical governance meeting, weekly perinatal meeting or monthly Maternity Clinical Governance committee meeting. An action plan will be agreed. Progress on the

action plan will be monitored at the monthly Maternity Clinical Governance committee meeting.

12. REFERENCES AND ASSOCIATED DOCUMENTATION

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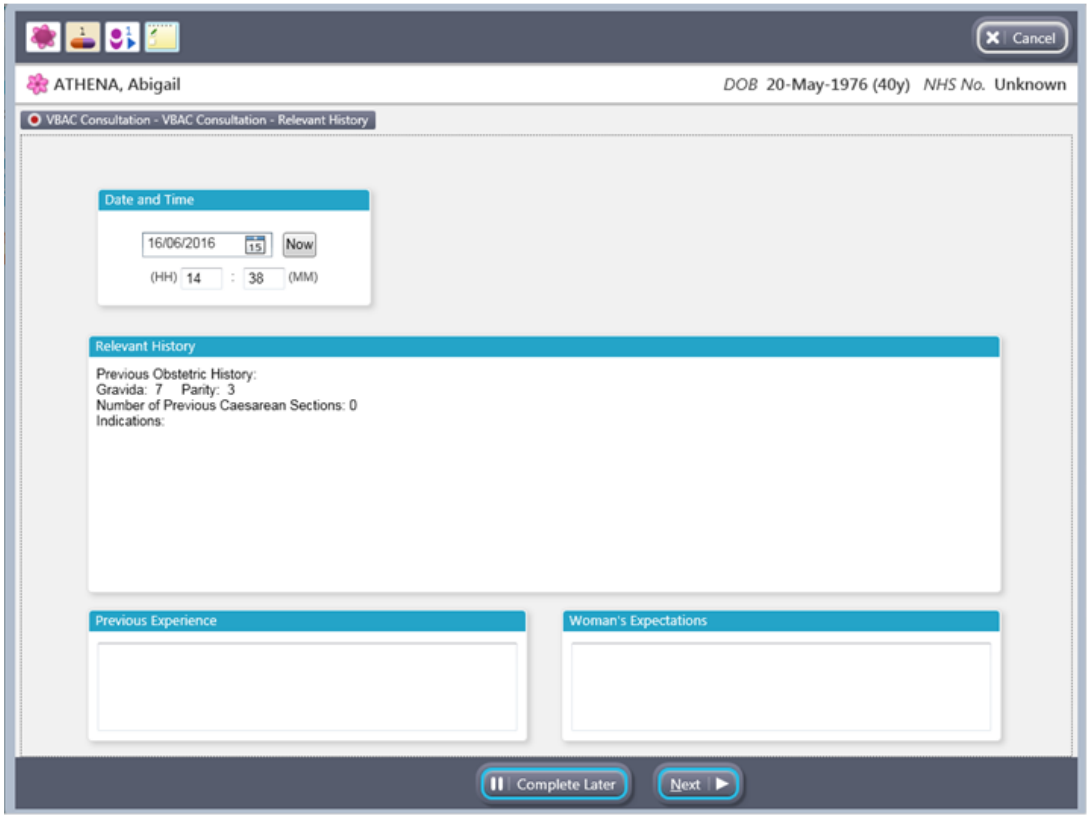
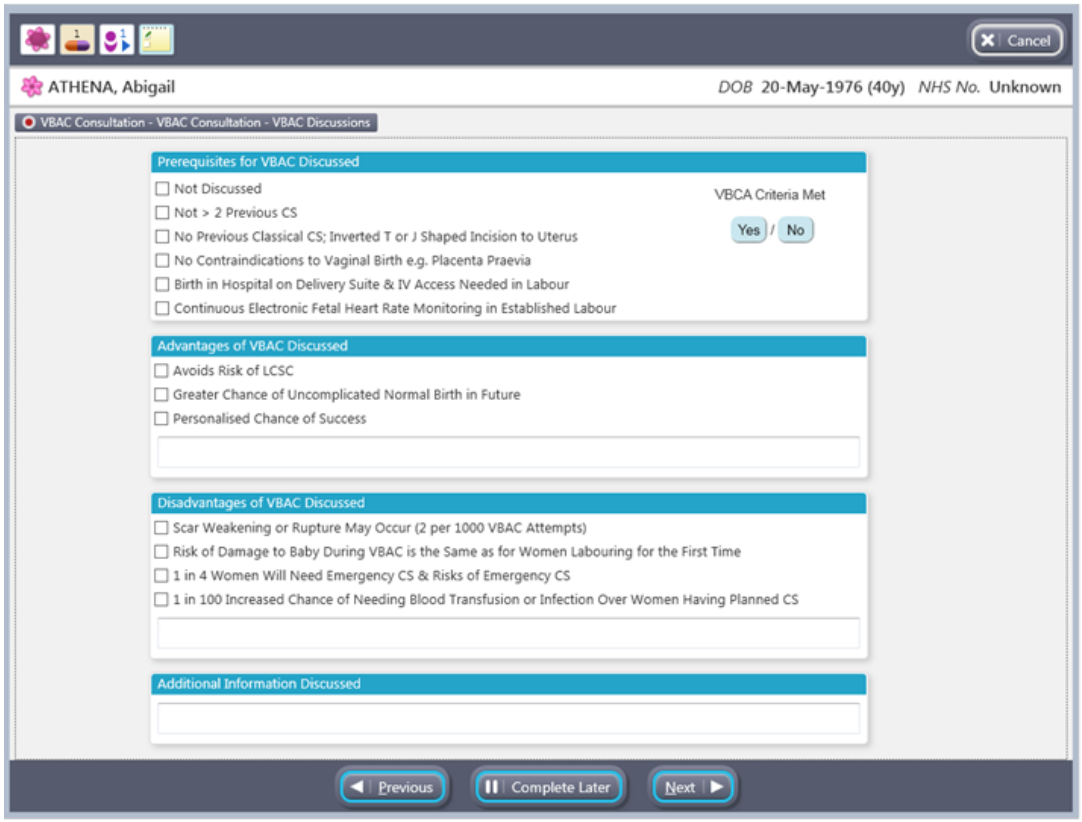
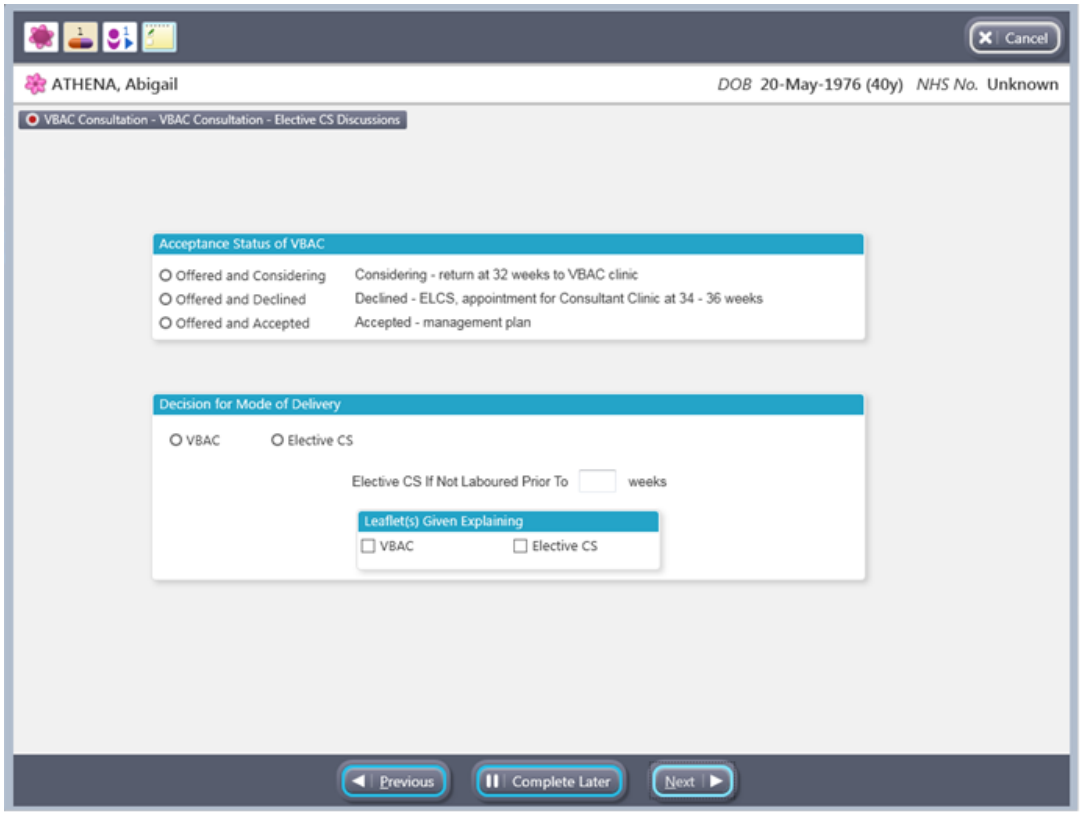
Appendix 1: K2 VBAC Proforma

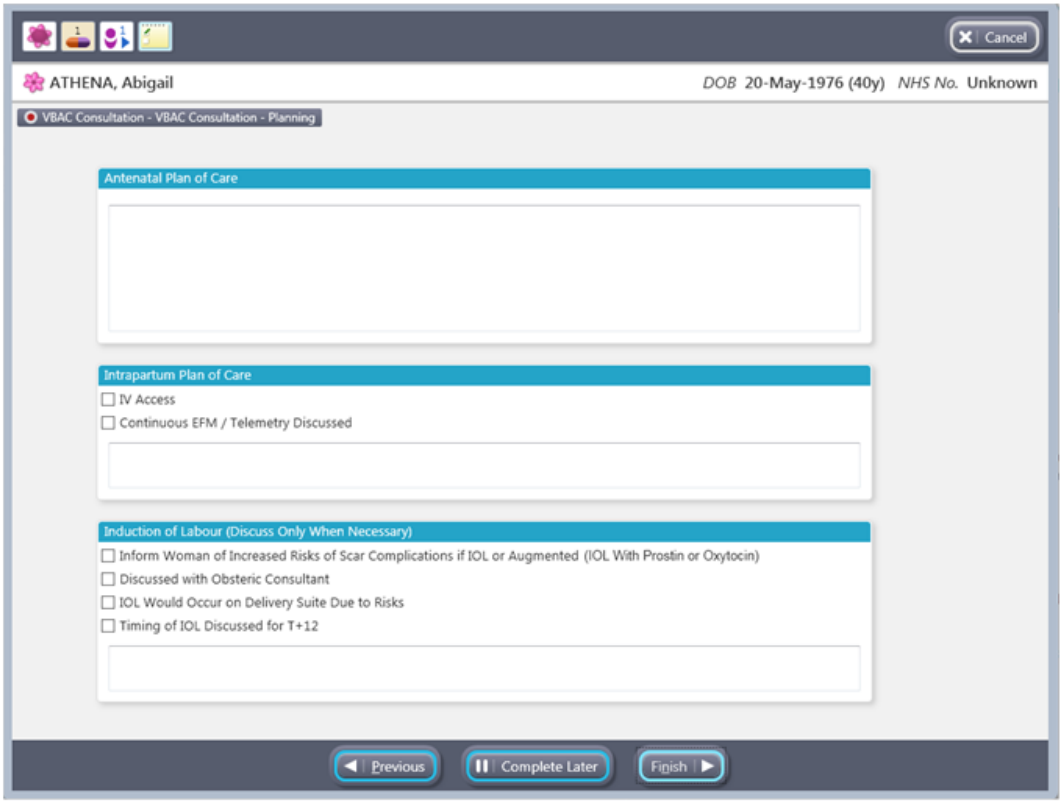
Screen Shots of New VBAC Wizard in K2



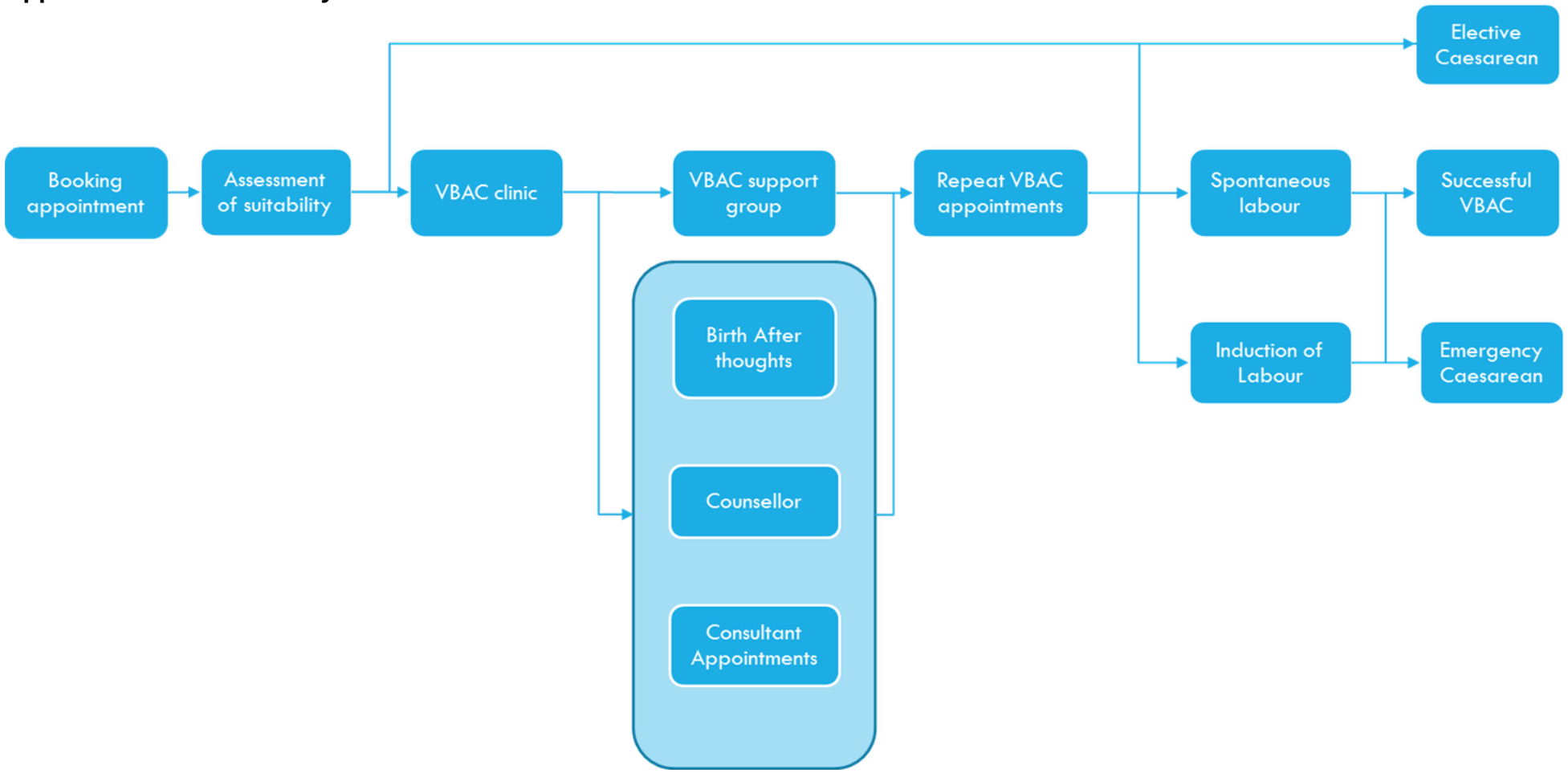


Appendix 1(cont.) K2 VBAC Proforma





Appendix 2 VBAC Pathway



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%	☐
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% of cases.				
Likelihood of	**VBAC**	**ERCS**		
		Maternal		
Uterine rupture	5 per 1000/0.5%	< 2 per 10 000/< 0.02%		☐
Blood transfusion	2 per 100/2%	1 per 100/1%		☐
Endometritis	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 100 000/0.004%	13 per 100 000/0.013%		☐
		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 effects)		☐
Antepartum stillbirth beyond 39^{+0} weeks while awaiting spontaneous labour	10 per 10 000/0.1%	Not applicable		☐
Hypoxic ischaemic encephalopathy (HIE)	8 per 10 000/0.08%	< 1 per 10 000/< 0.01%		☐
Information leaflet(s) provided: VBAC ☐ ERCS ☐ Other ☐				
Discussed:				
Continuous electronic fetal monitoring at the onset of regular uterine contractions				☐
Birth on the labour suite				☐
Need for intravenous (IV) access in labour				☐
Comments:				

Management plan in the event of:						
Preterm labour (< 37+0 weeks)	☐ VBAC	☐ Emergency caesarean delivery				
Spontaneous labour before ERCS date	☐ VBAC	☐ Caesarean delivery	☐ Depends on stage of labour – details below			
No spontaneous labour after 41 weeks – discussed with senior obstetrician	☐ Sweep	☐ Induction of labour (give details of agreed plan below)				☐ ERCS
Use of oxytocin in labour – discussed with senior obstetrician						
Details of induction of labour:						
ERCS booking details:						
Additional comments:						

Appendix 4: OOA PCH Referral form for Birth Options clinic

North West Anglia NHS Trust - Peterborough City Hospital Maternity Services

North West Ang
NHS Foundation T

Peterborough City Hospital Referral Form FOR ULTRASOUND, CONSULTANT CARE & VBAC CLINIC for cross boundary women

Name: Click or tap here to enter text.	**Midwife Name:** Click or tap here to enter text.
DOB: Click or tap here to enter text.	**MW Mobile Number:** Click or tap here to enter text.
DIS Number: Click or tap here to enter text.	Community co-ordinator email: Click or tap here to enter text.
NHS Number: Click or tap here to enter text.	**Date of midwife booking:** Click or tap to enter a date

Consultant name if specific consultant indicated: Click or tap here to enter text.

Address and Postcode: Click or tap here to enter text.
Telephone No: Click or tap here to enter text.
GP Name & Practice: Click or tap here to enter text.

LMP Click or tap to enter a date.	**EDD** Click or tap to enter a date.
Gest/Parity Click or tap here to enter text.	**BMI** Click or tap here to enter text.

USS Appointment (Dating Scan)

Dating/Nuchal Scan ☐ **Urgent within 7 days** ☐

Appointment Date range: From Click or tap to enter a date. (11^{+3}) to Click or tap to enter a date. (14^{+1})

Referral for VBAC Clinic

Reason for previous CS	Yes		Yes	Interpreter Required Choose an item.
Breech	☐	Fetal distress	☐	
Failure to progress	☐	Placenta praevia	☐	Language: Click or tap here to enter text.

Combined Dating Scan and Consultant Appointment (12 Weeks Gestation)

Genetic History	Diagnosis and details must be obtained, check with consultant if unsure Select from drop down	Comments:
Hereditary condition in family	Choose an item.	Click or tap here to enter text.
Family History of fetal abnormality	Choose an item.	Click or tap here to enter text.
Chromosomal disorder in patient or partner	Choose an item.	Click or tap here to enter text.

Other risks requiring Consultant led care appointment between 12 – 18 weeks gestation

The reason for consultant referral must be clear and specific, and be listed in the table on next page: If there is ANY significant medical history, the GP should be requested to send a summary letter to the consultant as soon as possible.

Is Consultant Appointment required? Choose an item.

NOTES to accompany referral form for cross-boundary women

If a patient has had a complicated previous pregnancy, please try to refer her to the same consultant in the next pregnancy. If she has diabetes, book into the Joint Diabetes Clinic. If she has severe mental health problems, HIV, a history of drug misuse or is in prison, book with Mr Lumb.

If the woman does not have any other reasons to be consultant-led care, she may be referred directly to the VBAC clinic, provided she meets the criteria stated.

If there is a family or personal history of a genetic, chromosomal or inherited disorder, information should be shared with the consultant BEFORE a referral is made, to see if it is indicated.

If a condition or concern is NOT listed in the table above, this should be discussed promptly with the consultant BEFORE a referral is made, to see if it is indicated.

Email peh-tr.obstetric-secretaries@nhs.net using the SBAR tool.

Substance misuse (illicit drugs / and or alcohol)	☐
Renal disease, e.g. renal failure, chronic pyelonephritis, transplant	☐
BMI ≥45	☐
Age >40y	☐
Late booking *(defined as >20 weeks with NO previous antenatal care)*	☐
Fetal abnormality or child with disability	☐
Previous pregnancy loss 14-24 weeks *(refer early as cerclage might be indicated)*	☐
Previous stillbirth or neonatal death	☐
Previous delivery at < 34 weeks	☐
Previous CS – not suitable for VBAC *(e.g. 3 previous CS)*	☐
Multiple pregnancy	☐
Previous pre-eclampsia or eclampsia	☐
Previous difficult delivery e.g. shoulder dystocia	☐
Previous IUGR or small baby <10th customised centile *(do NOT book GAP scans – this will be done by consultant)*	☐
Feels traumatised by previous delivery	☐

Date of Referral:
Click or tap to enter a date.

Referral form completed by:
Click or tap here to enter text.

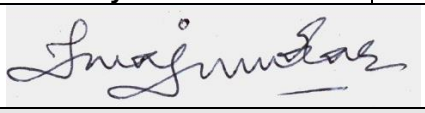
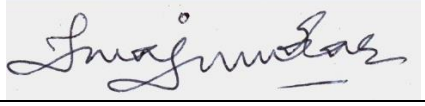
Please enter your contact number:
Click or tap here to enter text.

Please enter the name of your Trust:
Click or tap here to enter text.

Email the completed form to
Nwangliaft.maternityadmin@nhs.net

Quality Assurance Checklist - Version Number: Appendix 5

		Y/N/ n/a	COMMENTS (to author for any amendments)
1	**Title of document**	Y	
2	**Type of document (e.g. policy, guidance)**		
	Is it clear whether the document is a policy, guideline, procedure?	Y	
3	**Introduction**		
	Are reasons for the development of the document clearly stated?	Y	
4	**Content**		
	Is there a standard front cover?	Y	
	Are the key points identified? (Policies only)		
	Is the document in the correct format?	Y	
	Is the purpose of the document clear?	Y	
	Is the scope clearly stated?	Y	
	Are the definitions clearly explained?	Y	
	Are the roles and responsibilities clearly explained? (policies only)		
	Have recommendations from Counter Fraud/Internal Audit been included?	Y	
	*Does this policy concern the handling, moving or storage of personal identifiable or commercially sensitive information?		
	*If yes, has a Summary Privacy Impact Assessment been completed?		
5	**Evidence Base**		
	Is the type of evidence to support the document explicitly identified?	Y	
	Are key references cited?	Y	
	Are associated documents referenced?	Y	
6	**Approval Route**		
	Does the document identify which committee/group will approve it?	Y	
7	**Process to Monitor Compliance and Effectiveness (policies only)**		
	Are there measureable standards or KPIs to support the monitoring of compliance with the effectiveness of the document? (has Appendix D Compliance Monitoring been completed)		
8	**Review Date**		
	Is the review date identified?	Y	
9	**Equality and Diversity (policies only)**		
	Is a completed Equality Impact Assessment attached?		

Compliance Team:			
1.	Date of Compliance Team approval		
2.	Date Comments returned to author by Compliance Lead		
3.	Name of Compliance Lead		
Approval Committee:			
If the committee/group is happy to approve this document would the chair please sign below and send the document and the minutes from the approval committee to the author. To aid distribution all documentation should be sent electronically wherever possible.			
Name	**Tarang Majmudar Maternity Services Director**	**Date**	**19/09/2020**
Signature			
Ratifying Committee:			
If the committee/group is happy to ratify this document would the chair please sign below and send the document and the minutes from the ratifying committee to the author. To aid distribution all documentation should be sent electronically wherever possible.			
Name	**Tarang Majmudar Maternity Services Director**	**Date**	**19/09/2020**
Signature			

If answers to any of the above questions is 'no', then this document is not ready for ratification, it needs further review.

Appendix 6: Compliance Monitoring Table
Title: 2.11 Vaginal Delivery after Caesarean Section (VBAC)
Author: Sarah Kitchen

Document Section		Control	Checks to be carried out to confirm compliance with the policy	How often the check will be carried out	Responsible for carrying out the check	Results of check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting
		WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
		An audit will be undertaken according to the departmental annual audit plan	• Evidence that previous CS details have been obtained • Documentation of risk of uterine rupture for women planning VBAC	An audit will be undertaken according to the departmental annual audit plan	Nominated midwife identified on audit plan	Clinical Governance meeting	An audit will be undertaken according to the departmental annual audit plan frequency