Management of Vaginal Birth after Caesarean Section (VBAC)

CDDFT Guideline

<table>
<thead>
<tr>
<th>Reference Number</th>
<th>GUID/MAT/1409</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Management of Vaginal Birth after Caesarean Section (VBAC)</td>
</tr>
<tr>
<td>Version number</td>
<td>3.3</td>
</tr>
<tr>
<td>Document Type</td>
<td>Guideline</td>
</tr>
<tr>
<td>Original Policy Date</td>
<td>18/03/03</td>
</tr>
<tr>
<td>Date approved</td>
<td>14/5/13</td>
</tr>
<tr>
<td>Effective date</td>
<td>14/5/13</td>
</tr>
<tr>
<td>Approving body</td>
<td>Quality &amp; Health Care Governance Committee</td>
</tr>
<tr>
<td>Originating Directorate</td>
<td>Care Closer to Home</td>
</tr>
<tr>
<td>Scope</td>
<td>Care Closer to Home – Maternity</td>
</tr>
<tr>
<td>Last review date</td>
<td>14/2/13</td>
</tr>
<tr>
<td>Next review date</td>
<td>14/2/16</td>
</tr>
<tr>
<td>Reviewing body</td>
<td>Clinical Standards and Therapeutics Committee</td>
</tr>
<tr>
<td>Document Owner</td>
<td>Evidence Based Practice Group - Chair</td>
</tr>
<tr>
<td>Equality impact assessed</td>
<td>Yes</td>
</tr>
<tr>
<td>Date superseded</td>
<td>N/A</td>
</tr>
<tr>
<td>Status</td>
<td>Approved</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Unrestricted</td>
</tr>
<tr>
<td>Keywords</td>
<td>Vaginal, Birth, Caesarean Section</td>
</tr>
</tbody>
</table>

Approval

<table>
<thead>
<tr>
<th>Signature of Chairman of Approving Body</th>
<th>Mr Mike Wright</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name/Job Title of Chairman of Approving Body:</td>
<td>Executive Director of Nursing</td>
</tr>
<tr>
<td></td>
<td>Chair of Quality and Healthcare Governance Committee</td>
</tr>
<tr>
<td>Signed paper copy held at (location):</td>
<td>Library Services DMH</td>
</tr>
</tbody>
</table>
Management of Vaginal Birth after Caesarean Section (VBAC)

Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Introduction</td>
<td>4</td>
</tr>
<tr>
<td>2 Purpose</td>
<td>4</td>
</tr>
<tr>
<td>3 Duties</td>
<td>4</td>
</tr>
<tr>
<td>4 Management of Vaginal Birth after Caesarean Section (VBAC)</td>
<td>4</td>
</tr>
<tr>
<td>4.1 Preterm labour</td>
<td>5</td>
</tr>
<tr>
<td>4.2 Candidates for VBAC</td>
<td>5</td>
</tr>
<tr>
<td>4.3 Contradictions to VBAC</td>
<td>6</td>
</tr>
<tr>
<td>4.4 Special considerations</td>
<td>5</td>
</tr>
<tr>
<td>4.5 Antenatal counselling</td>
<td>6</td>
</tr>
<tr>
<td>4.6 Risks of serious complications</td>
<td>7</td>
</tr>
<tr>
<td>4.7 Labour</td>
<td>7</td>
</tr>
<tr>
<td>4.8 Induction of labour</td>
<td>7</td>
</tr>
<tr>
<td>4.9 Counselling in labour</td>
<td>8</td>
</tr>
<tr>
<td>5 Management of Labour for VBAC</td>
<td>9</td>
</tr>
<tr>
<td>5.1 Scar dehiscence &amp; rupture</td>
<td>9</td>
</tr>
<tr>
<td>5.2 First stage</td>
<td>9</td>
</tr>
<tr>
<td>5.3 Second stage</td>
<td>9</td>
</tr>
<tr>
<td>5.4 Third stage</td>
<td>10</td>
</tr>
<tr>
<td>6 Key Performance Indicators</td>
<td>10</td>
</tr>
<tr>
<td>7 References</td>
<td>11</td>
</tr>
<tr>
<td>8 Associated Documents</td>
<td>11</td>
</tr>
<tr>
<td>9 Equality Analysis/Impact Assessment</td>
<td>12</td>
</tr>
<tr>
<td>Appendix 1 VBAC checklist</td>
<td>17</td>
</tr>
</tbody>
</table>

Document Control Information

Version control table

<table>
<thead>
<tr>
<th>Date of Issue</th>
<th>Version Number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2003</td>
<td>1.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>December 2009</td>
<td>2.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>April 2010</td>
<td>2.1</td>
<td>Superseded</td>
</tr>
<tr>
<td>September 2011</td>
<td>3.0</td>
<td>Superseded</td>
</tr>
<tr>
<td>19/01/12</td>
<td>3.1</td>
<td>Superseded</td>
</tr>
<tr>
<td>09/02/2012</td>
<td>3.2</td>
<td>Superseded</td>
</tr>
<tr>
<td>14/5/13</td>
<td>3.3</td>
<td>Approved</td>
</tr>
</tbody>
</table>

Table of revisions

<table>
<thead>
<tr>
<th>Date</th>
<th>Section</th>
<th>Revision</th>
<th>Author</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2009</td>
<td>Full</td>
<td>Review to ensure guideline reflects: Current evidence based practice</td>
<td>Philippa Marsden</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Service provisions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHSLA requirements: Standard 2.</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Type</td>
<td>Changes</td>
<td>Author</td>
</tr>
<tr>
<td>--------------</td>
<td>------</td>
<td>------------------------------------------------------------------------</td>
<td>-----------------</td>
</tr>
</tbody>
</table>
| April 2010   | Partial | Minor amendments following CNST assessment: (page 8)  
re written plan regarding labour and delivery (page 10)  
re annual audit to ensure compliance | Jean Hatton     |
| September 2011 | Full | The need for documentation re action plan when in labour added (Page 6)  
Calculation re syntocinon converted to mls/hr (page 7)  
List of clinical features of scar rupture extended (page 8) | Jean Hatton     |
| December 2011 | Partial | Reviewed and amended in line with CDDFT policy for the development and management of policy and guidance documents  
KPI’s amended (page 13) | Jean Hatton     |
| February 2012 | Partial | Update following NHSLA Assessment - homebirth | Jackie Hendy    |
| March 2013   | Partial | Reviewed – no change to practice – flow and clarity re completion of proforma | J Woodward      |
1. Introduction

With a history of one previous delivery by Lower Segment Caesarean Section, the majority of women are suitable for a trial for Vaginal Birth after Caesarean Section in a subsequent pregnancy. The chance of successful vaginal delivery is between 70 – 80%. The incidence of “scar dehiscence” (opening of the scar without serious maternal or fetal consequence) is approximately 0.5% (1 in 200) but the incidence of “scar rupture” (with potential serious fetal or maternal consequences) is lower at 0.1% (1 in 1000). The need for hysterectomy is rare. Cautious use of oxytocin augmentation in spontaneous labour is not associated with an increased risk of dehiscence or rupture [OR1.2 (95%CI 0.7-2.1)]. However, induced labour, particularly with prostaglandin carries an increased risk of dehiscence or rupture.

2. Purpose

These guidelines have been developed to assist maternity staff to minimise the risks to mother and baby and to aid in the management in three specific areas:
- Antenatal management and counselling
- Induction of labour in cases of VBAC
- Management of labour for VBAC

3. Duties

This guideline applies to Consultant Obstetricians, Obstetric Registrar and Midwives involved in the care of women delivering vaginally after Caesarean section.

4. Responsibilities

All staff are responsible for ensuring they familiarize themselves with their role and responsibilities within this guideline.

Midwife
- The Midwife is responsible for referral to Shared care at booking.
- Monitoring and recording of maternal observations including blood pressure, pulse, temperature and frequency and strength of contractions as well as monitoring of the fetal heart in labour.
- Seeking medical advice where there is any deviation from the management plan.
- Women’s individual circumstances, including her personal motivation and preferences to achieve a vaginal birth may lead her to request a home birth. In such circumstances, an appointment to be arranged with a Consultant to discuss maternal choice and offer counselling about maternal and perinatal risks and benefits. A Supervisor of Midwives will also meet with woman to discuss planning of homebirth. All discussions in relation to homebirth will be documented fully within Health Records

Consultant
- Review notes pertinent to the previous LSCS – directly or by correspondence with other hospital
- Initial discussion with patient
  - Review the labour that resulted in LSCS
Management of Vaginal Birth after Caesarean Section (VBAC)

- Discuss outcomes for VBAC specific to individual circumstances. It is likely to be more successful if the woman has had previous normal deliveries.
- Discuss risks/disadvantages of VBAC and elective repeat Caesarean section. The following risks and benefits should be specifically discussed:
  - The patient should be informed that the risk of uterine rupture in spontaneous labour is 0.2 – 0.7%.
  - With VBAC the risk to the baby of perinatal death is the same as in their first pregnancy.
  - Planned VBAC reduces the chances of the baby having respiratory problems after birth: rates are 2-3% with planned VBAC and 3-4% with elective caesarean.
  - They should be informed that there is a 1% greater risk of blood transfusion than with elective caesarean.
  - Elective caesarean may increase the risk of serious complications in future pregnancies: see table below.

- This discussion should be recorded in the hand held notes by the Consultant / Registrar.
- Advise women to deliver in an obstetric unit.
- Offer RCOG information leaflet; plan VBAC for majority.
- The final decision re mode of delivery can be made either at the initial booking or towards term, but ideally by 36 weeks.
- The Consultant / Senior Registrar is to complete the VBAC checklist - see appendix 1, this should be completed and kept with the hand held notes and also documented within the maternity records. Showing:
  - A plan for place of delivery
  - A plan for mode of delivery
  - An individual management plan for labour
  - A plan if labour was to start early
  - Fetal heart monitoring in labour

- A plan if labour does not start spontaneously. All women planned for VBAC who have not delivered by 40-41 weeks should be reviewed by a Consultant in ANC and management plan instigated and documented in hand held notes.

Discussion on mode of delivery, plan for place of labour, individual management plan for labour and fetal heart monitoring in labour should be documented clearly in the antenatal hand held records by the Consultant/ registrar– this may be nearer term.

These guidelines outline agreed regional management for trial for vaginal birth after one previous lower segment Caesarean section (LSCS). Management of individual cases may vary and should be discussed with Consultant and documented in hand held notes and medical records.

4.1 Preterm labour
Should labour commence before 37 weeks refer to preterm labour guidelines
Individual management to be discussed with consultant.

4.2 Pre-labour Rupture of membranes
- Admit for observation, do not discharge home.
- Augmentation should be discussed with Consultant.

4.3 Candidates for VBAC
Management of Vaginal Birth after Caesarean Section (VBAC)

- Any woman who has had a single low transverse uterine incision from a previous caesarean delivery and has no contraindications to vaginal delivery can be considered for a VBAC.

NB. All women who have had a single caesarean section will be given a VBAC leaflet as part of their discharge information from the postnatal ward document on the postnatal tick sheet.

4.4 Contraindications to VBAC
- Previous classical Caesarean section
- T shaped or De Lees uterine scar
- Uterine transfundal surgery
- Previous uterine rupture
- Medical or obstetric complications that preclude vaginal delivery.

4.5 Special Considerations

Two Previous Caesarean Sections
Women with two uterine scars may also be considered for trial of labour at their request. However the risk of rupture is increased four fold (0.8% for single scar, 3.7% for two scars). The risk of uterine rupture need to be clearly discussed with the woman and documented in her notes. A Consultant must make this decision.

Twins
The management of twin gestations and VBAC has not been studied on a large scale but multiple small studies suggest that it is possible. Incidence of uterine dehiscence is however, twice that of singleton pregnancies and it is probably more appropriate to deliver by Caesarean. A Consultant must make the decision if VBAC is being considered.

Breech
In the case of breech presentation limited data suggests that ECV may be safe and equally successful for women attempting VBAC.

Macrosomia
Suspected macrosomia is not a contraindication to VBAC.

Inter-delivery Interval
An inter-delivery interval of less than 19 months is associated with a three-fold higher scar rupture rate.

4.6 Induction of Labour in cases of VBAC

| A decision to induce labour in a woman with a previous caesarean section should be made by a Consultant only. |

Spontaneous labour is associated with a much lower complication rate. The risk of uterine rupture is increased after induction (1.4% overall) compared to spontaneous labour especially after prostaglandin induction and oxytocin.

Therefore:
- Induction of labour should only be undertaken for valid obstetric indications,
- Offer membrane sweep at 41 weeks – performed in clinic or arranged by Consultant.
- The preferred method of induction is by forewater amniotomy (ARM) with judicious oxytocin augmentation (see below). This is a consultant decision regarding method of induction to be used – a management plan should be written in hand held notes.
Management of Vaginal Birth after Caesarean Section (VBAC)

- PG priming should be kept to a minimum – a consultant should assess the need for PG. If PG is necessary, ONE 3mg PG intravaginal tablet only should be used and must be administered on the delivery suite or high dependency area. Further doses of PG should only be used after discussion with Consultant.
- Oxytocin infusion should not be started for 6 hours following PG administration
- High infusion rates of oxytocin may increase the risk of uterine rupture further and as such the rate should not be increased beyond 20 milliunits/minute (60mls/hr)
- At ANC the above should be discussed with the patient and documented in the notes
- A cervical assessment should be performed by either the consultant or Registrar.

4.7 Counselling in Labour
When counselling a woman in labour who is uncertain whether to proceed with the trial of vaginal delivery the following may be a useful guide as to the possible outcome of the labour:

Other factors should also be considered such as IUGR, CTG, bleeding, the women’s own thoughts, reason for the original caesarean section, progress of the labour.

In the case of preterm labour, the success of VBAC is similar to at term but the risk of uterine rupture is lower.

If a women goes into preterm labour follow the VBAC guideline as above unless Obstetric complications.

5.0 Management of Labour for VBAC

| Action plan should be documented in the intrapartum notes on commencement of labour by the on call registrar and agreed by consultant |

5.1 ONSET
- Amniotomy (ARM) - should be considered when the cervix is >3cm dilated and labour is established to facilitate the management of subsequent slow progress.
- IV access - insert 16G ‘Venflon’ at the start of labour and take relevant blood tests
  - Blood tests – FBC, Group & Save (Cross match may be indicated in some cases)
- Registrar
  - to be informed of admission and initial findings on assessment/VE by midwife
  - to formally assess patient (including VE/ abdominal palpation and fetal wellbeing) if subsequent progress is slow (i.e. cervical dilation of <1cm per hour)

5.2 FIRST STAGE
Continuous electronic FH monitoring throughout active labour

Consider LSCS rather than FBS if pathological CTG (after discussion with consultant)
- Progress - expect progress of at least 1cm/hour from 3cm dilatation. If progress is less than this – experienced obstetrician to review. Vaginal examination - 4 hourly up to 7cm dilatation & 2 hourly thereafter:
  - if progress is less than 1 cm/hour, an experienced obstetrician must assess and discuss progress with consultant
- Augmentation
  - Syntocinon can only be commenced with authorisation by the on call Consultant
  - Use syntocinon guidelines as described in ‘Induction of Labour Guideline’ Do not exceed 20 mU/min (60mls/hr).
Aim for 3-4 contractions in 10 minutes

- **Epidural analgesia** is not contraindicated, as it does not mask signs of uterine rupture and it is not associated with a decrease in overall success rates.

### 5.3 SECOND STAGE

- **Length**
  - With epidural, if maternal and fetal conditions are good and vertex is not low cavity, allow a maximum of 1 hour for ‘passive’ descent.
  - If delivery is not imminent after 30 minutes of active pushing then an SPR/Consultant review should be requested.

- **Forceps/Ventouse** - unless the vertex is on or near the perineum (i.e. low cavity; 2-3cm below spines):
  - Registrar to examine and discuss with consultant before proceeding
  - If vertex is on or near the perineum (i.e. low cavity 2-3cm below spines) operative delivery can be performed in the labour room
  - If OA and less than 1cm below spines discuss with senior colleague and consider the need for trial in theatre
  - If OP and less than 2cm below spines discuss with Senior staff **consider trial of forceps/ventouse in theatre**
  - It is recommended that the on call consultant is present if a trial of vaginal delivery is to be undertaken in theatre
  - Syntocinon should only be commenced after full discussion with the consultant/third on call and should be used with extreme caution.

### 5.4 Scar dehiscence & rupture

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

**All Maternity staff must be aware** that there is no single clinical feature that is indicative of uterine rupture but the presence of any of the following peripartum should raise concerns of the possibility of this event. Rupture may occur for the first time in the SECOND STAGE

- Rising maternal pulse rate
- Abnormal CTG
- Severe abdominal pain, especially if persisting between contractions
- Chest pain or shoulder tip pain
- Sudden shortness of breath
- Acute onset scar tenderness
- Maternal tachycardia hypotension of shock
- Acute fetal heart rate abnormalities
- Cessation of previously efficient uterine activity
- Continuous scar pain (still occurs with epidural)
- Abnormal vaginal bleeding
- Haematuria
- Loss of station of the presenting part

### 5.5 THIRD STAGE

**Uterine scar**

- the integrity of the scar does not need to be routinely checked
- The uterine scar should formally be checked by **vaginal examination in theatre if clinically indicated** (e.g. persistent excessive vaginal bleeding post-delivery) **after discussion with on call Consultant**.
SPECIAL Points - Length of labour (VBAC) - inform consultant when labour is not progressing normally despite appropriate oxytocin augmentation. This review and discussion should be done earlier rather than later. Delivery or imminent delivery should be anticipated within 8-12hrs of being 3cm dilated with regular contractions.

5.6 Subsequent labours - the scar rupture rate does not decrease with each subsequent labour: women with a previous LSCS should have **ALL subsequent labours** managed as described above.

### 6. Key Performance Indicators

<table>
<thead>
<tr>
<th>Monitoring Criterion</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will perform the monitoring?</td>
<td>Maternity Services</td>
</tr>
</tbody>
</table>
| What are you monitoring? | a. Individual management plan for labour recorded.  
  b. Documented antenatal discussion on mode of delivery.  
  c. Documented plan for place of labour.  
  d. Plan for the monitoring of the fetal heart in labour recorded.  
  e. Plan for labour should this start early  
  f. Plan discussed with Consultant for labour should this not start as planned. |
| When will the monitoring be performed | Annually |
| How are you going to monitor? | Audit maternity hand held/ intrapartum care pathway notes using maternity audit toolkit. VBAC audit form |
| What will happen if any shortfalls are identified? | Audit results shared with Obs & Gynae Operational Group (OGOG)  
  Action plan agreed |
| Where will the results of the monitoring be reported? | Clinical Audit Meeting |
| How will the resulting action plan be progressed and monitored? | OGOG – Quarterly Clinical Audit Meeting |
| How will learning take place? | Mandatory days, Staff bulletins, team meetings |

### 7. References


8. Related documents

This policy should be read in conjunction with the following:
- CDDFT Booking guidelines
- CDDFT Induction of Labour Guideline
- CDDFT Preterm labour guidelines

This policy refers to the following guidance, including national and international standards:
- RCOG Guideline 45. Birth after Previous Caesarean Section. RCOG Feb 2007
- NICE CS 2004

<table>
<thead>
<tr>
<th>Full Assessment Form</th>
<th>v2/2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Department:</td>
<td>Care Closer to Home – Maternity Services</td>
</tr>
<tr>
<td>Title of policy, procedure, decision, project, function or service:</td>
<td>Vaginal birth after caesarean section</td>
</tr>
<tr>
<td>Lead person responsible:</td>
<td>Evidence Base Practice Group - chair</td>
</tr>
<tr>
<td>People involved with completing this:</td>
<td>Jackie Hendy</td>
</tr>
</tbody>
</table>

**Step 1 – Scoping your analysis**

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure women have the safest care that can be given
**Who is the policy, procedure, project, decision, function or service going to benefit and how?**

**Women undergoing a vaginal birth following caesarean section**

**What outcomes do you want to achieve?**

**No incidents – good outcome – good experience for women and their families**

**What barriers are there to achieving these outcomes?**

**Not adhering to guidelines and policies - non attendance at training and education**

**How will you put your policy, procedure, project, decision, function or service into practice?**

**Monitoring incidents and ensuring lessons are learned**

**Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?**

**None**

---

**Step 2 – Collecting your information**

**What existing information / data do you have?**

**Incident data**

**Who have you consulted with?**
Clinical colleagues

What are the gaps and how do you plan to collect what is missing?
N/A

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race
No

Sex/Gender
No

Age
no

Disability
No

Religion or Belief

Management of Vaginal Birth after Caesarean Section (VBAC)

No

Sexual Orientation

No

Marriage and Civil Partnership

no

Pregnancy and Maternity

No

Gender Reassignment

No

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills

No

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?
No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act?

No

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

N/A

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

Agreed at Obstetrics and Gynaecology Operational Group and approved at the quality & Health Care Governance Committee

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Audit of maternity records using Maternity audit toolkit annually

Step 6 – Completion and central collation

Once completed this Equality Analysis form must be attached to any documentation to which it relates and must be forwarded to Jillian Wilkins, Equality and Diversity Lead. jillian.wilkins@cddft.nhs.uk
### VBAC Checklist

**Consultant** ..........................................................

**Midwife** ..........................................................

#### Antenatal Care

<table>
<thead>
<tr>
<th>Signature ..................................................................................................</th>
<th>Date .......................</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for previous caesarean section</td>
<td></td>
</tr>
<tr>
<td>Gestation at booking</td>
<td>Weeks</td>
</tr>
<tr>
<td>Gestation at 1st consultant appointment</td>
<td>Weeks</td>
</tr>
<tr>
<td>Mode of delivery preferred by mother at:</td>
<td></td>
</tr>
<tr>
<td>- Booking</td>
<td>El CS</td>
</tr>
<tr>
<td>- 1st consultant appointment</td>
<td>El CS</td>
</tr>
<tr>
<td>- 36 week appointment</td>
<td>El CS</td>
</tr>
<tr>
<td>- Agreed plan for delivery</td>
<td>El CS</td>
</tr>
<tr>
<td>VBAC Leaflet given</td>
<td>Yes</td>
</tr>
<tr>
<td>VBAC Benefits discussed</td>
<td>Yes</td>
</tr>
<tr>
<td>VBAC Risks discussed</td>
<td>Yes</td>
</tr>
</tbody>
</table>

#### Care Plan

Plan of care arranged/discussed, including:

What happens when going into labour early?
- Proceed with VBAC?
- Discuss at the time?
- For emergency LSCS?

What happens if spontaneous labour occurs?
- Proceed with trial of VBAC?
- Discuss at the time?
- For emergency LSCS?

What happens if induction required?
- Proceed with planned induction?
  - Prostin
  - ARM
  - Syntocinon
- For elective LSCS?

Plan for fetal monitoring in labour -

#### Delivery Outcome

<table>
<thead>
<tr>
<th>Type of delivery</th>
<th>El CS</th>
<th>EmCS</th>
</tr>
</thead>
<tbody>
<tr>
<td>VBAC</td>
<td>Instrumental delivery</td>
<td></td>
</tr>
</tbody>
</table>

Reason for delivery (if outcome not as planned)

| Livebirth | Yes | No |
| Birth Weight | |
| Did mother attend VBAC class | Yes | No |

Completed form to be file in Patient’s records following delivery.