

Date 07/05/2026  
Your Ref  
Our Ref 11118

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Dear

**FREEDOM OF INFORMATION – CAESAREAN SECTION**

I write in response to your request for information in relation to Caesarean sections.

Question:

- Copies of current and historic (from 2011 onwards) guidelines on:
  - a. Maternal request Caesarean section (MRCS).
  - b. “Normal birth” / “active birth” / “physiological birth” promotion and any targets for vaginal/“normal” birth rates.

Answer:

a.	Caesarean Section Maternity Services Lothian Guidelines - enclosed
b.	We do not promote or have targets for any birth rates

Question:

- Annual data (last 5–10 years), by unit where possible:
  - Total births, total Caesareans, elective vs emergency Caesareans.
  - Number of MRCS carried out, and number of maternal requests declined.
  - For women whose MRCS request was declined, the eventual mode of birth (unassisted vaginal, instrumental, emergency Caesarean).

Answer:

Hospital @ Birth	Year	Total	Total Caesareans	Elective	Emergency
Royal Infirmary of Edinburgh	2016	6660	1974	717	1257
	2017	6338	1917	703	1214
	2018	6191	1890	700	1190
	2019	5963	1914	745	1169
	2020	5911	1984	749	1235
	2021	6124	2088	786	1302
	2022	5679	2002	783	1219
	2023	5370	2280	768	1512

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*Lothian NHS Board is the common name of Lothian Health Board*

	2024	5567	2382	837	1545
	2025	5266	2289	892	1397
<b>Royal Infirmary of Edinburgh Total</b>		<b>59069</b>	<b>20720</b>	7680	<b>13040</b>
<b>St John's Hospital at Howden</b>	2016	2611	927	487	440
	2017	2581	900	470	430
	2018	2445	887	455	432
	2019	2319	858	446	412
	2020	2206	896	435	461
	2021	2330	950	449	501
	2022	2307	950	456	494
	2023	2381	1074	462	612
	2024	2446	1163	508	655
	2025	2333	1129	480	649
<b>St John's Hospital at Howden Total</b>		<b>23959</b>	<b>9734</b>	4648	<b>5086</b>
<b>(blank)</b>	2016	140	15	9	6
	2017	137	12	9	5<
	2018	127	9	5<	5<
	2019	129	13	6	7
	2020	139	25	11	14
	2021	143	16	8	8
	2022	147	20	14	6
	2023	143	26	15	11
	2024	137	20	14	6
	2025	116	23	15	8
<b>(blank) Total</b>		<b>1358</b>	<b>179</b>	*	<b>73</b>
<b>Total</b>		<b>84386</b>	<b>30633</b>	*	<b>18199</b>

To protect the identity of the individuals involved any figure of 5 or less has not been shown in the table above. Since we do not have their consent to release this data from their records, the information is exempt under section 38(1)(b) of the Freedom of Information (Scotland) Act i.e. to provide it would breach the Data Protection Act (2018). \*This included combined figures.

Question:

- Any internal audits, minutes or briefing papers that:
  - a. Discuss reducing Caesarean rates / increasing "normal birth" rates.
  - b. Refer to targets, dashboards or performance measures on mode of delivery.

Answer:

a.	Nil available
b.	Again no meeting minutes that discuss performance measures on mode of delivery

Question:

- Copies of patient information leaflets given at 16 and 36 weeks about birth options, and any internal instructions about completing “promoting normal birth” documentation.

Answer:

[Birthplace decisions Information for pregnant women and partners on planning where to give birth](#)

This information is exempt under Section 25 of the Freedom of Information (Scotland) Act 2002

- Information otherwise accessible

(1) Information which the applicant can reasonably obtain other than by requesting it under section 1(1) is exempt information.

Nil internal processes about "promoting normal birth"

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at [www.itspublicknowledge.info/Appeal](http://www.itspublicknowledge.info/Appeal). If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: <https://org.nhsllothian.scot/FOI/Pages/default.aspx>

Yours sincerely

**ALISON MACDONALD**  
**Executive Director, Nursing**  
Cc: Chief Executive

## 1. INTRODUCTION:

Caesarean Section rates are increasing, both elective and emergency. 2021 Lothian figures show elective section rate 14.51%, emergency section rate 20.98% giving an overall caesarean section rate of 35.48%. Women are also increasingly choosing to opt for caesarean section over vaginal delivery. This guideline highlights the discussions and procedures required in preparation and procedure for caesarean section.

## 2. AIM:

To ensure a safe consistent approach to discussing, consenting and arranging caesarean section both in an elective and emergency situation

## 3. GUIDELINES

- Decision making for a caesarean section
- Organising a caesarean section
- Performing a caesarean section
- Care after caesarean section

### **1. Decision making for a caesarean section**

#### **Women requesting caesarean section**

Explore, discuss and record the specific reasons for request.

If a woman requests a caesarean section, use [Appendix A](#) to discuss the overall risks and benefits of caesarean section compared with vaginal birth and record this discussion has taken place. Include a discussion with other members of the obstetric team (obstetrician/ midwife/ anaesthetist) if necessary to explore the reasons for the request and ensure the woman has accurate information.

When a woman requests a caesarean section because she has anxiety about childbirth, offer midwifery led birth choices clinic or referral to perinatal mental health support team to help her address her anxiety in a supportive manner.

For women requesting a caesarean section, if after discussion and offer of support a vaginal birth is still not the preferred option, offer a planned caesarean section.

**When a woman decides on or declines a caesarean birth, document the factors that that are important to the woman when making her decision. [2004, amended 2021]-NICE**

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NICE and RCOG have written information for the public explaining the guidance on caesarean section easily accessible.

### **Options after previous caesarean section**

When advising about the mode of birth after a previous section consider

- Maternal preferences and priorities
- The risks and benefits of repeat caesarean section (see Appendix B)
- The risks and benefits of planned vaginal birth after caesarean section including the risk of unplanned caesarean section (see Appendix B)

Inform women who have had up to and including four caesarean sections that the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and that the risk of uterine rupture, although higher for planned vaginal birth, is rare (1 in 200)

Pregnant women with both previous caesarean section and a previous vaginal birth should be informed that they have an increased likelihood of achieving a vaginal birth (85-90%) than women who have had a previous caesarean section but no previous vaginal birth (72-75%).

### **Considering Caesarean Section in Specific Circumstances**

BMI- Do not use a BMI of >50 alone as an indication for planned caesarean section.

Breech presentation- pregnant women with a singleton breech presentation at term, for whom ECV is contraindicated or has been unsuccessful, should be offered caesarean section. **Before carrying out a caesarean birth for an uncomplicated singleton breech pregnancy, carry out an ultrasound scan to check that the baby is in the breech position. Do this as late as possible before the caesarean birth procedure. [2021]-NICE**

Multiple pregnancy- in otherwise uncomplicated twin pregnancies at term where the presentation of the first twin is cephalic, caesarean section should not routinely be offered outside a research context. In twin pregnancy where the first twin is not cephalic, the effect of caesarean section is uncertain but current practice is to offer planned caesarean section.

Placenta praevia- see separate guideline.

Preventing transmission of infection: HIV / Hepatitis B, C / Herpes Simplex- see separate guidelines.

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## **2.Organising a caesarean section**

### **Assess urgency and establish timing**

The urgency of caesarean section should be documented using the following standardised scheme in order to aid clear communication between healthcare professionals about the urgency of a caesarean section:

**CAT 1** – immediate threat to the life of the woman or fetus (Aim to deliver baby as soon as possible and in most cases **within 30mins** of making the decision)

**CAT 2** – maternal or fetal compromise which is not immediately life-threatening (Aim to deliver baby as soon as possible but in most cases **within 75 minutes** of making the decision)

**CAT 3** – no maternal or fetal compromise but needs early delivery

**CAT 4** – delivery timed to suit woman or staff (**Planned caesarean section**)

Take into account the condition of the woman and the unborn baby when making decisions about rapid delivery. Remember that rapid delivery may be harmful in certain circumstances

### **Timing of planned caesarean section**

The risk of respiratory morbidity is increased in babies born by caesarean section before labour, but this risk decreases significantly after 39 weeks. Therefore planned caesarean section should not routinely be carried out before 39 weeks.

- Discuss risks and benefits with the woman and consent (**Appendix A**)
- Discuss postnatal contraception and offer LARC during admission
- Consider if anaesthetic assessment required
- Complete caesarean section booking form on trak.
- If urgent, email to [csectionco-ordinator@nhslthian.scot.nhs.uk](mailto:csectionco-ordinator@nhslthian.scot.nhs.uk) or phone ext 26174
- Give written information to woman regarding caesarean section, after care, and enhanced recovery after surgery (EROSS)

### **How to organise an emergency caesarean section (SJH)**

- Decide on and document category of caesarean section (1-4)
- Consent patient
- Inform Midwife in charge
- Bleep theatre coordinator (blp3541) and inform them of category and patient details
- Bleep anaesthetist (blp3948) and inform them of category and patient details
- Consider if neonatal input required (blp3565)
- Send Group and Save sample as per BTS policy

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## How to organise an emergency caesarean section (RIE)

- Decide on and document category of caesarean section (1-4)
- Consent patient
- Inform Midwife in charge
- Use red phone if on labour ward or phone ext 23110 and inform them of category and patient details
- Bleep anaesthetist (blp 2204) and inform them of category and patient details
- Inform midwife in charge
- Consider if neonatal input required (blp1611)
- Send BTS sample/ phone BTS to see if suitable for electronic release

### **3: Performing Caesarean Section**

#### **Preparation for caesarean section**

Women's preferences for the birth should be accommodated where possible

Before caesarean birth, carry out a full blood count to identify anaemia, antibody screening, and blood grouping with saving of serum (NICE 2021)

Cross match and clotting samples should not be sent for otherwise uncomplicated pregnancies undergoing elective caesarean section.

EROSS protocol should be followed for all elective caesarean sections. Women having caesarean section with regional anaesthesia require an indwelling urinary catheter.

All necessary safety checks should be performed

#### **Prophylaxis**

Administer prophylactic antibiotics at caesarean section before skin incision if fetus is > 32 weeks gestation to reduce wound infection. Do not use co-amoxiclav when giving prophylactic antibiotics before skin incision for caesarean birth. [2011]

Dalteparin should be given to women for at least 10 days following caesarean section, but may be longer according to Thromboprophylaxis Guideline.

Use alcohol-based chlorhexidine skin preparation before caesarean birth to reduce the risk of wound infections. If alcohol-based chlorhexidine skin preparation is not available, alcohol-based iodine skin preparation can be used. NICE 2021

Use aqueous iodine vaginal preparation before caesarean birth in women with ruptured membranes to reduce the risk of endometritis. If aqueous iodine vaginal preparation is not available or is contraindicated, aqueous chlorhexidine vaginal preparation can be used. NICE 2021

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## **Anaesthetic Care**

To reduce the risk of aspiration pneumonitis, women should be prescribed a PPI to reduce gastric volumes and acidity before caesarean section.

Women who are having a caesarean section should be offered regional anaesthesia with opioid, and Diclofenac PR at the end of the procedure unless contraindicated.

Women having their operation under regional anaesthesia should have intravenous Phenylephrine and fluids to maintain blood pressure, if required.

Each maternity unit should have a drill for failed intubation during obstetric anaesthesia.

The operating table for caesarean section should have a left lateral tilt of 15 degrees applied to relieve aortocaval compression.

Post operative analgesia should follow local guideline.

## **Performing Surgery**

Preoperatively, ensure that the surgical safety checklist is completed and that contraception is planned. Ensure patient is catheterised before prepping the skin

The incision of choice should be the Joel Cohen incision (a transverse skin incision, 3cm above the symphysis pubis: subsequent tissue layers are opened bluntly and, if necessary, extended with scissors and not a knife)

When there is a well formed lower uterine segment, blunt rather than sharp extension of the uterine incision should be used

## **Forceps**

Forceps should only be used at caesarean section if there is difficulty delivering the baby's head. The effect on neonatal morbidity of the routine use of forceps at caesarean section remains uncertain.

## **Uterotonics**

Ensure appropriate uterotonics are given according to woman's individual risk assessment e.g. oxytocin 5iu, ergometrine IM/IV, oxytocin infusion

## **Placental removal**

At caesarean section, after optimal cord clamping, the placenta should ideally be removed using controlled cord traction and not manually, as this reduces the risk of endometritis.

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## Wound repair and closure

Consider if an intrauterine device is requested and fit if indicated.

Exteriorisation of the uterus is not recommended and intraabdominal repair of the uterus at caesarean section should be undertaken.

Use single layer or double layer uterine closure in caesarean birth, depending on the clinical circumstances. Note that single layer closure does not increase the risk of postoperative bleeding or uterine rupture in a subsequent pregnancy. [2021]

Neither the visceral nor the parietal peritoneum should be sutured at caesarean section.

In the rare circumstances that a midline abdominal incision is used at caesarean section, mass closure with a slowly absorbable continuous suture (loop PDS) should be used.

Routine closure of the subcutaneous tissue space should not be used, unless the woman has more than 2cm of subcutaneous fat.

Superficial wound drains should not be used at caesarean section because they do not decrease the incidence of wound infection or wound haematoma.

Consider using sutures rather than staples to close the skin after caesarean birth to reduce the risk of superficial wound dehiscence. NICE2019

## Umbilical artery pH measurement

Umbilical artery pH should be performed after all caesarean section for suspected fetal compromise, to allow review of fetal wellbeing and guide ongoing care of the baby.

## Documentation

This should include:

- any additional procedure including IUD insertion
- estimated blood loss
- deviations from EROSS Protocol if elective surgery, including duration of urinary catheter
- Antibiotics and Uterotonics administered

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#### **4:Care after Caesarean Section**

Women should be observed on a one-to-one basis by an appropriately trained member of staff until they have met recovery discharge criteria.

All women should have a MEWS chart.

Be vigilant for SIRS criteria and specific signs of sepsis.

Oral intake should only be withheld if there are any concerns about the patient or if instructed by the medical staff and accurate fluid balance documented.

Standard operating procedure for post operative care should be followed  
**“MEWS frequency of observation for all postnatal women”**

In addition to general postoperative care, women who have had a caesarean section should be provided with:

- information related to recovery after caesarean section.
- urinary catheter should be removed according to EROSS Guideline or as instructed by the operation note.
- ongoing care related to other comorbidities e.g. diabetes, preeclampsia.

Caesarean section wound care should include:

- removal of the dressing 72 hours after the operation
- assessing the wound for signs of infection (such as increasing pain, redness or discharge), separation, or dehiscence
- encouraging women to wear loose, comfortable clothes and cotton underwear
- gently cleaning and drying the wound daily once dressing removed
- planning the removal of sutures or clips if required

While women are in hospital after having a caesarean section, give them the opportunity to discuss with healthcare professionals the reasons for the operation and provide both verbal and printed information about birth options for any future pregnancies.

Women who are recovering well, are afebrile and do not have complications following their operation, should be offered discharge (after 24 hours) from hospital and be followed up at home.

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#### **4. ASSOCIATED DOCUMENTS:**

- a) Postoperative Analgesia
- b) Placenta praevia guideline
- c) Infection control guidelines
- d) Hepatitis B/HIV in pregnancy
- e) Prophylactic Antibiotics
- f) Thromboprophylaxis guideline
- g) Obesity guideline
- h) Breech guideline
- i) MEWS frequency of observation for all postnatal women

#### **5. REFERENCES:**

- I. Caesarean Birth- NICE clinical guideline NG 192, March 2021
- II. Birth After Previous Caesarean Birth Green-top Guideline No. 45, October 2015
- III. Planned Caesarean Birth Consent –RCOG Advice No. 14, August 2022

#### **6. AUTHOR/S:**

Author 1:

Author 2:

Author 3:

Author 4:

Author 5:

Author 6:

APPENDIX A: Benefits and risks of vaginal and caesarean birth- RCOG consent advice no 14  
APPENDIX B- Risks and benefits of opting for VBAC versus ERCS from 39+0 weeks of gestation-  
GTG 45

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Appendix A- **CHANGED TO CONSENT ADVICE NO 14**  
**Consent for Caesarean Section**

Consent form for planned caesarean birth

<b>Patient identifier:</b>				
<b>Name of proposed procedure:</b> Planned caesarean birth				
Birth of baby/babies through a cut in your abdomen (tummy) and uterus (womb).				
<b>Anaesthetic:</b> This procedure will require an anaesthetic (to ensure that you do not feel any pain). This will be discussed with you by an anaesthetist before the procedure.				
<b>Statement of health professional</b> (to be filled in by healthcare professional with appropriate knowledge of caesarean birth):				
<b>I have explained the procedure to the woman, specifically, I have explained:</b>				
<ul style="list-style-type: none"> <li>• This procedure involves birth of baby/babies through a cut in your abdomen and uterus.</li> <li>• Numbers quoted below are estimates only based on the data currently available.</li> </ul>				
<b>Summary estimates of risks of planned caesarean birth compared to planned vaginal birth to inform discussions.</b> Precise numerical estimates of risks cannot be given and will vary for individual women.				
	<b>Planned caesarean birth</b>	<b>Planned vaginal birth</b>		
<b>Risks for the woman</b>	<b>Perineal tears (third- and fourth-degree)</b>	0 per 100 000	560 per 100 000 vaginal births (about 1 in 179) – risk is higher for assisted vaginal birth than for unassisted vaginal birth	
	<b>Urinary incontinence occurring &gt; 1 year after birth</b>	27 520 per 100 000 (about 1 in 4)	48 700 per 100 000 (about 1 in 2)	
	<b>Faecal incontinence occurring &gt; 1 year after birth</b>	7410 per 100 000 (about 1 in 13)	No difference for unassisted vaginal birth 15 100 per 100 000 for assisted vaginal birth (about 1 in 7)	
	<b>Urinary tract injury</b>	About 1 per 1000*	0 per 1000	
	<b>Wound infection, which may require readmission to hospital for treatment</b>	2–7 per 100 (about 1 in 14–50)	Infection rates of perineal tears or episiotomy is variable ranging from less than 1 per 100 to 13 per 100, but there is less likelihood of readmission being required	
	<b>Hospital stay</b>	About 4 days on average	About 2 and a half days on average	
	<b>Uterine rupture in future pregnancy or birth</b>	1020 per 100 000 (about 1 in 98)* Risk is higher after multiple caesarean births and after emergency caesarean than after planned caesarean births	40 per 100 000 (1 in 2500) Risk is higher for planned vaginal birth in women who have had up to and including four caesarean births	
	<b>Emergency hysterectomy: removal of your uterus</b>	150 per 100 000 (about 1 in 670)	80 per 100 000 (1 in 1250)	
	<b>Placenta accreta spectrum (abnormally adherent or invasive afterbirth) in future pregnancy</b>	100 per 100 000 (1 in 1000)* Risk is higher after multiple caesarean births and after emergency caesarean than after planned caesarean births	40 per 100 000 (1 in 2500)	
	<b>Maternal death (death within 6 weeks of childbirth)</b>	24 per 100 000 (about 1 in 4200)	4 per 100 000 (1 in 25 000)	
	<b>Risks associated with anaesthesia</b>	As discussed with the anaesthetist	As discussed with the anaesthetist	
	<b>Risks for the baby</b>	<b>Skin lacerations/cuts</b>	1–2 per 100	Unlikely with unassisted vaginal birth Up to 10 per 100 with assisted vaginal birth
		<b>Childhood obesity</b>	4560 per 100 000 (about 1 in 22)	4050 per 100 000 (about 1 in 25)
<b>Asthma</b>		1810 per 100 000 (about 1 in 55)	1500 per 100 000 (about 1 in 67)	
<b>Higher neonatal mortality (death of babies within 28 days of birth)</b>		50 per 100 000 (1 in 2000)	30 per 100 000 (about 1 in 3300)	
* Figures based on planned and unplanned caesarean births				

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Appendix B- **GTG 45**

	Planned VBAC	ERCS from 39 <sup>wo</sup> weeks
<b>Maternal outcomes</b>	<ul style="list-style-type: none"> <li>• 72–75% chance of successful VBAC. If successful, shorter hospital stay and recovery.</li> <li>• Approximately 0.5% risk of uterine scar rupture. If occurs, associated with maternal morbidity and fetal morbidity/mortality.</li> <li>• Increases likelihood of future vaginal birth.</li> <li>• 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%.<sup>71</sup></li> <li>• Risk of maternal death with planned VBAC of 4/100 000 (95% CI 1/100 000 to 16/100 000).<sup>9</sup></li> </ul>	<ul style="list-style-type: none"> <li>• 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.</li> <li>• Virtually avoids the risk of uterine rupture (actual risk is extremely low: less than 0.02%).</li> <li>• Longer recovery.</li> <li>• 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.<sup>69</sup></li> <li>• 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 2 weeks prior to the procedure.<sup>70</sup></li> <li>• Future pregnancies – likely to require caesarean delivery, increased risk of placenta praevia/accreta and adhesions with successive caesarean deliveries/ abdominal surgery.</li> <li>• Risk of maternal death with ERCS of 13/100 000 (95% CI 4/100 000 to 42/100 000).<sup>9</sup></li> </ul>
<b>Infant outcomes</b>	<ul style="list-style-type: none"> <li>• Risk of transient respiratory morbidity of 2–3%.</li> <li>• 10 per 10 000 (0.1%) prospective risk of antepartum stillbirth beyond 39<sup>wo</sup> weeks while awaiting spontaneous labour (similar to nulliparous women).</li> <li>• 8 per 10 000 (0.08%) risk of hypoxic ischaemic encephalopathy (HIE).</li> <li>• 4 per 10 000 (0.04%) risk of delivery-related perinatal death. This is comparable to the risk for nulliparous women in labour.</li> </ul>	<ul style="list-style-type: none"> <li>• 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.<sup>72</sup></li> <li>• &lt; 1 per 10 000 (&lt; 0.01%) risk of delivery-related perinatal death or HIE.</li> </ul>

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

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