Sherwood Forest Hospitals
NHS Foundation Trust

TITLE: INDUCTION OF LABOUR GUIDELINE

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Document Type:	**GUIDELINE**

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Lead Division:	Women and Children's
Lead Specialty/ Department: (Or Division if 'divisionally' owned)	Maternity
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Sponsor (position/ role):	Head of Service – Obstetrics and Gynaecology

Name the documents here or record not applicable	
(these are documents which are usually developed or reviewed/ amended at the same time – ie a family of documents)	
Associated Clinical Policy	N/A
Associated Clinical Procedure(s)	N/A
Associated Clinical Pathway(s)	N/A
Associated Standard Operating Procedure(s)	N/A
Other associated documents e.g. documentation/ forms	N/A

Consultation Undertaken:	V8.1 • Minor amends agreed as part of the validation of evidence by the ICB LMNS for Saving Babies' Lives V3.2 Implementation Tool V8.0 • Whole document review to follow changes made to other guidelines, inclusion of new IOL method and referral process.

	• Minor amends for inclusive language • Comments from Matrons, Labour ward forum & Maternity & Gynaecology Clinical Governance Group. V7.2 • Minor amends following recommendations from a HSIB incident investigation to align guideline to NICE Inducing labour guideline [NG207] (2021). • Comments from Matron for Maternity governance and Obstetric Consultant V7.1 • Minor amends agreed as part of the validation of evidence by the ICB LMNS for Saving Babies' Lives V3 Implementation Tool V7.0 • Comments from consultant obstetricians • Labour Ward Forum • Maternity & Gynaecology Clinical Governance Group

Template control:	v2.0 September 2023

Amendments from previous version(s)

Version	Issue Date	Section(s) involved (author to record section number/ page)	Amendment (author to summarise)
8.1	Aug 2025	Section 5.4	• Clarity on membranes sweeps by community midwives
8.0	Jan 2025	Whole document, particularly section 5.3 and 5.4	• Amendments made re inclusive language. • Changes made to IOL referrals process • Additional IOL method added to guideline following successful role out with SOP as supportive guidance. • Amendments made to IOL gestation to be inline with Midlands framework and individual specific pregnancy condition guidelines.
7.2	April 2024	Sections 5.2.5, 5.6.1, and 5.9	• Amendments made as recommended from an incident investigation to align this guidance to section 1.7 'Prevention and management of complications' of the NICE Inducing labour guideline [NG207] (2021).
7.1	Nov 2023	Whole document, particularly sections 5.2.5 and 5.2.8	• Review undertaken to ensure content up to date in line with Saving Babies' Lives v3 and evidence base updated

CONTENTS

1 INTRODUCTION/ BACKGROUND

Induction of labour is a relatively common procedure. Every year in the UK approximately 33% of labours are induced (NHS Maternity Statistics, 2023). Labour is induced when it is thought that the outcome of the pregnancy will be better if labour is artificially started. A variety of clinical circumstances may indicate the need for induction of labour, with a greater or lesser degree of urgency. The essential judgement that the clinician and the pregnant woman/birthing individual must make is whether the interests of the mother/birthing person or the baby, or both, will be better served by inducing labour or continuing the pregnancy. The woman/birthing person's wishes must be taken into account, and the relative risks of continuing the pregnancy compared with inducing labour discussed with them (NICE, 2021).

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

The aim of this guideline is to provide clarity on the management of both high and low risk induction of labour therefore this clinical guideline applies to:

Staff group(s)

- Midwives
- Obstetricians

Clinical area(s)

- Community Midwifery
- Pregnancy Day Care Unit
- Antenatal Clinic
- Maternity Ward
- Sherwood Birthing Unit

Related Trust Documents

- Mechanical induction of labour SOP
- Augmentation of Labour Guideline

3 DEFINITIONS/ ABBREVIATIONS

Below is a list provided of common definitions and abbreviations used during this document:

IOL	Induction of Labour
ANC	Antenatal Clinic
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ARM	Artificial Rupture of Membranes
SROM	Spontaneous Rupture of Membranes
VBAC	Vaginal Birth After Caesarean
SBU	Sherwood Birthing Unit
MDT	Multidisciplinary Team
EPR	Electronic Patient Records
SOP	Standard Operating Practice
VE	Vaginal Examination
EPMA	Electronic Prescribing and Medicines Administration
SBLCBV3	Saving Babies Lives Care Bundle Version 3
BS	Bishop Score
BP	Blood Pressure
CO	Carbon Monoxide
CTG	Cardiotocograph
IUFD	Intra-Uterine Fetal Death
PET	Pre-Eclampsia Toxemia
BA	Bile Acids
ICP	Intrahepatic Cholestasis of Pregnancy
T+12	Term plus 12 days
EDD	Estimated Due Date of pregnancy
HT	Hypertension
MEWS	Maternity Early Warning Score
EFW	Estimated Fetal Weight
USS	Ultrasound Scan
IVF	In Vitro Fertilisation
ART	Assisted Reproductive Technology
mcg	Micrograms

4 ROLES AND RESPONSIBILITIES

Roles and responsibilities of assigned midwife for induction of labour

- The midwife caring for women/birthing individual undergoing IOL should communicate any change in clinical condition to the SBU co-ordinator and the obstetric registrar. The maternity ward co-ordinator should be informed as required.

- The SBU co-ordinator and the maternity ward should communicate throughout the shift regarding the progress of women undergoing IOL.

5 GUIDELINE DETAILS (including Flowcharts)

5.1 Discussion with women/birthing individual

The information is able to support information given clinical and includes:

- The reasons for induction being offered
- When, where and how the induction could be carried out, highlighting the point about delays and realistic timings. Hospital stays may be longer compared with spontaneous labour.
- The arrangements for support and pain relief (recognising that women/birthing individuals are likely to find induced labour more painful than spontaneous labour).
- Explain that induction of labour is a medical intervention that may affect their birth options and their experience of the birth process – including need for vaginal examination before and during induction, limitations on use of the birthing pool, not available to have a home birth.
- The alternative options if the woman/birthing individual chooses not to have induction – including expectant management, planned caesarean birth.
- The risks and benefits of induction of labour in specific circumstances and the proposed induction methods – including 24% of women/birthing individuals receiving pharmacological methods, such as Propess, for induction can experience hyperstimulation.
- That induction may not be successful and what the woman/birthing individual's options would be.

Oxytocin is also thought to promote the release of pain-relieving endorphins. If women experience fear-tension-pain cycle they are less likely to labour and may find the process more painful. Encourage women/birthing individuals and their partners to use the IOL room as a home away from home environment. See the IOL patient information leaflet for suggestions of items to bring with them to support their induction and labour journey.

5.2 Induction of labour in specific circumstances

5.2.1 Induction of labour to prevent prolonged pregnancy

- Membrane sweeping should be offered to all women/birthing individual with low risk pregnancy after 39+0 weeks, as per NICE guidance. Discuss with the woman/birthing individual whether they would like to have additional membrane sweeps if labour does not start spontaneously. Time should be given between membrane sweeps to allow labour to start. Advise that there is an increase in risk of infection following each membrane sweep and this risk should be considered again with each subsequent sweep.
- Aromatherapy should be offered to women accepting a membrane sweep.
- An induction of labour referral should be sent via the EPR at the 40 week antenatal appointment, for the IOL MDT to book. IOL can be offered from 41 weeks onwards if the woman/birthing individual wishes, as per NICE guidance. It is recommended that IOL should be commenced by 41+5 to achieve birth by 42 weeks. The date given should be based on the woman's early dating scan to ensure accuracy.

- Discuss that local evidence shows that $^{2}/_{3}$ women/birthing individuals spontaneously labour between 41+0 and 41+5. Therefore, we offer a routine postdates IOL at T+12 unless they wish to request an earlier date.
- When an IOL date is booked, priority may be given to those needing urgent IOL and a postdates IOL request prior to T+12 may be delayed to accommodate clinical need.

5.2.2 Preterm prelabour rupture of membranes (see separate guideline)

If a woman/birthing individual has preterm prelabour rupture of membranes after 34 weeks, the following should be considered before a decision about whether to induce labour:

- Risks to the woman/birthing individual (for example sepsis, possible need for caesarean)
- Risks to the baby (for example sepsis, problems relating to preterm birth)
- Local availability of neonatal intensive care facilities

5.2.3 Prelabour rupture of membranes at term (see separate guideline)

- Women/birthing people with confirmed rupture of membranes at term should be offered a choice of expectant management for up to 24 hours or augmentation (induction) of labour as soon as possible. The benefits and risks of these options should be discussed with them, and their individual circumstances and preferences need to be taken into account.
- If the woman/birthing individual chooses to wait, arrange an augmentation of labour for 24 hours following SROM. However, time to be considerate to the birthing person and family – Ideally aim for 24hrs post SROM but may be earlier depending on time of ruptured membranes i.e. SROM time of 2am but the birthing person wishes to come in at 21.00hrs.
- Induction should be carried out, based on the favourability of the cervix (consider a forewater ARM at this time if achievable), using Prostin for 6hrs followed by IV Oxytocin infusion. An individualised obstetric plan should be made.

5.2.4 Previous caesarean section

- If delivery is indicated, women/birthing individual who have had a previous caesarean section may be offered induction of labour with Foley balloon or Propess®, caesarean section or expectant management. For post maturity, IOL should be offered from T+7.
- Women/birthing individual should be informed that induction of labour with pharmacological methods (Propess®) carries an increased risk of scar dehiscence or uterine rupture which would lead to emergency caesarean section.
- An individualised management plan for labour should be made by a senior obstetrician with the woman/birthing individual and documented on the EPR.
- The consultant obstetrician on duty for SBU should be made aware of all women/birthing individuals undergoing induction of labour following a previous caesarean section.
- The woman/birthing individuals should be reviewed by a senior obstetrician and a plan of care made as soon as regular uterine activity commences
- Foley balloon catheter induction is the preferred first line method of induction for those women/birthing individuals who have had a previous caesarean section due to its low

risk of uterine rupture, hyperstimulation and scar dehiscence. This can remain in place for 24hrs.
- Propess® can still be used if not favourable for a Foley balloon catheter or the individual choses to have a pharmacological method, the woman/birthing individual should be reviewed 12hrs after insertion.
- If the cervix is favourable for an ARM following either method, an ARM should be performed and continuous fetal monitoring commenced.
- If unfavourable for ARM following Propess®, it may be reinserted for a further 12hrs. Or a Foley balloon catheter can be inserted, if possible, and reassessment made at 24hrs.

5.2.5 Fetal growth restriction/Small Baby

- **Growth restriction:** Growth restriction identified via a customised growth chart (GROW 2.0), with normal Dopplers may warrant induction of labour but the timing should be decided on by the MDT reviewing IOL bookings – see Appendix A for how to submit an IOL referral.
- If there is severe fetal growth restriction with abnormal Dopplers, induction of labour is not recommended as a means of achieving delivery.

- **Below 3rd centile:** In situations where the EFW is <3rd centile on a customised growth chart (GROW 2.0), with no other concerning features, induction of labour should be arranged from 37+0 weeks to achieve birth by 37+6.

- **Less than 10th – more than 3rd centile:** In fetuses with an EFW between 3rd and 10th centile on a customised growth chart (GROW 2.0), or an AC (abdominal circumference) between the 3rd and 10th centile delivery should be considered at 39+0 weeks. Birth should be achieved by 39+6 weeks. If there are other risk factors present, birth may be indicated prior to 39 weeks, taking into account the birthing individuals' wishes (SBLV3).

- In situations where there is a concern about suboptimal fetal growth (slowing growth velocity, a downward trend in the percentile) that does not fall into the above categories, the IOL MDT review allows for a holistic assessment of the baby that is not meeting its growth trajectory (supported by GROW 2.0). As well as taking into consideration any other pertinent risk factors, which support an evidence-based decision-making process to be carried out. This includes using SBLCBv3 recommendations to support decision-making.

5.2.6 Maternal diabetes (see separate guideline) Gestational Pre-Existing

- Plans for induction of labour individualised depending on the birthing individuals' diabetic control, whether there are any fetal consequences of the diabetes and whether the woman has pre-existing diabetes or gestational diabetes.

5.2.7 Maternal age >40 years

- For women/birthing individuals who are aged 40 years or more at 40 weeks gestation, induction of labour should be offered from 39+0 to 39+6, so that delivery is achieved for by 40 weeks.
- This should be discussed with the woman in ANC with a senior obstetrician.

5.2.8 Altered Fetal Movements (see separate guideline)

- Altered Fetal Movements IOL only applies if there are no risk factors for IUFD, and maternal and fetal wellbeing assessments (including fetal growth) are normal.
- For women/birthing individuals who have antenatal recurrent episodes of altered fetal movements, with no additional risk factors, induction of labour should be offered from 39+0 – 39+6 weeks.
- For women/birthing individuals who have experienced altered fetal movements from 39+0 – 39+6, induction of labour should be discussed and offered, even if this is the first episode. IOL should be offered between 39+0 - 39+6, and an IOL MDT referral is to be sent. This is based on recommendations within the Saving Babies' Lives Care Bundle V3.
- For women/birthing individuals who experience an episode of altered fetal movements from 40+0 weeks, induction of labour should be discussed and offered at the earliest opportunity and be within 48hrs. This is based on recommendations within the Saving Babies' Lives Care Bundle V3. Offer a cervical assessment for a membrane sweep and consideration of IOL method.

5.2.9 Hypertensive disorders of pregnancy (see separate guideline)

- **Chronic/gestationl hypertension with a BP less than 160/110mmHg and no other medical complications:** As long as the blood pressure is controlled, with or without antihypertensives, and no other medical complications are present, then delivery should not be planned before 37/40. The timing of delivery should be agreed between the mother/birthing individual and a senior obstetrician between 39+0 – 39+6.
- **PET & Mild hypertension (BP 140-149/90-99 & PCR>30mg/mmol):** Consider timing of delivery between 38-40 weeks depending on clinical condition and cervical assessment.
- **PET & Moderate hypertension (BP 150-159/100-109 Mean arterial Pressure (MAP) <125 or PCR>300mg):** Consider timing of delivery from 37+0 weeks depending on clinical condition and cervical assessment.

5.2.10 Intrahepatic cholestasis of pregnancy (see separate guideline)

- Recent good quality evidence of the fetal risks associated with severity of the levels of Bile Acids can be used to inform timing of delivery, depending on the level of peak BA.
- **Mild ICP (BA 19-39 µmol/L)**: offer planned delivery by 40 weeks. The risk of stillbirth is not increased above background population, if no other risk factors are present.
- **Moderate ICP (BA 40-99 µmol/L)**: offer planned delivery by 38-39 weeks. The risk of stillbirth is not increased until 38-39 weeks.
- **Severe ICP (BA 100 µmol/L or more)**: offer planned delivery by 35-36 weeks. Risk of stillbirth is higher than background risk.

5.2.11 IVF (only)

- Women/birthing individuals who have had IVF only should be given individualised care plans. There is limited evidence to support IOL in women having forms of Assisted Reproductive Technology (ART) except IVF.

5.3 Booking induction of labour

5.3.1 Midwifery led care (low risk women)

A midwife can book induction for prolonged pregnancy, via the referral pathway on the EPR. Ensure contact details for the woman/birthing individual are up to date, and advise that they will be contacted via telephone following the next IOL MDT meeting (held Monday & Thursday afternoons) to arrange admission date and time – see APPENDIX B.

5.3.2 Maternity Team care (high risk women)

- An obstetrician should discuss in clinic about an offer of induction of labour (see **5.1**).
- The IOL referral form on the EPR should be completed in full and authorisation is required to send it to the IOL MDT referral inbox – see APPENDIX A.
- If there are significant concerns about the woman/birthing individuals' or baby's wellbeing, the woman/birthing individual should be admitted for monitoring whilst induction is arranged.
- Referrals will be discussed at the twice weekly MDT (held Monday and Thursday afternoons) and the woman/birthing individual will be contacted directly with an induction date.

5.4 Methods for induction of labour

- Any woman/birthing individual who has an IOL booked can be offered a membrane sweep by a midwife within the 7 days leading up to the planned IOL date, if the individual is ≥37 weeks gestation at the time of the sweep. This means any midwife can offer a membrane sweep without a clinician having documented it within the plan of care. The consultant or registrar may make an individualised plan for sweeps.
- Foley balloon catheter method is the preferred method of induction of labour, unless there are specific contraindications or is unable to be inserted.
- Propess® is available on maternal request, when a Foley cannot be inserted or unless there are specific clinical contraindications (in particular the risk of uterine hyperstimulation).
- Amniotomy, alone or with oxytocin, can be used a primary method of induction of labour if the Bishop Score demonstrates a favourable cervix, eg. BS ≥7. Local evidence shows good outcomes for those attending for induction of labour and an ARM as a method of induction, with or without the need for oxytocin.
- When using oxytocin as part of induction of labour following ruptured membranes, it should be commenced immediately but can be deferred if this has been discussed with the woman/birthing individual and it is their request. This can be supported with an individualised obstetric plan.
- If oxytocin is required following ARM or spontaneous rupture of membranes, the regime should be followed as per the labour dystocia guideline.

If for any reason there are delays between the methods/ stages for induction of labour, such as a delay in amniotomy due to acuity, then an individual management plan must be made in regards to the monitoring of maternal and fetal wellbeing. A Datix should be completed escalating the delay.

5.5 Process for induction of labour

5.5.1 Place of care

- The following women/birthing individual should be admitted directly to SBU:

  Gestation <37 weeks
  Parity ≥ 4 (if receiving Foley balloon method can be cared for on Maternity ward in IOL rooms following CON review of individual clinical picture)
  EFW <3rd centile
  Multiple pregnancies
  Any other women/birthing individual for whom this is agreed as part of their plan of care.

- All other women/birthing individual should be admitted to one of the 4 induction rooms on the maternity ward.

5.5.2 Assessment on admission

- Perform baseline maternal observations – BP, pulse, respirations and temperature; CO reading, urinalysis and abdominal palpation to assess lie and presentation.
- Offer nicotine replacement therapy (NRT) to those who are currently smoking tobacco or are using their own products. Add to their EPMA record.
- Perform fetal assessment; commence CTG. There should be a reassuring CTG, which meets the computerised CTG criteria obtained over a minimum of 30 minutes prior to insertion of Foley, Propess® or Prostin®.
- Perform vaginal examination and assess modified Bishop's score.
- Record Bishop's score via vaginal assessment tab on EPR Induction record.

5.5.3 Administration of vaginal foley/prostaglandin

- All medications must be prescribed on EPMA on administration.
- It is good practice to prescribe simple analgesia when prescribing Propess® or Prostin®.
- Prostaglandins should be placed in the posterior vaginal fornix and must lie transverse – if unable to reach the cervix on VE a senior colleague or obstetric registrar should perform the assessment. For Foley balloon method – see Mechanical Induction of Labour SOP, this can only be inserted by a trained practitioner on completion of the competency package.
- Document findings and actions on the EPR, including completion of the IOL cycles tab on the EPR for insertion of Foley Propess® or Prostin®. Document the plan of care and update SBU co-ordinator.
- If the modified Bishop's score is ≥7, **Foley or Propess® are not required**. A plan should be made for transfer to SBU for amniotomy.

5.6 Monitoring of maternal and fetal wellbeing

Foley balloon catheter:

- Woman/birthing individual to lie on the bed for 30 minutes after administration of the Foley balloon catheter.
- Recommence computerised CTG for a minimum of 30 minutes. Discontinue only if normal.
- After 30 minutes, encourage mobilisation and normal diet/fluid intake.

- A wellbeing check should be carried out every (minimum) 12 hours following insertion of the catheter, including maternal observations and a CTG for fetal wellbeing assessment and contraction frequency. This is to be documented on the EPR.
- Those requiring more frequent maternal observations (PET, gestational HT) should continue to receive 4 hourly MEWS.
- Remove the catheter after 24 hours and perform a VE to assess whether ARM is possible. Document on the EPR IOL cycle that catheter has been removed, along with VE findings.
- If the catheter falls out, then perform a VE to assess whether the cervix is favourable for ARM.
- Whilst the woman/birthing individual is awaiting an ARM, (a minimum) 12hourly maternal observations and CTG should be continued.

Propess®:

Once the woman/birthing individual has been given Propess®/ Prostin® or is having uterine contractions/ tightening's, the Dawes Redman criteria is no longer valid. A non-computerised CTG must be used to monitor fetal wellbeing.

- Woman/birthing individual to lie on the bed for an hour after administration of Propess® or Prostin®
- ALL Propess® inductions need a post insertion CTG for 60 minutes which remains normal throughout.
- After an hour, encourage mobilisation and normal diet/fluid intake. Assess VTE risk, consider TED stockings.
- After 6 hours, perform a further CTG. **If using Propess® and there is no uterine activity after 12hrs, perform vaginal examination and reposition Propess® as necessary.**
- Women/birthing individuals undergoing induction of labour are all assessed as being "high risk" and a plan for ongoing monitoring. Monitoring for both maternal and fetal wellbeing should be as a minimum of 6hrly (including 30min CTG).
- Perform full assessment of maternal and fetal wellbeing at the onset of regular uterine activity; increasing pain requiring analgesia; spontaneous rupture of membranes.
- Vaginal examination and removal of Propess® is indicated for CTG concerns (suspicious CTG classification), hyperstimulation (contracting ≥5:10 minutes with CTG concerns), vaginal bleeding, and spontaneous rupture of membranes.
- A vaginal examination should also be done if there are contractions requiring more than simple analgesia. It may be appropriate for the Propess® to remain in place, but an awareness to monitor frequency and strength of the contractions following analgesia and a repeat examination may be required if the pain continues. Assess at this time if it is appropriate to remove or keep the Propess® in place.
- After 24hrs, perform vaginal examination to remove the Propess® and assess the cervix

    - Bishop's score ≥7 plan ARM
    - Bishop's score <7 - see **Unsuccessful induction 5.7**

5.6.1 Spontaneous rupture of membranes during induction

- In the event of spontaneous rupture of membranes during induction a full assessment of maternal and fetal wellbeing should be performed.
- A vaginal examination and removal of the Foley balloon catheter/Propess® is indicated.

- Document date, time and findings of SROM in the woman/birthing individuals' EPR.
- In the event of SROM with an unstable presenting part or when it is not well-applied to the cervix continuous CTG must be carried out. In this situation, risks, and benefits of continuing with induction should be discussed with the woman, and a caesarean birth should be considered. If the presenting part stabilises and the CTG is normal, then CTG can be discontinued, unless there are other indications for the CTG to remain in place.
- Following SROM during the IOL process, the SBU co-ordinator and obstetric team should be updated and ongoing augmentation of labour should be prioritised, due to the change in risk. Continuous CTG whilst in an IOL room, following SROM of clear liquor and not in established labour or contracting regularly is not required, unless there are other fetal or maternal concerns, and a plan is made with the obstetric team.
- Advise the woman/birthing individual that they can choose when to commence oxytocin infusion, and opt to delay starting this, but there may be an increased risk of neonatal infection, and/or prolonged labour.
- **If for any reason there are delays in transfer to SBU to continue augmentation due to acuity, then an individual management plan must be made in regards to the monitoring of maternal and fetal wellbeing. A Datix should be competed at this time.**

5.7 Unsuccessful induction

- If after 24hrs of Foley balloon catheter/Propess® the cervix has not ripened to be suitable for an ARM, the woman/birthing individuals' condition and the pregnancy in general should be fully reassessed by a **senior obstetrician**, and fetal wellbeing should be assessed with CTG.
- The subsequent management plan should be made by a senior obstetrician in consultation with the woman and these include:

    - Induction of labour with ARM and Syntocinon
    - Consider a further induction cycle, either Foley balloon catheter/Propess® if ARM is not possible
    - Caesarean section
    - It may be appropriate to offer a period of rest for the woman/birthing individual and to then repeat the cycles of IOL.

5.8 Uterine hyperstimulation

- Uterine tachysystole (ie 5 contractions in 10 minutes) may occur related to Propess®. In such cases a CTG should be performed. In the absence of CTG abnormalities, the Propess® should not be removed.
- In cases of uterine hyperstimulation (ie ≥5 contractions in 10 minutes) with CTG abnormalities, the Propess® should be removed and an obstetric team review requested.
- Tocolysis should be considered if uterine hyperstimulation occurs during induction of labour using 0.25mcg terbutaline subcutaneously *if there is evidence of fetal compromise or hyperstimulation causing pain, which does not improve on removal of the Propess®.*

5.9 High presenting part and risk of cord prolapse

- Take the following precautions to avoid the adverse effects of cord prolapse, which may occur if labour is induced:

- Before induction, abdominally assess the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim.
- During the preliminary vaginal examination, obstetricians and midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head.
- Carry out continuous CTG monitoring during induction after the membranes have ruptured, if the presenting part is not stable and not well-applied to the cervix. In this situation, discuss the risks and benefits of induction of labour with the woman/birthing individual, and if necessary, consider caesarean birth. If the presenting part stabilises and the CTG is normal, use intermittent auscultation unless there are clear indications for further cardiotocography.

5.10 Women/birthing individual's who decline induction of labour

- The woman/birthing individual's decision must be respected, and an individualised management plan should be discussed with them at the earliest opportunity.
- If not under the care of a consultant, transfer the woman/birthing individual to Maternity Team Care.
- From 42 weeks, a growth USS (if not completed in last 2 weeks) including a liquor volume (LV) & doppler measurement and CTG should be performed. With LV & doppler, and CTG should be carried out at least twice weekly.
- Consultant review at each visit.
- If monitoring is abnormal, discuss IOL again.

6 MONITORING COMPLIANCE AND EFFECTIVENESS

The numbers of Induction of Labour are collated monthly via the Maternity dashboard and any increases over the national data set are discussed through Maternity and Gynaecology Clinical Governance and actioned as appropriate.

7 EQUALITY IMPACT ASSESSMENT

- Guidance on how to complete an EIA
- Sample completed form

Name of service/policy/procedure being reviewed: Guideline for the Management of Induction of Labour			
New or existing service/policy/procedure: Existing Guideline			
Date of Assessment: March 2021			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or	b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?	c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality

	access issues to consider?		
The area of policy or its implementation being assessed:			
Race and Ethnicity:	None	N/A	N/A
Gender:	Female only	N/A	N/A
Age:	None	N/A	N/A
Religion:	None	N/A	N/A
Disability:	None	N/A	N/A
Sexuality:	None	N/A	N/A
Pregnancy and Maternity:	None	N/A	N/A
Gender Reassignment:	None	N/A	N/A
Marriage and Civil Partnership:	None	N/A	N/A
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation):	None	N/A	N/A

What consultation with protected characteristic groups including patient groups have you carried out? • None
What data or information did you use in support of this EqIA? • None
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? • None

Level of impact
From the information provided above and following EqIA guidance document please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Signature: Hayley Hill
Date: January 2025

8 APPENDICES

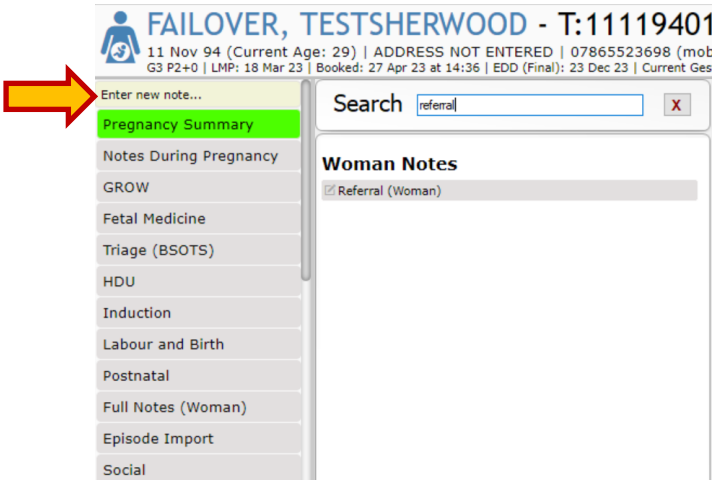
Appendix A – Step by Step guide to submitting an induction of labour referral for IOL MDT
Appendix B – Step by Step guide to submitting an induction of labour referral for Term+12
Appendix C – Pathway for booking induction of labour in the antenatal clinic

Appendix A - Step by Step guide to submitting an induction of labour referral for IOL MDT

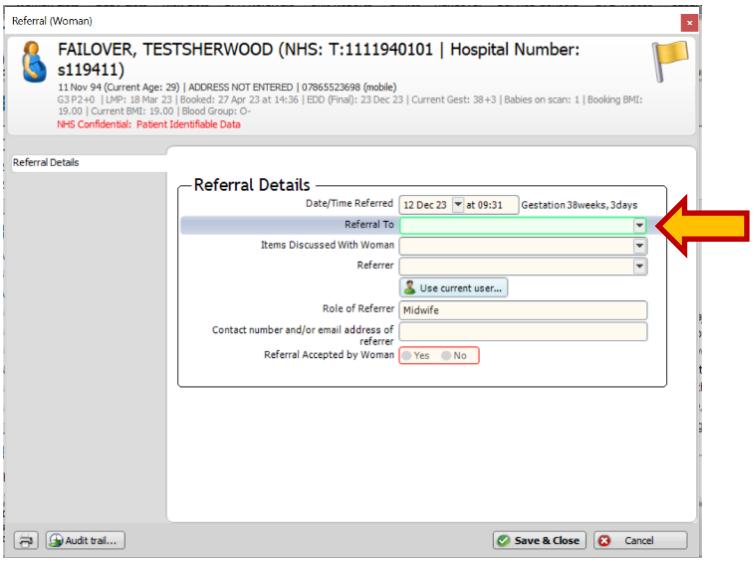
All Induction of labour referrals are to be submitted via the Referral option on BadgerNet.

Please follow the step by step instructions below to complete an induction of labour referral for discussion at the IOL MDT.

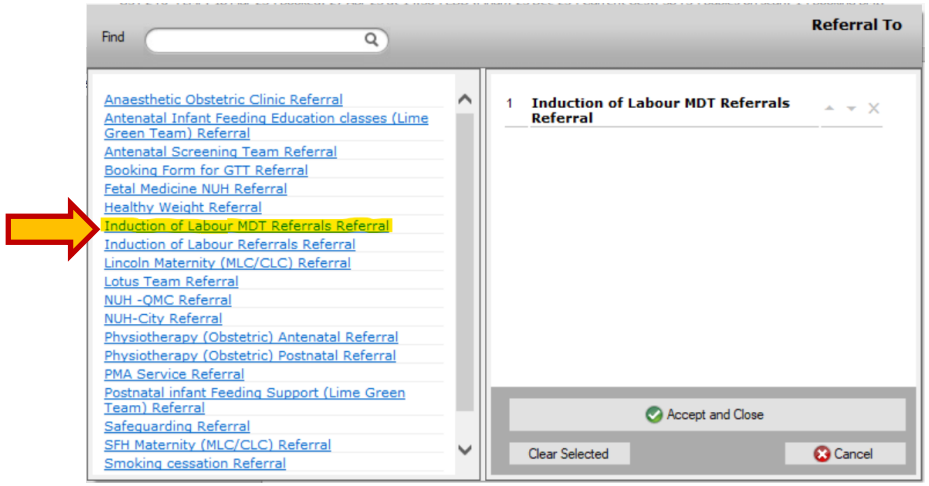
1. Search for '**referral**' in search bar on main page.



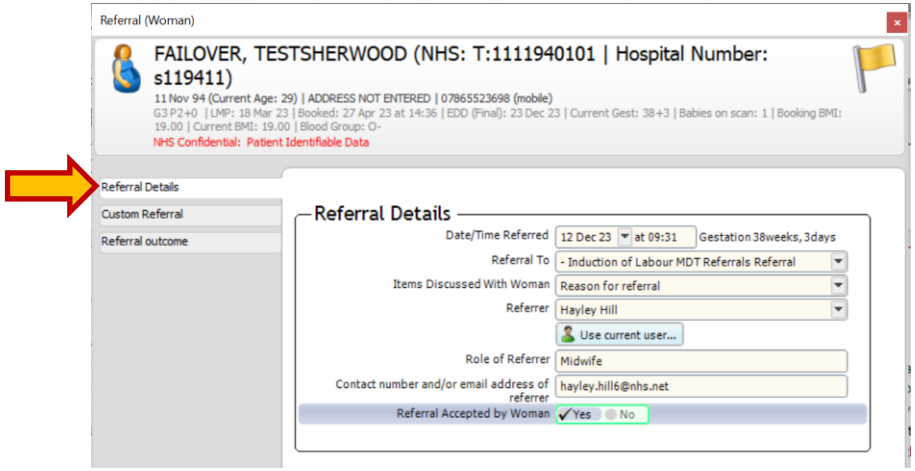
2. Open referral request & select '**Referral to**'



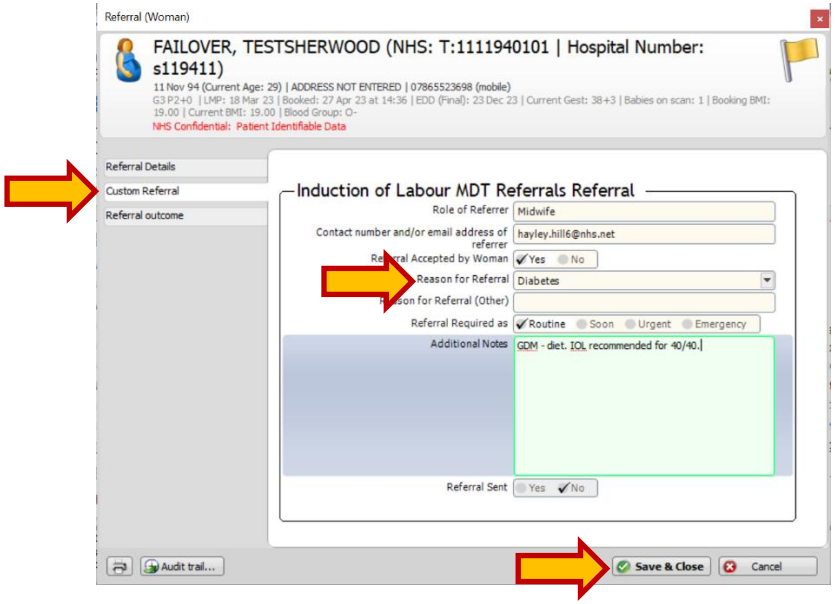
3. When requesting an IOL for MDT please select the highlighted option. The other option is solely for CMW to complete for low risk postdates inductions.

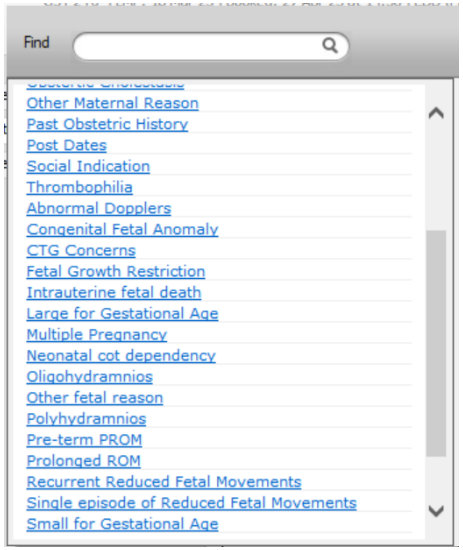


4. Then complete the remaining information on the first page of the referral – **Referral Details**



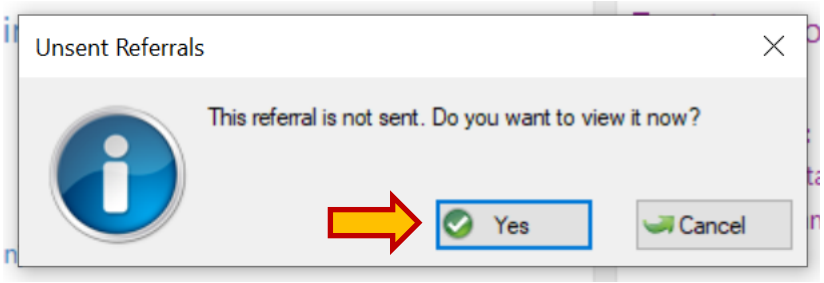
5. Next, complete the second page of the referral, **Custom Referral**. Here it will ask for reason for referral. If you've selected the correct referral option on the previous tab then there will be a comprehensive list of reasons for IOL starting with maternal reasons, followed by fetal reasons (see second picture below).
Please provide as much detail as you can in the Additional Notes, this will help to identify any additional risk factors, special considerations and an appropriate gestation for IOL. Please also include your recommendation of gestation for IOL if discussed with the patient. Once filled in click '**Save & Close'**.



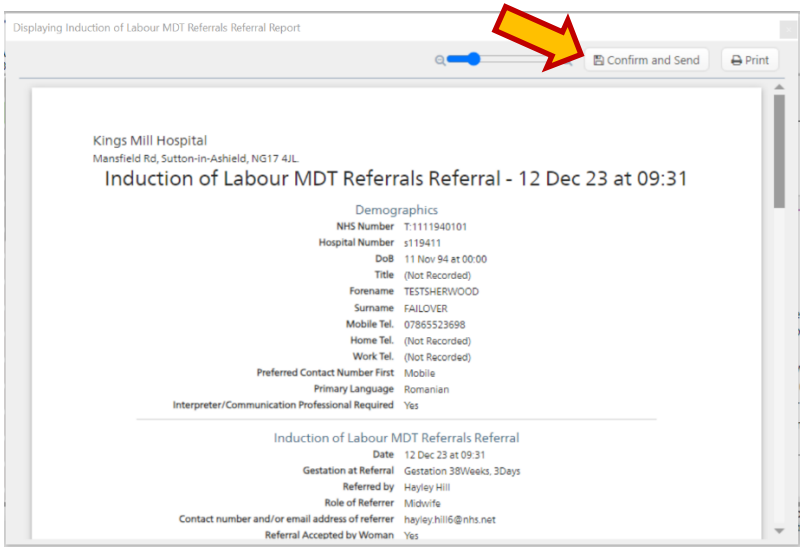


The list shown above is an example and does not show all reasons for referral available.

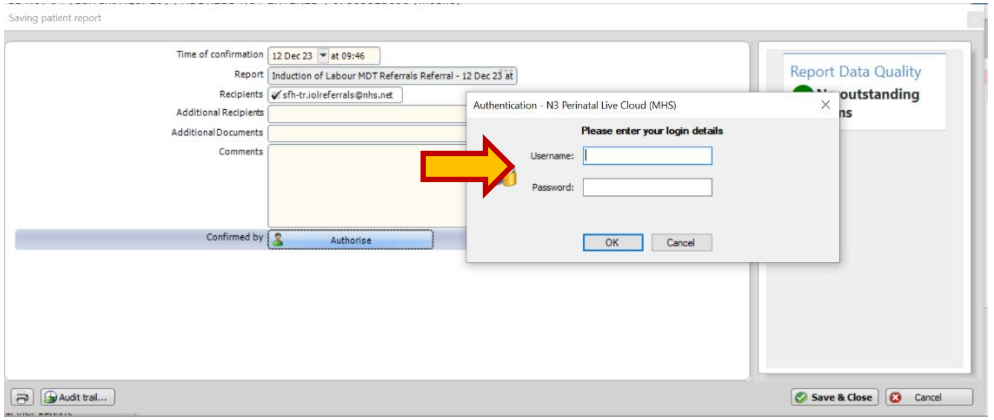
6. An alert will appear, stating you've got an unsent referral. Click '**Yes'** to view it now.



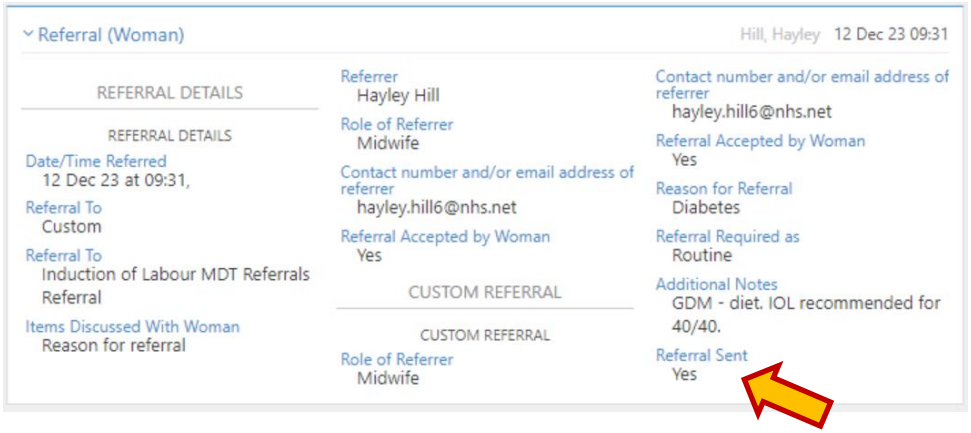
7. Your referral will appear. Click '**Confirm & Send'**.



8. This referral will now need authorisation. Complete this in order to send the referral. This will send the referral to the IOL referral inbox.



9. The referral can then be seen in Full Notes, and should state Referral sent – Yes.



10. Following your submission of the MDT IOL referral:
    - The referrals will be reviewed every Monday and Thursday prior to the planned IOL MDT by the IOL Lead MW, or the allocated MW that day if IOL Lead MW is not available.
    - They will be taken to the IOL MDT for discussion and if IOL indicated then an appropriate booking allocation will be made depending on work load and demand of IOL services.
    - The patient will be contacted by the IOL Lead MW, or allocated MW, the same day as booking allocation.
    - If IOL is declined, a plan will be made with the IOL MDT for any follow up appointments should this be recommended.

For any questions, queries or training please contact:

Hayley Hill RM – IOL Lead Midwife Hayley.hill6@nhs.net Ext. 2771

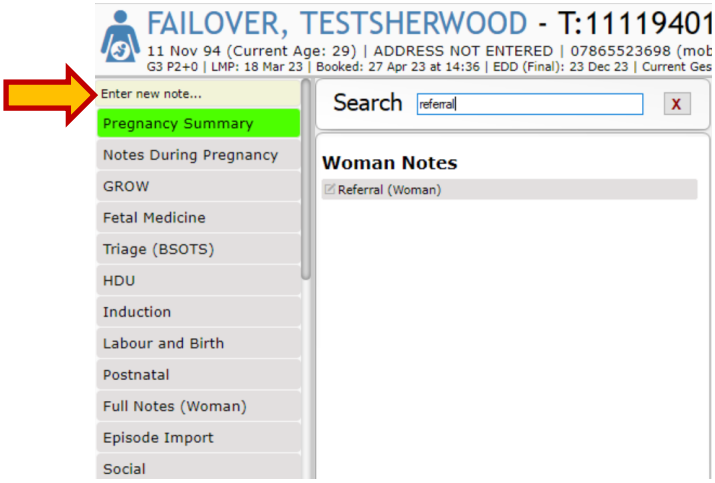
Nicola Armstrong – Digital Midwife Nicola.armstrong7@nhs.net Tel: 07920 503 114

Appendix B - Step by Step guide to submitting an induction of labour referral for Postdates

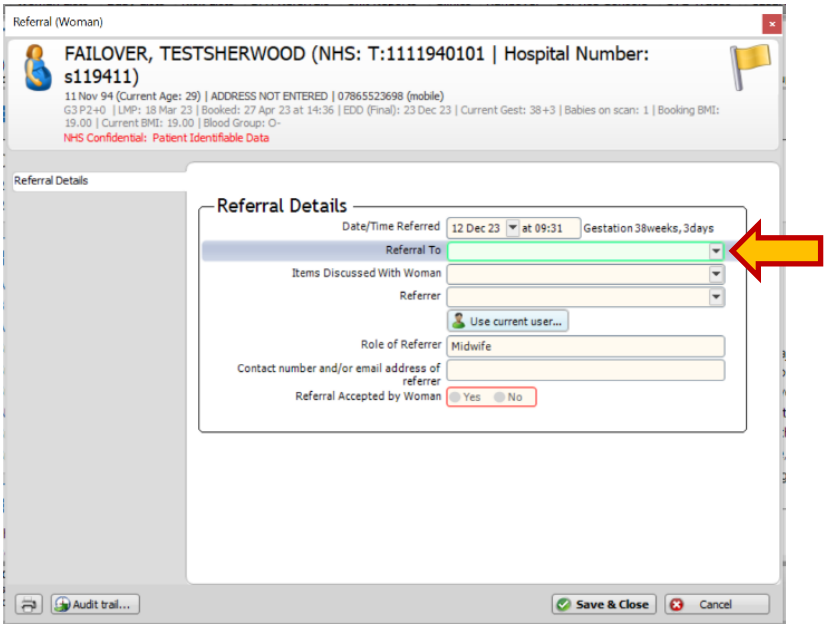
Referrals for Low Risk CMW lead patients for Term +12 Induction of Labour should be submitted via BadgerNet at the 40 week appointment to allow time for referral to be seen by MDT for appropriate booking allocation.

Please follow the step by step instructions below to complete an induction of labour referral for Term +12.

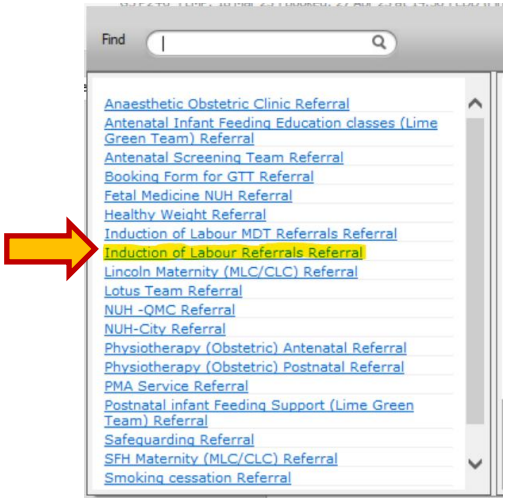
1. Search for '**referral**' in search bar on main page.



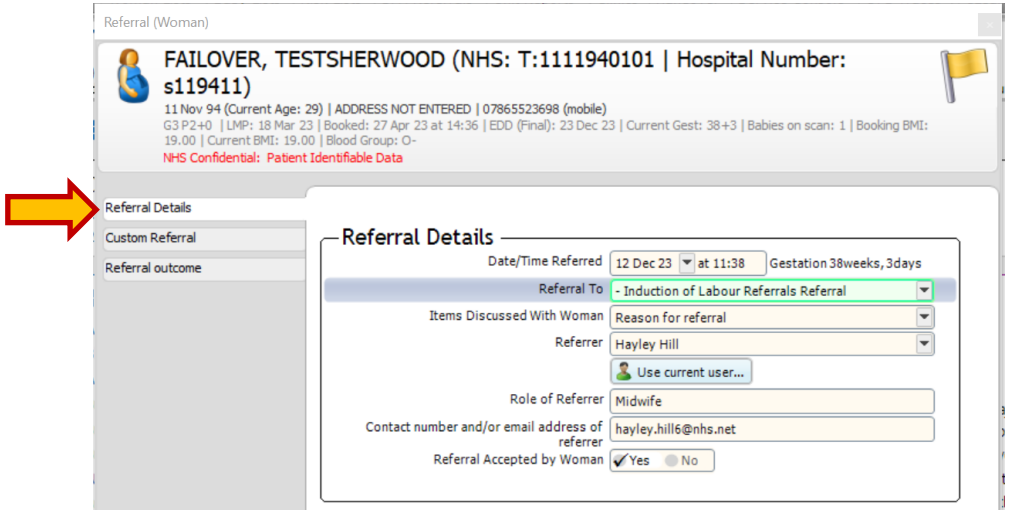
2. Open referral request & select '**Referral to'**



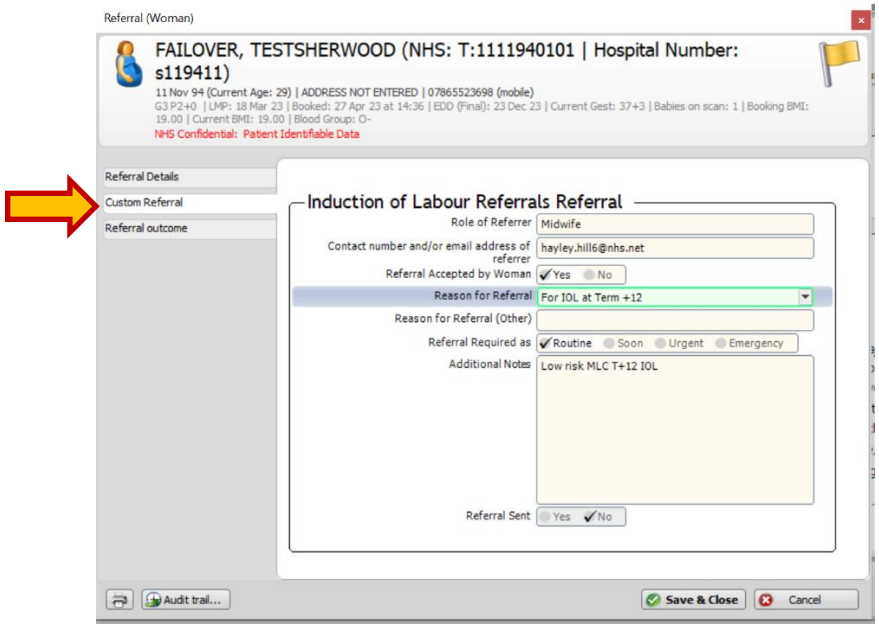
3. When requesting a Term+12 IOL please select the highlighted option. The other option is solely for high risk IOL referrals which need to be discussed at the MDT.



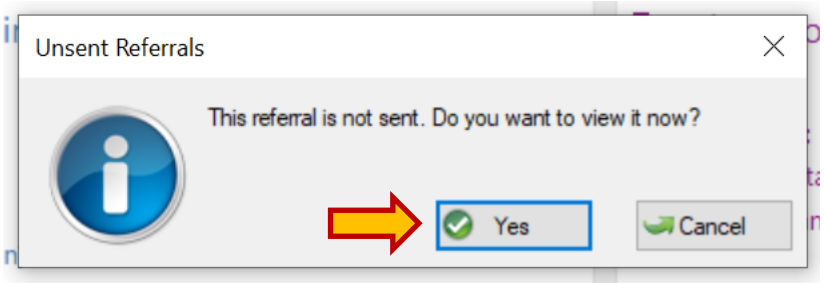
4. Then complete the remaining information on the first page of the referral – **Referral Details**



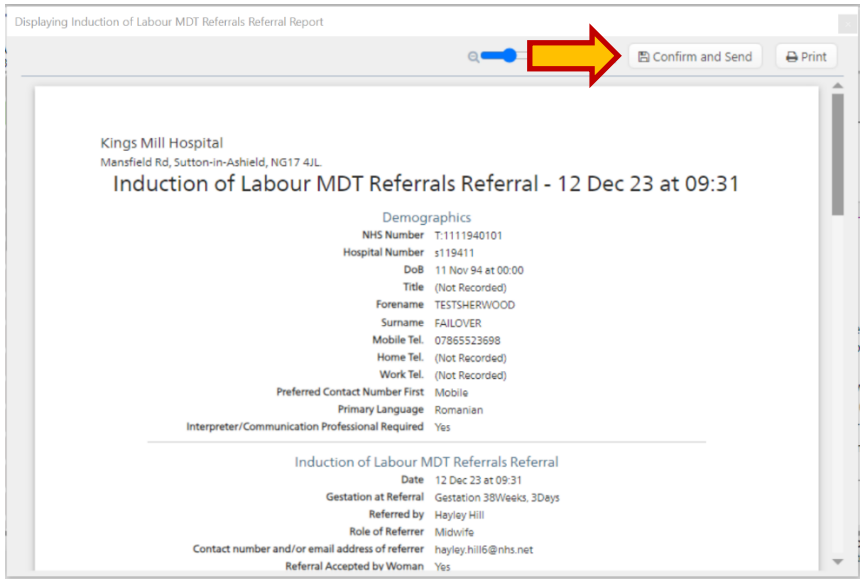
5. Next, complete the second page of the referral, **Custom Referral**. Here it will ask for reason for referral. If you've selected the correct referral option on the previous tab then there should be only one option available, **For IOL at Term +12**. Once filled in click '**Save & Close'**.



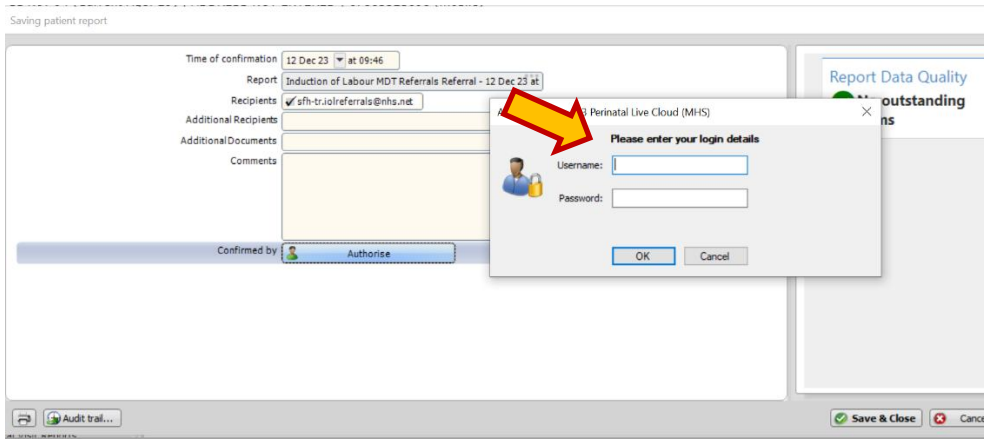
6. An alert will appear, stating you've got an unsent referral. Click '**Yes'** to view it now.



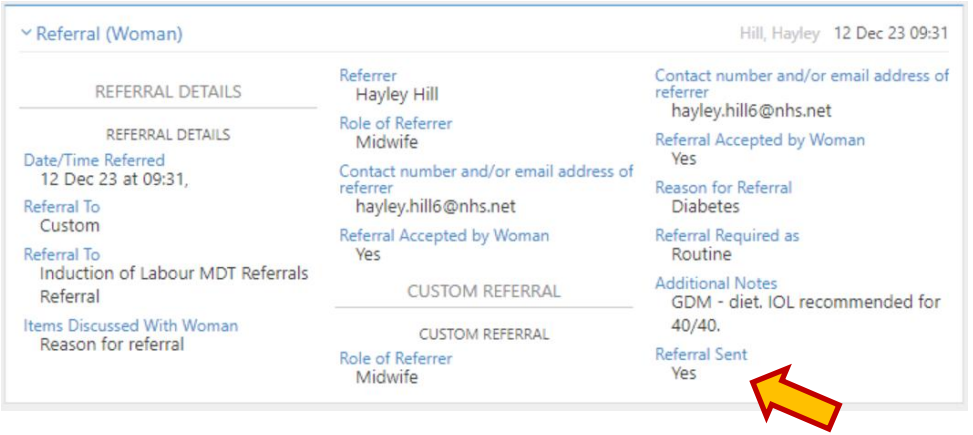
7. Your referral will appear. Click '**Confirm & Send'**.



8. This referral will now need authorisation. Complete this in order to send the referral. This will send the referral to the IOL referral inbox.



9. The referral can then be seen in Full Notes, and should state Referral sent – Yes.



10. Following your submission of the IOL Term +12 referral:

- The referrals will be reviewed every Monday and Thursday prior to the planned IOL MDT by the IOL Lead MW, or the allocated MW that day if IOL Lead MW not available.
- They will be taken to the IOL MDT for appropriate booking allocation depending on work load and demand of IOL services. If necessary, due to work load, T+10/11 will be offered instead but will be explained to the patient that if a slot becomes available for T+12 then they may be moved to that date instead.
- The patient will be contacted by the IOL Lead MW, or allocated MW, the same day as booking allocation.

For any questions, queries or training please contact:

Hayley Hill RM – IOL Lead Midwife Hayley.hill6@nhs.net Ext. 2771

Nicola Armstrong – Digital Midwife Nicola.armstrong7@nhs.net Tel: 07920 503 114

Appendix C

PATHWAY FOR BOOKING INDUCTION OF LABOUR IN THE ANTENATAL CLINIC