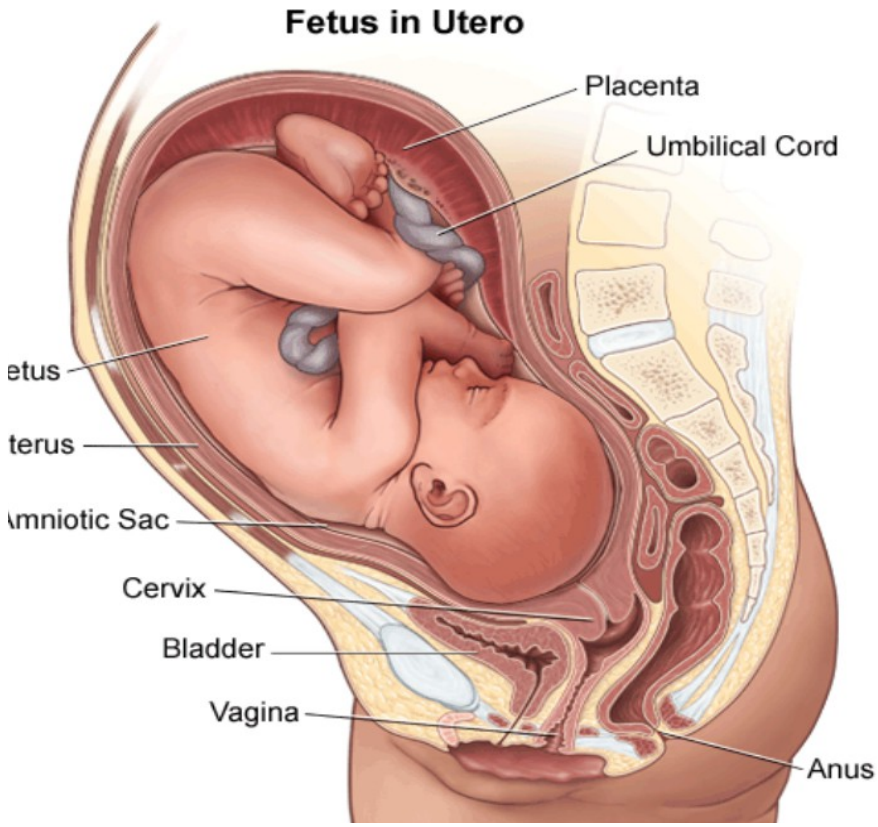
You have been given this leaflet because your midwife/doctor is considering that you may need to have induction of labour. This leaflet will explain about the process of induction of labour as well as the benefits, the risks, and the alternatives should you wish to decline induction. If you require further information, please speak to your midwife or doctor.

What is induction of labour?

During pregnancy your baby is surrounded by a fluid-filled membrane (sac) which offers protection whilst your baby is developing in the uterus (womb). The fluid inside the membrane is called amniotic fluid (your waters).



Towards the end of your pregnancy the cervix (neck of the womb) softens and shortens. This is sometimes called “ripening of the cervix”.

Before or during labour the membranes rupture (break). This is often known as “your waters breaking”.

During labour your cervix dilates (widens) and the uterus contracts to push your baby out.

Labour is a natural process that usually starts on its own between 37 and 41 weeks into the pregnancy, leading to the birth of your baby.

Induction of labour is a process designed to help start labour. Your midwife or doctor may offer and advise an induction of labour if it is felt that it would be best for your health or the health of your baby. On average in the UK 34% of labours are induced, so 3 in every 10 pregnancies. When induction of labour is being advised your doctor or midwife will discuss your options with you before you make a decision. This will include explaining the procedure, why it is being advised and any risks to you or your baby, as well as what level of monitoring you and your baby would be offered during the induction process.

Why might I be offered induction of labour?

The most common reasons for induction of labour are:

- To avoid pregnancy lasting longer than 42 weeks (known as prolonged pregnancy).
- If your waters break but your labour does not start within 24 hours.

If There are other indications when your doctor thinks starting labour early is safer for you or your baby. These would be discussed with you

If your pregnancy is more than 42 weeks (Prolonged Pregnancy)

Even if you have had a healthy, trouble-free pregnancy, you will be offered induction of labour between 41 weeks and 42 weeks. This is in line with The National Institute for Health and Care Excellence (NICE) Guidelines and World Health Organisation (WHO) recommendations. It is also based on research evidence that induction of labour at or beyond term (40 weeks) leads to better outcomes for babies.

The National Maternity and Perinatal Audit (NMPA) have investigated the link between the rates of induction of labour and adverse 'perinatal outcomes'(complication or outcome for baby) in each hospital in England. The results show that hospitals with a higher induction of labour rate had a lower risk of stillbirth and mechanical ventilation (support with breathing) of babies born after 37 completed weeks of gestation (Gurol-Urganci et al 2022).

The risks associated with a pregnancy continuing beyond 41+0 weeks include increased likelihood of:

- caesarean birth
- the baby needing admission to a neonatal intensive care unit
- Stillbirth and neonatal death

Inducing labour from 41+0 weeks may reduce these risks but they may also impact a birth experience. Your midwife will be able to support you in your decision making, using the BRAIN tool to help guide an informed conversation. You will find details of the BRAIN decision making tool at the end of this leaflet.

If your waters break but your labour does not start within 24 hours

The bag of waters around your baby act as a barrier to any bacteria in your vagina. When your waters break this barrier is no longer there, because of this there is a slightly increased risk (up to 1 in 100) of your baby getting a serious bacterial infection compared with only 1 in 200 when the bag of waters are intact. For approximately 8 in 100 pregnancies, the waters break before labour has begun. If your waters break after 37+0 weeks, waiting 24 hours for labour to start naturally has a very low risk of infection to the baby. 6 in 10 people will go into labour naturally

within 24 hours of their waters breaking. However, after that period, induction will be offered as the risks of infection for your baby start to increase.

Is there anything that can be done to promote labour before having an IOL?

Your midwife will offer you the option of having a membrane sweep at 39 weeks. It is your choice whether to have this procedure or not.

A membrane sweep is an internal examination in which the midwife gently places a gloved finger just inside your cervix (neck of the womb) and makes a sweeping circular motion to separate the membranes (sac around the baby) from the cervix. There is evidence that this can help release natural labour hormones for some women.

The midwife will help you get into a position that makes it easier to reach your cervix, the procedure can be uncomfortable but doesn't take long and your midwife will support you through this.

Membrane sweeping is a safe procedure and does not increase risk of infection or your waters breaking before labour. You may experience some contractions and/or slight mucus or blood-stained loss from the vagina for 24 hours after the sweep, this is referred to as a "show" and will not cause harm to you or your baby.

Labour may start naturally within a couple of days of the sweep, but if not, your midwife may discuss repeating it. It is completely normal for your cervix to be completely closed until you start labour and therefore it will not be possible to carry out a membrane sweep, if this is the case your midwife will offer you a mutually agreeable date to attempt the procedure again.

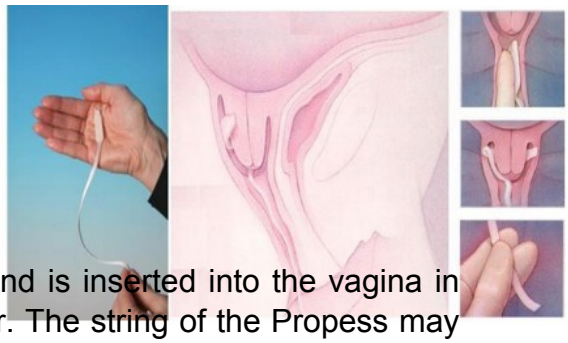
There are many old wives' tales that are said to promote labour, however there is no evidence available to support herbal supplements, acupuncture, castor oil, hot baths, enemas and sexual intercourse.What types of induction are there?

There are different methods of induction. The type recommended to you will depend on your health, pregnancy, if you have had any baby's before and your baby's wellbeing. Your midwife or doctor will discuss with your which method is recommended for you. The options are:

- Prostaglandin (Propess or Prostin)
- Mechanical (balloon catheter)
- Artificial Rupture of Membranes (ARM/ breaking your waters)
- Oxytocin (hormone) drip

Some of these options follow on from each other. These are discussed below.

Prostaglandin



Prostaglandins are hormonal drugs (May be called a pessary or vaginal tablet) that help induce labour by encouraging your cervix to soften and shorted. This allows the cervix to open and contractions to start.

Most inductions will start with a Propess™ prostaglandin. Propess looks like a small tampon and is inserted into the vagina in the same way as a tampon by a midwife or a doctor. The string of the Propess may be felt at the opening to your vagina.

Before Propess is given, your baby will be monitored on a CTG machine (cardiotocograph) for about 30 minutes. Once the Propess has been inserted, the baby will be monitored for a minimum of 30 minutes. After this, you can walk around and mobilise as much as you want.

After the Propess is inserted, labour may start straightaway, or it may take several days before your baby is born. Both reactions are normal as everyone reacts differently to the induction process. The midwives will keep you informed of your progress and offer support. The Propess will remain inside you for up to 24 hours, before being removed easily by pulling on the string.

If you have not gone into labour, or the cervix has not opened enough for your waters to be broken, after 24 hours you will be offered a Prostin™ tablet. It is the same medication as Propess but is dissolved over 6 hours and absorbed by the cervix.

Things to know:

- Prostaglandin sometimes causes vaginal soreness.
- A small number of women experience some reactions such as nausea (feeling sick), vomiting or diarrhoea.
- Very occasionally, prostaglandin can cause the uterus (womb) to contract too much. If this happens, you will be given medication to relax the uterus.
- Most women will need further help to go into labour.

Mechanical

A balloon catheter induction (also known as mechanical) is usually offered if you have had a previous caesarean section.

This is because there are risks from hormonal pessaries: if they make you contract too often, they can damage the scar from your previous caesarean section.

The midwife or doctor places a catheter (thin plastic tube) through the cervix and inflates the balloon with 30ml of water. The balloon is the size of a golf ball and sits above the cervix, stimulating your body's natural labour hormones to be released, dilating the cervix. The balloon is left in for 12-18 hours. Occasionally it will fall out within this time, in which case the midwife will monitor progress with the offer of a vaginal examination.

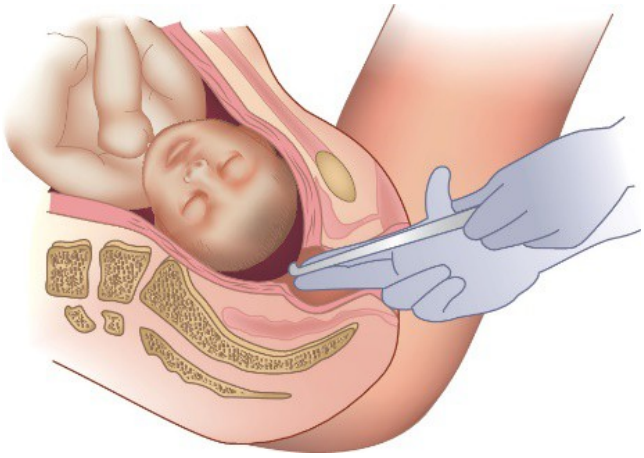
Things to know:

- The vaginal examination needed to perform this procedure may cause you some discomfort.

Artificial Rupture of Membranes

ARM (breaking your waters) can be performed if the cervix has started to dilate (open). The midwife will use a long, sterile instrument to make a small hole in the bag of fluid around your baby during a vaginal examination.

If your cervix is already open enough when you go in for an induction, this will be the first method used. However, if your cervix is not open enough (less than 3cm open) you will require prostaglandin or mechanical induction first.



After you have had an ARM, your midwife will observe you and your baby's heart rate for approximately 30-60 minutes. You will be offered a vaginal examination after about fours to check whether there have been any changed to your cervix (an indication that labour has progressed).

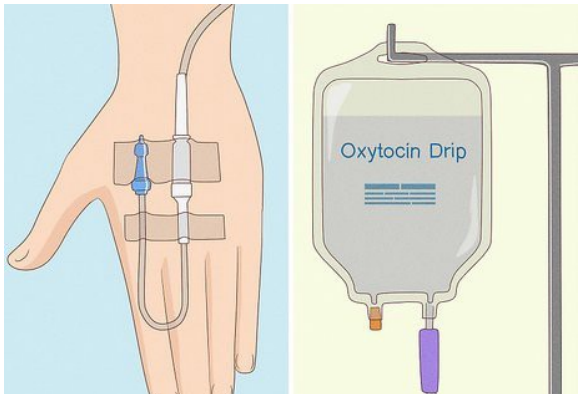
If your contractions do not start after an ARM, you will be offered the hormone drip which is made of synthetic Oxytocin,

a man-made version of the hormone your body naturally makes in labour. You can choose whether to have this infusion, or delay starting this, but it may mean your labour takes longer and there may be an increased risk of infection to the baby. You will be supported to discuss your preference with your midwife or doctor at the time.

Things to know:

- The vaginal examination needed to perform this procedure may cause you some discomfort.
- Although ARM is usually straightforward, it can increase the risk of cord prolapse (this is where the cord falls in front of the baby's head and can become compressed) bleeding and infection

Oxytocin



Oxytocin is the hormone that drives labour, making your contractions happen and your cervix open.

There is a synthetic (manufactured) version of the hormone which is used to stimulate labour. It is given intravenously (via a 'drip') in your hand or arm.

A drip is inserted using a needle that will leave a short, small plastic tube in your vein allowing fluids and oxytocin to be given. The midwife will monitor your contractions and the amount of oxytocin you receive will be adjusted according to this.

Once the drip has started, your baby's heartbeat will be monitored using the CTG throughout the rest of your labour. However, this does not mean you have to lie on the bed. Your midwife will help you find the most comfortable positions for labour.

Things to know:

- You may be restricted by the wires from the CTG if a wireless monitor is not available, but you can still stand, sit on a birthing ball, lay on your side or kneel on the bed with the monitor on.
- People have reported that the oxytocin drip is painful, so you may wish to consider your pain relief options before starting the drip.
- Sometimes oxytocin can cause the uterus to contract too frequently, which may affect the pattern of your baby's heartbeat. If this happens you will be asked to lie on your left side and the drip will be slowed to reduce the number and strength of your contractions. Another drug may be given to cancel the effect of the oxytocin

Can I go home during the induction?

If you are being induced because you have gone past your due dates you may be encouraged to have an outpatient induction if you have no other risk factors, live

within a 30-minute drive of the hospital and have transport back to the hospital. This means you will go home for the first 24 hours of the induction (whilst the Propess is inside).

Benefits of outpatient induction of labour are:

- Being in your own home environment rather than in a hospital
- Research shows people cope with early labour better at home
- People who have an outpatient IOL report a better birth experience

If you go home for an outpatient IOL you will be told to call the hospital that evening to update the team on how you are doing, whether contractions have started and how your baby's movements are. You will be advised to return to the hospital after 24 hours of having your Propess unless you experience the following:

- Vaginal bleeding
- Persistent abdominal pain that does not have breaks like contractions
- Your waters break
- You have concerns about your baby's movements

If these happen, you will need to contact the Ward team or the Maternity assessment Unit

How long will my induction take?

The length of induction is different for every person and depends on how ready the neck of womb is for birth (cervix). In general, it may take two to five days from the start of the IOL for your baby to be born.

Occasionally you may encounter a delay in the induction of labour process. This usually occurs once your cervix has opened enough for your waters to be broken and so you are awaiting a bed on delivery suite. Transfer to delivery suite can only occur when there is both a room and a midwife available to look after you on a one-to-one basis. The order in which people are transferred to delivery suite is based on an assessment of their whole clinical background.

Unfortunately, we are unable to predict how long this delay may be, however, we aim to keep you fully informed, comfortable and both you and your baby's health monitored throughout your stay.

If your induction is delayed, please discuss with your midwife or doctor where the most appropriate place is for you to wait as it may be possible for you to wait at home. Please be assured we only delay inductions in the interest of safety for all mothers and babies we are providing care for.

What are the risks involved with induction of labour?

- Over-contracting of the womb may occur with prostaglandins or oxytocin. This will mean 5 or more contractions in 10 minutes; you will feel as though there is no break between contractions. If this occurs Propess can be removed, or Oxytocin turned off until contractions return to a normal rate. We can give you medication to reduce contractions if needed.
- Some women experience nausea, vomiting or diarrhoea after the Propess or Prostin is inserted. If this occurs talk to your midwife who will discuss the options with you.
- The main disadvantage of IOL is a woman's experience of the labour process, with lower birth satisfaction scores compared to women who spontaneously labour. Therefore, we only recommend an IOL when there are clinical needs or risks.

What pain relief can I have?

You will be offered emotional support and whatever pain relief is appropriate to you- in the same way as if your labour had not been induced. You will be encouraged to use your own coping strategies for pain relief as well. There are several options your maternity unit may provide for pain relief during the initial induction stages:

- **Water**- water has been proven to reduce pain during labour. The Maternity Units have baths available with can help you relax and will aid your body's natural oxytocin production to help your labour progress.
- **Transcutaneous electrical nerve stimulation (TENS)**- you can buy or hire your own TENs machine to use in your induction and labour. TENs use electrical impulses to stimulate nerves at the height of contractions which helps provide pain relief by blocking messages of pain to the brain.
- **Paracetamol**- Paracetamol is the lightest form of medicinal pain relief offered; it can help take the edge of in the early stages of labour. Please don't take your own whilst in hospital, or if you do, let your midwife know so we can ensure it is prescribed on your drug chart.
- **Oramorph**- this is the strongest pain relief we offer during induction of labour on the ward. Oramorph is a small drink of morphine. The drug is fast acting and quickly out of your system and therefore safe for your baby. As it is an opioid drug it can make you feel drowsy and sometimes sick. You can be given anti-sickness medication if this happens to you.

Once you are in established labour you can then access:

- **Entonox**- Also known as 'gas and air'. This is pain relief you breathe in through a tube and mouthpiece. It quickly enters your body providing pain

relief and helps you with deep breathing. You will be advised to breathe it throughout your contraction. Once you stop breathing it in it will quickly leave your system. It can make you feel dizzy.

- **Pethidine**- this is an opioid drug like morphine that is administered via an injection, normally into your thigh. This drug does cross the placenta so can sometimes make the baby sleepy. It has a lasting effect of approximately 3 hours, so your midwife will normally advise this earlier in labour, so baby is not born sleepy or requiring help with breathing. If you do have it later in labour your baby may require more help with feeding initially due to being drowsy.
- **Epidural-**
    - **What is it?** this is an anaesthetic given through an injection into your back. It numbs the pain nerves in your spine, so you no longer feel contractions. You will be given a button to press to give yourself top ups of the epidural as you need them with the support and guidance of your midwife.
    - **The procedure:** If you request an epidural, you will have a conversation with an anaesthetist (specialist doctor) to discuss the risks and benefits. Once you consent to the epidural it can then take 20-30 minutes for the anaesthetist and midwife to sign out the medications and set up for the procedure. You will be asked to sit over the side of the bed so the anaesthetist can access your back. The anaesthetist and midwife will talk you through the whole procedure and support you to stay as still as possible whilst they give you the epidural.
    - **Other considerations:** sometimes it can take a few attempts to get the epidural in the right place, this is quite common. Sometimes the epidural does not work effectively and may need to be reinserted. Sometimes a patch of nerves is missed and whilst most places are numb you can experience a patch of break through pain. The epidural will make your bladder numb so you will be advised to have a catheter (small plastic tube into your bladder) to ensure you keep passing urine. You may experience numb legs which will restrict your movement and ability to mobilise, this wears off around 6 hours after your last dose of epidural.

What happens if induction does not work?

If you do not go into labour following induction of labour your midwife and doctor will discuss your options with you and check, you and your baby thoroughly. Depending on your wishes and circumstances you may be offered:

- A caesarean delivery

- The option to stop the IOL and try again after a break (the next day or later, if appropriate)

What happens if I choose not to be induced?

Your doctor or midwife will explain why they recommend induction or labour, but it is your choice whether or not to go ahead. If you choose not to be induced, we will offer you the option to have regular checks of your baby's heartbeat and may offer you a scan to check the amount of fluid around the baby and the placenta. However, these checks can only tell us how your baby is at the time of the check.

What do I do on the day of my induction?

Each unit has a different process for the day of induction which will be explained to you at the time your induction is booked. You may have a prearranged time or have to call the unit on the day of your induction.

When you are admitted for your induction you will have your blood pressure, pulse, temperature and urine checked. Your baby will be monitored prior to the induction being commenced.

In most cases you will start off in a 6 bedded bay area with other women also having an induction of labour. Once you are in established labour (when your cervix is more than 4cm open) you will be moved to a private room on delivery suite/ midwifery led unit. We recognise that it can be frustrating to see other women leaving the bay in labour if your contractions have not started. Everyone responds differently to the IOL process and if your labour progresses more slowly, this does not mean you are doing anything wrong.

What should I bring with me?

You may be in the hospital for a number of days during the IOL process and you may spend some time waiting. You should bring your hospital bag with you when you come (even if you are planning an outpatient induction). Things we would recommend bringing in addition to your hospital bag are:

- A device to watch films/ tv
- A way to play music and headphones
- Books/ magazines/ newspapers/ colouring books and pens
- Games to play with your partner
- Eye mask and/ or earplugs to help you sleep

- Snacks
- Medications- please bring any regular medications you take during pregnancy with you for your stay
- Birthing balls- most units provide birthing balls, but you are welcome to bring your own with you
- Pillow- whilst a pillow will be provided for you, many people choose to bring in their own pillow for comfort from home also

You will be provided with breakfast, lunch and dinner alongside water/ teas and coffee whilst you are an inpatient. Any other snacks and meals for your birthing partner must be provided by yourself.

Visiting times

Your birth partner can attend your initial induction assessment with you on the ward. They are also able to be with you all the time once you are on delivery suite, either in active labour or to have your waters broken. Each trust has slightly different visiting times on the wards whilst an inpatient, so please speak to your midwife or doctor to find these out.

Other resources

NHS England- Inducing  Labour:

NICE Guidance for the  Public:

The National Maternity and Perinatal Audit (NMPA)Gurol-Urganci I, Jardine J, Carroll F, Frémeaux A, Muller P, Relph S, et al (2022) National Maternity and Perinatal Audit Project Team. Use of induction of labour and emergency caesarean section and perinatal outcomes in English maternity services: A national hospital-level study. BJOG. 2022;129:1899–1906. https://doi.org/10.1111/1471- 0528.17193

BRAIN- a tool for better conversations

Whilst making your decision about induction of labour you may find it useful to use the BRAIN tool below to help you ask the right questions to your midwife or doctor.

Benefits
What are the benefits of an induction of labour for you and your baby?

Risks
What are the risks of an induction of labour? Are there any specific side effects that would be personal to you?

Alternatives
What are your alternatives to an induction of labour?

Intuition
How do you feel about the idea of an induction of labour?

Nothing
What if you do nothing? You don't have to make a decision straight away; you can take some time to decide the best course of action for you.

If you have any further questions or concerns, please speak to you Midwife who will be happy to help and discuss through this leaflet in more detail and answer any questions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