

GS30 - Induction of Labour Guideline

Category:	Guideline
Guideline Number:	GS30
Summary:	This document provides guidance for all clinical staff caring for women/birthing people during the Induction of labour process. It is applicable to all women/birthing people who require induction of labour within the Oxford University Hospitals NHS Foundation Trust.
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This document is uncontrolled once printed.

It is the responsibility of all users to this document to ensure that the correct and most current version is being used.

This document contains many hyperlinks to other related documents.

All users must check these documents are in date and have been ratified appropriately prior to use.

Document History

Version valid from	Version number	Reason for review/update
23/09/2025	5.1	Hypertension guidance update and Place of Birth Setting – Spires MLU addition
07/07/2025	5.0	3 Yearly review
08/10/2024	4.3	<ul style="list-style-type: none"> Opel 3 and 4 indications for IOL Appendix 2 - correction
06/10/2023	4.2	<ul style="list-style-type: none"> Appendix 2 - Decision Making Tool to inform Induction of Labour updated to include guidance for when unit is declared Opel 3 (RED) and Opel 4 (BLACK) Link to the Escalation Policy for the Management of Delay in IOL added to page 19
19/12/2022	4.1	<p>Point 109 on page 17 changed from: As a minimum there should be an hourly review of fetal movements and maternal well-being, unless the woman/birthing person is asleep or is mobilising off the ward. This should be documented on the Induction of Labour Chart.</p> <p>to: Women/people should be counselled to escalate any concerns following gel administration and be made aware that fetal movements should remain normal throughout this process.</p>
25/07/2022	4.0	<p>Comprehensive review to align with NICE guidance NG207 published in November 2021</p> <p>GDM POSSIBLE COMPLICATIONS changed from:</p> <ul style="list-style-type: none"> Macrosomia (AC >95th centile and/or EFW >95th centile at 36 weeks accelerated growth from previous scans) <p>to:</p> <p>*Macrosomia (EFW >95th centile at 36 weeks or accelerated growth from previous scans)</p> <p>Appendix 2 Indications and Timings of Induction (page 22) updated to reflect change above</p>
04/05/20	3.0	New outpatient pathway using mechanical induction of labour.

		Updated recommendations for gestation of induction for use during Covid pandemic.
21/09/18	2.6	
10/05/18	2.5	
17/05/17	2.4	
06/02/17	2.3	
21/11/16	2.2	
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06/06/16	2.0	

Consultation Schedule

Who? Individuals or Committees	Rationale and/or Method of Involvement
Consultant Obstetricians	Verbal and email
DS Midwife Manager	Verbal and email
Document Review Group (DRG)	Review and approval

Contents

Document History	2
Consultation Schedule.....	3
Contents.....	3
Who should read this document?.....	6
Key Standards/Messages	6
Background/ Scope	6
Key Updates in v5.1.....	7
Aim(s)	7

Full Guideline	7
Antenatal Considerations	7
Induction of labour in specific circumstances (see Appendix 2 for indications and timing of induction of labour).....	9
Induction of Labour (IOL) for Pregnancy lasting more than 41 weeks	9
Gestational age at which labour started, as a proportion of labours which started spontaneously (NICE 2021 statistics).....	10
Preterm and Term Rupture of Membranes.....	11
Induction of labour in women/birthing people with a previous caesarean section	11
Maternal Request (Updated in v5.0)	12
Breech presentation	12
Fetal growth restriction.....	12
Suspected Fetal Macrosomia (without diabetes) (Updated in v5.0).....	13
History of Precipitate Labour.....	13
Women/People Above the Age of 40 years.....	13
Other indications for induction (Hypertension/Diabetes etc).....	14
Intrauterine fetal death.....	14
Methods of Induction of labour	14
Membrane Sweeping.....	14
Vaginal PGE 2.....	14
Mechanical IOL – Dilapan (New in v5.0) (Please also see Dilapan SOP).....	15
Antenatal Management and Booking of Planned Induction of Labour	16
When Women/Birthing People Wish to Continue Pregnancy Beyond Recommendation	17
Prolonged Pregnancy	17
Admission and Management of Induction of Labour.....	17
Vaginal Prostaglandin (Also see Appendix 3).....	18
Place of induction.....	18
Prostaglandin gel	18
Artificial Rupture of Membranes (ARM)	18
Place of Birth following IOL (New in v5.1).....	19
Process for when the Service is Unable to Induce Women/People due to Clinical Acuity.....	19
Management of Delay in IOL.....	19

Uterine Hyperstimulation During Induction of Labour	19
Unsuccessful (Failed) Induction of Labour	20
Review	20
EPR Considerations / Booking of Induction of labour (Updated in v5.0)	20
Implementation plan	20
References	22
Bibliography	22
Appendix 1 – Decision Making Tool to inform Induction of Labour (Updated in v5.1).....	23
Appendix 2 – Technique for Insertion of Prostaglandin Gel.....	27
Appendix 3 – Induction of Labour using Prostaglandin Tablets.....	28
Nulliparous Induction.....	28
Multiparous Induction without a uterine scar	29
Appendix 4: IOL Pathway: Primigravida.....	30
Appendix 4 (cont.): IOL Pathway: Multiparous.....	31
Appendix 5: Responsibilities.....	32
Appendix 6: Education and Training.....	32
Appendix 7: Definitions and Acronyms.....	33
Appendix 8: Equality Impact Assessment	34

Who should read this document?

1. This guideline should be read by all maternity clinical staff within the Oxford University Hospitals Foundation Trust (OUHFT) who are involved in providing care for women/people having (or clinically advised to have) an induction of labour (IOL).

Key Standards/Messages

3. Women/birthing people should be counselled to escalate any concerns following gel or dilapan administration and be made aware that fetal movements should remain normal throughout this process.
4. A woman/birthing person's preferences for birth should be discussed at the early stages of pregnancy and documented in their record. These may include declining or delaying a recommended induction, or the desire for a planned caesarean section. These preferences should be confirmed at the latter stages of pregnancy as well.
5. Induction of labour may be offered when birth of the baby is considered to be safer (for maternal or for fetal reasons) than continuing the pregnancy, taking into account the risks of the induction process itself on the mother and the risks of prematurity on the baby.
6. Occasionally, the birth itself needs to be timed in order that the specialist resources can be made available for labour or the early neonatal period.
7. Induction of labour should only be considered when vaginal birth is felt to be an appropriate and safe mode of birth.
8. When induction of labour is requested due to psychological issues or anxiety, consider referral to the Birth Choices Clinic (via EPR pool) or perinatal mental health team.
9. Induction of labour is not a benign intervention and should only be offered for a clear clinical indication.
10. When an induction of labour is clinically indicated, women/people should be informed of the benefits and risks of such an intervention. The opportunity to discuss birth options/preferences should be provided which may include declining or delaying an induction, expectant management, or a planned caesarean section.
11. Induction for maternal request or previous precipitate labour should not be routinely offered in the absence of other indications.
12. Other than for prolonged pregnancy, the decision to offer induction of labour should be agreed with a Consultant Obstetrician.

Background/ Scope

13. Induction of labour is a common intervention, occurring in up to 30% of pregnant women/people in the UK.
14. Care in the planning and appropriate use of induction is required. Women/people should be provided with all the information required for them to make an informed choice about induction of labour.
15. This guideline is applicable to all women/birthing people who require induction of labour within the Oxford University Hospitals NHS Foundation Trust.

Key Updates in v5.1

- **(Updated in v5.1)** For **chronic/gestational/pregnancy induced hypertension (PIH)** where blood pressure is well controlled and the woman/pregnant person is an outpatient - **IOL may be commenced from 39 weeks** based on the woman/pregnant person's preference.
- **(New in v5.1)** Place of Birth Setting section added on **page 19**.
- Other updates are marked up as **(Updated in v5.1)** or **(New in v5.1)** throughout the document.

Aim(s)

- Ensure induction is offered appropriately
- Ensure induction procedure happens safely and expeditiously

Full Guideline

Antenatal Considerations

16. Women/birthing people's preferences for birth should be discussed from an early stage of pregnancy. Individual circumstances should be taken into consideration when discussing options. These may include expectant management, declining or delaying a recommended induction, or the desire for a planned caesarean section. These preferences should be confirmed at the latter stages of pregnancy as well. Any preferences should be clearly documented in the notes.
17. Women/birthing people who intend to decline a recommended induction or would like to explore the option of a planned caesarean section, should be referred to the Birth Choices clinic (or Consultant Obstetrician) to make an individualised plan for birth.
18. Induction of labour may be offered for a variety of reasons, including in the following circumstances (this list is not exhaustive):
 - Pregnancy greater than 41 weeks
 - Pre-labour rupture of membranes at term/preterm pre-labour rupture of membranes. See [Pre-labour Rupture of Membranes \(PROM\) at ≥ 37 weeks gestation at Term Guideline/ SOP /Preterm Pre-labour Rupture of Membranes \(PPROM\) Guideline](#)
 - Maternal Age
 - Diabetes
 - Hypertension/Pre-eclampsia
 - Cholestasis
 - Previous traumatic birth
 - Antepartum Haemorrhage
 - Intrauterine Death
 - Fetal indications
 - Intra-Uterine Growth Restriction
 - Multiple pregnancy

19. At the 38-week antenatal visit, all women/birthing people (in the absence of any pre-existing plans for birth) should be offered verbal information about the risks associated with pregnancies that last longer than 42 weeks and their options. These include:
 - membrane sweeping
 - induction of labour from 41+0 weeks onwards
 - expectant management
20. Explain to women/birthing people that induction of labour is a medical intervention that will affect their birth options and their experience of the birth process. This could include that:
 - vaginal examinations to assess the cervix are needed before and during induction, to determine the best method of induction and to monitor progress
 - their choice of place of birth will be limited, as they may be recommended interventions (for example, oxytocin infusion, continuous fetal heart rate monitoring and epidurals) that are not available for home birth or in Midwife-Led Birth Units
 - there may be limitations on the use of a birthing pool
 - there may be a need for an assisted vaginal birth (using forceps or ventouse), with the associated increased risk of obstetric anal sphincter injury (for example, third- or fourth-degree perineal tears)
 - pharmacological methods of induction can cause hyperstimulation – this is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise
 - an induced labour may be more painful than a spontaneous labour
 - their hospital stay may be longer than with a spontaneous labour
21. The Doctor or Midwife should take into consideration and explain the following points to women/birthing people being offered induction of labour:
 - the reasons for induction being offered
 - the risks and benefits of induction of labour in specific circumstances and the proposed induction methods
 - **(Updated in v5.0)** ensure women/birthing people are given/directed to written information about induction and are provided with the opportunity to ask questions, and time to think about their options. Document this discussion and record any specific birth plans on Badgernet.
 - the alternative options of expectant management or Caesarean birth if the woman/birthing person chooses not to have induction of labour, or decides at a later stage that they no longer wish to proceed with the induction process
 - the arrangements for support, pain relief (recognising that women/birthing people are likely to find induced labour more painful than spontaneous labour)
 - that induction may not be successful and what the woman/birthing person's options would be should that be the case

Induction of labour in specific circumstances (see Appendix 2 for indications and timing of induction of labour)

Induction of Labour (IOL) for Pregnancy lasting more than 41 weeks

22. Give women/birthing people with uncomplicated pregnancies every opportunity to go into spontaneous labour and explain to them that labour usually commences spontaneously by 42+0 weeks.
23. **(New in v5.0)** The NICE guideline states that the available evidence is not robust enough to recommend a specific of gestation for induction in uncomplicated pregnancies but suggests that it should be recommended between 41+0 and 42+0 weeks taking the woman/birthing person's preferences into consideration.
24. **(New in v5.0)** Women/birthing people should be informed that the relative risk of caesarean section, stillbirth and admission to SCBU may increase over time with pregnancy beyond 41+0 weeks.
25. Although induction of labour may reduce these risks women/birthing people should also consider the impact that an induction of labour may have on their birth experience.
26. **(New in v5.0)** OUHFT will aim to book induction of labour from 41 weeks onwards in uncomplicated pregnancies taking the woman/birthing person's preferences into consideration. The service will endeavour to provide a date as close to that requested. At times of increased clinical workload there may be delays however, the date provided should be no later than 41+4 weeks, unless it is the woman/birthing person's preference for a later date.
27. If a woman/birthing person chooses expectant management and opts not to have induction of labour, discuss the woman/birthing person's options from this point on with their and record the woman/birthing person's decision in their record (see section below for women/birthing people opting to continue pregnancy beyond 42 weeks).
28. Women/birthing people who opt for expectant management should be given the opportunity to revisit their options at each antenatal encounter if they choose to do so.
29. **(New in v5.0)** The information within the table below may be used to inform women/birthing people of the incidence of spontaneous labour at different gestations and may help in their decision making regarding their preference for induction of labour.

Gestational age at which labour started, as a proportion of labours which started spontaneously (NICE 2021 statistics)

Gestational age (weeks)	Proportion of spontaneous labours that started at this gestational age	Cumulative proportion of spontaneous labours that started by this gestational age
31 weeks and under	2.4%	2.4%
32+0 to 36+6 weeks	5.3%	7.7%
37+0 to 37+6 weeks	5.1%	12.8%
38+0 to 38+6 weeks	12.1%	24.9%
39+0 to 39+6 weeks	25.4%	50.3%
40+0 to 40+6 weeks	32.5%	82.8%
41+0 to 41+6 weeks	16.2%	99.0%
42+0 weeks and over	0.9%	100%

Preterm and Term Rupture of Membranes

30. See [Preterm Pre-Labour Rupture of Membranes](#) and [Pre-labour Rupture of Membranes \(PROM\) ≥ 37 Weeks](#) for guidance on recommended induction timings.

Induction of labour in women/birthing people with a previous caesarean section

31. See also [Vaginal Birth After Caesarean Section \(VBAC\)](#) Guideline.
32. If birth needs to be expedited the woman/birthing person should be offered an induction of labour or a caesarean section.
33. The decision to induce a woman/birthing person with a previous caesarean section should be made after a discussion with a Consultant Obstetrician.
34. The Midwife/Doctor should discuss the following with the woman/birthing person if they choose to have an induction:
 - proposed method of induction
 - that induction could lead to an increased risk of emergency caesarean section
 - that the use of oxytocin would lead to an increased risk of scar dehiscence/uterine rupture (1 to 2% in induced/augmented labours)
 - selected parameters of progress that would lead to recommendation of emergency caesarean section
35. These should be documented in the woman/birthing person's maternity record.
36. Induction of labour is not recommended in women/people with two or more caesarean sections or those who have had a previous upper segment uterine scar.
37. Prostaglandin gel/tablets are contraindicated in women/people with a previous caesarean section.
38. The clinician may refer to the table below from the [RCOG \(2015\) green top guideline no.45](#) when counselling women/people about their options:

Appendix V: VBAC success and uterine rupture risks of planned VBAC labours

		Spontaneous	Induced	Augmented
AHRQ meta-analysis ⁹	VBAC success	*74% (95% CI 72–75%)	63% (95% CI 59–67%)	68% (95% CI 64–72%)
	Uterine rupture	*0.47% (95% CI 0.28–0.68%)	1.2% (95% CI 0.7–1.9%)	1.1% (95% CI 0.9–1.5%)
NICHD study ^{18,103} (n = 17 898 VBACs)	VBAC success	80.6%	67.4%	73.9%
	Uterine rupture	0.36%	1.02%	0.87%
Australian population study ²² (n = 10 958 VBACs)	VBAC success	52.6%	51.4%	61.6%
	Uterine rupture	0.15%	0.68%	1.91%
UK Obstetric Surveillance System case-control study ²⁰	Uterine rupture	0.13%	0.36%	0.28%

*refers to overall rates when spontaneous, induced and augmented labours are combined, although the large majority of data are derived from spontaneous labour.

39. Women/people may choose to discontinue an induction and opt for a caesarean section at any stage of the process and this decision should be respected by clinical staff.
40. Oxytocin may be used for induction of labour but should be preferably avoided once the woman/birthing person is contracting and in established labour.

Maternal Request (Updated in v5.0)

41. Induction of labour should not routinely be performed for maternal request but can be considered in individual circumstances. Women/people requesting this should be referred to the birth choices clinic for an individualised birth plan taking into consideration their individual circumstances and preferences.

Breech presentation

42. Refer to [Breech Presentation and Birth](#) guideline for further information.
43. Induction of labour is not recommended with singleton pregnancies in a breech position at term.
44. When expedited birth is indicated in preterm breech, an individualised plan should be made after review by a Consultant Obstetrician and induction of labour may be appropriate in certain circumstances.

Fetal growth restriction

45. Refer to [Growth Scans](#) guideline.
46. All inductions for fetal growth restriction should be requested through FMU/SGA clinic.

Suspected Fetal Macrosomia (without diabetes) (Updated in v5.0)

47. According to NICE guidance, macrosomia is defined as a baby with an estimated fetal weight (EFW) >95th at or after the 36-week scan.
48. Women/people with a third trimester ultrasound with EFW predicted to be >95th centile without gestational or pre-existing diabetes should be referred to antenatal clinic to discuss their options for birth.
49. There are 3 options for birth which should be discussed with the woman/birthing person. These are expectant management, induction of labour or planned caesarean section.
50. Women/people should be informed that there is uncertainty about the benefits and risks of induction of labour compared to expectant management, which has also been highlighted in [The Big Baby Trial](#) (Gardosi et al, 2025).
51. However, current NICE guidance states:
 - with induction of labour the risk of shoulder dystocia may be reduced compared with expectant management
 - **(Updated in v5.1)** with induction of labour the risk of third- or fourth-degree perineal tears may be increased compared with expectant management (this was not seen in the Big Baby Trial)
 - there is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between expectant management and induction of labour
 - they will also need to consider the impact of induction on their birth experience and on their baby.
52. NICE guidance does not specify a recommended time frame for induction of labour for suspected fetal macrosomia. If the woman/birthing person opts for an induction of labour, this should be arranged from 39 weeks onwards based on the preferences of the woman/birthing person.

History of Precipitate Labour

53. Previous precipitate labour is not an indication for induction of labour in the absence of any other indications.

Women/People Above the Age of 40 years

54. In the UK the proportion of pregnancies in women/people aged 40 is almost 4% and the average age of childbirth is continuing to increase.
55. Maternal age is associated with an increased risk of obstetric complications including placental abruption, placenta praevia, malpresentation, low birthweight, preterm and post-term delivery, stillbirth and postpartum haemorrhage.
56. Pre-existing maternal medical conditions including hypertension, obesity and diabetes increase with advancing maternal age as do pregnancy related maternal complications such as pre-eclampsia and gestational diabetes. These medical co-morbidities can all influence fetal health and are likely to compound the effect of age on the risk of pregnancy in an older mother.
57. The incidence of stillbirth at term is higher in women/people of advanced maternal age. At 39 to 40 weeks of gestation this equates to 2 in 1000 for women/people \geq 40 years old compared to 1 in 1000 for women/people < 35 years old.

58. (Updated in v5.0) For nulliparous women/people over the age of 40 years, an induction of labour has a higher chance of being unsuccessful, and consideration should be given to the alternative of planned caesarean section. An antenatal clinic discussion should take place, and a plan made based on the woman/birthing person's individual preferences.
59. In this cohort induction should be offered at
- 40 weeks for women/people >40 and ≤42 years old with no additional risk factors.
 - 39 weeks onwards for women/people ≥43 years old or >40 years old with risk factors.

Other indications for induction (Hypertension/Diabetes etc)

60. Please refer to relevant guidelines
61. Refer to Appendix 2 for recommended timing of induction

Intrauterine fetal death

62. Refer to [Intrauterine Fetal Death Guideline](#).

Methods of Induction of labour

Membrane Sweeping

63. Women/people should be offered a membrane sweep if vaginal delivery is planned at all antenatal appointments from 39 weeks.
64. A membrane sweep may be carried out in the woman/birthing person's home, antenatal clinic, or hospital.
65. A membrane sweep should not be offered in the presence of ruptured membranes.
66. The presence of Group B streptococcus is not a contraindication to membrane sweeping in the presence of intact membranes.
67. The Midwife or Doctor should:
- Check the placental location on last scan
 - Provide a full explanation of the procedure
 - Inform the women/people that a membrane sweep may increase the chance of spontaneous labour.
 - Obtain and record verbal consent
 - Inform the woman/birthing person that membrane sweeping is not associated with an increase in maternal or neonatal infection, but the procedure can result in increased levels of discomfort and bleeding.
68. Discuss with women/people whether they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep.

Vaginal PGE 2

69. Vaginal PGE2 is a method of induction of labour.
70. This is the recommended method of induction at OUHFT for all nulliparous women/people and inpatient induction in whom cervical preparation is indicated.

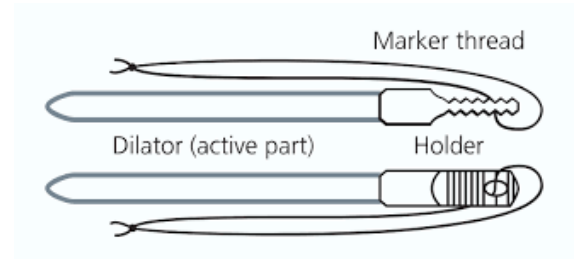
71. Within the OUH NHS Foundation Trust this is administered as a 1 mg or 2mg gel or less commonly, as a 3mg tablet (please see Appendix 3).
72. **The recommended regimen for nulliparous and multiparous women/people is shown in Appendix 4: IOL pathway.** An individualised care plan may be made in growth restricted babies.
73. Inform women/people of the risk of hyperstimulation and that this can be reversed with tocolysis.
74. Do not use if there is a significant risk of uterine hyper-stimulation due to intra-cervical prostaglandin administration (i.e. a fully effaced cervix and palpable membranes).
75. Perform a vaginal examination 6 hours after initial dose of gel to assess the state of the cervix and whether the woman/birthing person is contracting or not.
76. If at the next examination, artificial rupture of membranes (ARM) is possible, this should be performed regardless of Bishop score
77. **For nulliparous women/people:**
 - if ARM is not possible, please follow the guidance in **Appendix 4 – IOL Pathway**
78. **For multiparous women/people:**
 - If ARM is not possible, please follow the guidance in **Appendix 4: IOL Pathway**
79. For women/people having their 3rd baby or more, the decision to administer Prostin should be made by a Consultant Obstetrician please see **Appendix 4: IOL Pathway.**
80. The maximum dose of prostaglandin is 4mg gel in 24 hours. If this is not adequate to allow ARM see 'Failed induction' section below.
81. Prostaglandin is contraindicated in
 - Women/people with a previous caesarean section
 - Known hypersensitivity to prostaglandins
 - Is there was hyperstimulation with the 1st dose of prostaglandin gel.

Mechanical IOL – Dilapan (New in v5.0) (Please also see [Dilapan SOP](#))

82. Mechanical induction is the preferred method of induction of labour for women/people opting for induction of labour with a previous caesarean section. It can also be offered to low risk multiparous women/people having a postdates induction of labour.
83. If women/people in whom prostaglandin gel induction is recommended, make an informed choice to opt for mechanical induction, then this should be accommodated where appropriate and safe to do so.
84. Mechanical induction has been shown to have a reduced incidence of hyperstimulation when compared with induction with prostaglandin gel.
85. Outpatient induction may be offered to women/people having a postdates induction.
86. At OUHFT Dilapan induction is the preferred method of mechanical induction. This form of induction is initiated on Level 6 maternity.
87. Dilapan is a small blunt ended rod, a little larger than a matchstick, that is used to open (dilate) the cervix and is a non-hormonal way of opening the cervix. The rod is made of a hydrogel aquacryl inert (harmless) substance that when inserted into the neck of the cervix, absorbs secretions from the vagina and cervix. This causes the rods to slowly increase in diameter and

the pressure created helps to gradually stretch open the cervix over 12 to 15 hours. Between 3 to 5 Dilapan rods can be inserted at one time.

88. A long grasper is then used to pick up the Dilapan rod and guide it into the cervix. This is repeated until 3 to 5 rods have been inserted. The number of rods inserted will vary from person to person. These rods expand to approximately 1cm each and help to gently open the cervix in preparation for labour and birth.



Benefits:

- This is a non-hormonal method of induction.
- The woman/birthing person can return home for 12 to 15 hours and then return to Level 6 to have them removed.
- The procedure is safe in a low-risk pregnancy.

Risks:

- There is a slight chance the membranes may break during the procedure slightly increasing the chance of infection
- Some people find the procedure uncomfortable, and a few are unable to tolerate it at all. In this case, the procedure should be stopped and alternative options considered.
- It may not be successful at inducing labour.

Antenatal Management and Booking of Planned Induction of Labour

89. At the 40-week appointment the Midwife should:

- perform a full routine antenatal assessment (see Antenatal Care Guideline)
- offer a membrane sweep following explanation of the procedure, and perform a sweep if consent is given, informing the woman/birthing person of the findings afterwards
- explain the woman/birthing person may experience discomfort and the passing of a show
- advise to contact a maternity unit if there is any bleeding, spontaneous rupture of membranes, abdominal pain or contractions
- In women/people in whom a birth plan has not already been agreed, discuss the options available to them and if it is their preference discuss the timing of induction for postdates.
- Explain that the unit will make every effort to book an induction at the preferred gestation although an exact date may not be possible to facilitate.
- arrange admission date and time for induction as per IOL criteria
- record all discussions in the woman/birthing person's health records indicating their full understanding of their plan of care.

When Women/Birthing People Wish to Continue Pregnancy Beyond Recommendation

90. It is important to have an open conversation with women/people who choose to continue their pregnancy beyond the gestation that IOL is recommended.
91. The main reasons for IOL are because of concerns regarding either maternal or fetal wellbeing or both, and this should be explained to the woman/birthing person in a non-judgmental way.
92. The woman/person should be reviewed by an obstetrician who should discuss alternative options if the woman/birthing person chooses not to have induction of labour or decides at a later stage that they no longer wish to proceed with the induction process.
93. Women/people should have the opportunity to discuss their concerns and have enough information to make an informed choice which should be respected by the healthcare professionals caring for them.
94. **(Updated in v5.0)** The discussion should be clearly documented on Badgernet if an individualised plan has been agreed.

Prolonged Pregnancy

95. The main concern with prolonged pregnancy is the increased risk of still birth. The relative risk of stillbirth increases significantly from 41 weeks gestation. It is important for women/people who decline IOL to have regular fetal monitoring.
96. **(Updated in v5.0)** Women/people opting for expectant management beyond the recommended gestation for birth should be counselled re the risks by an obstetrician and offered daily/alternate day fetal monitoring via CTG. However, they should be made aware that there is no predictive value in this monitoring, and it only tells us how the baby is at that time.
97. If the woman/birthing person agrees to have daily/alternate day CTG's, these can be arranged via Day Assessment Unit (DAU) by emailing DayAssessmentUnitMaternity@ouh.nhs.uk – label the request as 'priority'.
98. If a woman/birthing person expresses in the antenatal period that they would decline IOL, refer to an Obstetric Consultant/Consultant Midwife who will develop a plan of care in partnership with them.

Admission and Management of Induction of Labour

99. Admit, obtain and review full history (check and confirm placental location on 36-week scan), and perform:
 - a full antenatal examination
 - a full set of observations
 - abdominal examination
 - fetal heart assessment using Pinard stethoscope or Sonicaid
100. Discuss the induction process with the woman/birthing person in order to set expectations, especially in relation to the timeline.

101. See below for appropriate place of induction
102. Further Care:
 - Give woman/birthing person information regarding discomfort associated with procedure and pain relief options
 - Obtain verbal consent
 - Perform external [electronic fetal monitoring](#) (EFM) using a cardiotocograph machine (CTG) until fetal wellbeing is confirmed (usually about 20 minutes)
 - Assess cervix using Bishop score and record findings on the Induction of labour chart

Vaginal Prostaglandin (Also see Appendix 3)

103. Insert prostin gel/pessary into posterior vaginal fornix if Bishop's score <7.
104. Advise woman/birthing person to remain lying down (left / right lateral) for at least 30 minutes following prostaglandin administration, during which time EFM should continue.
105. Provided initial monitoring is within normal parameters, discontinue CTG and revert to 4 hourly Intermittent Auscultation (IA) unless there is a clinical indication to do so earlier.
106. Reassess fetal wellbeing using cardiotocography (CTG) trace of 20 minutes once regular/painful contractions have commenced.
107. If at any time throughout the procedure the fetal heart rate is outside normal parameters or hyperstimulation evident, continue CTG and inform obstetric registrar/consultant.
108. Women/people should be counselled to escalate any concerns following gel administration and be made aware that fetal movements should remain normal throughout this process.
109. Maternal observations (temperature, pulse, B/P) should be carried out daily prior to the onset of labour. These should be recorded on the MEOWS chart on Badgernet. Some women/people will require more frequent observations – in these cases an individual management should be documented in the intrapartum record.
110. Encourage the woman/birthing person to mobilise freely and consider using non-pharmacological pain relief.

Place of induction

Prostaglandin gel

111. Most women/people will be given the prostaglandin gel in the IOL bay. However, in certain circumstances such as IUGR with abnormal Cerebroplacental ratio (CPR) or severe PET, IOL should be carried out on Observation Area (OA).

Artificial Rupture of Membranes (ARM)

112. Most women/people can have the ARM in the IOL bay as long as there is adequate staffing to allow appropriate monitoring. However, the ARM should happen on Observation Area or Delivery Suite if:
 - Prostin was administered in OA
 - Multiple pregnancy
 - The woman/birthing person is diabetic on a basal bolus insulin regime (see Diabetes guideline)

- The fetal head is not fixed in the pelvis (due to the risk of cord prolapse if ARM is performed when the fetal head is not engaged)

Place of Birth following IOL (New in v5.1)

- If a woman/birthing person meets the criteria for a Spires birth prior to commencing an IOL and were to establish in labour following the administration of Dilapan, a single Prostaglandin gel or following an ARM as the only induction method, they may opt to transfer to the Spires for labour and birth.
- Prior to transfer to Spires, the woman/birthing person should have a full holistic assessment of maternal and fetal wellbeing by their midwife, to exclude chronic hypoxia and uterine hyperstimulation.
When a Prostaglandin gel has been used, this assessment should include a cardiotocogram when uterine contractions have begun.
- If requiring more than one dose of Prostaglandin gel and subsequent ARM and oxytocin, a DS birth is recommended in order to facilitate continuous fetal monitoring and appropriate obstetric input. Please see the **section on extended criteria for Birth of the Spires MLU on page 8** of the [Midwife Led Unit Homebirth Criteria Guideline](#).

Process for when the Service is Unable to Induce Women/People due to Clinical Acuity

113. There will be occasions when accommodating the IOL work in a timely fashion may be challenging due to volume and complexity of emergency work in the Delivery Suite.
114. At 9 am the Safety Huddle Team, including the IOL Midwife, Bleep Holder, DS coordinator and DS Consultant Obstetrician, will review the IOL work for the day. If delays are anticipated, collaboratively the Safety Huddle Team will decide and plan any necessary rescheduling, along with an explanation and apology to the woman/birthing person and their partner.
115. Necessary midwife escalation processes should be followed if there are delays in the induction process secondary to staffing issues. Please see the [Escalation Policy for the Management of Delay in IOL](#).
116. A specific plan of care for each woman/birthing person should be documented in the maternal health records. Any rescheduling should be made by midday at the latest. This should be only under exceptional circumstances and ideally IOL should continue as planned.

Management of Delay in IOL

117. A delay in IOL is classified as one that is delayed beyond 6 hours. Please see the [Management of Delayed IOL Framework](#) for further guidance on managing this situation.

Uterine Hyperstimulation During Induction of Labour

118. Uterine hyperstimulation, where the uterus is contracting > 5 in 10 minutes and fetal heart rate abnormalities are detected, may occur in up to 5% of inductions.
119. This is more common with Prostaglandin induction than mechanical induction of labour.
120. If uterine hyperstimulation is diagnosed
 - Position the mother into left lateral position

- Notify medical staff
 - Continue with electronic fetal monitoring
121. Consider the administration of Terbutaline 250mcg subcutaneously.
122. *Use of Terbutaline notes:*
- Contra-indications: Heart disease, cardiac arrhythmia, hyperthyroidism
 - Observations: check pulse rate and blood pressure (and blood glucose if mother is diabetic)
 - Side effects: palpitation, tremor, nausea
 - Watch for: breathlessness, chest pain.

Unsuccessful (Failed) Induction of Labour

123. If ARM is not possible following two doses of prostaglandin gel, the woman/birthing person should be reviewed by a senior obstetrician.
**A third prostaglandin gel is not licensed for use and should not be offered or prescribed.*
124. If ARM is not impossible after two doses of prostaglandin gel, induction of labour has failed.
125. Discuss with a Consultant Obstetrician and discuss the options with the woman/birthing person including:
- caesarean section
 - abandon process and await onset of labour
126. In some cases, consideration may be given to using oxytocin infusion with intact membranes on consultant advice only.
127. A plan of care will be made based on the consultant's input and woman/birthing person's decision and documented in the woman/birthing person's health records.

Review

128. This guideline will be reviewed every 3 years, as set out in the Policy for the Development and Implementation of Procedural Documents.
129. This guideline may need to be revised before this date, particularly if national guidance or local arrangements change, where implementation is unsuccessful or where audits necessitate a guideline review.

EPR Considerations / Booking of Induction of labour (Updated in v5.0)

130. When booking an induction of labour, send referrals via Badgernet.
131. For out of area referrals for IOL, please email ouh-tr.OUHInductions@nhs.net.
132. Read [SOP - Patient Pathway for IOL](#) for more information

Implementation plan

No .	Recommendation for Implementation	Action to be taken	Evidence of Action	Responsible Person	Date Action to be completed by	R.A.G. Action completion status ^[2]
1	Raise awareness of updated guideline	Include updated guideline in Monthly Guidelines Updates Table	Email circulating Monthly Guideline Updates Table sent to all maternity matrons to disseminate news of updates to their teams. Upload of Monthly Guideline Updates Table to SharePoint	Quality Team	Within 1 week of guideline being ratified at MCGC	
2	Raise awareness of updated guideline	Include QR code to Monthly Guidelines Updates Table in Maternity Bulletin	Publication of Maternity Bulletin including QR code to Monthly Guidelines Updates Table in every	Communications Manager – Chief Nursing Officers Team	Within 1 month of guideline launch date	

		'And Breathe'	publicatio n of Maternity News Booklet			
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[Cochrane Review. Vaginal Prostaglandin for Induction of Labour at Term. Kelly et al. 2009](#) (accessed 03/06/2025)

[Gardosi et Al, \(2025\) Induction of labour versus standard care to prevent shoulder dystocia in fetuses suspected to be large for gestational age in the UK \(the Big Baby trial\): a multicentre, open-label, randomised controlled trial](#) The Lancet, Volume 405, issue 10491 p1743-1756 17th May 2025 (accessed 30/06/25)

[MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal deaths of babies born in 2023](#) (accessed 03/06/2025)

[Middleton et al \(2020\) Induction of labour at our beyond 37 weeks gestation](#) (accessed 03/06/2025)

National Institute for Health and Care Excellence (NICE) (2021) Inducing Labour Clinical Guideline (NG207) Available from: <https://www.nice.org.uk/guidance/ng207> [Accessed on 03/06/2025]

[National Institute of Health Care Excellence \(NICE\) \(Published 29/09/2023\) Intrapartum care NG235](#) (accessed 03/06/2025)

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UK MBRRACE perinatal surveillance report 2020. <https://www.npeu.ox.ac.uk/assets/downloads/mbrpace-uk/reports/perinatal-surveillance-report-2019/MBRRACE-UK Perinatal Surveillance Report 2019 - Final v2.pdf>

Royal College of Obstetricians and Gynaecologists (RCOG) (2015) *Birth After Previous Caesarean Birth*, green top guideline no. 45, appendix V, Available online at: https://www.rcog.org.uk/media/kpkjwd5h/gtg_45.pdf,

Winnerholm U-B et al (2019) IOL at 41 weeks versus expectant management and induction of labour at 42 weeks (SWEPI): multicentre, open label, randomised, superiority trial. British Medical Journal; 367 <https://doi.org/10.1136/bmj.l6131>.

Appendix 1 – Decision Making Tool to inform Induction of Labour (Updated in v5.1)

CLINICAL CONDITION	RECOMMENDED GESTATION OF IOL (WEEKS)*		PRIORITY LEVEL*
	Minimum	Maximum	
POST DATES (Updated in v5.1) (Women may opt to delay until 42 weeks in line with NICE guidance)	41+0	41+4	1 (take maternal preference into consideration)
PRE-EXISTING DIABETES (Individual plan by Diabetic team depending on clinical picture) Type 1 or 2	37+0	38+6	1
UNCOMPLICATED GDM Diet/Metformin Stable blood glucose (most readings in target) Normal amniotic fluid volume & normal growth	40+0	40 + 6	2
COMPLICATED GDM *Macrosomia (EFW >95 th centile at 36 weeks or accelerated growth from previous scans) on case-by-case basis/consultant decision Poor blood sugar control	39+0	40+0	2
MATERNAL AGE 40 to ≤ 42 years old at booking (without additional risk factors) ≥ 43 years old at booking or >40 to ≤ 42 years at booking with additional risk factors.	40+0 39	40+3 39+3	2 2
IUGR/SGA (FGA Clinic) Including low CPR/Raised Dopplers	Booked through FGA clinic only		1
PRE-ECLAMPSIA Diagnosed at <37+0	Consultant decision		1

Diagnosed at $\geq 37+0$ weeks	Induce as soon as possible after diagnosis (usually within 48 hours)		1
CHRONIC/GESTATIONAL (PIH) HYPERTENSION BP well controlled and outpatient (Updated in v5.1 - may be commenced from 39 weeks based on the woman/pregnant person's preference.)	from 39 weeks	39+6	2
Inpatient due to complications	From 37+0 as per consultant decision	-	1
ISOLATED PROTEINURIA (PCR ≥ 30)	40+0	41+0	2
OBSTETRIC CHOLESTASIS (irrelevant of treatment): Bile acids 40-99 (AT ANY STAGE)	39+0	39+6	2
Bile acids >100 (AT ANY STAGE)	37+0	First available after 37 weeks	1
SYSTEMIC LUPUS ERYTHMATOSIS (SLE) (no other complications)	40	41+0	3
SLE (with complications)	Booked via SS		2
PATIENTS ON FULL THERAPEUTIC ANTICOAGULATION IF MDT RECOMMENDATION After discontinuing LMWH for 24 hours – to avoid repeated episodes of missing anticoagulation	40+0	41+0	1
APH (IF INPATIENT AND EMERGENCY)	Individualise		1
Macrosomia (non-diabetes) EFW >95 th centile Timing to be agreed at antenatal consultation with senior obstetrician	From 39+0	-	1 (based on agreed timing with woman/birthing person)
Multiple pregnancy – DCDA twins	37	38	2
FETAL ANOMALY Only gastroschisis / neural tube defect / in-utero therapy / MCDA twins (not others)	Booked through FMU		1

<p>↓PAPP-A / ↑Ut AD but normally grown and no evidence of PET (if SGA then must be booked through FMU):</p> <p>Either</p> <ul style="list-style-type: none"> • Uterine artery doppler (UtAD) @20 weeks: combined pulsatility index (PI)> 3.0 <p>Or</p> <ul style="list-style-type: none"> • ↓ PAPP-A < 0.31 	40+0	41	2 (Priority <u>1</u> if both risk factors are present)
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Very abnormal UtAD with combined PI >3.5	Decision for timing will be decided by the FMU consultant
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PREVIOUS TRAUMATIC BIRTH / SPECIAL ARRANGEMENTS FOR PARTICULAR CLINICIAN TO ATTEND BIRTH	Booked through Birth Choices clinic Ideally not earlier than 39 weeks	Liaise with relevant clinicians if needs to be deferred
Previous Intrauterine fetal demise	Individualised care planning by responsible Consultant Obstetrician Usually at 39 weeks but can be 38 to 39 weeks if 2 consultant obstetricians agree	3
MENTAL ILLNESS	Booked ONLY as part of Perinatal Mental Health plan following MDT	1

THE FOLLOWING ARE NOT ROUTINE INDICATIONS FOR IOL:

IVF
PGP
Epilepsy
Polyhydramnios
Reduced fetal movements (unless another indication or persistent RFMs after 39 weeks)
ITP (unless arranged by SS Team)
Anxiety / other mental illness unless part of perinatal mental health plan
Haemophilia
APH not admitted

***RECOMMENDED GESTATIONAL AGES AND PRIORITY LEVELS**

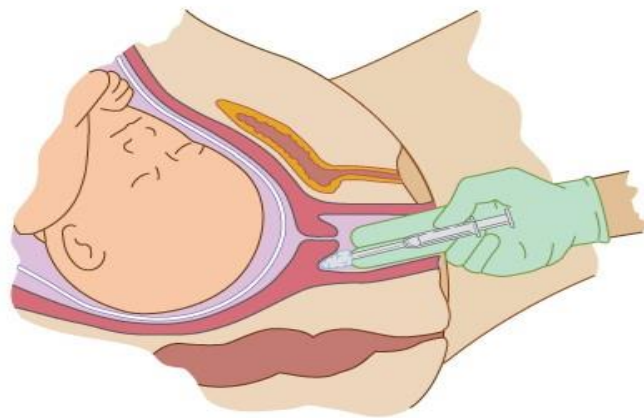
Priority Level 1: Recommended to book IOL at **minimum** gestation. If this day is full, then there is flexibility to look at the following days up to the maximum gestation if the service is under pressure. Once booked priority 1 cases should not be moved.

Priority Level 2: Recommended to book IOL close to or at **maximum** gestation (not to go beyond maximum). If this day is full, then there is flexibility to look at the preceding days and bring the IOL forwards if required.

Priority Level 3: Could be deferred if there are more urgent cases – Not to be a priority above Level 1 or 2.

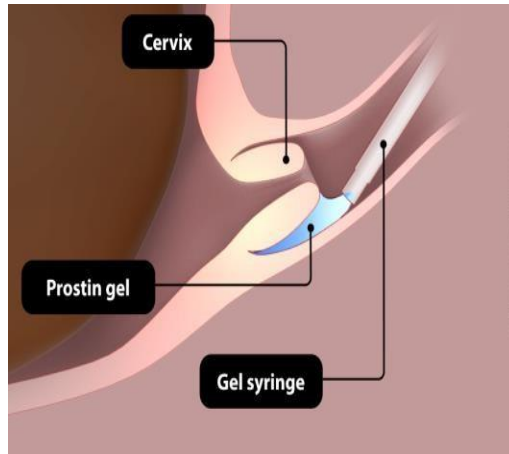
PLEASE NOTE: Triaging of out of guidance IOL requests will occur on a daily basis and requesters will be asked to contact the woman/birthing person if the request does not meet the department agreed criteria on indication or timing

Appendix 2 – Technique for Insertion of Prostaglandin Gel



Prostaglandin gel

The gel should be inserted into the posterior fornix avoiding administration into the cervix. Post administration
The pregnant person should remain left lateral for at least 30 minutes with continuous fetal monitoring. Please refer to the induction of labour proforma for plan of continued care post PGE2 administration.



The Practice Development Midwifery Team will be supporting midwives who would like help with inserting PGE 2.

For further information please refer to the [Induction of Labour Guideline](http://ouh.oxnet.nhs.uk/Maternity/Maternity%20Guideline%20Documents/Induction%20of%20Labour/Induction%20of%20labour%20COVID%20Full%20guideline%20v3.0.pdf)
<http://ouh.oxnet.nhs.uk/Maternity/Maternity%20Guideline%20Documents/Induction%20of%20Labour/Induction%20of%20labour%20COVID%20Full%20guideline%20v3.0.pdf>

Appendix 3 – Induction of Labour using Prostaglandin Tablets

If prostaglandin gel is not available, then prostaglandin tablets can be used instead.

These tablets contain the same drug (prostaglandin E2) as the more usual prostaglandin gel, but the bioavailability (the amount that gets released into the woman/birthing person) is different. For this reason, the standard dose is different.

Prostaglandin vaginal tablet 3mg is equivalent to prostaglandin gel 2mg.

Trials show that there is no significant difference in the maternal outcomes where 2 to 3mgs of prostaglandin are used. The caesarean section rate and outcomes for the baby are similar.

However, there is a non-significant increase in the need for oxytocin augmentation in women/people given tablets, so gel should still be used as a first choice option if it is available.

Nulliparous Induction

Time	Dose of prostaglandin
0 Hours	If Bishop score \leq 5, give prostaglandin vaginal tablet 3mg
6 Hours	If Bishop score \leq 5, give prostaglandin vaginal tablet 3mg
24 Hours	Perform ARM, commence oxytocin infusion within 2 hours of ARM

Use the same regime for women/people being induced for pre-labour SROM

Multiparous Induction without a uterine scar

Time	Does of prostaglandin
0 Hours	If Bishop score ≤ 5 , give prostaglandin vaginal tablet 3mg
6 Hours	Perform ARM, start oxytocin infusion within 2 hours of ARM. Be ready to reduce dose of oxytocin or stop the infusion when labour establishes

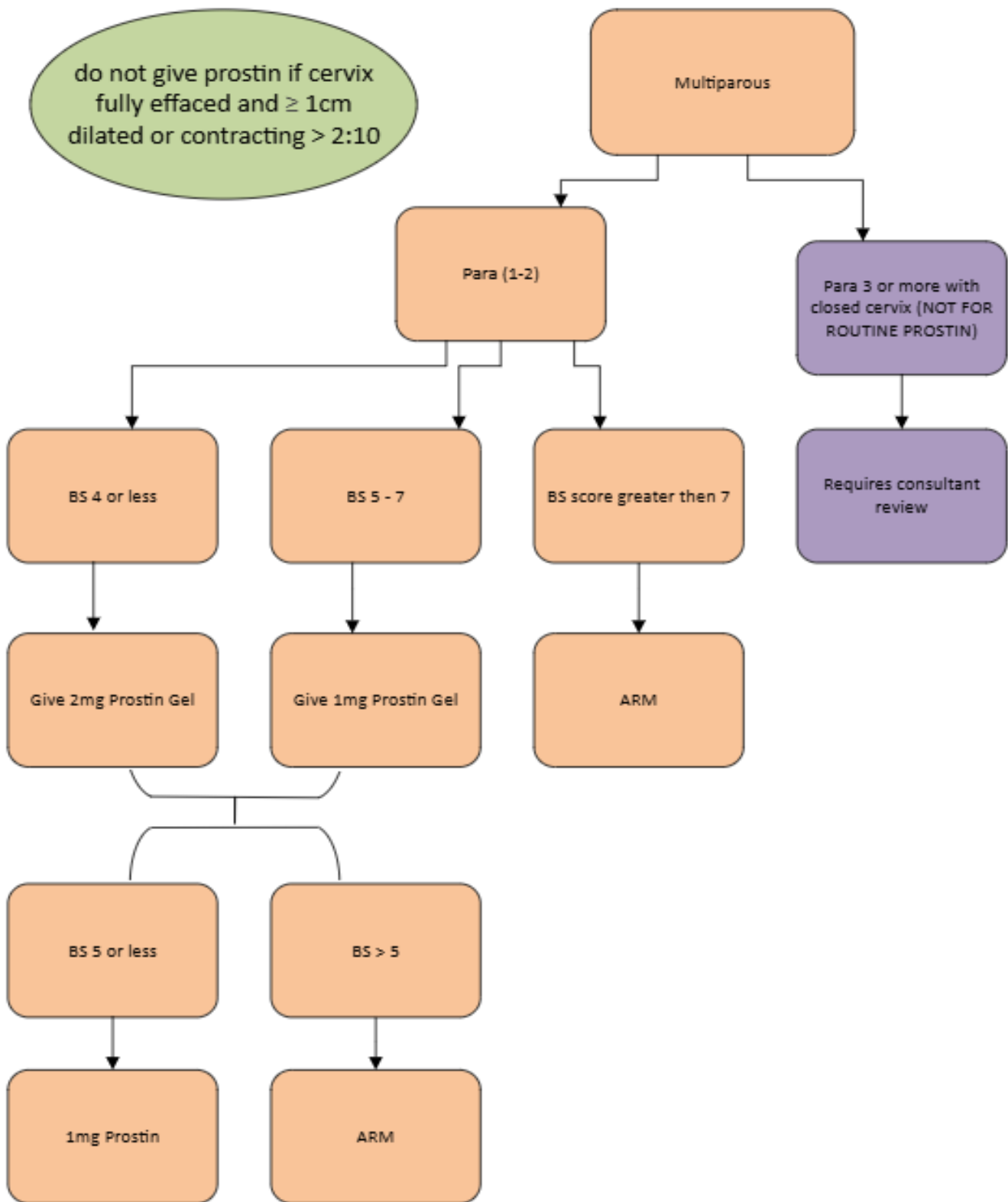
Use the same regime for women/people being induced for pre-labour SROM

Appendix 4: IOL Pathway: Primigravida



do not give prostin if cervix fully effaced and ≥ 1 cm dilated or contracting $> 2:10$

Appendix 4 (cont.): IOL Pathway: Multiparous



N.B.
Max 4mg Prostin Gel can be administered within 24-hour period

Appendix 5: Responsibilities

156. The Obstetric Consultant Lead for Delivery Suite and Delivery Suite lead team have delegated authority for ensuring the service is run as per the guideline and monitor its effectiveness.
157. The IOL Team have delegated authority that staff are aware of the Patient Pathway for IOL and liaise with wider teams as required.
158. All Managers in the Maternity Directorate are responsible for ensuring staff are aware of the Patient Pathway for IOL
159. Individual Staff are responsible for referring women/people who require IOL.

Appendix 6: Education and Training

160. There is no mandatory training is associated with this guideline. Ad hoc training sessions based on an individual's training needs will be defined if a midwife is allocated to the induction bay.
161. The Practice Development team will support any education required with regards to the induction process.

Appendix 7: Definitions and Acronyms

ARM (artificial rupture of membranes)	This is the intentional rupture of the amniotic sac by a healthcare provider.
Bishop Score	Bishop score is a pre-labour scoring system to assist in predicting whether induction of labour will be required. The total score is achieved by assessing the following five components on vaginal examination. Cervical dilation Cervical effacement Cervical consistency Cervical position Fetal station
CPR	Cerebroplacental ratio
CTG (Cardiotocography)	A technique for monitoring the fetal heart and contractions during pregnancy and labour
EFW	Estimated Fetal Weight
FMU	Fetal Medicine Unit
GDM	Gestational Diabetes Mellitus
Induction of labour (IOL)	To artificially initiate uterine contractions. This leads to progressive dilatation, effacement of cervix and birth of the baby. Includes women/people with intact membranes and those with spontaneous rupture of membranes but not in labour.
IVF	In-vitro fertilisation
PET	Pre-eclamptic toxæmia
SGA	Small for Gestational Age
SS (Silver star team)	The obstetric medicine team at OUHFT
VBAC	Vaginal birth after Caesarean

Appendix 8: Equality Impact Assessment

1. Information about the guideline, service or function

What is being assessed?	
New Guideline/Procedure <input type="checkbox"/>	New Service/Function <input type="checkbox"/>
Existing Guideline/Procedure <input checked="" type="checkbox"/>	Existing Service/Function <input type="checkbox"/>
Staff member completing assessment: Marie Barnard	
Name of Guideline: Induction of Labour Guideline	
Details about the guideline/service/function: This document provides guidance for all clinical staff caring for women/people during the Induction of labour process. It is applicable to all women/people who require induction of labour within the Oxford University Hospitals NHS Foundation Trust.	
Review Date:	Date assessment completed: 03/06/2025
Signature of staff member completing assessment: Marie Barnard	Signature of staff member approving assessment:

2. Screening Stage

Who benefits from this guideline, service or function? Who is the target audience? (tick all that apply)		
Patients <input checked="" type="checkbox"/>	Family/Carers <input type="checkbox"/>	Not applicable <input type="checkbox"/>
Staff <input checked="" type="checkbox"/>	Other (specify):	
Does the guideline, service or function involve direct engagement with the target audience?		
Yes <input checked="" type="checkbox"/>	Continue with full equality impact assessment	
No <input type="checkbox"/>	Full equality impact assessment not required	

3. Research Stage

Notes:

If there is no impact for a particular group or characteristic, mention this in the Reasoning column and refer to evidence where applicable.

¹Race categories follow those used in the National Census by the Office for National Statistics. Consideration should be given to the specific communities within broad categories such as Bangladeshi people.

²Please select age groups which may be impacted by the guideline, service or function and complete as appropriate.

³Religion or Belief covers a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus; it also covers people who do not have a faith. Consider these individually and collectively when determining impacts.

Characteristic		Positive Impact	Negative Impact	Neutral Impact	Not Enough Information	Reasoning
Sex and Gender Reassignment	Men (incl. trans men)			x		All genders of pregnant people will have equal access to Induction of labour care.
	Women/people (incl. trans women/people)			x		
	Non-binary people			x		
Race¹	Asian or Asian British			x		All pregnant people will benefit from this guideline. Consideration should be taken if not able to read written English – including for white British people. Pictorial explanations may need to be used. Where English is not spoken or not first language, then language line should be used for consultations, especially when giving information of medication uses and doses.
	Black or Black British			x		
	Mixed Race			x		
	White British			x		
	White Other			x		
	Other:			x		

Disability	Disabled people			x		If the woman/birthing person has any learning difficulties an advocate should be in attendance. If they have a hearing loss– a British Sign Language Interpreter should be offered which can be done via language line.
	Carers			x		
Age²				x		This guideline is only applicable to adult pregnant people. Please consult the Children’s BNF or gain advice from a paediatrician before if the pregnant person is less than 18 years old.
Sexual Orientation				x		This guideline does not discriminate with regards to sexual orientation, as all people will have equal access to the advice and treatments described above.
Religion or Belief³				x		This guideline does not discriminate with regards to belief or religion, as all people will have equal access to the advice and treatments described above.
Pregnancy and Maternity		x				The advice in this guideline is for pregnant people therefore will have a positive impact on this group.
Marriage or Civil Partnership				x		This guideline does not discriminate with regards to marriage or civil partnership, as all people will have

						equal access to the guidance and care described above.
Other Groups /Characteristics	For example: homeless people, sex workers, rural isolation.			x		This guideline does not discriminate with regards to social situations, as all people will have equal access to the guidance and care described above.

List the sources of information used in the table below

OUH trust Equality impact assessment procedure guideline – available via trust intranet

Annual Equality and Diversity Report, Workforce Race Equality Standard Data, or the Equality Delivery System 2 report

Using the table below, list any protected groups you will target during the consultation process, and give a summary of those consultations.

Group	Summary of consultation

List any other individuals/groups that have been or will be consulted on this guideline, service or function.

This guideline will be reviewed prior to publication by relevant Midwives, Obstetricians and Obstetric Physicians. A pharmaceutical review will be sought if appropriate to the guideline.

4. Summary Stage

<p>Outcome Measures</p> <p>List the key benefits that are intended to be achieved through implementation of this guideline, service or function and state whether or not you are assured that these will be equitably and fairly achieved for all protected groups. If not, state actions that will be taken to ensure this.</p>
<p>The benefits of this guideline will be to improve the care of women/people having/or advised to have an induction of labour. This guideline will help to ensure that women/people are risk assessed appropriately and involved in the decision making around induction of labour (IOL). Their choices should be clearly explained, and the health care professional should ensure all options discussed are understood by the woman/birthing person and their birthing partner. All plans for IOL care will be made in partnership with the woman/birthing person. Access to health care provision should be with the most appropriate member(s) of the MDT in accordance with national guidance.</p> <p>Consideration should be taken in those pregnant women/people who may not be able to understand or read written English – including for white British women/people. Pictorial explanations may need to be used. Where English is not spoken or understood, then language line should be used for consultations, especially when giving information of medication uses and doses. If the pregnant woman/birthing person has any learning difficulties an advocate should be in attendance. If they are D/Deaf or d/Deaf or have a hearing impairment– a British Sign Language Interpreter should be offered and can be accessed via language line.</p>
<p>Positive Impact</p> <p>List any positive impacts that this guideline, service or function may have on protected groups as well as any actions to be taken that would increase positive impact.</p>
<p>This guideline has been written specifically to support the induction of labour care provision for pregnant women/people, therefore this is a positive impact for this group.</p>
<p>Unjustifiable Adverse Effects</p> <p>List any identified unjustifiable adverse effects on protected groups along with actions that will be taken to rectify or mitigate them.</p>

No adverse effects predicted on any group

Justifiable Adverse Effects

List any identified unjustifiable adverse effects on protected groups along with justifications and any actions that will be taken to mitigate them.

No adverse effects predicted on any group

Equality Impact Assessment Action Plan

Complete this action plan template with actions identified during the Research and Summary Stages

Identified Risk	Recommended Actions	Lead	Resource Implications	Review Date	Completion Date
Pregnant women/people with learning disabilities having an understanding the information	Consider if the use of an advocate is required				
Difficulty accessing follow up and appointments for pregnant women/people who are homeless or have limited means of transport for appointments	<p>Consider whether telephone appointments could be arranged.</p> <p>Consider whether hospital transport is appropriate.</p> <p>Consider whether a more local hospital e.g., the Horton may be an appropriate place for antenatal care</p>				
