GIG CYMRU NHS WALES | Bwrdd Iechyd Addysgu Powys | Powys Teaching Health Board

Induction of Labour Guideline

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Powys Teaching Health Board is the operational name of Powys Teaching Local Health Board
Bwrdd Iechyd Addysgu Powys yw enw gweithredol Bwrdd Iechyd Lleol Addysgu Powys

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Section	Contents	Page
	Associated Policies and Written Control Documents	2
	Version control	3
	Engagement and Consultation	3-4
1.0	Introduction	4
2.0	Objective	4-5
3.0	Equality, diversity and inclusion	5
4.0	Safeguarding	5-6
5.0	Definitions	6
6.0	Roles and Responsibilities	6
6.1	Head of Department	6
6.2	Midwives	6
7.0	Process	7
7.1	Recommendations for IOL	7-8
7.2	Discussion regarding IOL	8-9
7.3	Process of booking IOL	9
7.4	If Induction of labour is declined	10-11
7.5	Methods of IOL in Powys	11
7.6	Women who have had a previous caesarean section	12
7.7	Pre-labour rupture of membranes	12
7.8	Methods not recommended for induction of labour	12
7.9	Outpatients induction	12-14
8.0	Monitoring, Compliance / Audit	14
9.0	Policy Review and Change Control	14
10.0	References	14
	Appendices	
1	Comparison of induction of labour (IOL) at 41 weeks vs 42 weeks	15
2	Pregnancy over 42 weeks' gestation vs opting for IOL	15
3	Table 1. Gestational age at which labour started, as a proportion of labours which started spontaneously Data	16
	Equality Impact Assessment	17

Associated Policies and Written Control Documents
NICE Guidelines for Induction of Labour (2021). https://www.nice.org.uk/guidance/ng207

Version Control

Version	Summary of Changes/Amendments	Publication Date
1	Initial Issue	Apr 2005
2	Reviewed	Apr 2006
3	Reviewed & Updated to NICE Guidance 2008	Sep 2009
4	Review & minor format alterations	Nov 2013
5	Review, update human rights, risk comparison	Sept 2016
6	Review with change to updated NICE Guidance 2021. Update equality, diversity and inclusion statement. Change the name of guidance to induction of labour from women who decline induction of labour	20/05/2026

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Midwife
Consultant Midwife

Circulated to the following for Consultation

Date	Group/staff
3/6/2025	Powys Midwives
3/6/2025	Obstetric links / Obstetric units
3/6/2025	- Bronglais General Hospital
3/6/2025	- Wrexham Maelor Hospital
3/6/2025	- Princess Royal Hospital Telford
3/6/2025	- Glangwili General Hospital
3/6/2025	- Grange University Hospital
3/6/2025	- Hereford County Hospital
3/6/2025	- Prince Charles Hospital
3/6/2025	- Singleton Hospital
3/6/2025	Safeguarding team - Powys
3/6/2025	Women and Children’s guideline group members

Groups approved at

Date	Group
01/07/25	Maternity Guidelines group
19/08/25	Women and Children's Policies and Procedures Governance Group

1.0 Introduction

Induction of labour (IOL) occurs for several reasons. There are very important reasons why women may be offered an IOL, including underlying medical reasons, pathologies of pregnancy, multiple pregnancies and post-maturity. Induction is one of the most common interventions offered to pregnant women in the UK, with almost a third of all women reported to have their labour's induced in 2018.There is wide variation in IOL rates between maternity units, and the number of inductions has risen by 60% in the past ten years.

The decision to undergo an IOL is an important one for many women. It is essential to support women prior to them deciding about this intervention by discussion of current, high-quality evidence to facilitate women to weigh up risks and benefits and make an informed choice. Estimated due dates (EDD) should be discussed with women and families, indicating that it is normal for a woman to have her baby up to about two weeks on either side of the EDD. Having conversations about IOL during the antenatal period may be useful to give the woman and her family time to consider all the options.

All information should be tailored to a woman's specific clinical and psychosocial circumstances. Midwives should discuss care plans with women and the wider maternity team where appropriate. Specific evidence-based guidance for women with more complex medical and pregnancy needs can be accessed through national (e.g. NICE) and local guidelines. Women can feel pressured into accepting an induction and therefore detailed discussion is essential to support women to make the choices that are right for them. Some women do not understand the process of IOL and do not feel involved in the decision-making process. This can negatively impact their experience.

2.0 Objective

The standard definition of a normal full-term pregnancy is up to 42 weeks. Most women will labour spontaneously before this date. NICE recommendations state that all women whose labour does not start spontaneously should be offered routine induction of labour from 41 completed weeks of pregnancy (NICE, 2021). This guideline is

intended to guide midwives in this process. It is the role of the midwife within this guideline to support women to make informed decisions regarding their care. This guideline is a guide to support midwives to provide relevant, up to date information to make an informed decision whether to accept induction.

3.0 Equality, Diversity and Inclusion

Powys Teaching Health Board Maternity Services is committed to:

- The elimination of unlawful and unfair discrimination
- The active promotion of equality of opportunities; for women and their families and our workforce
- The protection of the human rights of women and their families and our workforce
- The promotion of inclusive relationships between groups who share protected characteristics and those who don't
- The valuing of the diversity inherent in the communities we serve and in our workforce.

The words woman and women have been used throughout this document as this is the way that the majority of those who are pregnant and having a baby will identify. For the purpose of this document, this term includes girls. It also includes people whose gender identity does not correspond with their birth sex or who may have a non-binary identity.

When translation services are required, there is the expectation that a face-to-face translator or digital interpretation services will be provided. The Language Line App is available to all maternity staff to use for this purpose. Consideration is required with written documents and leaflets to be provided in a woman's preferred or 1st language.

For further support and advice contact PTHB Equality Team:
powys.equalityandwelsh@wales.nhs.uk

4.0 Safeguarding

Midwives should complete a routine risk assessment for lone working if there are any concerns. If there is any known risk to lone working or completing home visits, ensure the PTHB home risk assessment is shared in a timely manner. Midwives should ensure any updates regarding safeguarding if passed to the smoking advisors. If any safeguarding concerns or significant risk factors are identified for a child or young person/vulnerable adult, practitioners must follow Wales Safeguarding Procedures (2019) and SGP036 Safeguarding Policy Policies & Written Control Documents - SGP 036 Safeguarding

Policy.pdf (sharepoint.com). Advice and support concerning any safeguarding issue can be sought from PTHB Safeguarding Team via the Safeguarding Hub on 01686 252806 or email PowysTHB.Safeguarding@wales.nhs.uk (Monday-Friday 09:00-17:00, excluding Bank Holidays). Outside of office hours, Local Authority can be contacted on 0345 0544 847 or contact Silver on Call. All registered practitioners should access appropriate safeguarding supervision and training as per guidance. Safeguarding Supervision (sharepoint.com)

5.0 Definitions

- PTHB- Powys Teaching Health Board
- IOL- Induction of Labour
- CIS- Clinical Information Sharing
- NICE- National Institute of Health and Care Excellence
- EDD- Estimated Due Date
- NMC- Nursing and Midwifery Council
- BMI- Body Mass Index
- IUGR- Intrauterine Growth Restriction
- DGH- District General Hospital
- MLC- Midwife Led Care

6.0 Role/Responsibilities

6.1 Head of Department

The Head of the Department must:

- Ensure all staff read and understand this procedure
- Arrange regular review to monitor compliance with this procedure

6.2 Midwives

Midwives are responsible for ensuring that services are accessible to women in the local community. Women and their families are informed of the services available to them and that women who decline routine induction of labour are followed up and given appropriate midwifery care.

All midwives must provide care that is safe and effective for women and their families (NMC 2018). Information provision and care planning are core midwifery skills. No additional training is required. Care plans and documentation are reviewed on a one-to-one basis with a senior midwife as required and audited on an annual basis.

7.0 Process

7.1 Recommendations for IOL

Pregnancy lasting longer than 41 weeks

Women with uncomplicated pregnancies should be given every opportunity to go into spontaneous labour. Explain to women that labour usually starts naturally before 42^{+0} weeks, based on the gestational age estimated by their dating scan. 99.0% of women will labour spontaneously by 42^{+0}. Additionally, 16.2% of women will labour spontaneously between 41^{+0}-41^{+6}. See Appendix 3.

NICE guidelines do not specify a definite date for recommendation of induction of labour. However, it recommends induction from 41^{+0} and recommends birth by 42^{+0}. The midwife should discuss this with women for them to make an informed choice and choose when they would like to have an induction for prolonged pregnancy.

Explain to women that some risks associated with a pregnancy continuing beyond 41^{+0} weeks may increase over time and these include:

- Increased likelihood of caesarean birth
- Increased likelihood of the baby needing admission to a neonatal intensive care unit
- Increased likelihood of stillbirth and neonatal death.

Discuss with women that induction of labour from 41^{+0} weeks may reduce these risks, but that they will also need to consider the impact of induction on their birth experience when making their decision. Midwives should discuss the above risks in depth with women and their birthing partners.

Midwives should note and discuss with women that each health board has individual policies regarding IOL for post maturity and recommendations for gestation at which this should be offered. Within Powys, we follow national guidelines from NICE that highlight the above recommendations. Midwives should take this into consideration.

Be aware that, according to the 2020 MBRRACE-UK report on perinatal mortality, women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may benefit from closer monitoring and additional support.

The report showed that across all births (not just those induced):
- Compared with white babies (34/10,000), the stillbirth rate is: -

- More than twice as high in black babies (74/10,000)
- Around 50% higher in Asian babies (53/10,000)
- The stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for women living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000).

Do not routinely offer induction of labour to women with a history of precipitate labour to avoid a birth unattended by healthcare professionals.

7.2 Discussion regarding IOL

Explain to women 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 recommended 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. Midwives should discuss available pain relief options in different settings with women.
- Their hospital stay may be longer than with spontaneous labour.

Discuss with women being offered induction of labour:

- The reasons for induction being offered
- When, where and how induction could be carried out
- The arrangements for support and pain relief

- The alternative options if the woman chooses not to have induction of labour, or decides at a later stage that she no longer wishes to proceed with the induction process
- The risks and benefits of induction of labour in specific circumstances, and the proposed induction methods
- That induction may not be successful, and how this would affect the woman's options

When offering induction of labour:

- Give women time to discuss this information with others (for example, their partners, birthing companion or family) if they wish to do so before deciding
- Encourage women to look at other information (for example, by providing written information leaflets or encouraging them to look at information on the NHS website)
- Ensure women have the opportunity to ask questions, and time to think about their options
- Recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman’s decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given. Record the woman’s decision in her notes.

7.3 Process of booking IOL

Midwives should offer to discuss recommendations for induction and what it entails at the term appointment. This will allow enough time for the woman and midwife to discuss preferences and book an induction date if the woman wishes.

If women decide they wish to accept induction of labour, the midwife should contact the chosen district general hospital to book in their chosen date -

Bronglais Hospital – 01970 635633 (Gwenllian Ward)
Wrexham Maelor Hospital- labour ward 03000 847976
Glangwili General Hospital - 01267 283135 (AN ward)
Princess Royal Hospital Telford- AN ward 01952 565922
Grange University Hospital- 01633 493978 (AN ward)
Hereford County Hospital- 01432 372994 (AN ward)
Prince Charles Hospital- 01685 728890 (AN ward)
Singleton Hospital- Ward 19 - 01792 285405

Where a woman is booked for an induction, offer membrane sweeps prior to admission on no less than a 48 hourly basis after 39 weeks unless there is an individualized care plan from a consultant.

7.4 If induction of labour is declined

If a woman chooses not to have induction of labour, discuss the woman's options from this point on with her (for example, expectant management or caesarean birth) and record the woman's decision in her notes. The woman's wishes should be documented in the handheld records, and a Clinical Information Sharing (CIS) form should be completed and disseminated to the wider team.
Discuss with women who choose not to have their labour induced, if they wish to have additional fetal monitoring from 42 weeks. Women in Powys should be advised to be referred for a consultant review at their chosen hospital for a plan for fetal monitoring and this should be discussed and documented by a consultant.
A plan of care should be clearly documented in the handheld records including a review of any other risk factors – i.e. BMI, IUGR. Women who have made an informed choice to decline induction of labour should continue to receive expert midwifery care. Women should be offered follow-up care in accordance with her back up DGH's guideline for women who decline induction.
Midwives should keep accurate records of contacts made and appointments offered. Copies of letters should be included in a woman's notes.

Advise women that:

A- Monitoring only gives a snapshot of the current situation, and cannot predict reliably any changes after monitoring ends, but provides information on how their baby is at the moment and so may help them decide on options for birth

B- Adverse effects on the baby (including stillbirth), and when these events might happen, cannot be predicted reliably or prevented even with monitoring

C- Fetal monitoring might consist of twice weekly cardiotocography and ultrasound estimation of maximum amniotic pool depth.

Only a consultant obstetrician can make a plan for fetal monitoring postdates. Following discussion of recommendations, if women decline to attend a consultant obstetric review for prolonged pregnancy and a plan for additional monitoring, they cannot be offered any further monitoring as indicated above. If this is the case, women in Powys should be offered twice weekly antenatal appointments. The midwife should re-visit the woman's plans for post maturity.

Advise women who choose to await spontaneous onset of labour, that after 42^{+0}, it is recommended to birth in a district general hospital where continuous fetal monitoring is recommended and available. Offer women who choose to await the spontaneous onset of labour the opportunity to discuss their decision again at all subsequent reviews, if they wish to do so.
Advise women to contact their midwife or maternity unit if they change their mind before their next appointment, or as soon as possible if they have concerns about their baby (for example reduced or altered fetal movements).

Women who choose to decline IOL between 41^{+0}-42^{+0} should still be managed as MLC and would not require a CIS. It is only once a woman exceeds 42^{+0} and declines IOL that they would be viewed care pathway A- obstetric-led intrapartum care.

7.5 Methods of IOL in Powys

Membrane Sweeps
At antenatal visits after 39^{+0} weeks, discuss with women if they would like a vaginal examination for membrane sweeping, and if so, obtain verbal consent from them before carrying out the membrane sweep.
Discuss with women whether they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep no less than interval of 48 hours.
Explain to women:

- What a membrane sweep is
- That membrane sweeping might make it more likely that labour will start without the need for additional pharmacological or mechanical methods of induction
- Pain, discomfort and vaginal bleeding are possible from the procedure.

Midwives should undertake the following precautions prior to performing a membrane sweep to avoid the adverse effects of cord prolapse:

- Before membrane sweep, 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 membrane sweep, midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head

At the routine 38-week appointment, advise women that they can be offered a membrane sweep from 39 weeks' gestation. An additional appointment can be offered to all women at 39 weeks' gestation for a membrane sweep and aromatherapy blend F oils can be offered from 39

weeks (see MAT065) If the woman declines, they can be offered a membrane sweep and aromatherapy oils at their 40-week appointment.

7.6 Women who have had a previous caesarean birth

Advise women who have had a previous caesarean birth that:

- Induction of labour could lead to an increased risk of emergency caesarean birth
- Induction of labour could lead to an increased risk of uterine rupture
  the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods).
- Some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar).
- Advise women that they can choose not to have induction of labour or caesarean birth, even when it may benefit their or their baby's health.

7.7 Pre-labour rupture of membranes

See MAT097 for guideline on Pre-labour Spontaneous Rupture of Membranes.

7.8 Methods not recommended for induction of labour

Be aware that the available evidence does not support the following methods for induction of labour:

- herbal supplements
- acupuncture
- homeopathy
- castor oil
- hot baths
- enemas
- sexual intercourse.

7.9 Outpatient induction

NICE guidance states 'Consider outpatient induction of labour with vaginal dinoprostone preparations or mechanical methods in women who wish to return home, and who have no co-existing medical conditions or obstetric complications. Discuss with the woman the benefits and risks of returning home and respect her decision.'

Within Powys, induction of labour is not offered. Women opt to attend their chosen DGH for induction of labour. Thus, these health board policies would be followed. Some health boards offer outpatient induction of labour that would potentially be offered to some Powys women. Consequently, Powys midwives must be aware that some women may return home to await events after induction and to be aware that if a woman progresses quick, they may phone for midwife attendance.

If IOL is commenced and a woman returns home to await events, they should be made aware that the recommendation is for them to return to a DGH when events commence. If a woman declines to do so and decides to remain in Powys, a CIS should be written and disseminated.

The following health boards offer outpatient induction:

1. Aneurin Bevan
    - For uncomplicated pregnancies that are Term + 12 onwards.
    - Women must have access to transport and live within 60 minutes of the Grange University Hospital
    - Have a Bishops Score of less than 7 on vaginal examination
    - Have a reassuring pre and post prostaglandin fetal heart rate
    - Once IOL process has been started women are out of criteria for home or MLU birth. It is recommended that once women commence labour after IOL outpatient process has commenced that they return to labour ward.

2. Cardiff and Vale
    - For uncomplicated pregnancies from Term^{+10}
    - No more than two previous births
    - Women must have access to transport and a telephone and live within 30 minutes of the University Hospital of Wales
    - Have a Bishops Score of less than or equal to 4 on vaginal examination
    - Have a reassuring pre and post induction of labour fetal heart rate

3. Swansea Bay
    - For uncomplicated pregnancies from Term^{+12}
    - Women must be para 3 or less
    - Women must have transport, access to a phone and live within 30 minutes of the hospital
    - Have a Bishops Score on less than 7 on vaginal examination

4. Wye Valley

- For uncomplicated pregnancies from 40^{+12}
- Women must be between parity 0-3
- Women must have their own transport, access to a phone and live within 30-45 minutes from the hospital
- Have a reassuring pre and post IOL CTG
- Once IOL process has been started women are out of criteria for home or MLU birth. It is recommended that once women commence labour after IOL outpatient process has commenced that they return to labour ward.

8.0 Monitoring, Compliance / Audit

All employees following this guidance will hold a current midwifery qualification and be on the midwifery part of the NMC Register.

Providing evidence-based information and care is an integral part of a midwife's role. No additional training or resources will be need to implement this guideline. Close links should be maintained with the local DGH to ensure information given to women about local procedures is correct.

The number of women who decline induction of labour will be audited through midwifery clinical audits on an annual basis.

9.0 Review and change control

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

10.0 Reference and Bibliography

Birthrights (2016) Consenting to treatment
http://www.birthrights.org.uk/library/factsheets/Consenting-to-Treatment.pdf accessed 19/07/16

Birthrights (2016) unassisted birth: the legal position
http://www.birthrights.org.uk/library/factsheets/Unassisted-Birth.pdf
accessed 19/07/16

NICE (2021) Guideline for induction of labour. NICE: London

Nursing and Midwifery Council (2015). The Code. NMC London

Royal College of Midwives (2019). Midwifery Care for Induction of Labour. midwifery-care-for-induction-of-labour-a4-2019-16pp_2v2.pdf

Appendix 1: Comparison of induction of labour (IOL) at 41 weeks vs 42 weeks

	IOL at 41 weeks	IOL at 42 weeks
Maternal death/uterine rupture	0%	0%
Perinatal Death	1/2835 0.04%	10/2834 0.35%
Caesarean Section	326/2836 11.5%	344/2834 12.1%
Instrumental/Operative vaginal birth	213/2535 8.4%	226/2534 8.9%
Unassisted/spontaneous vaginal birth	1860/2281 81.5%	1836/2280 80.5%
NICU admission	85/2834 3%	123/2827 4.4%
Neonatal Morbidity: MAS	14/2835 0.49%	22/2829 0.78%
Neonatal Morbidity: HIE	2/1381 0.14%	3/1374 0.22%

Appendix 2:

Pregnancy over 42 weeks' gestation vs opting for IOL

Pregnancy over 42 weeks	Induction of labour
Stillbirth (2 per 1000)	Stillbirth (1 per 1000)
Meconium aspiration	Hyperstimulation of the uterus
Placenta not working effectively leading to growth restriction	Failure to go into labour
Caesarean section	Fetal distress
Large baby leading to shoulder dystocia	Post-partum hemorrhage
Prolonged labour	Prolonged labour
	Instrumental delivery
	Increased levels of pain

	If oxytocin required – rupture of uterus, post-partum hemorrhage
	Shoulder Dystocia

Appendix 3:

Table 1. Gestational age at which labour started, as a proportion of labours which started spontaneously Data from NHS Hospital Episode Statistics/Maternity Services Data set 2019-20

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%	5.1% 12.8%
38+0 to 38+6 weeks	12.1%	12.1% 24.9%
39+0 to 39+6 weeks	25.4%	25.4% 50.3%
40+0 to 40+6 weeks	32.5%	82.8%
41+0 to 41+6 weeks 16.2% 99.0%	16.2%	99.0%
42+0 weeks and over	0.9%	100%

Bwrdd Iechyd Addysgu Powys
Powys Teaching Health Board

Equality Impact Assessment

It is not mandatory to complete an Equality Impact Assessment (EIA) for a written control document. If you feel it would be of benefit, please complete the box below and attach an EIA as an appendix to this document.

Has an Equality Impact Assessment (EIA) been completed		**NO**
Name of the person giving this response	Sioned Evans Community Midwife	
If NO:	**N/A**	
If YES:		