

Induction of Labour (IOL)

Prioritisation and Escalation Framework

Purpose

To support safe, equitable and effective prioritisation of women undergoing planned and urgent induction of labour, particularly during periods of high acuity on antenatal ward and central delivery suite (CDS).

Scope

This framework applies to all women for whom induction of labour is indicated. Acute clinical concerns always override planned prioritisation categories.

Planned Induction of Labour – Prioritisation

Planned induction of labour prioritisation entails scheduling antenatally agreed inductions according to clinical risk. If a delay is anticipated, this approach allows for proactive management of IOL through suitable monitoring, ongoing surveillance and timely rescheduling.

Planned IOL Priority Categories

PRIORITY	Definition and Timeframe	Indication for Induction of Labour
HIGH (Priority 1)	Planned but time – critical. Delay increases maternal or fetal risk. IOL to be scheduled at diagnosis or within 24 hours.	• SROM > 24hrs (if SROM and GBS+ liaise with labour ward to admit immediately) • Moderate/severe PET • SGA <3rd centile or static growth and abnormal Doppler's • Insulin dependant diabetes (Pre existing or GDM) • Reduced fetal movements with other risk factors • Fetal anomaly • Post maturity > 14 days (if declined at 40^{+ 12}) • Maternal medical conditions eg – cardiac, haematology, • Recurrent antenatal APH
MODERATE (Priority 2)	Planned, risk accumulating. Short delay acceptable with monitoring. IOL to be scheduled within 24 - 72 hours depending on clinical indication (arrange ongoing	• VTE on treatment • Reduced fetal movements with no other risk factors • SGA 3rd to 10th centile or static growth with normal dopplers • Previous obstetric history of stillbirth or neonatal death • Fetal condition requiring NICU (including multiple births)

	monitoring of maternal and fetal wellbeing if appropriate)	• Cholestasis with bile acids >100 • Post Maturity 40^{+ 12}) • SROM <24hrs in absence of evidence of infection or GBS • Oligohydramnios with normal fetal movements • GDM on oral medication or diet controlled • PIH/mild PET • Maternal Age • Psychiatric conditions where continuing pregnancy presents risk eg schizophrenia/severe eating disorders. • Maternal medical conditions like epilepsy
LOW (Priority 3)	Elective or preference-based. Proceed subject to capacity. IOL scheduled to suit service and woman's choice. Consideration for Outpatient Induction of labour if no fetal risk factors present.	• Macrosomia • GGP • Maternal request/social reasons • Low PAPP-A with normal growth and no other risk factors • Mental Health i.e previous traumatic birth or anxiety • Raised BMI

Prioritisation for transfer to Labour Ward for Artificial Rupture of Membranes (ARM)

Women undergoing IOL and awaiting ARM should be prioritised according to their planned IOL priority category, unless change in their clinical condition necessitates escalation for an urgent transfer.

Additional Safeguards

- Women in planned priority 1 awaiting ARM should be reviewed daily as part of the multi-disciplinary discussion regarding clinical prioritisation of elective procedures, including elective LSCS
- Planned priority 2 women should be escalated if delay exceeds 72 hours.
- Any clinical deterioration mandates immediate re-categorisation
- Women waiting for transfer to CDS for continuation of IOL should be prioritised and discussed with CDS obstetric team and coordinator following morning and evening antenatal ward rounds. This should be documented in handover proforma.

Clinical Judgement and Escalation

- This framework supports but does not replace clinical judgement
- Individual circumstances may warrant deviation from the matrix
- All deviations must be clearly documented in the clinical record
- Any delay in transfer to labour ward for ARM exceeding the prioritisation level time-frame, should be escalated to the Manager on Call and support requested from neighbouring maternity units to attempt transfer to arrange ARM.