Provider line of sight table on report recommendations for submission to the funders	
Please can the provider complete the following details to allow for ease of access and rapid review	
Project and Title of report, including HQIP Ref. ***e.g., Ref. XXX, Project and report title***	**Ref 546, National Maternity and Perinatal Audit (NMPA)** **Induction of Labour Snapshot Audit, Based on births in NHS maternity services in England, Scotland and Wales during 2023**
1. What is the report looking at/what is the project measuring?	**Maternity and perinatal outcomes following induction of labour at NHS trusts and boards**
2. What countries are covered?	**England, Scotland and Wales**
3. The number of previous projects (e.g., whether it is the 4th project or if it is a continuous project)	**1st version of this project**
4. The date the data is related to (please include the start and end points – e.g., from 1 January 2016 to 1 October 2016)	**1 January 2023 to 31 December 2023**
5. Any links to NHS England objectives or professional work-plans (only if you are aware of any)	Saving Babies' Lives Care Bundle version 2.0. • Risk assessment and management of babies at risk of fetal growth restriction (FGR). • Raising awareness amongst pregnant women of the importance of reporting reduced fetal movements (RFM), and ensuring providers have protocols in place, based on best available evidence, to manage care for women who report RFM. • Reducing the number of preterm births and optimising care when preterm delivery cannot be prevented • Prior to 39 weeks gestation, induction of labour or operative delivery is associated with small increases in perinatal morbidity. However, at 39 weeks gestation and beyond, induction of labour is not associated with an increase in caesarean section, instrumental vaginal delivery, fetal morbidity or admission to the neonatal intensive care unit. Thus, a recommendation for delivery before 39 weeks should be based upon objective concerns. • It is self-evident that a woman's autonomy is paramount and that care should be delivered in a way which informs and empowers. Women should have access to best practice care and their decision to accept or decline an intervention should always be respected. • For uncomplicated pregnancies NICE guidance on induction of labour should be followed20. In all cases of induction, it is important women receive a clear explanation about why they are being offered induction and that the risks, benefits and alternatives are discussed. • 2.9 Accepting the proviso that all management decisions should be agreed with the mother in the cases of fetuses <3rd centile and with no other concerning features, initiation of labour and/or delivery should occur at 37+0 weeks and no later than 37+6 weeks gestation. Delivery <37+0 weeks can be considered if there are additional concerning features, but these risks must be balanced against the increased risks to the infant of delivery at earlier gestations30. • 2.10 Fetuses between 3rd – 10th centile will often be constitutionally small and therefore not at increased risk of stillbirth. Care of such fetuses should be individualised and the risk assessment should include Doppler investigations, the presence of any other high risk features for example, recurrent reduced fetal movements, and the mother's wishes. In the absence of any high risk features, delivery or the initiation of induction of labour should be offered at 39+0 weeks. • 3.5 Maternity providers are encouraged to focus improvement in the following areas: . Ensuring appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks).

	• Outcome indicator: i. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. • Prior to 39 weeks gestation, induction of labour or operative delivery is associated with small increases in perinatal morbidity and neurodevelopmental delay. Thus, a recommendation for delivery needs to be individualised and based upon evidence of fetal compromise (for example, abnormal CTG, EFW <10th centile or oligohydramnios) or other concerns (for example, concomitant maternal medical disease, such as hypertension or diabetes, or associated symptoms such as antepartum haemorrhage). • At 39 weeks gestation and beyond, induction of labour is not associated with an increase in caesarean section, instrumental vaginal delivery, fetal morbidity or admission to the neonatal intensive care unit. Induction of labour therefore, could be discussed (risks, benefits and mother's wishes) with women presenting with a single episode of RFM after 38+6 weeks gestation. It is important that women presenting with recurrent RFM are additionally informed of the association with an increased risk of stillbirth and given the option of delivery for RFM alone after 38+6 weeks. • For fetuses with an EFW <3rd centile in later pregnancy delivery should be initiated at 37+0 weeks' gestation (or earlier if there are other concerning features present depending on the protocol). • In fetuses with an EFW between the 3rd and 10th centile, other features must be present for delivery to be recommended prior to 39 weeks, as described above, for the definition of FGR (for example, fetal [based on Doppler assessment] or maternal [maternal medical conditions or concerns regarding fetal movements]). If FGR cannot be excluded, then delivery after 37 weeks should be discussed with the mother and an ongoing management plan individualised. • For all fetuses with an EFW or AC <10th centile where FGR has been excluded, delivery or the initiation of induction of labour should be offered at 39+0 weeks after discussion with the mother. • For women who decline induction of labour or delivery after 39+0 weeks, counselling must include a discussion regarding evidence that there is no increase in risk for the baby or for the mother from delivery/induction at this gestation and that there is no evidence to determine how fetuses with SGA/FGR should be monitored if pregnancy continues. **Saving babies' lives: version 3** • One of the key interventions in Elements 2 and 3 of the SBLCBv3 is offering early birth for women at risk of stillbirth. It is important that this intervention is not extended to pregnancies that are not at risk. • Considering how the risks of induction of labour change with gestational age • For uncomplicated pregnancies, NICE guidance on induction of labour should be followed. In all cases of induction, it is important that women are given a clear explanation of why they are being offered induction and that the risks, benefits and alternatives are discussed. • At 39+0 weeks' gestation and beyond, induction of labour is not associated with an increase in caesarean section, instrumental vaginal birth, fetal morbidity or admission to the neonatal intensive care unit. The NICE guidance and data from the ARRIVE study provide contradictory evidence as to whether induced labours are associated with a longer hospital stay or more painful labours. Induction of labour may also increase the workload of the maternity service, which has the potential to impact on the care of other women. 2.18 All management decisions regarding the timing of FGR infants and the relative risks and benefits of iatrogenic delivery should be discussed and agreed with the mother. When the EFW is <3rd centile and there are no other risk factors (see 2.20), initiation of labour and/or delivery should occur at 37+0 weeks' gestation and no later than 37+6 weeks' gestation. 2.19 In fetuses with an EFW between the 3rd and <10th centile, delivery should be considered at 39+0 weeks' gestation. Birth should be achieved by 39+6 weeks' gestation. Other risk factors should be present for birth to be recommended prior to 39 weeks (see 2.20).

	2.20 In fetuses with declining growth velocity and EFW >10th centile, the risk of stillbirth from late-onset FGR should be balanced against the risk of late preterm delivery. In infants where declining growth velocity meets delivery should be planned from 37+0 weeks' gestation unless other risk factors are present. Risk factors that should trigger review of timing of birth are: reduced fetal movements, any umbilical artery or middle cerebral artery Doppler abnormality, cCTG that does not meet criteria, maternal hypertensive disease, abnormal sFlt1: PlGF ratio/free PlGF or reduced liquor volume. 3.6 Maternity providers are encouraged to focus improvement in the following areas: c. ensuring appropriate use of induction of labour when RFM is the only indication (for example, induction of labour for RFM alone is not recommended prior to 39+0 weeks' gestation) Outcome indicators 3d. Rate of induction of labour when RFM is the only indication before 39+0 weeks' gestation. NHS Long Term Plan 3.8. Maternal mortality occurs in fewer than 1 in 10,000 pregnancies. But we can do even better. Significant regional variation in extended perinatal mortality still exists72. Of the term babies who died in 2016, different care might have led to a different outcome for 71% [73]. Women from the poorest backgrounds and mothers from Black, Asian and Minority Ethnic (BAME) groups are at higher risk of their baby dying in the womb or soon after birth [74]. 3.9. Through the Long Term Plan, the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. 3.10. An independent evaluation of the Saving Babies Lives Care Bundle (SBLCB), which supports the ambitions set out in Better Births, has shown a 20% reduction in the stillbirth rate at maternity units where it was implemented. We aim to roll out the care bundle across every maternity unit in England in 2019. 6.3. the NHS will reduce variation across the health system, improving providers' financial and operational performance 6.19. Reducing unwarranted variation will be a core responsibility of ICSs. We expect all ICSs, supported by our national programmes, to bring together clinicians and managers to implement appropriately standardised evidence-based pathways. **Better births** Personalised Care. i. Every woman should develop a personalised care plan, with her midwife and other health professionals, which sets out her decisions about her care, reflects her wider health needs and is kept up to date as her pregnancy progresses. ii. Unbiased information should be made available to all women to help them make their decisions and develop their care plan. **Better Births Four Years On** 58. […] two core themes which run throughout all of its activities: providing safer care, and providing more personalised care to women. 72. The Better Births vision is for personalised care, centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information and supported by digital tools. 74.[…] personalisation, based on a robust and continued assessment of an individual's circumstances and choices and, based on a relationship of trust between the woman and her clinicians, is a prerequisite for the safest care. **Maternity Transformation Programme:** • Increasing choice and personalisation • Promoting good practice for safer care, including the 'halve it' target for stillbirths and neonatal brain injuries. • Sharing data and information – improving data quality and availability, harnessing digital technology

Please can the provider complete the below for each recommendation in the report							
No	**Recommendation**	**Intended audience for recommendation**	**Evidence in the report which underpins the recommendation** *(including page number)*	**Current national audit bench-marking standard if there is one**	**Associated NHS payment levers or incentives**	**Guidance available (for example, NICE guideline)**	**% project result if the question previously asked by the project (date asked and result). If not asked before please denote N/A. This is so that there is an indication of whether the result has increased or decreased and over what period of time**
R1	**Recommendation 1:** Maternity care commissioners and maternity networks* should ensure that their constituent units use their local data and national data on variation in IOL practice and disparities in outcomes to inform the planning of service provision, and in the counselling of women and birthing people accessing their services. *English local maternity and neonatal systems (LMNS), the Scottish Perinatal Network, and the Wales Maternity and Neonatal Network	Maternity care commissioners and maternity networks	Key Finding 1: Just under one third (32%) of women and birthing people experienced an IOL; of those, 30% gave birth by caesarean. Key Finding 2: Increasing maternal age was strongly associated with increasing likelihood of giving birth by caesarean following IOL, and those giving birth at or after 41 weeks of gestation and those from ethnic minority groups had a higher likelihood of giving birth by caesarean. Key Finding 3: Babies born to women and birthing people from Black ethnic groups were more likely, and babies born to women and birthing people from Asian, Mixed or 'Other' ethnic groups were less likely, to be assigned an Apgar score of less than 7 at 5 minutes following IOL than babies born to white women and birthing people. **Key Findings and Recommendations, page 5** In 2023, 32.4% women and birthing people experienced IOL, with similar proportions seen across England (32.2%), Scotland (34.6%) and Wales (34.2%). Trust/board min–max: 15.7%–46.4%. **IOL rates and maternal characteristics, page 6** Caesarean birth occurred following 29.7% of inductions. **Mode of birth, page 7**	None known	N/A	Inducing Labour, NICE guideline [NG207], 04 November 2021 Midwifery Care for induction of labour, RCM Blue Top Guidance September 2019 Intrapartum Care, NICE guideline [NG235], 29 September 2023 Caesarean Birth, NICE guideline [NG192], 31 March 2021 Saving babies' lives: version 3, NHS England, 23 April 2025 The NHS Long Term Plan, NHS England, January 2019	Question not previously asked

			1.59% of babies born following IOL had an Apgar score of less than 7 at 5 minutes. **5-minute Apgar score, page 9**				
R2	Maternity care commissioners should undertake a structured review to identify the drivers of practice variation in IOL care within their networks, such as clinical culture, local policies and protocols and clinical leadership, to target a reduction in unwarranted variation in IOL care processes and outcomes.	Maternity care commissioners	Key Finding 4: Unexplained variation in IOL rates extended to the mode of birth and 5-minute Apgar score experienced by women and birthing people and their babies following induction of labour. Key Finding 5: There was wide variation between trusts and boards in the proportion of caesarean births following IOL, 40% had rates that were higher or lower than the expected range. **Key Findings and Recommendations, page 5** Figure 1: Funnel plot showing case-mix adjusted caesarean birth rates following IOL across trust/boards. **Mode of birth, page 7** Figure 3: Funnel plot showing case-mix adjusted rates of Apgar score of less than 7 at 5 minutes across trusts/boards. **5-minute Apgar score, page 9**	None known	N/A	Inducing Labour, NICE guideline [NG207], 04 November 2021 Midwifery Care for induction of labour, RCM Blue Top Guidance September 2019 Intrapartum Care, NICE guideline [NG235], 29 September 2023 Caesarean Birth, NICE guideline [NG192], 31 March 2021 Saving babies' lives: version 3, NHS England, 23 April 2025 The NHS Long Term Plan, NHS England, January 2019	Question not previously asked

R3	Digital teams in the Government health departments should work with maternity data controllers and software developers to incorporate processes and systems into the next version update of each dataset that support maternity care providers to record data items, such as gestational age at induction, maternal decision-making, the indication, method(s) and duration of induction.	Digital teams in the Government health departments, maternity data controllers and software developers	Key Finding 6: IOL was recorded as unsuccessful for 6% of women and birthing people. However, this may have been influenced by a lack of a standardised definition, along with concerns about coding accuracy and data completeness. Key Finding 7: A number of key data items relating to IOL are not included or are incomplete in the national maternity datasets, these include the method, indication for and duration of induction. **Key Findings and Recommendations, page 5** **Unanswered questions about IOL, page 11**	None known	N/A	None known	Question not previously asked
R4	The Royal College of Obstetricians and Gynaecologists (RCOG) should work collaboratively with stakeholders to develop a standardised definition for the diagnosis and reporting of 'unsuccessful induction of labour'	RCOG	Key Finding 6: IOL was recorded as unsuccessful for 6% of women and birthing people. However, this may have been influenced by a lack of a standardised definition, along with concerns about coding accuracy and data completeness. Key Finding 7: A number of key data items relating to IOL are not included or are incomplete in the national maternity datasets, these include the method, indication for and duration of induction. **Key Findings and Recommendations, page 5** **Unanswered questions about IOL, page 11**	None known	N/A	None known	Question not previously asked