*OK could you please tell me about your… erm… how you talk to women about induction of labour?*

So, it’s always about their choice, whether they get induced.. they can always decline it.. making that really obvious rather than ‘I have to be induced now,’ and I say, ‘no, you don’t have to do anything. It’s your choice,’ and give them information so they can make a balanced decision and talking about, erm.. why we’re offering induction and why we time it that way, also talk about the risk of stillbirth going up, and then talk about placenta function, and, erm.. then talk about the different types of induction we ↑offer, looking at women’s risk factors, whether or not they’d be recommended outpatient induction..

*Mmm..*

..or recommend the other route. Erm.. I guess, talking through so looking if this person is having their first baby, low risk, then thinking about, erm.. kind of, like, what we offer here. They can come in, have their assessment, and if all that meets criteria and the CTG, erm.. and a Bishop Score below ↑four.. maybe, I ↑think, erm.. then that we can.. that person then meets criteria for a pessary and, kind of, saying, describing what.. that it has a tape, erm.. that contains hormones in it, kind of, impregnated and where that sits, behind your cervix.. erm.. what we’re hoping to do by that.. so by starting off contractions, sorting the cervix, with the aim then of either being able to break her waters, erm.. and then start the syntocinon drip if she doesn’t want to mobilise. And I think it’s giving them the option, although, kind of, our guideline says syntocinon straight away, that actually, mobilising, trying to get normality in there as well is also an option if she wants it. Erm.. and then saying that they go home and come back and having that assessment to see if it’s worked, CTGs, kind of, go through it, step-by-step process.

*Yeah*.

I guess that’s how I’d talk to someone about it.

*There’s quite a lot to talk about, isn’t there?*

Quite a lot to talk about, in a very short period of time.

*So when do you normally talk to women about induction of labour?*

So I try and.. so, erm.. kind of, comes in so if someone’s low risk.. I touch on it a little bit at the thirty-six week appointment and that.. I might at the thirty-eight week appointment, like, I say ‘actually, when I see you at forty weeks these are the kind of things we’re going to be offering, would you have a chance to look at it.. ↑online?’ So, generally NHS choices and places I point them to about induction of labour for more information, and also our trust ↑website ‘cos you can get some of the leaflets online for ↑them.

*Yeah.*

So that’s my first, kind of, step.. so when I see them, erm.. at forty weeks, talking about a sweep isn’t the first time they’ve heard about it.

*Yeah.*

They can then have beforehand, have read information about the pros and cons and then actually have a chance to have a more in-depth conversation about when I see them at forty, erm.. at forty weeks appointment and then again at the forty-one week appointment. So giving them what they want step-by-step, to talk about it.

*Yeah. And how do you know if they’re, this is a real basic question, how do you know if they’re high risk or low risk, erm.. whether they would be eligible for outpatient induction?*

So yes, looking back from antenatally, so, I guess, talking through their medical history from booking them, that’s kind of.. I guess.. where the risk assessment bit starts, and looking back throughout their pregnancy, so looking at, erm.. their, kind of, admissions into Day Assessment Unit, why they’re seen in Day Assessment Unit, erm.. is it reduced movements, bleeding, like, what else is going on, I guess, through their history that, kind of, comes into that risk assessment ↑point.

*Yeah.*

Erm.. also looking is it something that person wants, because the idea for someone coming into hospital, being assessed, giving them medication and going home again.. to them, some people that can be really frightening and actually ‘no, I want to start it, I want to stay in hospital and feel safe and secure.’ I think that person’s opinion of what they see as normal or safe for them comes into it massively as ↑well, into how I then.. what I, kind of, recommend to that ↑person.

*So you’ve met women whose preference it would be to stay in hospital.*

Stay in hospital. That’s very minimal because most people would hate.. when you explain to them about the induction of labour process, saying that.. I think it’s also taking out the first bit of when you get induced, you’re not having your baby on that ↑day.. I think people often think they’re having their baby on that day that my induction’s booked but actually no, this is a, erm.. a slow process.. and, I guess, with.. talking about, erm.. going home is that, actually you get to go home and be in your own home environment.. and being able to relax, and that side of it, so when people have that information for most people that’s seen as a positive..

*Yeah.*

..to be able to go home and not spend their entire induction period in hospital.

*So they see it as a positive.*

So most women see it as a positive being able to go home and then come back as a positive, but there’s a few women who are actually, ‘no, when I start it, I just want to stay.’

*Yeah, yeah. Why do you think that is?*

I think it’s the.. I think.. probably it links into when we see people so early in labour, when things have started, they just want to be with us.. they think that being with us is being is the safest place, but we also know from the evidence that the early phase of labour, latent phase of labour when it’s not being induced, you’re safer off being at home and coming in to us a bit later. I wonder if some of that is translated again to being induced and just wanting to be with people in the hospital because they think it’s a safer place.

*So they want to stay with us because they think it’s a safer place.*

But I think that’s quite a small number of women who probably have that view.

*So on the whole, the women you talk to..*

They like.. like the idea.. idea of an outpatient induction.

*OK and what do you think they like about going home?*

I think it’s if they have pregnant friends and family say, like, erm.. I guess, who know the induction room is quite small, that it’s.. I guess, there’s not.. not much privacy when you’re being induced and you come into ↑hospital, erm.. that you cannot.. almost, like, being stuck into this building of.. ‘how far can I go?’ They ask you. ‘So when you say I can go for a wander for a bit, so how far am I allowed to go?’ And so you, kind of, have that, kind of.. I guess, they’re in our house, they think they’re in our house and we’re controlling, like, what they do, like, rules-wise, does that make sense?

*Yeah*.

Erm.. and I think the idea of going home means that some women who really would like to have a normal vaginal birth or love labour to progress normally, a lot of women seem to be informed about going home and spending time at home and having had that quiet environment, being in their own space for a whole [inaudible] through ↑normally.

*Yeah*.

Or they might have kids at home or younger children at home that actually the idea of being in hospital for that period of time and then while labour’s actually active if I can reduce the childcare I need for that point so I can save it for later on I think that’s another reason some women like the idea of an outpatient induction.

*Yeah. So these are the kind of things you discuss with women.*

I think it’s the kind of thing women bring up.

*With you*.

When talking about it. Yeah. I guess it wouldn’t be one of my selling points, like, oh, if you’re struggling with childcare this is a great part of it. I think that just comes through as you talk to ↑women.. ↑about it.

*It, kind of, naturally comes out.*

Naturally flows from the conversation.. I’d say.

*Cool. So you’ve described the process, they’ve read some information, they’ve maybe had a membrane sweep, or something like that, and then.. so at what point do you book the induction and how do you do it?*

So generally when I see them at their, erm.. forty-one week appointment, erm.. we have a computer system, it’s, kind of, like, our obstetric diary..

*Yeah*.

..where we can book in induction, but I think also on that system elective sections get booked in as well. Erm.. so, I guess, it’s done on a computerised system from, erm.. from my clinic where I work, I can do it there. But there are times when the other slots are completely full then I need to come and.. or call and liaise with the induction of labour midwife or I might liaise with the, erm.. kind of, the shift leader on labour ward..

*Sure*.

..as my next port of call when I can’t get a slot somewhere else, or if.. or if someone’s asked me to book in an outpatient induction at a different time frame than we recommend.

*Oh OK.*

So, kind of like, oh, ok how can.. so either.. so we offer it at between term plus ten and term plus ↑twelve, so if someone says ‘well I would really like that but I want to do it at term plus thirteen,’ you’re thinking that’s slightly.. that’s out of our guideline of when we recommend it and so, that’s an example, who will I, kind of, call or contact? Who can I liaise that with.. the, erm.. the outpatient induction of labour midwife. Erm.. also thinking about.. you know.. my team consultant.

*Yes*.

So yeah.. so, kind of, places where I can refer the information whether we can facilitate that but actually, we shouldn’t facilitate it because it’s slightly out of our guideline.

*Yeah, fair enough. Alright so the women have erm.. participate in that decision, yeah, and you’ve kind of.. collaborate with other people..*

Exactly. So it’s not.. I guess, when it comes to.. it’s our, kind of.. guidance and it’s.. as well as picking a date, it’s not just my choice, it’s depending on her’s as well. And like I’ve said, if we don’t have enough space or there isn’t enough slots booked in, or there’s erm.. I think we probably.. I can’t remember how many slots we have booked in per day.. for outpatient induction, but if they’re full I’m thinking actually.. this is the time that person has recommended, who else can I speak to.. to.. kind of, facilitate it.

*Yeah, fair enough. So when you fill in all the details on the computer system, into the diary, how do you, erm.. tell the person on the receiving end of that information that they would be eligible for outpatient induction potentially?*

So you can pick different slots that, kind of, say outpatient induction or not and also you have a box you can write information in.

*Like a free text.*

Free text.. on our system, sorry, give you more information, our system so when you go and book an induction, you put the woman’s name, her gravida and parity, any kind of, like, obstetric history or medical history you want to put in there… erm… you can choose the different times of the day but then erm.. and then.. so it’s quite.. you can be as descriptive as you want in putting information in ↑there.

*Yeah*.

So that the person on the other end of the screen can see why you booked this person in, or that person’s history quite quickly.

*So then off they go.*

Erm.. so yeah, so you get a generated letter.. so off they go.. like, where information is so we generally give an information ↑leaflet. So they’ve heard me talk about it and they’ve read the information leaflet as well. Erm.. they would then come to [the hospital], erm.. go to reception, kind of, there, meeting a midwife who would then, kind of, invite them in, erm.. that person should generally go through what the induction process is again and give that woman a chance to ask any questions that she might have as well.

*Sure, sure.*

So I think that’s how the day starts for them.

*Yeah. And erm.. in terms of the experiences you have had of caring for women who were low-risk at that point and you booked an outpatient induction of labour kind of slot, erm.. what’s your feeling about what happened next? Did.. did you have someone go through that process.. or.. what do you think happened?*

Erm.. I think we.. [inaudible] not that recently.. I think one of them recently hasn’t fitted, like, the outpatient induction of labour process. Erm.. looking after people in labour who’ve come in.. trying to remember off the top of my head [laughter]. Erm.. for some people they’ve gone home and then, like, they might need a further pessary, before us moving in, erm.. but, I guess, some people are still grateful for that time of being at ↑home.

*Yeah*.

And coming in.. so it’s a balance between the two.

*Yeah. Erm.. so you said you haven’t really had many women lately who’ve met the criteria. What sort of things happen that mean that’s not possible any more?*

So for someone I booked in for induction, erm.. so they’ve either had previous history, so, erm.. they’ve had a previous caesarean section and so they’ve come in.. erm.. so then I wouldn’t have recommended outpatient induction. Erm.. or.. I guess, sometimes.. or they’ve had obstetric cholestasis or there was then something else that made them not, like, I couldn’t offer that.

*Not eligible.*

Not eligible for it. I think that’s what’s happened recently, like, I think in my clinic.

*Yeah. That’s OK.* Can you remember any of your women having outpatient induction?

I can.. when I’ve seen them postnatally at home, they just love the fact that they’ve been able to go home and come back in, and I think the lady I’m thinking about didn’t then need anything further. She was then, erm.. her cervix was.. what’s the word?

*Favourable?*

Favourable enough that they could, erm.. perform an artificial rupture of membranes and then take her round to Labour Ward. So.. so for her that process worked really nicely. She was able to be at home, come in and then, kind of, follow on and Labour Ward was able to accept her..

*Yeah*.

..to come round to Labour Ward to then be supported. So for her I think it worked really well. And there’s others that I’ve looked after who, erm.. I guess, talking to me about their experiences.. that sometimes it can be, like, a bit.. a bit of a ↑delay going home, coming in, that actually if they’d stayed with us for that period of time, we may’ve been able to get them round to Labour Ward sooner to, kind of, facilitate having them on Labour Ward sooner so..

*Oh right. So what do you think happened, why do you think there was a delay?*

Erm.. I think they were saying, thinking about it, that actually, if that person was with us, instead of being home for twenty-four hours, they would’ve had an examination ↑sooner maybe and then thinking, OK fine, would we have given a, erm.. a pessary ↑earlier, erm.. or.. sorry, not the pessary.. but would we have given another form of induction drug earlier than, like, waiting for that twenty-four hours if we hadn’t seen any changes in that person’s cervix. Erm.. so yeah, I think that’s their thinking behind it.

*Yeah*.

But I think if we can.. if that person is low risk and we give them that choice to facilitate, erm.. I guess.. a better experience, I guess, of the induction ↑process ‘cos, erm.. supporting of, erm.. hormonally in induction, or looking to their stories afterwards.. like, some of the hardest bits of the induction process is waiting to go around, or seeing the person in front of you, kind of, go round before them..

*Oh OK*.

So that kind of ‘oh god, I was number one in the queue but now I’ve jumped to number three,’ and.. but, I guess, if you were at.. home you wouldn’t have that experience.. you can almost switch off from that.. what’s happening.. whereas when you’re in hospital in a room, or in that small.. it’s not even a room.. it’s a small section that’s yours, it’s quite hard to tune out from.. where it’s happening.. it’s hard to tune in to your labour, your contractions and.. I guess, the things that we know normality brings. So, like having, erm.. a.. an environment that’s relaxed, an environment that’s dark, that you feel safe, you feel comfortable in without distractions.. we know those things help someone tune in, erm.. to labour, to help labour progress which if we can.. I think.. so it’s quite hard in that induction room where you have beeping lights, erm.. beeping noises, lights, erm.. the hustle and bustle of just being in hospital brings as well.

*Sure.*

Yeah.

*I think lots of people comment on that kind of thing in the literature anyway about the environment. OK, so it sounds like, from what you’re saying, there’s not many women… certainly the women you’ve looked after recently… who meet the criteria.*

Yes.. [sigh] which is.. also, erm.. for me the criteria for induction of labour, erm.. outpatient induction of labour.. also when I’m thinking about my own practice is it, like, we forget it’s there, that you’ve been so used to having women come in.. and say ‘oh yeap, actually you are suitable for our induction of labour process,’ so I think it’s a mixture of both of them. So if we’re looking at it as a whole, is it that sometimes we forget we ha.. have that option for an outpatient induction.. that we think actually, this is.. we forget we have another side path.

*Another option.*

Another option to just come in, stay, you come in at 3, 4 or whatever and then just stay with us until you eventually have your baby.

*Yeah. So women don’t.. aren’t aware that it’s an option.*

Yeah, it could be that as well. Maybe that’s why we’re seeing less of it. Erm.. is it that.. what’s the word? Erm.. the profile of ↑it has ↑dropped I ↑guess. Yeah.

*Yeah. Fair enough. And erm… in terms of how far away people live, do you think that’s an issue?*

So my clinic’s in [small town].

*Yeah… How far is that then? On a bad day it’s probably..*

Could be, like, a 40 ↑minute stretch on a bad day, but I’ve been able to get here in 25 ↑minutes before.. so it all depends on what time of day you come in, what time you’re leaving and I imagine for women who are further afield, like, as far as [town further away] erm.. and, I guess, the other side of our city.. that might be an indication that, actually, ‘when I’m in I want to stay in’. Erm.. also I wonder if cultural, cultural, erm.. shifts are changing.. ‘cos looking at, like, erm.. like, just for curiosity.. being part of different erm.. Facebook groups, or social media groups, the women are talking about labour, and how they are then talking about induction of labour and at the moment it seems quite ↑negative, like, erm.. I looked at something and it said, ‘oh you don’t have to be induced, it’s your choice,’ and just how people put things across is, erm.. I guess, things like.. and speakers and writers like Milli Hill, for example, how they put information across, I think a lot of women are seeking more information. So I had a lady.. this.. lady, erm.. yeah, she probably gave birth a few weeks ago. She had been suitable for an outpatient induction.

*Sure*.

It was her second baby, low risk, she fitted all the criteria and, erm.. giving her all the options she was, like, ‘no I don’t want to be induced,’ she didn’t want a sweep, like, all the things we offered her she was, like, ‘no erm.. I am well, my baby is well.. I’m happy to go in for a CTG, for an ultrasound scan, to have, like, a conversation with the doctors and I’ll think about what date.. I would.. if I want to accept induction of labour, but right now I’m.. I’m happy.’ And I think she had her baby at term plus thirteen and I got to see her at home for, like, her final discharge and I asked her what her experience was and she was like, ‘yeap, I felt really well informed, I did what was right for me and my baby,’ and that’s the other side of induction, I guess, is giving someone the information, those options and, I guess, then them following through with it.

*So do you think people are more aware of their options than they used to be?*

Hmmm..

*Not really. Or do you think that’s a specific group of people who are*..

Looking at my.. looking at the women I see I think it’s a specific group of ↑women who will naturally in all areas of their life will go out and seek information, and seek evidence and kind of compare and contrast, whereas I think there is a lot of women who will just go, ‘you’re the midwife, you know what’s best,’ and more, kind of.. if we recommend this, they’ll say ‘I’ll go for that.’

*Yeah*.

But not actually, I guess, weighing up for them.. the pros and cons.. they do their own kind of information.. their own kind of search or evidence seeking, so there are a set of women who are.. find out information for themselves, like, ‘yeap I take your recommendation, but putting that all together, this is what I’d like to do.’

*Yeap. So that lady wanted to wait.*

She wanted to wait.

*Yeah. Which is fair.*

Which is fair, yeah.

*OK fine. Does outpatient induction of labour affect your workload at all?*

Currently not.

*No? So no extra time really to explain it. You’d be explaining it anyway.*

I’d be explaining it anyway. Erm.. so no, it doesn’t really affect my workload.

Yeah.

And, I guess, also because erm.. working in community, working in the birth centres, I work on Labour Ward sometimes, but I’m not involved in the.. I’m generally not involved, like, being an induction of labour midwife, so she’ll, kind of, first initially meet them and coordinating it. I might.. I’ll look after them on Labour Ward once they’ve, kind of, reached that stage of erm..

*The ongoing care.*

..ongoing care, yeah. Either being in established labour, or us thinking about, erm.. breaking their waters and starting an oxytocin drip. So for me I’d say no.

*No, fair enough. So, in your view, how do you feel about outpatient induction.*

I think I really like it and I think there being another choice.. of still trying to, erm.. give a woman the choice of going home to their own environment, erm.. but also looking at risk factors I ↑guess, that actually, you are completely suitable for this, so let’s try to make room for you to go home, to see if… with this.. additional drug, get.. get your labour started, or actually, erm.. kind of, get you, I guess, to improve.. what’s the word I’m looking for again.. ah.. favourability of the cervix, I guess, at home instead of being in the hospital. I guess, trying to improve women’s experiences. I think coming from a Trust where as a student that was the norm, that we’ve always had.. had that kind of option. Women had the choice of going home and coming ↑back.

*So that was working well there?*

Yeah. It was working well erm.. in the old Trust where I was from. So I think it would be quite nice to give women the option to have it here as well.

*Why do you think it was working so well there.. from your recollection?*

Maybe it was culture, it was something that we did.. that we offered. And so it wasn’t seen.. it was just seen as another pathway that we had. For me, coming in as a student, that’s what I knew.. that’s what we did.. so for me as a person, as a student, it didn’t affect my workload because.. you didn’t know any different. Yeah.

*Yeah. I think that’s pretty much all my questions. So have you got anything else that you wanted to tell me about outpatient induction?*

No.

*Thank you very much.*