Labour and birth

Information booklet for mums & families

This information booklet is for women who are pregnant in North West London.

Try and read this booklet early on and throughout your pregnancy.
It has a lot of useful information for you to refer to.

This booklet accompanies the information provided in the North West London **mum & baby app** or North West London maternity booklets:

Your pregnancy, **Personal care plans** and **After your baby's birth** (available at: www.bit.ly/NWLmaternityinformation)

Contents

Early signs of labour

In the week building up to your labour starting you might experience some of the following:

- increased clear vaginal discharge
- mild upset stomach or diarrhoea
- feeling energetic or restless
- frequent practice contractions or tightenings of the uterus known as 'Braxton Hicks' and/or backache.

Some women won't notice any of these signs, and it is nothing to worry about if you don't feel any different towards the end of pregnancy.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/labour-signs-what-happens/
- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/how-will-i-know-when-labour-has-started

As your labour starts you may notice some of the following signs:

The 'show'

During pregnancy, a plug of thick mucus forms in the cervix, and as the body prepares for labour this plug may pass out through the vagina. This can happen one to two weeks before labour, during labour or sometimes not at all. It appears as a clear or pink/slightly blood stained jelly-like substance, and you might notice it once or on a few occasions. You don't need to call your midwife about this unless you are worried, however if you notice that it is heavily blood stained or that you are losing fresh blood, call your maternity triage/assessment unit straight away.

Contractions

When early labour (sometimes known as the latent phase) starts, you may experience irregular contractions that vary in duration and strength. This can sometimes last for a few days, and it is important to rest when you can until they become regular. When your contractions become strong and regular, it may be helpful to start timing them (approximately how often they are coming and how long they last for).

If it is your first baby, you will normally be advised to come to the maternity unit when your contractions are every three minutes and lasting for 60 seconds. If it is your second or subsequent baby, you may be advised to come to the maternity unit when your contractions are every five minutes and lasting for 45 seconds.

You can call your maternity unit for support at any time, and a midwife will advise you on when to come to the maternity unit. If you're planning a homebirth, your midwife will come and visit you at home at the appropriate time.

Many women find trying different positions, walking, a warm bath, distraction and relaxation techniques, massage and resting in between contractions useful when at home. It is important to have regular light snacks (even if you don't feel hungry) and to sleep when possible. It is also important to drink, taking regular small sips of fluids in order to remain hydrated. You don't need to drink more than you would normally.

For more information visit:

- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/what-do-when-labour-starts

Your waters breaking

The amniotic sac is the fluid filled bag that your baby grows inside during pregnancy, and this sac will break before your baby is born. When it breaks, the fluid will drain out from the vagina.

Most women's waters break during labour, but it can happen before labour starts. If your waters break, you may feel a slow trickle or a sudden gush of fluid. This fluid is normally clear or pink in colour, however sometimes a baby can pass their first poo (called meconium) inside the sac, causing the fluid to become green or yellow.

If you think your waters have broken it is important to call your maternity triage/assessment unit straight away, particularly if you think you can see meconium. If you think your water's have broken, wear a thick sanitary pad as your midwife will ask to see this when you attend your maternity unit for a check-up. You can also take a photo of the initial loss of fluid as this can help with the assessment.

Make sure you take plenty of pads and a change of clothes with you on your journey into the maternity unit as once your waters have broken, you will continue to leak amniotic fluid. If your waters do break before labour, it is likely that your labour will start naturally within 24 hours, however if it doesn't start it may be recommended that your labour is induced (started with the aid of medications) to reduce the risk of infection for both you and your baby. Your maternity team will discuss this with you and agree a plan if this is the case.

For more information visit:

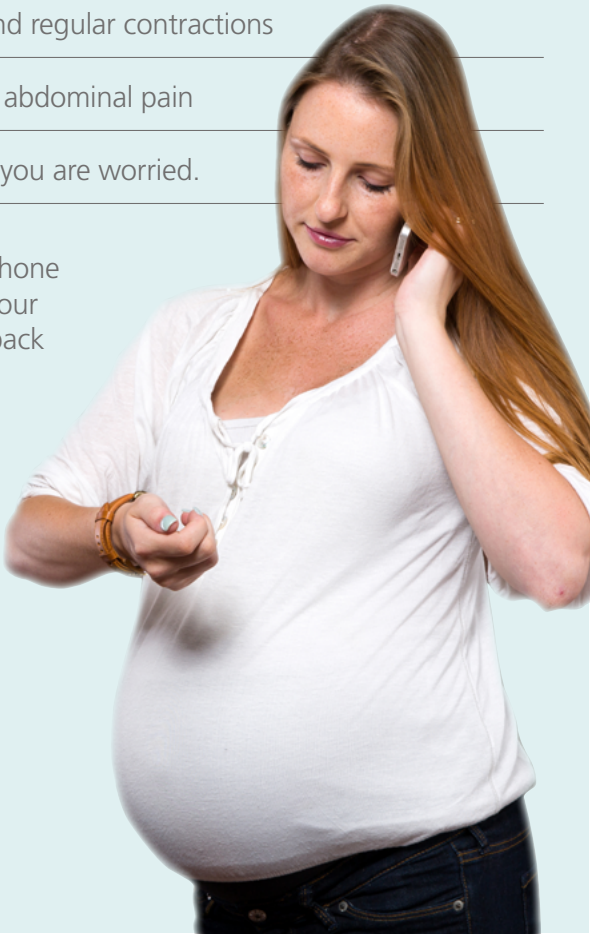
- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/what-expect-when-your-waters-break

When to call…

Call your maternity triage/assessment unit OR birth centre if:

- your waters break
- you have any fresh red vaginal bleeding
- your baby isn't moving as often as usual
- you have strong and regular contractions
- you have constant abdominal pain
- you feel unwell or you are worried.

You can find the telephone contact numbers for your maternity unit at the back of this booklet.



Stages of labour

Early stage/latent phase

Early labour (sometimes called the latent phase) can last anything from a few hours to a few days. In this time you may have periods of regular contractions, followed by periods of irregular contractions that can even stop for a few hours. During early labour your cervix will go from being thick, closed and firm to being soft, thin and stretchy. This change enables the cervix to start opening.

See page 20 of this booklet for more information on coping in early labour.

For more information visit:

- **Tommy's**
  www.tommys.org/pregnancy-information/im-pregnant/pregnancy-news-and-blogs/what-latent-phase-labour

First stage

Active labour is often said to begin when contractions are strong, regular and lasting at least 60 seconds, and your cervix is open to at least four centimetres.

During the first stage of labour your contractions will continue to come regularly, and become progressively stronger. This stage of labour can last around six to 12 hours if it's your first baby, and is often quicker if it's your second or third baby.

When you arrive at your maternity unit (or your midwife comes to your home) and throughout the first stage of labour your midwife will offer regular assessments of your progress and wellbeing, and the wellbeing of your baby, including:

- your observations (blood pressure, pulse and temperature)
- abdominal palpation
- listening to your baby's heartbeat
- vaginal examination to assess the progress of labour and position of your baby.

Your midwife will support you with different positions and coping strategies, including pain relief if needed. If your midwife is concerned about you or your baby at any point, she will ask a senior midwife or obstetrician for a second opinion. This can sometimes mean transferring to the labour ward if you are at home or in a midwifery-led unit.

Towards the end of the first stage you may experience something known as 'transition' which can makes some women feel scared or out of control. This is common and is soon followed by an urge to push as the cervix reaches 10 centimetres dilated, and the baby moves down into the birth canal. Your midwife will support you closely during this stage.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/what-happens-during-labour-and-birth/
- **National Childbirth Trust**
  www.nct.org.uk/birth/first-stage-labour

Second stage

This stage of labour starts when your cervix is ten centimetres dilated and your baby's head is moving into the birth canal. This is normally accompanied by a pressure in your bottom, followed by an urge to push which can feel difficult to control and similar to the sensation of needing to open your bowels.

Some women may not get an urge to push, particularly if they have an epidural. If this is the case, your midwife will help guide you by feeling for a contraction on your abdomen and letting you know when to push.

Your midwife will check your baby's heartbeat regularly and support you to try different positions.

When your baby's head is nearly born, your midwife will encourage you to gently breathe and avoid pushing if possible. This ensures your baby's head stretches your perineum slowly and can help reduce tearing.

The second stage of labour ends with the birth of your baby. This stage of labour can last up to four hours if it's your first baby, and is usually much quicker if it's your second or third baby.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/what-happens-during-labour-and-birth/#second-stage-of-labour
- **National Childbirth Trust**
  www.nct.org.uk/birth/second-stage-labour

Third stage

This stage is the time between the birth of your baby and the expulsion of your placenta.

After your baby is born, he/she will still be attached to the umbilical cord, which is attached to the placenta inside the womb. The cord should be left intact and not cut immediately, unless there is a problem with your baby's breathing, or you are bleeding heavily.

There are two options for the delivery of your placenta. The first option is known as **physiological third stage**, and the other is **active third stage**.

Physiological third stage

This option may be suitable if you are planning a natural birth. If you require an assisted birth, or if your midwife is worried you may be at a higher risk of bleeding after birth, this may not be recommended for you. Some research has found that bleeding after birth can be slightly increased if the placenta is expelled naturally, however if you are fit and healthy with good iron levels pre-birth, this is unlikely to cause any problems for you.

After your baby is born, he/she will remain attached to the placenta via the umbilical cord, which provides oxygen and blood supply whilst your

baby also starts to breathe. After 10-15 minutes this blood supply will naturally stop as the placenta separates from the womb. At this point the cord can be secured and cut. Soon after you will feel some mild contractions in the womb and perhaps an urge to push. You may find adopting upright positions helps, and your placenta will slide out easily. This is normally painless as the placenta is soft.

Active third stage

If you opt for an active third stage, or if your midwife recommends it after the birth of your baby, your midwife will give you an injection of a medication that causes the womb to contract. This injection normally takes a few minutes to work, and at this point the baby's cord will be secured and cut. Your midwife/doctor will then place gentle pressure on your lower abdomen and carefully pull on the umbilical cord, causing the placenta to deliver. This process normally takes between 10-20 minutes.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/what-happens-during-labour-and-birth/#third-stage-of-labour
- **National Childbirth Trust**
  www.nct.org.uk/birth/third-stage-labour

Monitoring your baby

During labour, your midwife will listen to your baby's heartbeat to check his/her wellbeing, and to ensure he/she is coping well with labour.

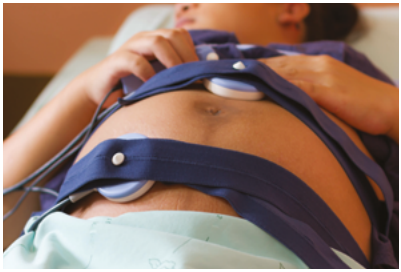
There are three different ways your midwife can check this, by using either:

- a hand-held machine
- a pinard stethoscope; or
- continuous electronic fetal monitoring.

If you've had a normal and healthy pregnancy, and your labour started naturally after 37 weeks, you will normally be offered monitoring using a small-hand held machine which produces the sound of your baby's

heartbeat. This is the same machine that your midwife/doctor used to listen to your baby's heartbeat during pregnancy.

Your midwife will listen to your baby's heartbeat intermittently and regularly throughout labour. Your midwife may choose to listen to your baby's heartbeat with a pinard stethoscope. Like a traditional stethoscope you will not be able to hear the heartbeat but the midwife will hear it clearly.



Continuous electronic fetal monitoring (sometimes called a CTG) is a machine which is used to record your baby's heartbeat and the contractions of your womb constantly throughout labour. It may be recommended that you have this type of monitoring if you've had any complications during pregnancy or labour. Midwives and/or doctors will look at this recording regularly throughout labour. You will need to wear two belts around your abdomen to keep the monitors in place. In some units a wireless machine may be available (this is known as telemetry), which means you may be able to move around more freely.

Additional monitoring may be recommended if your midwives or doctors are concerned about your baby's heartbeat during labour, this could be either a:

- fetal scalp electrode (FSE) which is attached directly to your baby's head
- fetal blood sample (FBS), this test involves checking your baby's oxygen levels by taking a small sample of blood from your baby's head.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/what-happens-during-labour-and-birth/
- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/monitoring-your-baby-labour

Positions for labour and birth

During labour, it is good to stay as active as possible, and to try different positions. By doing this you will encourage your baby through the birth canal in the best position for birth, whilst also helping your own comfort and coping ability. Staying active and upright is also known to shorten the length of labour.

You can try:

- walking
- standing with support from your birth partner
- going up and down stairs
- rocking/swaying
- using a birthing ball
- sitting upright or squatting
- all fours position (on your hands and knees) or kneeling
- lying on your side, supported by pillows (when you want to rest).

During birth, your midwife will support you to try different positions. It is important to listen to your body, and try whatever feels right for you. The positions you can adopt may depend on whether you've chosen to have a water birth, or if you have an epidural.

For more information visit:

- **Baby Centre**
  www.babycentre.co.uk/l25025610/16-birthing-positions-for-labour-images
- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/movement-and-positions-during-labour

Planned caesarean birth

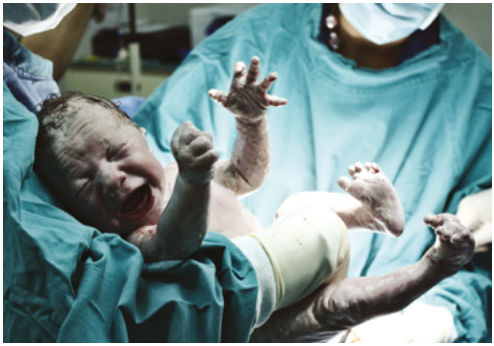
Just over one in 10 women will have a planned caesarean birth. This is due to a variety of factors, and the decision will be made together with your obstetric and midwifery team.

The day before your caesarean you will be asked to take some medications. These should be taken the night before and also on the morning of your operation, as directed. You should not eat any food after midnight but may drink water until 6am on the morning of your operation.

On the day of your caesarean you will normally arrive at your maternity unit early in the morning. Sometimes if the labour ward is busy, you may have to wait for a period of time before your operation can start. In the operating theatre, your chosen birth partner can normally accompany you and can stay by your side throughout the surgery, unless, for medical reasons, you require a general anaesthetic.

The majority of women have a spinal anaesthetic or combined spinal epidural which causes the body to go numb from the abdomen to the feet. A catheter will need to be inserted into your bladder, and this will be normally removed the following day. Once the operation starts, the baby is normally born within 10 minutes, and all being well you can have skin-to-skin contact with him/her in the operating theatre while the operation is completed.

After the surgery you will spend a few hours in a recovery area, and a nurse or midwife will check your observations regularly. You can start bonding with and feeding your baby during this time. Your anaesthetic will wear off after a few hours.



You will normally stay on a postnatal ward for one to three nights, depending on your recovery. You will be given regular painkillers. You will be helped to become mobile once the anaesthetic wears off. Early mobilisation and blood thinning injections

are recommended to reduce the risk of developing blood clots after surgery.

For information about having an emergency caesarean birth, see page 33 of this booklet.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/caesarean-section/what-happens/
- **National Childbirth Trust**
  www.nct.org.uk/birth/what-happens-during-elective-or-emergency-caesarean-section
- **RCOG: Choosing to have a caesarean**
  www.rcog.org.uk/en/patients/patient-leaflets/choosing-to-have-a-caesarean-section/

Birth with twins

During pregnancy you will have an appointment to discuss your options for the birth of your twins. More than 40 per cent of twins are born vaginally with the remainder being born by either planned or emergency caesarean.

In some cases a planned caesarean will be recommended, for example, if your babies share one placenta, or the first baby is in the breech (bottom first) position.

During labour, it is recommended that your babies have continuous electronic fetal monitoring, as the risk of complications during labour is higher for twins. It may also be recommended that you have an epidural, in case you require an emergency caesarean birth quickly. There will be more people at the birth of twins, often two midwives, two obstetricians and two neonatal doctors.

If you have triplets or more, planned caesarean birth would be recommended for you as the safest way to deliver your babies.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/giving-birth-to-twins/
- **The Multiple Birth Foundation**
  www.multiplebirths.org.uk/
- **Twin and Multiple Births Association**
  www.tamba.org.uk

Premature labour and birth

A baby that is born before 37 weeks gestation is considered to be 'premature' or 'preterm'.There are different categories of prematurity;

- extremely preterm (less than 28 weeks)
- very preterm (between 28 and 32 weeks)
- moderate to late preterm (between 32 and 37 weeks).

In the UK, roughly one in every 13 babies will be born prematurely.

Call your midwife or maternity unit if you're less than 37 weeks pregnant and you have:

- regular period type pains or contractions
- constant abdominal pain
- a "show" – the mucous plug that sits inside the cervix during pregnancy. This can be clear or blood stained
- fresh red bleeding from the vagina
- a gush or trickle of fluid from your vagina – this could be your waters breaking
- backache that's not usual for you, or pressure in the vagina or rectum.

Preterm birth carries risks because babies who are born too soon may not be fully developed, and need specialist help for life outside of the womb. Preterm babies are also at risk of longer term health problems.

Causes of preterm birth

A baby may be born prematurely as a result of preterm labour or because an earlier birth is recommended, due to complications that may have arisen during the pregnancy (affecting the mother or the baby).

In many cases, it is not clear why labour starts early, however factors known to increase the risk of preterm labour include the following:

- premature rupture of the membranes (your water's breaking early)
- some infections, such as chorioamnionitis, which effects the membranes and amniotic fluid protecting the baby
- multiple pregnancy (the average twin pregnancy is 37 weeks in length, and the average triplet pregnancy is 33 weeks in length)
- previous preterm birth
- having a placenta that is 'low-lying' (meaning it either partially or completely covers the cervix) or having a placental abruption (meaning the placenta starts to separate from the wall of the womb)
- maternal medical conditions, including diabetes or conditions linked to inflammation (eg. Crohns disease)
- being a smoker, drinking alcohol or using illegal substances
- low Body Mass Index (having a weight that is considered to be low for your height)
- biopsy's or LLETZ treatments to remove abnormal cervical cells
- having a weak cervix that might open during pregnancy
- polyhydramnios (excessive amniotic fluid)
- intra-hepatic cholestasis of pregnancy (a pregnancy condition effecting your liver)
- abnormalities of the shape of the womb.

Sometimes, you may develop a complication during your pregnancy and your healthcare professional may recommend preterm delivery. Examples of conditions that may require preterm delivery include:

- moderate to severe pre-eclampsia (a pregnancy condition causing high blood pressure which can also affect some of your internal organs)
- poorly controlled diabetes
- intrauterine growth restriction (when your baby's growth slows down or stops)
- if your waters break early and you are developing an infection
- other medical complications of pregnancy.

Women who are considered to be at risk of starting labour prematurely may be offered treatment to maintain the pregnancy for as long as safely possible.

What happens if I go into preterm labour?

Depending on how many weeks pregnant you are, you may be offered medicines to try and slow down or stop your labour, antibiotics to reduce the risk of developing an infection, and steroid injections that are given to you, to help your baby's lungs develop and prepare for life outside the womb should they be born early. If your baby is extremely preterm (less than 28 weeks) you may need to be transferred to a maternity unit with a neonatal intensive care unit. In North West London every maternity unit has a local neonatal unit/special care baby unit caring for sick or preterm babies, however not every unit has a neonatal intensive care unit.

What happens if my baby is born prematurely?

Babies born before 34 weeks are likely to need extra help with breathing, feeding and keeping warm, and would therefore be transferred to the neonatal unit for care. This care is provided by a highly skilled neonatal team. Your baby may need to be in an incubator, however once they are stable you should be able to hold them and have skin-to-skin contact.

Colostrum and breast milk are very beneficial for babies that are born early. If your baby is too small to feed you can express your breast milk and this will be given to your baby via a tube. The neonatal team will support you with expressing your milk.

Once your baby/babies can breathe on their own, feed via the breast or bottle and have gained weight, you will be able to take them home. This can often take several weeks if your baby was born extremely preterm.

You will be supported by the maternity team whilst you and your baby remain in the maternity unit. There are also many organisations that provide support to parents of preterm babies.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/premature-early-labour/
- **Bliss**
  www.bliss.org.uk
- **Tommy's**
  www.tommys.org/pregnancy-information/pregnancy-complications/premature-birth-information-and-support

Coping strategies and pain relief in labour

As labour progresses, there are plenty of options available to help you manage the sensation of the contractions as they get stronger and more intense.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/pain-relief-labour/
- **Labour Pains**
  www.labourpains.com/home
- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/pain-relief-labour-and-birth

Coping in early labour

The early labour (or latent) phase is usually spent at home, and there are plenty of things you can try to ease any discomfort you have whilst also encouraging labour to progress well.

These simple techniques can also help throughout labour:

- having a warm bath or shower
- sleeping/resting in between contractions
- eating and drinking, little and often
- staying calm and relaxed and focusing on deep, slow breathing
- distraction techniques such as cooking or watching TV
- massage from your birthing partner, particularly on the lower back and/or shoulders
- trying different positions or going for a gentle walk.

For more information visit:

- **National Childbirth Trust**
  www.nct.org.uk/birth/working-pain-labour

Self-hypnosis/deep relaxation techniques

There are certain breathing and self-hypnosis techniques which many women find beneficial when experiencing labour. The techniques must be learnt and practised, and are taught by a qualified practitioner. You can ask your midwife about this, or simply search online for local services/practitioners.

For more information visit:

- **Which Choices**
  www.which.co.uk/birth-choice/getting-ready-to-give-birth/what-is-hypnobirthing

Complementary therapies

This includes aromatherapy, acupuncture, homeopathy and reflexology. Ask your midwife what your chosen maternity unit offers or search for a local practitioner online. Certain techniques should not be used during pregnancy or birth, so always consult a qualified practitioner before trying a complementary therapy.

For more information visit:

- **Baby Centre**
  www.babycentre.co.uk/a1027876/complementary-therapies-for-labour-pain

TENS (transcutaneous electrical nerve stimulation)

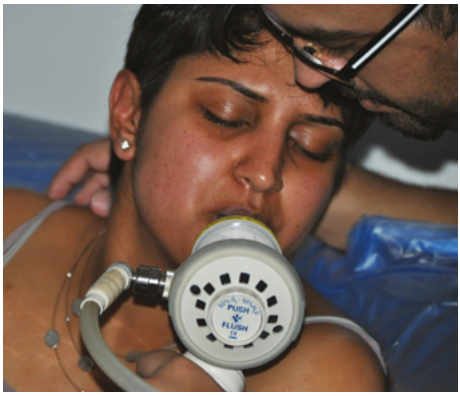
This small machine is attached to your back using sticky electrode pads, and it sends mild and painless electrical pulses through your body, disrupting the nerves that transmit pain. It may also boost your body's natural pain-killing endorphin production. TENS is most effective in early labour.

TENS machines can be hired or purchased online, or in some larger retailers. Make sure the machine you get is designed specifically for labour as there are many different types.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/pain-relief-labour/#tens-machines
- **Which choices**
  www.which.co.uk/reviews/tens-machines/article/should-i-use-a-tens-machine-during-labour

Gas and air (Entonox)



This is a mixture of oxygen and nitrous oxide gas, and is breathed in through a mouthpiece which you have control of yourself. It can be used throughout established labour and can reduce the amount of discomfort you feel from the contractions.

If you are planning a homebirth, a midwife can bring a cylinder of entonox to your home for you to use. It is available in all midwifery-led and obstetric units. Short term use in labour causes no harmful side effects and you can often stay mobile whilst using it. It can also be used in the birthing pool. Entonox can make some women feel light-headed, sleepy or nauseous – if this happens you can stop using it and the effects will subside.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/pain-relief-labour/#gas-and-air-entonox-for-labour

Water in labour and birth

Using water (either in a bath or birthing pool) is known to be an effective method of providing pain relief and aiding relaxation in labour.

If your pregnancy and labour have been straight-forward, using a birthing pool may be particularly suitable for you. The water will be kept at around body temperature and you can get in and out as you wish during labour. Many women also opt to give birth to their baby in the pool, which is a safe option if all is well with you and your baby during labour. If you are planning a homebirth, you can hire a birthing pool. Discuss this with your midwife if you want to know more about having a water birth at home or in your maternity unit.

For more information visit:

- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/where-can-i-give-birth/how-prepare-waterbirth
- **National Childbirth Trust**
  www.nct.org.uk/birth/use-water-birth-pools-labour

Opioid injections (pethidine/diamorphine/meptid)

These are strong pain-killing drugs, which are given by injection. They normally take around 20-30 minutes to take effect, and last between two to four hours. They may help you to cope with the pain and to relax, however they do have some side effects which require consideration.

Opioid injections may make you drowsy and can cause nausea and vomiting. Your midwife will normally offer an anti-sickness medication at the same time to prevent this from happening.

Opioid injections cross the placenta and can affect your baby's ability to breathe if he or she is born soon after it is given. If your midwife doesn't think the medication would have enough time to wear off before birth, it will not be recommended as a pain relief option for you. Opioid injections may also affect your baby's first feed after birth.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/pain-relief-labour/#pethidine-injections-in-labour
- **Labour pains**
  www.labourpains.com/FAQ_Pain_Relief

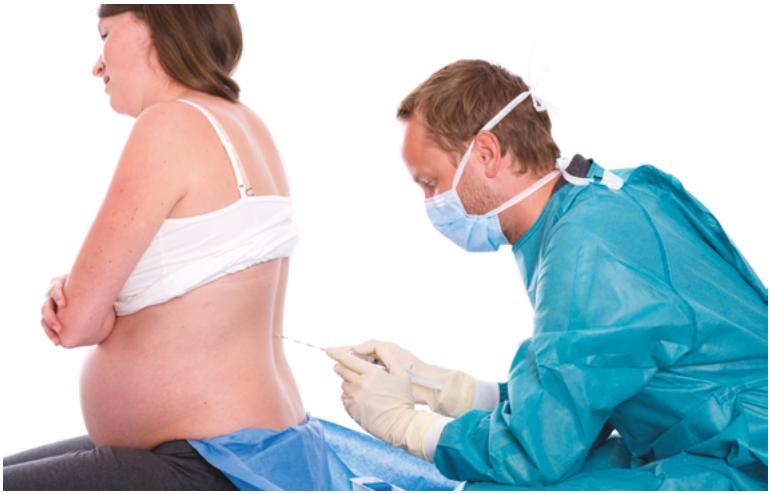
Epidural

Epidurals are the most effective pharmacological form of pain relief in labour. This method of pain relief can only be given on an obstetric unit (labour ward) by an anaesthetist.

An epidural is a special type of anaesthetic that is given as an injection into the back, numbing the nerves that carry pain impulses to the brain. Once the first dose is given it takes around 20 minutes to work, then either you or your midwife will top-up the medication as needed to maintain comfort.

An epidural usually provides effective pain relief, however some women do not always find it works fully, and it may need to be adjusted or re-sited. If you have an epidural you will also need to have a drip in your hand and continuous electronic fetal monitoring.

Some women are still able to move around after an epidural, whereas others find it more difficult due to their legs feeling heavy and unable to support their weight. If you want to walk with an epidural it is essential that a midwife first checks that your legs are strong enough, and somebody must always walk with you for support. Some women will find passing urine difficult, if this happens a catheter may be needed to empty your bladder. Depending on your stage of labour, this catheter may stay in until the day after birth.



An epidural can affect your blood pressure, so this will also need to be monitored regularly. Having an epidural can make the second stage of labour longer, and may increase the likelihood of you needing an assisted birth. It can also cause itching or shivering. Other risks of epidurals include severe headaches or rarely nerve damage.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/pain-relief-labour/#epidural
- **Labour pains**
  www.labourpains.com/FAQ_Pain_Relief

My team for labour and birth

Midwives are your main carers in labour, whether you choose to have your baby at home, in a midwifery-led birth centre or on an obstetric labour ward. Women in established labour will normally receive one-to-one care in labour from a named midwife. Your midwife will support you during labour, ensuring you and your baby are well and safe.

Obstetricians will be involved in your care if any complications or more complex needs arise during labour and/or birth. If an induction of labour is recommended for you, or if your labour and/or birth slow down it is likely that you will be seen by an obstetrician. If there are concerns with your health, the health of your baby or if an assisted or caesarean birth is recommended you will also be seen by and cared for by an obstetrician who will work in partnership with your midwife.

Maternity support workers may work under the direct supervision of your midwife to provide you with support during labour. They may also help you with feeding your baby immediately after birth.

Anaesthetist - If you have an epidural during labour, this will be put in by an anaesthetist. If you require a caesarean birth, you will also be cared for in theatre by an anaesthetist, in partnership with an obstetrician and your midwife. Anaesthetists may also become involved in your care if you have any complications or need a higher level of care due to medical conditions.

Theatre team - If you have a planned or emergency caesarean birth, there will be staff in the theatre to assist the anaesthetist, obstetrician and midwife who are caring for you. You may also be in theatre if an assisted birth is recommended, or if you have any complications after the birth that require more intensive care.

Student midwives/doctors - During labour and birth, there may be a student midwife or doctor working with your named midwife. Student midwives or doctors may provide you with care and support under direct or indirect supervision of the midwife, depending on their stage of training. Care will only be provided with your consent, and your midwife will discuss this with you.

Admin/clerical - The team of midwives and doctors in birth centres and labour wards are supported by a team of reception, clerical and administrative staff that you may meet. Please ensure you inform the clerical team if you have any changes to your contact number, address or GP to ensure that information is recorded correctly on key documentation.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/antenatal-team-midwife-obstetrician-pregnant/
- **National Childbirth Trust**
  www.nct.org.uk/pregnancy/your-care-through-pregnancy-labour-and-birth and www.nct.org.uk/pregnancy/healthcare-professionals-pregnancy-and-labour

Assisted birth

Assistance with labour and birth may be recommended either prior to your due date, for medical reasons, when you go beyond your due date and/or during labour.

For more information visit:

- **Tommy's**
  www.tommys.org/pregnancy-information/labour-birth/assisted-birth
- **Which Choices**
  www.which.co.uk/birth-choice/safety-and-interventions/inductions-and-interventions-in-labour

When pregnancy goes beyond your due date

If you have had a healthy pregnancy without complication and haven't gone into labour by 41 weeks you will have a routine appointment with your midwife to discuss the next steps.

You will be offered a membrane sweep at this appointment, which is an internal examination of the cervix. During this examination your midwife will insert the tip of her finger into your cervix and sweep around the bag of membranes that cover your baby's head. This has been shown to release hormones that may encourage labour to start within 24 hours. Sometimes the cervix isn't yet open, and a sweep isn't possible. You may be invited to return for several sweeps. At this appointment your midwife will also offer you a date to have your labour induced. This is normally recommended by 41 weeks and three, four or five days (depending on your maternity units guidelines and availability). Some maternity units are able to offer complementary therapy to encourage labour to start naturally. Ask your midwife about this.

For more information visit:

- **Tommy's**
  www.nhs.uk/conditions/pregnancy-and-baby/over-40-weeks-pregnant-overdue

Induction of labour

These interventions will always be discussed with you, to ensure you fully understand the risks and benefits, and your consent will be gained prior to anything happening.

How is labour induced?

Around 30 per cent of women are recommended an induction of labour for varying reasons. Your midwife or obstetrician will have a full discussion with you in the antenatal period routinely at your 36 or 40 week appointment regarding induction of labour and the benefits and risks of this, enabling you to make a fully informed decision. Methods used to induce labour vary depending on a range of factors. Your doctor and midwife will discuss the different methods with you and advise a method based on your personal circumstance.

When you come into the maternity unit for your induction, a midwife will undertake a full assessment of you and your baby and this will include electronic fetal monitoring (CTG) of your baby's heartbeat and to see if you are having any contractions. Then the midwife or doctor will assess your cervix by undertaking a vaginal examination. Following this examination options for induction will be discussed with you.

Some women may need only one of the steps below and others will need all three to get them to established labour (four centimetres dilated with strong, regular contractions):

Step 1

Prostaglandin

Many women find that their cervix is not quite 'ready' for labour yet, and in this case your midwife will insert a gel or pessary containing a hormone known as prostaglandin during vaginal examination. The gel works over six hours, and you will be asked to stay in the maternity unit for this time. The pessary is released slowly over twenty four hours, and if you and your baby are responding well you may be able to go home during this time. Some women find that the gel or pessary is enough to start contractions and labour. Other women may not experience any changes. After the medication has had time to work, a midwife will assess the cervix again and see if it is possible to break the waters. Some women may be offered further doses of prostaglandins.

Balloon catheter

If the prostaglandin pessary does not work or is not suitable for your circumstance, you may be offered a balloon catheter. This is a small balloon which is inserted in the cervix, putting pressure on it, causing your body to release its own natural labour hormones that may cause mild cramps and dilatation of the cervix. The balloon catheter works over 12-24 hours to stretch and soften the cervix in preparation for labour.

Step 2

Amniotomy

Some women (particularly those who have had a baby before) may be told that their cervix is thin and starting to open. In this case it will be recommended that your waters are broken artificially, this is called amniotomy. A midwife will insert a small sterile hook into the vagina to make a hole in the bag of waters that surrounds your baby. After the waters are broken, labour may start on its own. Amniotic fluid may continue to drain from the vagina for the duration of your labour.

Step 3

Oxytocin drip

For those women whose contractions do not start after the waters are broken, a hormone called oxytocin will be recommended. Oxytocin is diluted and given in small amounts directly into a vein through a cannula inserted into your hand or arm. The oxytocin drip causes your womb to have contractions. The drip is usually given continuously until your baby is born. A midwife will be caring for you and monitoring you and your baby closely for the duration of labour.

Frequently asked questions

How long can induction take?

Induction can take anything from a few hours to a few days. Bring plenty of things to distract you, as there can be a lot of waiting whilst the medications start to work.

What if the induction does not work?

If the induction is unsuccessful your midwife and doctor will discuss your options with you. These options may include waiting, trying something else or a caesarean birth.

Is induction painful?

Vaginal examinations may be uncomfortable but should not be painful. It is felt that induced labour (particularly with an oxytocin drip) can be more uncomfortable than natural labour. You can discuss your options for pain relief with your midwife at every stage of the induction process.

Do I have to have an induction?

Your midwife/doctor will explain why induction has been recommended for you/your baby, including the risks and benefits of having it at the time advised, versus waiting. If you choose not to have the induction, or to postpone it, you may be offered additional monitoring to observe you and your baby's wellbeing.

Interventions in labour

Breaking your waters (amniotomy)

Before, or during labour your waters will normally break at some point (although sometimes they don't – and some babies are born in their amniotic sac). If your labour seems to have slowed down or there are concerns about your baby's wellbeing, your midwife might recommend breaking your waters. This is done during a routine vaginal examination, it does not hurt your baby, and has been shown to sometimes reduce the length of labour.

Oxytocin (known as synto or syntocinon)

Oxytocin is the naturally occurring hormone that causes your womb to have contractions. If your contractions slow down, or aren't effective in causing the cervix to dilate, it may be recommended that you have a synthetic oxytocin drip which is given in small amounts directly into a vein via a cannula. It makes contractions stronger and more regular. If you have an oxytocin drip, close monitoring of you and your baby (using continuous electronic fetal monitoring) is recommended.

Episiotomy

An episiotomy is a cut that is made (with your consent) to the perineum (the area between your vagina and your rectum) to assist in the birth of your baby. Your midwife or doctor may recommend this if your baby's heartbeat suggests that he or she needs to be born as quickly as possible, if you are having an assisted birth, or if there is a high risk of a serious tear affecting your rectum. An episiotomy is repaired using dissolvable stitches and normally heals within a month of birth.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/episiotomy/

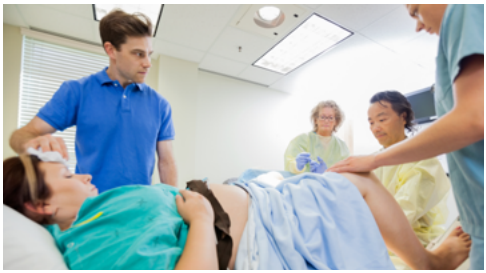
Ventouse/Forceps

In some cases your doctor may recommend assisting the birth of your baby by using either a ventouse or forceps.

This may occur where the second stage of labour (the pushing stage) is longer than expected, where your baby's head isn't in the best position to come through the birth canal or if there are changes to his/her heartbeat meaning that birth needs to be as soon as possible.

A ventouse is a metal or plastic suction cup that is placed on your baby's head. Forceps are curved metal tongs that are placed around your baby's head.

You will be offered pain relief for an assisted birth, with either local anaesthetic or an epidural. The delivery will be managed by an obstetric doctor, your midwife will be present to help and support you.



Your doctor will gently pull using the ventouse or forceps whilst you push during your contractions. Sometimes several pulls are needed, or if one method doesn't work, the other may be tried. You are more likely to need an episiotomy, particularly if forceps are used.

In rare circumstances, if neither ventouse or forceps successfully deliver your baby, a caesarean birth might be recommended.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/ventouse-forceps-delivery/
- **RCOG: Assisted birth**
  www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps/

Emergency caesarean birth

Around 15 per cent of babies are born by emergency caesarean section, either during pregnancy or labour. The most common reason for this is a concern with the health of the baby, meaning that to continue in labour is not thought to be the safest option.

Most women will have an epidural or spinal anaesthetic to ensure they do not feel the operation, however in some cases where the pain relief isn't adequate, or there isn't enough time to put the spinal in, a general anaesthetic might be advised.

There are some associated risks with caesarean section delivery, for both you and your baby and your team will discuss these risks with you prior to the surgery.

Recovery from emergency caesarean is the same as recovery from a planned caesarean.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/caesarean-section/#what-happens-during-a-caesarean
- **National Childbirth Trust**
  www.nct.org.uk/birth/what-happens-during-elective-or-emergency-caesarean-section

Immediately after birth

Meeting your baby for the first time

Meeting your baby for the first time can cause many different emotions in new parents. After months of build up to the birth, you may feel elation and an instant rush of love but don't be concerned if you initially feel dazed and disconnected, or have concerns over whether the baby is alright. Making an emotional connection with your baby can take time. It is important to remember that there is no right or wrong way to feel about your newborn and that for some parents it can take quite a while to adjust to the fact that labour is over and their new baby has arrived.

For more information visit:

- **UNICEF**
  www.unicef.org.uk/babyfriendly/baby-friendly-resources/video/meeting-baby-for-the-first-time/

What happens straight after birth

Skin-to-skin contact

After your baby is born, so long as he/she is well, you will be encouraged to have immediate skin-to-skin contact. This type of contact is known to be beneficial to both mother and baby by:

- regulating your baby's breathing, heart rate, temperature and blood glucose levels
- soothing and calming your baby
- encouraging early breastfeeding and increased milk production
- supporting longer term breastfeeding success.

Even if your baby needs help with breathing after birth, or to be seen by a neonatal doctor, you will be offered skin-to-skin contact as soon as practically possible.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/breastfeeding-first-days/#skin-to-skin-contact
- **La Leche League GB**
  www.laleche.org.uk/whats-big-deal-skin-skin/

You: straight after birth

After your placenta has been delivered, your midwife or doctor will ask to check and see if you have any tears to the perineum and/or vagina that might require stitches. If you do need stitches, your midwife or doctor will explain this to you.

Before stitching your midwife or doctor will ensure the area is numbed with local anaesthetic, or if you have an epidural already, this will be topped up. Most tears will be repaired in your birthing room, more significant tears require repair in an operating theatre. Tears are repaired using dissolvable stitches and normally heal within a month of birth.

All women will lose some blood after giving birth, this happens because the area of the womb where the placenta was attached takes time to heal. Bleeding may be heavy immediately after the birth, but will reduce significantly over the next few days and weeks. Bleeding will normally last between two and six weeks. Your midwife will check on your bleeding regularly straight after birth.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/you-after-birth/
- **RCOG: Third and fourth degree tears**
  www.rcog.org.uk/en/patients/patient-leaflets/third--or-fourth-degree-tear-during-childbirth/
- **National Childbirth Trust**
  www.nct.org.uk/birth/after-your-baby-born

Your baby: straight after birth

During skin-to-skin contact with your baby, he or she may show early feeding cues. Your midwife will support you in feeding your baby shortly after birth. Some babies want to feed very soon after birth, whereas others take several hours to show signs that they are ready to feed.

Your baby's weight will be checked, and a midwife or neonatal doctor will check him/her from top-to-toe to exclude any major abnormalities. Your baby will be offered a supplement of Vitamin K.

In some rare cases, your baby may need to be transferred to the neonatal unit for a period of time for specialised treatment. This is more common with babies born prematurely, very small, with an infection or through a particularly complicated birth. If this happens to you, you will have plenty of support and help from your maternity team.

For more information visit:

- **NHS Choices**
  www.nhs.uk/conditions/pregnancy-and-baby/your-baby-after-birth/

Vitamin K for newborn babies

Soon after birth, your midwife will offer to give your baby vitamin K by either injection (once only) or oral drops (which are given in three doses). This is to prevent a rare but serious blood disorder, and can be given by injection or oral drops. If you opt for oral drops your baby will need to receive further doses.

For more information visit:

- **National Childbirth Trust**
  www.nct.org.uk/parenting/vitamin-k

Identification for your newborn baby

After the birth, the midwife will prepare two infant identity bands. Each band will include the mum's surname and the hospital number. Details will be checked with the mum and/or partner against the mum's printed patient identity band before placing it on the baby. A unique NHS number and hospital number will be generated for your baby shortly after birth. The NHS number will remain with your baby throughout its life.

For more information visit:

- **NHS England**
  www.nhs.uk/NHSEngland/thenhs/records/nhs-number/Pages/what-is-the-nhs-number.aspx

Personal care plans

During pregnancy, we encourage every woman to complete their own personal care plans in partnership with their midwives and/or doctors.

Completing these plans will support you in your preferences for pregnancy, birth and parenthood. Plans are available for:

- **Health and wellbeing in pregnancy** complete at the beginning of (or anytime during) your pregnancy
- **Personalised birth preferences** complete at/from 32-34 weeks of pregnancy
- **After your baby is born** complete from 34 weeks of pregnancy
- **Birth reflections** complete after your baby's birth

Your plans can be hand written in the **Personal care plans** booklet or completed on the North West London **mum & baby app** (then printed if you wish).

In the app you will find a wide selection of useful and important information about pregnancy, birth and what happens after your baby is born. You can download the free app to your smartphone or tablet via the App Store or Google Play.

You can also access the information contained within the app in booklet format from your local maternity unit or online. There are booklets available on **Your pregnancy, Personal care plans** and **After your baby's birth**. Ask your midwife about getting this information if you're not sure.

You can visit:

- www.bit.ly/NWLmaternityinformation for your electronic copies of these booklets

Maternity Voices

Ask your midwife about your local Maternity Voices Partnership group. These groups consist of mums-to-be, new mums, midwives, doctors and other allied health professionals who meet to discuss, learn and help share ideas for improved services across North West London.

Find your local group at :

- www.nationalmaternityvoices.org.uk/toolkit-for-mvps/find-an-mvp/

Would you like to talk to someone about the birth?

Some women may find it helpful to talk to someone about their birth options. This is especially true if they have had a pregnancy, labour or birth that was difficult previously, or if something unexpected happened.

It is not unusual to be unsure about your options or what effect any choices may have on this pregnancy and birth. You can speak to your midwife, and if needs be she will refer you to a 'birth options' clinic, which is normally run by the consultant midwife at your chosen maternity unit.

If you are considering requesting a planned caesarean section birth, this decision would be made with you and the specialist midwifery and obstetric teams. Ask your midwife to refer you to the appropriate clinic, where you will be able to discuss your options.

Comments and complaints

During your antenatal care, if you have a comment or complaint you can speak to any member of the maternity team and they will be able to put you in touch with the relevant manager.

Whilst you are in hospital, if you have a comment or complaint, please ask your care provider if you can speak to the ward manager or midwife in charge.

You can also ask your midwife for your local PALS (Patient Advice and Liaison Service) contact details.

Contacts

After 18-20 weeks gestation:	
• any non-pregnancy related concerns, such as skin concerns or a persistent cough • pain or burning on passing urine • flare ups of any pre-existing conditions • unusual vaginal discharge or discomfort • diarrhoea and/or vomiting for over 48 hours.	**Call your GP OR local Urgent Care Centre if out of hours**
• vaginal bleeding • a reduction or change in your baby's movements • high fever (temperature over 37.5°c) • water leaking from the vagina • itching on the hands or feet • diarrhoea and/or vomiting combined with high fever, stomach pain, very dark urine or blood in the stools • headache accompanied by bad swelling in the hands, feet or face and/or problems with vision • moderate/severe abdominal pain that is either constant or comes and goes.	**Call your maternity triage/assessment unit at your booked maternity hospital**

After 37 weeks gestation/when expecting labour:	
• heavy vaginal bleeding (that isn't the mucous show) • a reduction or change in your baby's movements • contractions that are becoming strong and regular in pattern • water leaking form the vagina, water's 'breaking' • moderate/severe constant abdominal pain • feeling unwell or worried something is wrong • ANY of the symptoms in the previous table.	**Call your maternity triage/assessment unit OR** **birth centre/ planned place of birth at your booked maternity hospital**

It is not advised that you call 999 or 111 for advice, or for an ambulance. Please call your local maternity triage/birth centre directly for advice. If they feel it is necessary, they will recommend that you call an ambulance (999). We do not recommend using the NHS 111 service for pregnancy-related advice.

Ambulances are for medical and life-threatening emergencies only, and should not be used as a mode of transport to hospital in labour without the advice of a medical professional.

Useful contact numbers

Chelsea & Westminster Hospital

General enquiries/switchboard	0203 315 6000
Early pregnancy unit	0203 315 5073
Antenatal clinic	0203 315 6000 option 3/4
Maternity triage	0203 315 6000 option 1
Day assessment unit	0203 315 5850
Antenatal ward	0203 315 7801
Community midwives	0203 315 5371
Labour ward	0203 315 6000 option 1
Birth centre	0203 315 6000 option 2

Hillingdon Hospital

General enquiries/switchboard	01895 238 282
Early pregnancy unit	01895 279 440
Antenatal clinic	01895 279 442
Maternity triage	01895 279 054/441
Day assessment unit	01895 279 746
Antenatal ward	01895 279 462
Community midwives	01895 279 441/472
Labour ward	01895 279 054/441
Birth centre	01895 279 880

Northwick Park Hospital

General enquiries/switchboard	0208 864 3232
Early pregnancy unit	0208 869 2058
Antenatal clinic	0208 869 2870/5478
Maternity triage	0208 869 2890
Day assessment unit	0208 869 5103
Antenatal ward	0208 869 2910
Community midwives	0208 869 2871
Labour ward	0208 869 2890
Birth centre	0208 869 2930

Queen Charlotte's & Chelsea Hospital

General enquiries/switchboard	0203 313 0000
Early pregnancy unit	0203 313 5131
Antenatal clinic	0203 313 5220
Maternity triage	0203 313 4240
Day assessment unit	0203 313 3349
Antenatal ward	0203 313 5195
Community midwives	0203 313 5184
Labour ward	0203 313 5167
Birth centre	0203 313 1140

St Mary's Hospital

General enquiries/switchboard	0203 312 6666
Early pregnancy unit	0203 312 2185
Antenatal clinic	0203 312 1244 option 2
Maternity triage	0203 312 5814
Day assessment unit	0203 312 7707
Antenatal ward	0203 312 1141
Community midwives	0203 312 1158
Labour ward	0203 312 1722
Birth centre	0203 312 2260

West Middlesex University Hospital

General enquiries/switchboard	0208 560 2121
Early pregnancy unit	0208 321 6070
Antenatal clinic	0208 321 5007
Maternity triage	0208 321 5839
Day assessment unit	0208 321 5953
Antenatal ward	0208 321 5950
Community midwives	0208 321 2581
Labour ward	0208 321 5946/5947
Birth centre	0208 321 5182

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Download the North West London **mum & baby app** for free from the App Store or Google Play.

This booklet was developed by the NHS in North West London as part of the maternity early adopters project.

NHS
Imperial College Healthcare
NHS Trust

NHS
The Hillingdon Hospitals
NHS Foundation Trust

NHS
North West London
Collaboration of Clinical Commissioning Groups

NHS
London North West University Healthcare
NHS Trust

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

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