Aneurin Bevan University Health Board

Outpatient Induction of Labour Guideline

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Division/Department	Maternity/ Families and Therapies
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3	8th February 2026	Emma Mills/ Mary Bilcliffe/ Hannah McLoughlin
2	8th January 2025	Emma Mills
1	10th October 2018	Emma Mills

Policy on a Page: Key Messages

Aim:

To provide support for clinical decision making in the context of outpatient induction of labour.

Summary of key changes (for revised documents only)

- Updated to include utilization of cervical ripening balloon catheter (CRB).
- Updated to align with updated Induction of Labour Guideline (ABUHB, 2025).

Key Requirements:

Eligibility

- Low-risk pregnancy, 40+12, All Wales midwifery-led criteria.
- Lives within 60 minutes, has transport + phone.
- Bishop's score <7 and reassuring fetal monitoring.
- Some single Pathway B conditions allowed.

Information Needed

- Why induction is offered, risks/benefits, process, alternatives, when to seek help.

Target Audience:

Obstetric, Maternity and Anaesthetic teams working in ABUHB.

Training:

Training needs will be identified through appraisal and clinical/ educational supervision.

Contents

1. Introduction/Overview

This document is a clinical guideline designed to support safe, effective practice and multidisciplinary team working.

This document uses the term woman, but recognises that not all people having babies within Aneurin Bevan University Health Board identify as women, and therefore applies to all people who are pregnant.

2. Scope

This guideline applies to all clinicians working within maternity services.

3. Statement/Background

In the United Kingdom (UK), 34% of births were induced in 2022 (NMPA Project Team, 2022), seeing a significant rise over a 10-year trajectory. There are many obstetric indicators for induction of labour; however, this guideline centres on women who meet the criteria for midwifery led care at birth in accordance with the All Wales Midwifery-Led Care Guideline (Wales Maternity and Neonatal Network, 2022).

In Aneurin Bevan University Health Board (ABUHB), women are offered induction of labour at 40 weeks and 12 days onwards when they meet the above criteria for midwifery led care. Women in this situation have received midwifery led care up to this point and are at low risk of pregnancy and intrapartum complications. Outpatient induction of labour for low-risk women experiencing a post-dates pregnancy has several benefits:

- Increase in maternal satisfaction,
- Reduction in length of antenatal stay in hospital,
- Reduced bed occupancy in the maternity unit,
- The potential for a reduction in financial costs to the service.

Studies of outpatient induction of labour are still limited; however, many hospitals have implemented the procedure. A small number of audits

conducted by London hospitals have concluded that the practice is safe and effective when compared to induction of labour in an inpatient setting with no significant difference in fetal or maternal outcomes. One London audit shows a small decrease in emergency caesarean section rates for the outpatient group and concluded that the only adverse outcome in this group was a higher rate of hyperstimulation (London Strategic Clinical Networks, 2015).

Within ABUHB maternity services, out-patient induction of labour has been offered to women who meet the criteria since 2018. Although the numbers of women opting into this service have been relatively low, there has been positive qualitative feedback in terms of women's satisfaction.

4. Aim

To provide support for clinical decision making in the context of outpatient induction of labour.

5. Main Body

Criteria for Outpatient Induction of Labour

The following criterion has been reviewed in line with the All-Wales Midwifery-Led Care Guideline (Wales Maternity and Neonatal Network, 2022);

- Uncomplicated pregnancy requiring induction for prevention of prolonged pregnancy (40 weeks and 12 days onwards).
- Women who meet the criteria for midwifery led care in pregnancy as per *Appendix 2: All Wales Place of Birth Assessment Criteria* (**Pathway C**) of the All-Wales Midwifery-Led Care Guideline (Wales Maternity and Neonatal Network, 2022).
- Women who have transport available and live within 60-minutes of the Grange University Hospital (GUH).

- Women who have discussed out-patient induction of labour with a midwife or doctor, and who have read the out-patient induction of labour patient information sheet.
- Women who have access to a telephone.
- Women who have a Bishop's score of less than 7 on vaginal examination.
- The presence of reassuring pre and post prostaglandin fetal heart rate monitoring.

In addition, women who meet the **Pathway B** criteria of the All-Wales Midwifery-Led Care Guideline (Appendix 2: All Wales Place of Birth Assessment Criteria) (Wales Maternity and Neonatal Network, 2022) in the following singular circumstances may be offered outpatient induction of labour;

- Women who have well controlled asthma.
- Women who have previously had a baby considered small for gestational age (SGA), but have had normal and reassuring growth scans in the current pregnancy by 36 weeks' gestation (in line with Gap and Grow parameters).
- Women who have previously had a baby considered large for gestational age (LGA) but have had normal and reassuring growth scans in the current pregnancy, and a normal glucose tolerance test (GTT).
- Women who have had a previous 3rd/ 4th degree tear with no ongoing issues.
- Multi-parous women with a body mass index (BMI) between 35- 39.9, who have had a previous unassisted vaginal birth, a normal GTT and normal and reassuring growth scans in the current pregnancy.

However, all other women in **Pathway B** and those in **Pathway A** (Appendix 2: All Wales Place of Birth Assessment Criteria) (Wales Maternity

and Neonatal Network, 2022) are not suitable for an offer of an outpatient induction of labour. Equally, if a woman has more than 1 indicator on Pathway B, they are not considered suitable for an offer of outpatient induction of labour.

Information for Women

Information provided to women and their families should be clear and concise, delivered verbally at the point of counselling and decision making and supported by the *Outpatient Induction of Labour* patient information leaflet. A discussion should be documented in the records and include:

- The reasons for induction being offered.
- The options in relation to when, where and how induction could be carried out.
- The risks and benefits of outpatient induction of labour.
- The process of induction of labour.
- Arrangements for accessing support and monitoring of maternal and fetal well-being.
- Alternative options should the woman chose not to have induction of labour.
- What options are available to the woman if induction of labour is not successful.

Recommended Methods for Outpatient Induction of Labour

Cervical Ripening Balloon Catheter

One cycle of the Cervical Ripening Balloon Catheter (CRB). This needs to be removed between 12- 24-hours in line with the *Induction of Labour Guideline* (Aneurin Bevan University Health Board, 2025).

Propess

One cycle of vaginal PGE2 controlled release pessary (Propess). One dose over 24-hours in line with the *Induction of Labour Guideline* (Aneurin Bevan University Health Board, 2025).

Process for Outpatient Induction of Labour

- IOL booked as outpatient in Day Assessment Unit (DAU) at 40 weeks and 12 days following discussion of all available options and verbal consent confirmed. The ABUHB Outpatient Induction of Labour pictogram and/ or patient information leaflet should be given/ shared/ signposted via BadgerNotes.
- On the day of IOL, confirm gestation, indication for IOL and plan of care with the woman.
- A full antenatal assessment should be carried out, including electronic fetal heart monitoring and vaginal examination to assess the cervix. The CTG should be performed for 30-minutes or until fetal wellbeing is confirmed using Dawes-Redman analysis if there is no uterine activity. If uterine activity is present, use the CTG without Dawes-Redman analysis. This should take place regardless of induction method.
- If the Bishop's score is less than 7, Propess 10 mg or a CRB should be administered per vagina. Please refer to induction methods as per Table 1 below.
- Repeat electronic fetal heart monitoring should be performed for 30-minutes or until fetal wellbeing is confirmed using Dawes-Redman analysis if there is no uterine activity. If uterine activity is present, use the CTG without Dawes-Redman analysis. Discontinuation of the CTG should only take place in the absence of any non-reassuring features.

- Clear information should be given to the woman both verbally and in writing in the form of the aforementioned patient information leaflet. This conversation should include;
    - What to expect following the procedure,
    - What time to return for assessment,
    - The 24-hour contact telephone number for the Maternity Triage Unit/ Alongside Birth Centre,
    - And circumstances which would warrant contacting the obstetric unit prior to the planned assessment.
- The woman should be asked to return to the Day Assessment Unit/ Maternity Triage (**please note regional variations in DAU opening hours*) for repeat fetal heart monitoring approximately 12-hours following insertion of the Propess or CRB, unless uterine contractions commence earlier or the woman's membranes rupture spontaneously, in which case the woman should contact Maternity Triage/ the Alongside Birth Centre for advice.
- Women having a pharmaceutical out-patient induction of labour (Propess) should be advised to birth on the obstetric unit at the Grange University hospital.
- Women having a mechanical method of out-patient induction (CRB) may be suitable to birth on the midwifery led pathway if they labour following the induction process with **no** prostaglandin use.
- The woman should be given a time to return to the Induction Ward (B3) 24-hours following the insertion of the Propess pessary and 12-24 hours following the insertion of a CRB, at which point the pessary/ CRB will be removed and a plan will be made for continuation of the induction of labour as an inpatient

Table 1 Induction Methods

Method	Cautions	Contraindications	Side Effects	Administration	Post administration	Removal
Dinoprostone (PROPESS®)	Effect of oxytocin enhanced. History of asthma, epilepsy, glaucoma / raised intra-ocular pressure, hypertension, risk factors for	Active cardiac disease. Active pulmonary disease. Abnormal CTG, suspected chronic hypoxia. Fetal malpresentation.	Uterine tachysystole/ hyperstimulation, nausea, vomiting, diarrhoea.	Inserted into the posterior fornix of the vagina.	CTG performed for 30-minutes or until fetal wellbeing is confirmed using Dawes-Redman analysis if there is no uterine activity. If uterine activity is present, use the CTG without Dawes-Redman analysis. The woman should be advised to inform the midwife if she has any of the following: • Contractions. • Vaginal bleeding.	Remove after 24-hours unless otherwise indicated.

	dissemin ated intravasc ular coagulati on, uterine rupture and uterine scarring.	Grand multiparas. Placenta praevia or unexplained vaginal bleeding during pregnancy.			• Reduced fetal movements. • If it falls out or drops in vagina. • If membranes rupture. • If there are any other concerns. Woman should have repeat CTG's every-12 hours. Maternal observations should be performed at every presentation.	
Intracer vical Balloon Catheter	Not to be used with SROM/PR OM due	Patient receiving prostaglandi ns.	Maternal discomfort during/	Insert speculum to visualise cervix and clean.	CTG performed for 30-minutes or until fetal wellbeing is confirmed using Dawes-Redman	Recommend ed for removal between 12-

/ Cervical Ripening Balloon (CRB)	to risk of cord entanglement with uterine balloon. Not to be used with prostaglandins.	SROM/ PROM. Abnormal CTG, suspected chronic hypoxia. Fetal malpresentation. Grand multiparas. Placenta praevia or unexplained	post application Device expulsion Spotting caused by cervical irritation	Advance the catheter with stylet into the cervical opening. Once the uterine balloon has entered the cervix remove the stylet before advancing further. Advance CRB until both balloons are through the cervical canal. Inflate the uterine balloon with 40 mls of sterile saline using a standard 20 ml luer-lock syringe through	analysis if there is no uterine activity. If uterine activity is present, use the CTG without Dawes-Redman analysis. The woman should be advised to inform the midwife if she has any of the following: • Contractions. • Vaginal bleeding. • Reduced fetal movements. • If it falls out or drops in vagina. • If membranes rupture.	24-hours. Must be removed at 24-hours. If the CRB has not self-expelled, deflate balloons through the corresponding valves marked **"V"** and **"U"** in 20ml increments. Remove device in

		vaginal bleeding during pregnancy. Previous classical uterine incision or major uterine scar (Not inclusive of previous transverse CS). Active genital herpes.		the **red** Check-Flo valve marked **"U".** Once inflated, gently pull the device back until the uterine balloon sits against the internal os. The vaginal balloon, now visible, should be inflated with 20 mls of sterile saline through the **green** Check-Flo valve marked **"V".** Once the balloons are fixed in place remove speculum.	• If there are any other concerns. All women should have repeat CTG's every 12-hours, unless otherwise indicated. Maternal observations should be performed at every presentation.	case of SROM to facilitate active labour management.

		Any contraindications to labour induction. Presenting part above pelvic inlet. Polyhydramnios.		Add more fluid to each balloon in turn, in 20ml increments up to a maximum of 80 mls per balloon. See reference images below. **DO NOT OVERINFLATE BALLOONS.**		

6. Roles and Responsibilities

Obstetric, Maternity and Anaesthetic teams have roles and/ or responsibilities in ensuring this policy is applied within clinical practice for the purpose of safe and effective care.

7. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics, midwifery and fetal surveillance have been consulted with in the development of this policy.

8. Equality Impact Assessment

An Equality Impact Assessment was completed for the purpose of this policy update. The overall negative impact assessment risk score was noted as low.

9. Training Requirements

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

10. Audit and Review

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

Induction of labour rates and maternal/ neonatal outcomes will be monitored via the local maternity dashboard. Adverse maternal/ neonatal

outcomes will be reviewed on an individual basis via local governance arrangements. Patient experience will be gauged through CIVICA and Putting Things Right procedures.

11. References

Aneurin Bevan University Health Board (2025). *Induction of Labour (IOL) Guideline.* Available at: https://wisdom.nhs.wales/health-board-guidelines/aneurin-bevan-file/induction-of-labour-iol-guideline/ (Accessed: 26 February 2026).

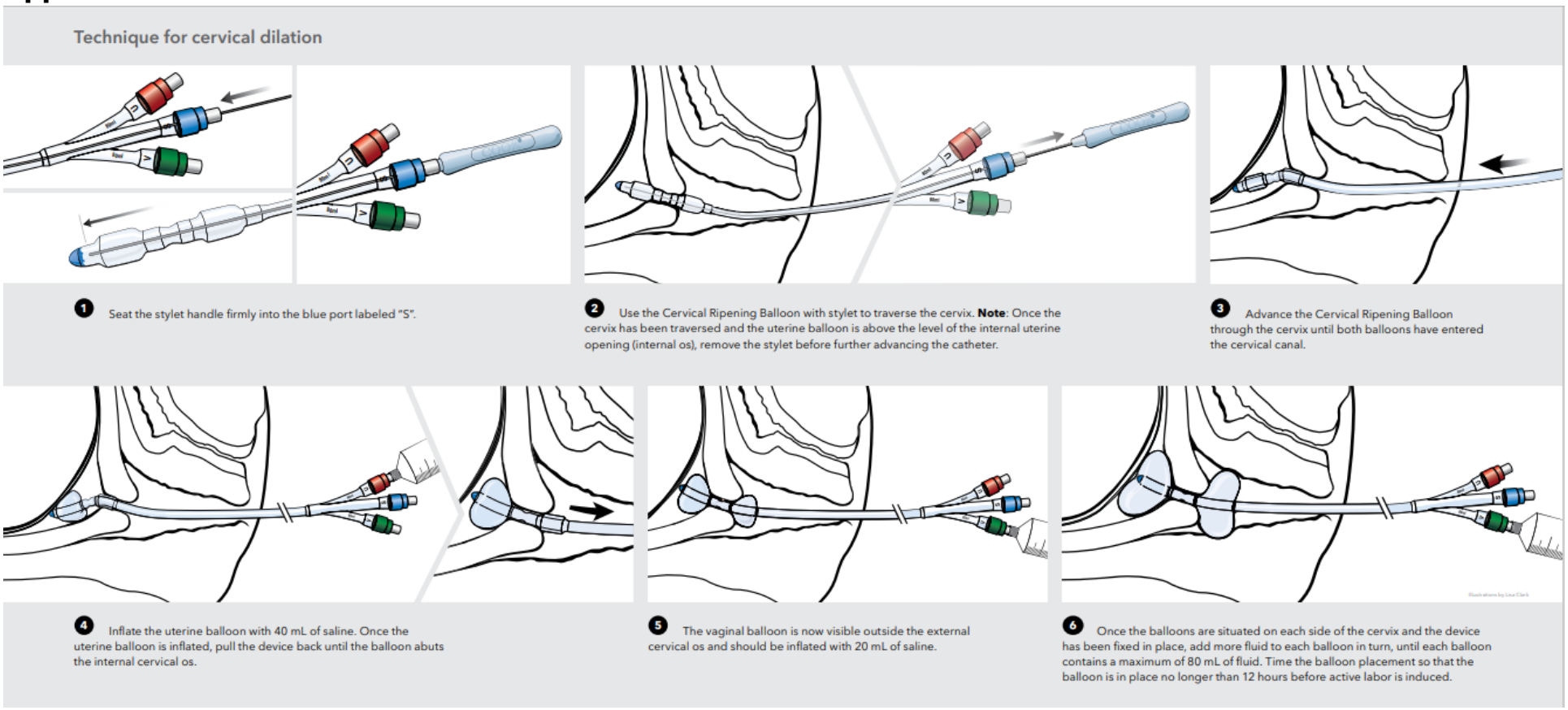
London Strategic Clinical Networks (2015) *Outpatient induction of labour in low risk women: A best practice toolkit*. Available at: https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/11/Outpatient-induction-of-labour-in-low-risk-women_A-best-practice-toolkit.pdf (Accessed: 26 February 2026).

NMPA Project Team. National Maternity and Perinatal Audit: Clinical Report 2022. Based on births in NHS maternity services in England and Wales between 1 April 2018 and 31 March 2019. London: RCOG; 2022.

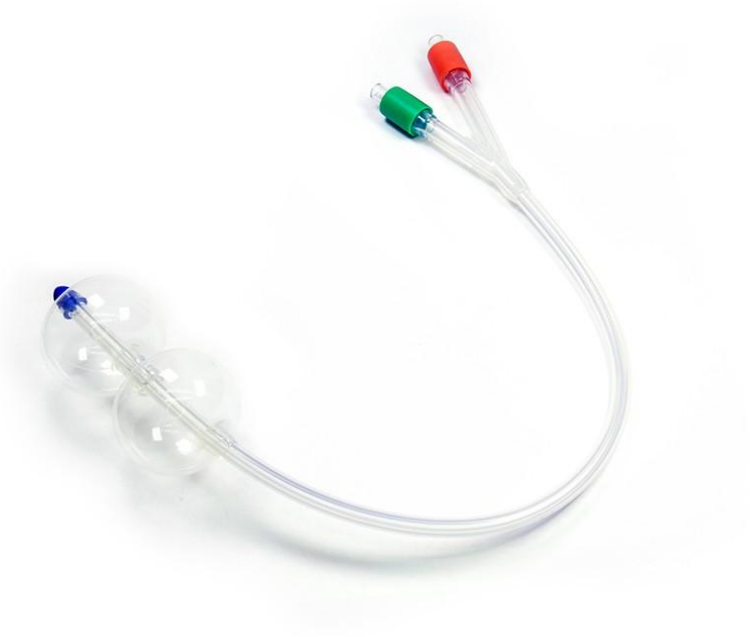
Wales Maternity and Neonatal Network (2022) *All Wales Midwifery-Led Care Guideline (6th Edition)*. Published October 2022. Available at: https://wisdom.nhs.wales/all-wales-guidelines/all-wales-guidelines/all-wales-midwifery-led-care-guideline-2022/ (Accessed: 26 February 2026).

12. Appendices

Appendix 1: Cooks Balloon Catheter



Appendix 2: Kimal Balloon Catheter



For further information, please access the following hyperlink which provides application guidance;

Induction With Balloon | How To Use Cervical Ripening Balloon | SCW Medicath