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Royal Cornwall Hospitals NHS Trust

Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline

V3.0

July 2023

Summary

Delay in the 1st Stage

A diagnosis of delay in the established first stage of labour needs to take into consideration all aspects of progress in labour and should include

- Cervical dilation of <2cm in 4 hours (first labours)
- Cervical dilation <2cm in 4 hours or a slowing of labour for second or subsequent pregnancies
- Decent and rotation of the head
- Changes in strength, duration and frequency of uterine contractions

If delay is suspected

- Consider the full clinical picture (NEW)
- Consider ARM if intact membranes
- Inform delivery suite co-ordinator that you have undertaken an ARM for suspected delay (regardless of birth setting)- NEW
- Plan for a 2 hour review

ARM

If ARM is declined or membranes are already ruptured, escalation to an obstetrician should be undertaken who should review the patient and make an informed individualised plan of care (NEW)

Primiparous

If delay is confirmed, escalate to obstetrician and the use of oxytocin should be considered

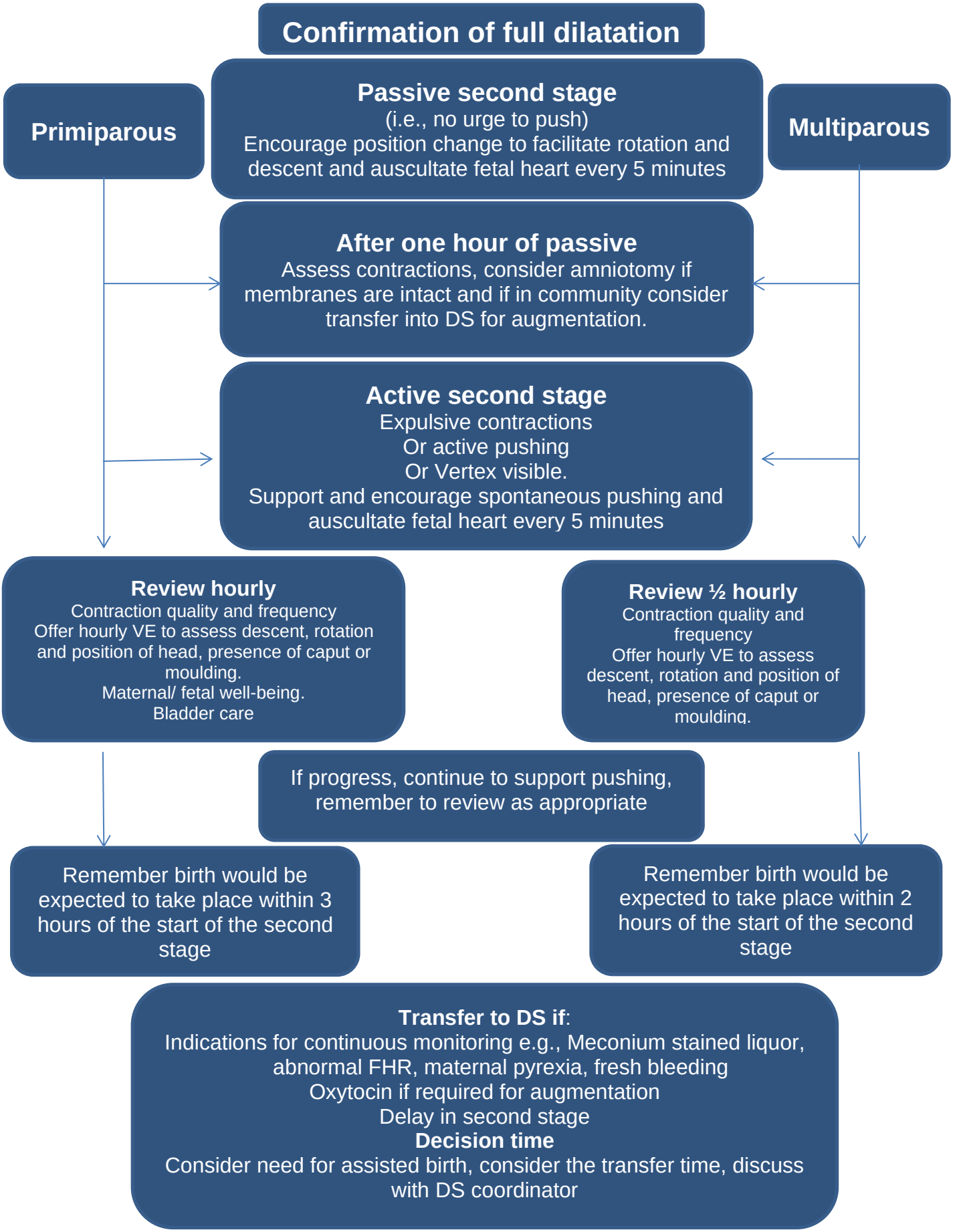
Multiparous

Should be seen by an experienced obstetrician who should make an assessment to rule out obstructed labour, before making a decision regarding the use of oxytocin

- All women with confirmed delay in the first stage of labour should be offered support and effective pain relief
- Continuous electronic fetal monitoring should be advised for women with confirmed delay in established labour

Whilst documentation of 'anterior lip' is acceptable to describe a cervix on the diagram of the VE sticker, this should be documented and treated as 9cm dilated in the context of progress/confirming delay (NEW)

- The woman should be advised to have a vaginal examination 4 hours after commencing oxytocin in established labour. If there is less than 2 cm progress after 4 hours of oxytocin, further obstetric review is required to consider an individualised plan including a discussion on the option for (NEW) caesarean section.
- If there is 2 cm or more progress, vaginal examinations should be advised 4 hourly.


Confirmation of full dilatation
Primiparous
Passive second stage
(i.e., no urge to push)
Encourage position change to facilitate rotation and descent and auscultate fetal heart every 5 minutes
Multiparous
After one hour of passive
Assess contractions, consider amniotomy if membranes are intact and if in community consider transfer into DS for augmentation.
Active second stage
Expulsive contractions
Or active pushing
Or Vertex visible.
Support and encourage spontaneous pushing and auscultate fetal heart every 5 minutes
Review hourly
Contraction quality and frequency
Offer hourly VE to assess descent, rotation and position of head, presence of caput or moulding.
Maternal/ fetal well-being.
Bladder care
Review ½ hourly
Contraction quality and frequency
Offer hourly VE to assess descent, rotation and position of head, presence of caput or moulding.
If progress, continue to support pushing, remember to review as appropriate
Remember birth would be expected to take place within 3 hours of the start of the second stage
Remember birth would be expected to take place within 2 hours of the start of the second stage
Transfer to DS if:
Indications for continuous monitoring e.g., Meconium stained liquor, abnormal FHR, maternal pyrexia, fresh bleeding
Oxytocin if required for augmentation
Delay in second stage
Decision time
Consider need for assisted birth, consider the transfer time, discuss with DS coordinator

1. Aim/Purpose of this Guideline

1.1 This guideline is for all midwives providing care to a woman in labour and birth and on how to identify and manage delay in the first and second stage of labour, in a low-risk woman. For further details regarding the use of Oxytocin please refer to the Oxytocin in the First and Second Stage of Labour Clinical Guideline.

1.2 This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

1.3 This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

This guideline covers care of a healthy woman in labour at term (37- 41+6 week's gestation). This guideline covers the care of all women in labour but should be used in conjunction with the guidelines relating to specific conditions such as suspected or confirmed preterm labour; women with an intrauterine death of their baby; women with coexisting severe morbidities such as pre-eclampsia or diabetes; women who have multiple pregnancy. The management of the third stage of labour is covered in a separate clinical guideline.

2.1. Stages of labour

2.2.1 Latent stage of labour

See Latent Phase of Labour Management Clinical Guideline (cornwall.nhs.uk).

2.2.2 **First stage of labour**

There are regular painful contractions, and there is progressive cervical dilatation from 4cm.

2.2.3 **Second stage of labour**

2.2.3.1. This is a finding of full dilatation.

If you are undertaking intermittent auscultation and suspect full dilatation, document the fetal heart every 5 minutes to ensure transition to second stage is not missed.

2.2.3.2. Passive Second Stage is a finding of full dilatation in the absence of involuntary expulsive contractions.

If you are undertaking intermittent auscultation during passive stage, document FH every 5 minutes.

2.2.3.3. If you are allowing an hour for descent with a woman with epidural analgesia and a CTG is in progress, document the fetal heart every 15 minutes.

Active Second stage is a finding of expulsive contractions with full dilatation of the cervix or active maternal effort following confirmation of full dilatation of the cervix in the absence of expulsive contractions or when the baby is visible. Auscultate and document the fetal heart at least every 5 minutes, irrespective of the choice of fetal monitoring.

2.3. Initial maternal and fetal Assessment

2.3.1. When performing an initial assessment of a woman in labour listen to her story and take into account her preferences and her emotional and psychological needs. Read any personalised birth plan that is provided.

2.3.2. Review the woman's antenatal handheld and electronic records including all antenatal screening results and record the reason for admission on the admission proforma.

2.3.3. Ask about the length and strength and frequency of her contractions, and establish when regular, painful contractions commenced.

2.3.4. Discuss options for pain relief.

2.3.5. Auscultate the fetal heart rate at first contact with the woman in labour, and at each further assessment.

2.3.6. Carry out initial auscultation with a pinard/sonicaid.

2.3.7. Auscultate the fetal heart for a minimum of 1 minute immediately after a contraction and record it as a single rate.

2.3.8. Palpate the maternal pulse to differentiate between maternal heart rate and fetal heart rate.

2.3.9. Do not perform CTG on admission for low-risk women in suspected or established labour as part of initial assessment.

2.3.10. Offer cardiotocography if intermittent auscultation indicates possible fetal heart rate abnormalities. Remove the cardiotocography if the trace is normal after 20 minutes.

2.3.11. The method of fetal surveillance will be planned according to the individual assessed risk and maternal choice (refer to Intrapartum Continuous Electronic Fetal Monitoring (CEFM) and ST Analysis Clinical Guideline (cornwall.nhs.uk).

2.3.12. If fetal death is suspected despite the presence of an apparently recorded fetal heart rate, offer ultrasound assessment to check fetal viability and ensure it is not maternal pulse.

2.3.13. If there is suspected rupture of membranes, establish the time this occurred, and assess the colour of the liquor, clear, meconium, stained or blood stained.

2.3.14. If vaginal bleeding is reported, its volume, character, timing, and relationship to any pain must be assessed and abnormal bleeding distinguished from a 'show'.

2.3.15. Ask the woman about her baby's movements in the last 24 hours prior to labour and document. If reduced fetal movements are reported, CTG monitoring should be offered in labour.

2.3.16. Record observations on a Modified Early Obstetric Warning Score (MEOWS) chart and carry out urinalysis.

2.3.17. Palpate abdomen, document symphysis fundal height measurement (if not on scan pathway) lie, presentation, position, and engagement of presenting part.

2.3.18. Palpate the strength of contractions if present.

2.3.19. Observe the colour of the liquor if membranes have ruptured.

2.3.20. Depending upon the history, a vaginal examination may be performed to confirm the diagnosis of labour.

2.3.21. All multiparous women should be encouraged to remain in midwife led or hospital setting one hour post vaginal examination, if in latent phase, prior to discharging home.

2.3.22. Ensure all findings are discussed with the woman and birthing partner and agree and document a plan for labour.

2.4. First stage of labour

2.4.1. Commence a partogram once labour is established and document the following observations on the partogram.

2.4.2. Every 15 minutes the fetal heart should be auscultated for a minute immediately following a contraction and recorded as a single rate on the partogram and any deviation documented in the intrapartum notes.

2.4.3. Every 30 minutes: palpate the frequency, strength, and duration of contractions over a 10-minute period.

2.4.4. Do not offer or advise clinical intervention if labour is progressing normally and the woman and baby are well.

2.4.5. Every hour: check maternal pulse.

2.4.6. Check water temperature and maternal temperature hourly, if using birthing pool.

2.4.7. Every 4 hours (unless clinically indicated to do more frequently) perform a full set of observations and calculate and document a MEOWS score on the MEOWS chart. If the score indicates escalation to the obstetric team use the SBARD hand over tool.

2.4.8. Offer abdominal palpation and vaginal examination (VE) 4 hourly to assess progress or if there is concern about progress or in response to the woman's wishes.

2.4.9. Encourage and document frequent emptying of urinary bladder, adhering to the Bladder Care for the Obstetric Patient Clinical Guideline (cornwall.nhs.uk).

2.4.10. Expected progress is increasing cervical dilatation of ½ cm per hour.

2.4.11. Do not regard ARM alone for suspected delay as an indication to start CTG.

2.4.12. For any deviation transfer to obstetric led care.

2.4.13. Personal protective equipment is available and should be used as per IPAC guidance.

2.5. Support and care throughout labour

2.5.1. A woman in established labour should receive supportive one-to-one care with consideration of emotional and psychological needs.

2.5.2. A woman in established labour should not be left on her own except for short periods or at the woman's request.

2.5.3. The woman's wishes in relation to her birth plan should be discussed with her and her birth partner at the time of admission and on-going throughout her labour.

2.5.4. Do not intervene if labour is progressing normally, any intervention should be discussed with the woman and the discussion and rationale documented in her notes.

2.5.5. Do not leave the woman without means to request assistance.

2.5.6. Encourage involvement of birth partner(s).

2.5.7. Encourage the woman to mobilise and adopt comfortable positions.

2.5.8. Encourage the woman to adapt the environment to meet her individual needs.

2.5.9. Puerperal sepsis is a leading cause of maternal mortality and therefore good hygiene is essential in caring for women in labour. Blood borne infections are becoming increasingly common and therefore good hygiene is also vital in protecting caregivers.

- All caregivers working in clinical areas must adhere to the bare-below the elbows policy. (RCHT Trust Policy).
- Thorough hand washing must occur prior to and after any contact with a woman – this includes abdominal examination, vaginal examinations, and when changing any bedding/dressings etc.
- Single–use, non- sterile gloves, should be used for vaginal examinations in labour and for a delivery.
- If a procedure is to be performed e.g., urethral catheterisation, episiotomy or episiotomy repair and instrumental deliveries, then sterile gloves should always be worn.
- A clean pair of sterile gloves must always be worn to inspect the perineum after delivery and for suturing.

2.6. Conducting a vaginal examination

- Wash Hands Remove And Put On Non-Sterile Gloves From The Box.
- At The End Of The Examination Peel Off Gloves And Dispose Immediately In The Clinical Waste.
- Wash Your Hands Again.
- If Vulva Is Visibly Soiled Clean Before Vaginal Examination With Tap Water.

2.7. Delay in the 1st stage

A diagnosis of delay in the established first stage of labour needs to take into consideration all aspects of progress in labour and should include:

- Cervical Dilatation Of Less Than 2 Cm In 4 Hours For First Labour.
- Cervical Dilatation Of Less Than 2 Cm In 4 Hours Or A Slowing In The Progress Of Labour For Second Or Subsequent Labour.
- Descent And Rotation Of The Fetal Head.
- Changes In The Strength, Duration, And Frequency Of Uterine Contractions.

2.8. Management of delay in first stage of labour

Throughout labour all women should be offered support, hydration, and appropriate and effective pain relief if required.

2.8.1. If delay in the established first stage of labour is suspected, ensure the full clinical picture is considered. Artificial rupture of membranes (ARM) should be considered for women with intact membranes, following explanation of the procedure and advice that it will shorten her labour by about an hour and may increase the strength and pain of her contractions. Inform the Delivery Suite coordinator that you have undertaken an ARM, regardless of the birth setting (New 2022) and plan for a 2-hour review.

2.8.2. Whether or not a woman has agreed to an ARM, all women with suspected delay in the established first stage of labour should be advised to have a vaginal examination 2 hours later, and if progress is less than 1 cm, diagnosis of delay is made.

2.8.3. Primigravid women for who delay in the established first stage of labour is confirmed, advice should be sought from an obstetrician and the use of oxytocin should be considered.

2.8.4. If ARM is declined or membranes are already ruptured, escalation to an obstetrician should be undertaken who should review the patient and make an informed individualised plan of care.

2.8.5. Review the patient within 30 minutes of admission to delivery Suite. If the obstetric team are unavailable, it must be clearly documented in the notes why and when a review is expected. The coordinator should review the patient to assess the urgency. If a Dr is required urgently, immediate escalation to the Obstetric Consultant on call should take place. Until the review happens the coordinator should be kept up to date with any changes.

2.8.6. In women for whom delay in the established first stage of labour is confirmed, and ARM has been previously declined, an ARM should be recommended and she should be advised to have a repeat vaginal examination 2 hours later whether her membranes are ruptured or intact.

2.8.7. The woman should be informed that the use of oxytocin following spontaneous or artificial rupture of the membranes will bring forward her time of birth but will not influence the mode of birth or other outcomes.

2.8.8. Multiparous women with confirmed delay in the first stage should be seen by an experienced obstetrician who should make an assessment to exclude obstructed labour, before making a decision regarding the use of oxytocin.

2.8.9. All women with delay in the established first stage of labour should be offered support and effective pain relief.

2.8.10. The woman should be advised to have a vaginal examination 4 hours after commencing oxytocin in established labour. If there is less than 2 cm progress after 4 hours of oxytocin, further obstetric review is required to consider an individualised plan including an option for (New 2022) caesarean section.

2.8.11. If there is 2 cm or more progress, vaginal examinations should be advised 4 hourly.

2.8.12. Whilst documentation of 'anterior lip' is acceptable to describe a cervix on the diagram of the VE sticker, this should be documented and treated as 9cm dilated in the context of progress/confirming delay (New 2022).

2.8.13. Where a diagnosis of delay in the established first stage of labour is made, continuous EFM should be offered.

2.9. Second Stage of labour

2.9.1. Passive Second stage is a finding of full dilatation with no urge to push. Auscultate fetal heart immediately after a contraction for 1 minute at least every 5 minutes and palpate the maternal pulse to differentiate between the two heartbeats.

2.9.2. If no urge to push at 1 hour undertake vaginal examination to assess rotation and descent and if membranes intact offer amniotomy and inform the Delivery Suite coordinator that you have performed an ARM. If no membranes intact discuss with Second midwife or delivery suite coordinator to make a further plan.

2.9.3. Be cautious of a woman with no urge after 20 minutes in a woman with no epidural. A prolonged passive second stage may indicate obstructed labour. In community/birth unit setting use the 'stop and share' sticker to fully review.

2.10. Active Second stage of labour

2.10.1. Documentation during the second stage of labour should be written chronologically on the obstetric notes page.

2.10.2. Auscultation of the fetal heart should occur immediately after a contraction for at least 1 minute at least every 5 minutes and palpate maternal pulse simultaneously with auscultation and record every 15 minutes (refer to intermittent auscultation guideline).

2.10.3. Every 15 minutes: document frequency and strength of contractions.

2.10.4. Every hour: calculate a MEOWS score and document on a MEOWS chart.

2.10.5. Regularly check for full bladder.

2.10.6. Encourage upright position: standing, kneeling, squatting.

2.10.7. Consider the woman's hydration needs.

2.10.8. Assess progress- offer a vaginal exam hourly in second stage or in response to woman's wishes, including fetal position and station.

2.10.9. In community and standalone birth centers, the midwife should complete a pause label to assess likelihood of the baby being born within 3 hours from full dilatation for Primiparous and 2 hours from full dilatation for multiparous (this includes time allowed for passive and active Second stage). Take into consideration transfer time.

2.10.10. Consider performing an episiotomy to expedite delivery if there is suspected fetal compromise or if there is concern of serious perineal tear.

2.10.11. If a deviation from normal labour occurs, at any stage, request review from the obstetric on call team and recommend transfer to the obstetric lead unit.

2.11. Diagnosis of delay in Second stage of labour

Primigravid:

2.11.1. Birth would be expected to take place within 3 hours of the start of the second stage in most women.

2.11.2. A diagnosis of delay in the active second stage should be made when it has lasted 2 hours and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

Multiparous:

2.11.3. Birth would be expected to take place within 2 hours of the start of the second stage in most women.

2.11.4. A diagnosis of delay in the active second stage should be made when it has lasted 1 hour, and women should be referred to a healthcare professional trained to undertake an operative vaginal birth if birth is not imminent.

2.12. Management of delay in Second stage of labour in hospital setting

2.12.1. Where there is delay in the second stage of labour, or if the woman is excessively distressed, support and sensitive encouragement and the woman's need for analgesia/anaesthesia are particularly important.

2.12.2. If contractions are inadequate at the onset of the second stage, the use of oxytocin should be considered. In community setting discuss with second midwife or delivery suite coordinator re the need to transfer into RCHT.

2.12.3. In Primiparous women, if after 1 hour of active second stage progress is inadequate, delay is suspected. Following vaginal examination, amniotomy should be offered if the membranes are intact and inform the Delivery Suite coordinator.

2.12.4. Women with confirmed delay in the second stage should be assessed by an obstetrician. If there is any concern about fetal wellbeing, delivery should be undertaken.

2.12.5. Oxytocin is rarely indicated as treatment for delay in Second stage, however, if decision made to use it must be started by an Obstetrician and only after review (for multips, this MUST be carefully considered with involvement with a senior obstetric decision).

2.12.6. A senior review is required prior to recommencing Oxytocin.

2.12.7. Following initial obstetric assessment for women with delay in the second stage of labour, on-going obstetric review should be maintained every 15–30 minutes, for a maximum of 1 hour.

2.13. In the community consider ambulance transfer time

When delay in the second stage is identified ensure that you consider the transfer time to RCH to optimise potential for the baby to be born within 3 hours for Primiparous and 2 hours for multiparous from finding of full dilatation, irrespective of passive or active second stage.

2.14. Sharps and swab count

When the delivery pack is opened swabs should be counted and the count repeated when the delivery is completed. This should be documented on the proforma in the notes following delivery.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	See Tool
Lead	Audit Midwife
Tool	1. Was a partogram started once labour established? 2. Are contractions documented every 30 minutes? 3. Is maternal pulse documented as per guideline? 4. Is MEOWS documented every 4 hours? 5. Is a vaginal examination offered/considered 4 hourly? 6. Is the swab count documented? 7. Was a vaginal examination offered hourly in second stage? 8. Was delay in first or second stage recognised and acted upon appropriately? 9. Was the oxytocin proforma completed?
Frequency	1% or 10 sets, whichever is the greatest, of all health records of women who have delivered, will be audited over the lifetime of the guideline or earlier if identified through Patient Safety process.
Reporting arrangements	A formal report of the results will be received at the Maternity Forum or Clinical Audit Forum.
Acting on recommendations and Lead(s)	• Any deficiencies identified on the annual report will be discussed at the Maternity Patient Safety Meeting or Clinical Audit Forum. • Action leads will be identified, and a time frame set for the action to be completed. • The action plan will be monitored by the Maternity Patient Safety Forum or Clinical Audit Forum.
Change in practice and lessons to be shared	• A lead member of the forum will be identified to take each change forward where appropriate. • Patient Safety Newsletter.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Labour First and Second Stage and Delay in Labour First and Second Stage V3.0
This document replaces (exact title of previous version):	Labour First and Second Stage and Delay in Labour First and Second Stage V2.2
Date Issued/Approved:	June 2023
Date Valid From:	June 2023
Date Valid To:	June 2026
Directorate / Department responsible (author/owner):	Sophie Haynes, Obstetric Consultant
Contact details:	01872 252730
Brief summary of contents:	This guideline is for all midwives providing care to a woman in labour and birth and how to identify and manage delay in the first and second stage of labour, in a low risk woman.
Suggested Keywords:	Labour, first, second, vertex, latent, established, antacids, oral, intake.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Caroline Amukusana
Links to key external standards:	CNST 4

Information Category	Detailed Information
Related Documents:	• RCHT Electronic fetal monitoring guideline. • RCHT Care of the bladder during labour. • RCHT Guideline for the management of delay in first stage of labour. • RCHT Guideline for the management of delay in the second stage of labour. • NICE (2014) Intrapartum care for healthy women and babies.
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
2008	V1.0	Initial version	Theresa Williams and Chris Edwards Supervisors of Midwives
Sept 2010	V1.1	Updated in line with NICE guidance	Theresa Williams and Chris Edwards Supervisors of Midwives
Sept 2011	V1.3	Renewed and updated with compliance monitoring tool	Theresa Williams and Chris Edwards Supervisors of Midwives

Date	Version Number	Summary of Changes	Changes Made by
Aug 2012	V1.4	Change to compliance monitoring only	Jan Clarkson Maternity risk manager
7th April 2016	V1.5	Benchmarked with NICE Guidance CG190 and included following statement in accordance with serious investigation action plan: All multiparous women to be encouraged to remain in midwife led or hospital setting one hour post vaginal examination, even if in latent phase, prior to discharging home.	Sarah-Jane Pedler Interim Practice Development Midwife
6th April 2017	V1.6	Flow chart added. Amalgamation of two guidelines. Labour first and second stage clinical guidelines for care of a woman and Delay in First and second stage of labour, in the low risk woman clinical guidelines for identification and management Amendments to indicate time scales for transfer in community setting when delay in second stage identified.	Community team leaders Sarah-Jane Pedler, Practice Development Midwife Clare Sizer, Risk Management Midwife
14th March 2018	V1.7	Additions to 2.2: Second stage of labour as part of action plan from a serious investigation.	Sarah-Jane Pedler Practice Development
13th July 2018	V1.8	Additions to 2.2 see New 2018 documenting fetal heart rate.	Sarah-Jane Pedler Practice Development Midwife
August 2019	V1.9	Additions to sections 2.7.1 and 2.7.4 following recommendations from the Health Safety Investigation Branch (HSIB) regarding escalation, communication and review of patients.	Sarah-Jane Pedler Practice Development Midwife

Date	Version Number	Summary of Changes	Changes Made by
July 2020	V2.0	Full update. GDPR updated template. 1.4. Inclusion statement. Minor amendments for clarity only except: 2.4.7. First stage of labour; 4 hourly observations, calculate MEOWS score, document on partogram. Use SBARD handover tool if escalation required. 2.7.2. Correction made:delay in first stage of labour is confirmed if progress is less than 1cm at VE 2 hours after suspected delay. 2.9.4. Second stage of labour; calculate MEOWS every hour and document on MEOWS chart. Appendix 1 updated Governance template Appendix 2 updated EIA template	Rob Holmes, O&G Consultant
September 2022	V2.1	Addition of delay in first stage algorithm and additions to sections 2.7 following HSIB recommendations	Tamara Thirlby Patient Safety Midwife
February 2023	V2.2	Addition of hygiene standards in labour (archive of hygiene standards guideline)	Tamara Thirlby Patient Safety Midwife
June 2023	V3.0	Full Update with minor amendments to 2.3.1, 2.3.6 and 2.10.10.	Sophie Haynes, Obstetric Consultant.

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Labour First and Second Stage and Delay in Labour First and Second Stage Clinical Guideline V3.0
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Catherine Wills, Practice Development Midwife
Contact details:	01872 255019

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This guideline is for all midwives providing care to a woman in labour.
2. Policy Objectives	To ensure all women in first and second stage of labour receive the appropriate level of care and recognise and manage delay in first and second stage of labour.
3. Policy Intended Outcomes	Safe delivery of babies and improved maternal experience.
4. How will you measure each outcome?	Compliance Monitoring Tool.
5. Who is intended to benefit from the policy?	Compliance Monitoring Tool.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Guideline Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, Practice Development Midwife.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis