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Royal Cornwall Hospitals NHS Trust

Latent Phase of Labour Management Clinical Guideline

V3.1

June 2023

1. Aim/Purpose of this Guideline

1.1. To provide guidance to Midwives and Obstetricians on the management of latent phase of labour.

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

2.1. Definition of latent and established first stages of labour.

The timely diagnosis of active labour is acknowledged as problematic both for women and their caregivers (RCM 2012). For the purposes of care provision use the following definitions of labour:

2.1.1. **Latent phase of labour** is defined as a period of time, not necessarily continuous, when there are painful contractions **and** there is some cervical change, including cervical effacement and dilation up to 4cm (NICE 2017).

2.1.2. **Established first stage of labour** when there are regular painful contractions **and** there is progressive cervical dilatation from 4cm (NICE 2017).

2.1.3. It is important to recognise that that multiparous women with no uterine activity may have cervical dilation 4cm and above, these women are not in the latent phase of labour but do have a favourable cervix. A nulliparous woman with irregular uterine activity and cervical dilation 4cm and above should not be defined as being in the latent phase of labour, this labour is likely to be obstructed and should be managed accordingly (NEW 2022).

2.2. Antenatal Education

As part of the birth planning discussion at approximately 36 weeks gestation, a discussed should take place with women and the birth partner(s) about what to expect in this phase of labour and a record of this discussion documented (NEW 2022).

2.2.1. Women should be given information antenatally about:

- What to expect in the latent phase of labour.
- Optimum Environments – including the advantages of staying at home or returning home following the diagnosis of the latent phase of labour (NEW 2022).
- Working with pain and discomfort.
- How to contact midwifery advice and support and what to do in an emergency.

2.2.2. An in-depth discussion should include:

- How to differentiate between Braxton-Hicks contractions and active labour contractions.
- The expected frequency of contractions and how long they last.
- Recognition of amniotic fluid (“waters breaking”).
- Description of normal vaginal loss including after a membrane sweep (NICE 2014).
- Discuss fetal movements and encourage the woman to report any changes. Explain that a reduction in fetal movements is not normal in either the latent phase or established labour.
- The RCHT patient information leaflet: The latent phase of labour: what it is it and how to cope should be given to women at 36 weeks gestation in addition to verbal information.

2.3. Telephone Support and Triage

Midwives should exercise their professional judgement when triaging potential labour by telephone and only advise to stay at home following a discussion of potential coping strategies and whether the woman feels comfortable and confident to do this (NEW 2022). All information should be documented on the

electronic maternity record including a thorough risk assessment to determine if the woman is safe and happy to remain at home during this stage of labour (NEW 2022).

2.3.1. Speak to the woman directly. If English is not her first language and there is difficulty with communication, then a face-to-face assessment is recommended. Use the trust translation telephone service via the intranet.

2.3.2. During the telephone conversation, as a minimum, the clinician should:

- Establish the woman`s account of her pregnancy (including any risk factors) and possible signs of labour she is experiencing.
- The strength, frequency and duration of any contractions and how well the woman appears to be coping with these contractions.
- Any vaginal loss the woman may have experienced (including SROM).
- Ask about the baby`s movements, including any changes.
- Ask the woman how she is, and about her wishes, expectations and any concerns she may have.
- Give information about what to expect in the latent phase of labour and how to work with any pain she experiences.
- Provide advice regarding methods of pain relief both non- - pharmacological and simple pharmacological analgesia If a woman requires analgesia see section 2.7.
- Provide guidance and support to the woman’s birth companion(s).
- Agree a plan of care including who she should contact next and when.
- The telephone call should be of sufficient length to assess how the woman copes during a contraction.
- If a third telephone contact is made the midwife should invite the woman for assessment in the community, the birth centre or maternity unit.

2.3.3. Immediate admission is indicated for women who experience the following complications of pregnancy, with a consideration of the safest mode of transport:

- Continuous abdominal pain (with or without vaginal bleeding).
- Vaginal bleeding.
- Reduced fetal movements.

- Scar pain (VBAC).
- Meconium-stained liquor.

2.3.4. Following telephone triage, the midwife may decide the woman needs a face-to-face assessment. When performing an assessment, listen to the woman and take into account her preferences and emotional and psychological needs (NICE 2017).

2.4. Face to Face Clinical Assessment

2.4.1. Observations of the Woman

2.4.1.1. Undertake a full risk assessment that includes a thorough review of handheld and electronic maternal notes and history and determine the appropriate care pathway, irrespective of any previous plan.

2.4.1.2. Investigations for maternal wellbeing should be documented on a MEOWs chart.

2.4.1.3. Undertake a urinalysis. If unable to undertake urinalysis on admission, it must be completed prior to any discharge home in the latent phase (New 2022).

2.4.1.4. Ask about length, strength and frequency of contractions.

2.4.1.5. Ask her about any pain she is experiencing and discuss her options for pain relief (See section 2.7).

2.4.1.6. Ask about and record any vaginal loss.

2.4.1.7. Assess the appropriate method for fetal monitoring based on the clinical risk factors. This assessment must include a history of baby's movements within the last 24 hours.

2.4.1.8. Auscultate the fetal heart rate.

2.4.1.9. If there is uncertainty about whether a woman is in established labour, a vaginal examination maybe helpful after a period of assessment but not always necessary.

2.4.1.10. If the woman appears to be in established labour, offer a vaginal examination considering the women's wishes.

2.4.1.11. All women under consultant led care should be discussed with or reviewed by a senior obstetrician prior to implementing any care plan.

2.4.1.12. Offer the woman individualised support and analgesia if needed.

2.4.1.13. If there is a delay in performing the labour assessment of more than one hour from admission (or before if clinically

appropriate) escalate to the Delivery Suite Co-ordinator using SBARD.

2.4.1.14. If the birth is imminent, assess whether birth in the current location is preferable to transferring the woman to Delivery Suite. Discuss with the D/S Co-ordinator (NICE 2017).

2.4.1.15. Women should not be discharged home until they have been assessed for at least one hour after admission.

2.4.2. Observations of the baby:

2.4.2.1. Ask the woman about the baby`s fetal movements in the last 24 hours.

2.4.2.2. Palpate the woman`s abdomen to determine fundal height and document on GROW chart (This is not necessary if the patient is having serial growth USS) the baby`s lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions.

2.4.2.3. Measuring the fetal heart rate as part of the initial assessment. Offer auscultation of the fetal heart rate at first contact with a woman in suspected or established labour, and at each further assessment:

- use a pinard stethoscope or handheld Doppler ultrasound.
- The baseline of the fetal heart (FH) should be assessed when the fetus is at rest and between contractions.
- Carry out auscultation immediately after a contraction for at least a full minute and the value recorded as a single figure (i.e. not as a range). Palpate the woman’s pulse to differentiate between the heartbeats of the woman and baby (NEW 2022).
- The normal rate is 110 – 160 bpm but consideration must be given to what is expected for each individual fetus.
- Intermittent Auscultation cannot establish the type of deceleration, therefore any deceleration heard will warrant further investigation.

2.4.2.4. Fetal activity is a positive feature of fetal well-being. Fetal movement (FM) must be discussed. An acceleration at the time of FM would demonstrate a non-hypoxic fetus.

2.4.2.5. Do not perform CTG for women with a low-risk pregnancy (NICE 2017).

2.4.2.6. Risk assess the need for a CTG if any risk factors and explain why it is necessary (NICE 2017).

2.4.2.7. Offer continuous cardiotocography if there are any risk factors listed in 2.3.3. and/or 2.4.3. and explain to the woman why this is being offered.

2.4.2.8. Offer cardiotocography if intermittent auscultation indicates possible fetal heart rate abnormalities and explain why this is being offered. If the trace is normal after 20 minutes, return to intermittent auscultation unless the woman asks to stay on continuous cardiotocography (NEW 2022).

2.4.2.9. If fetal death is suspected despite the presence of an apparently recorded fetal heart rate, offer real-time ultrasound assessment to check fetal viability (NEW 2022).

2.4.2.10. Do not use Dawes Redman criteria as it is not valid during the Latent Phase of labour (Redman statement 2019). Use traditional CTG and perform a structured review of all the features; document the classification on the preformatted antenatal CTG sticker at the end of the trace.

2.4.2.11. If the labour assessment is being undertaken in the community setting and a CTG is indicated, the woman must be transferred to the obstetric unit using the most appropriate method of transport considering transfer times (NEW 2022).

2.4.3. Observations of the woman indicating obstetric review or transfer to Delivery Suite:

- Maternal pulse 120 bpm on 2 occasions 30 least minutes apart.
- A single reading of either diastolic BP of 110 mmHg or more or systolic BP of 160 mmHg or more.
- Either raised diastolic BP of 90 mmHg or more or raised systolic BP of 140 mmHg or more on 2 consecutive readings taken at least 30 minutes apart.
- A reading of 2+ protein on urinalysis and a single reading of either raised diastolic BP (90 mmHg or more) or raised systolic BP (140 mmHg or more).
- Temperature of 38 °C or above on a single reading or 37.5° or above on two consecutive readings 1 hour apart (NEW 2022).
- Any vaginal blood loss other than a “show”.
- Rupture of membranes more than 24 hours before the onset of established labour (NEW 2022).
- The presence of meconium.
- Pain reported by the woman that differs from the pain normally associated with contractions.

- Any risk factors recorded in the woman`s notes that indicate the need for obstetric –led care (unless there is a documented “outside guidelines” care plan in the woman`s notes and no new risk factors or concerns developed since the plan was made).

2.4.4. Observations of the unborn baby indicating obstetric review or transfer to D/S:

- Any abnormal presentation including cord presentation.
- Transverse of oblique lie (NEW 2022).
- Suspected SGA or macrosomia.
- Suspected anhydramnios or polyhydramnios.
- Abnormality of FH detected: Abnormal baseline (lower than 110 bpm or above 160 bpm), rising baseline, presence of decelerations, repetitive overshoots.
- Reduced fetal movements in the last 24 hours reported by the woman.

2.4.5. Vaginal Examination:

2.4.5.1. When offering and conducting a vaginal examination:

- Be sure that vaginal examination is necessary and will add important information to the decision-making process.
- Explain the reason for the examination and what will be involved.
- Recognise that a vaginal examination can be very distressing for a woman, especially if she is already in pain, highly anxious and in an unfamiliar environment (NEW 2022).
- Ensure the woman has given informed consent and ensure her privacy dignity and comfort.
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth partner (NICE 2017).

2.4.5.2. Do not perform a stretch and sweep unless consent has been gained by the woman prior to the examination.

2.4.5.3. All multiparous women must be encouraged to remain in a midwife led or hospital setting for 1 hour post vaginal assessment, if in latent phase, and auscultate the fetal heart prior to discharging home.

2.5. Practices which may have a negative impact on woman`s experience:

2.5.1. Avoid referring to women as “only” being in latent phase or “not in labour” as this can devalue the woman`s experience.

2.5.2. Focussing on only objective measures such as frequency of contractions. By the midwife focussing on the woman`s experience, the woman may be less anxious and consequently not require early admission.

2.6. If the woman seeking advice/ attends for assessment reports painful contractions, but is not in established labour or has a prolonged latent phase of labour.

2.6.1. There is no standard definition for prolonged latent phase of labour. The teaching literature for midwives states that early labour can take up to 6-8hrs. However in reality it often lasts much longer and it is not unusual for women to be in the latent phase of labour for 2-3days.

2.6.2. It is good practice to offer women choice with the option to remain within the hospital setting for a period of time and it is important that it is their choice and they are asked where they feel safest (NEW 2022). During the latent phase of labour, it is important to:

- Recognise that a woman may experience painful contractions without cervical change, and although she is described as not being in labour, she may think of herself as being ‘in labour’ by her own definition.
- Offer individualised support, and analgesia if needed.
- Advise the woman to eat and drink normally and to ensure that as well as periods of activity, she should rest from time to time (particularly at night when she would normally be asleep) to conserve her strength and energy.
- Acknowledge that a longer latent phase can be distressing, demoralising and exhausting: treat every woman as an individual and consider her own particular needs and wishes when discussing and agreeing a plan of care.
- Ensure all relevant considerations including a holistic risk assessment is carried (how she appears to be coping, degree of support, the nature of contractions, any comorbidities or risk factors not just the assessment of the woman`s cervix have been considered.
- For those women who are distressed and do not wish to return home do not insist that they return home against their wishes.

2.6.3. If a woman remains an inpatient during the latent phase of labour, her individual needs should be taken into consideration (NEW 2022). There should be contact of a clinical nature hourly as a minimum.

There must be regular contact for general wellbeing including how she is coping and checking that she passes urine regularly. Although the woman may not be in established labour by clinical definition, she may need frequent or ongoing support from a healthcare professional. Birth companions should also be supported and guided on how they can support the woman during this phase of labour (New 2022).

Clinical assessments during the latent phase of labour must include:

- 4 hourly MEOWs.
- Hourly assessment of fetal wellbeing by enquiry regarding fetal movements and auscultation of the fetal heart.
- Hourly assessment of the length strength and frequency of contractions.

2.6.4. As part of maintaining regular contact and support, it is important to recognise when the woman's labour may have established through recognition of any of the following (NEW 2022):

- A change in the woman's behaviour.
- A change in the length, strength or frequency in the contractions.
- The woman reporting that she feels her labour has progressed.

2.7. Pain relief

2.7.1. Advise the woman and her birth companions that breathing exercises, immersion in water, TENs and massage may reduce pain during the latent phase.

2.7.2. Advise that Paracetamol 1g may be taken every six hours up to a maximum of eight tablets in 24 hours.

2.7.3. Women who receive Dihydrocodeine should be observed in hospital for at least one hour following administration and the fetal heart auscultated prior to discharge.

2.7.4. Pethidine should only be prescribed as a STAT dose by the obstetric team. Following this the woman should stay in the hospital for at least 4 hours and the fetal heart should be auscultated prior to her discharge if she goes home.

2.7.5. Any subsequent doses require review by a member of the obstetric team and further STAT prescription.

2.7.6. Any patient who receives two doses of pethidine in the latent phase should not be discharged home and should remain an inpatient. The woman should have an obstetric review if she does not establish labour and a CTG performed if deemed necessary by the Obstetrician.

2.7.7. It is important for clinicians to be aware that heavy sedation may occur following opiates including Dihydrocodeine and pethidine. This can present as a woman who appears to have stopped contracting whilst continuing to labour and is unaware and relaxed due to the effects of analgesia.

2.7.8. Do not offer or advise yoga or acupressure for pain relief during the latent stage of labour. if a woman wants to use any of these techniques, respect her wishes (NEW 2022).

2.7.9. Do not routinely recommend aromatherapy as a form of analgesia. however, if the woman wishes to use this for relaxation and you have appropriate training it can be offered as per the aromatherapy guidance (NEW 2022).

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	1. Was the labour assessment undertaken in the appropriate setting? 2. Was a vaginal examination offered to determine stage of labour? 3. Were women advised to remain inpatients appropriately if receiving analgesia not available over the counter (pethidine, Oramorph or Dihydrocodeine)? 4. Were fetal observations performed a minimum of 4 hourly? 5. were maternal observations performed a minimum of 4 hourly? 6. Were multiparous women advised to stay for a minimum of 1 hour post VE? 7. Was the fetal heart auscultated prior to discharge?
Lead	Audit midwives
Tool	Excel spread sheet used to analyse data.
Frequency	Once in the lifetime of the guideline. Earlier if identified by patient safety.

Information Category	Detail of process and methodology for monitoring compliance
Reporting arrangements	• Maternity Forum and the Clinical Audit Forum. • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next Maternity Forum and Clinical Audit meeting and an action plan agreed.
Acting on recommendations and Lead(s)	• Maternity Forum and Clinical Audit meeting will develop an action plan. • Action plan leads will be identified and a time frame for completed actions.
Change in practice and lessons to be shared	• Required Changes to practice will be identified and actioned within a time frame agreed on the action plan. • A lead member of the forum will be identified to take each change forward where appropriate. • The results of the audits will be distributed to all staff through the Patient Safety Newsletter as per the action plan.

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:	Latent Phase of Labour Management Clinical Guideline V3.1
This document replaces (exact title of previous version):	Latent Phase of Labour Management Clinical Guideline V3.0
Date Issued/Approved:	17 November 2022
Date Valid From:	June 2023
Date Valid To:	November 2025
Directorate / Department responsible (author/owner):	Sarah Harvey-Hurst, Clinical Matron
Contact details:	01872 252684
Brief summary of contents:	This guideline applies to all midwives assessing women on the telephone and face to face in the latent phase of labour who are planning an expectant birth between 37 – 42 weeks gestation.
Suggested Keywords:	Latent Labour Stage Management Pregnancy Phase
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:	None required
Related Documents:	References:

Information Category	Detailed Information
	• NICE (2007) Intrapartum care: management and delivery of care to women in labour. London. • NICE (2014) Guideline Intrapartum care: care of healthy women and their babies during childbirth • RCM (2012) Evidence based guidelines for midwifery-led care in labour: The latent phase. Royal College of Midwives • Redman C. Statement on the use of Dawes Redman. 30/09/2019
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
2 Apr 2015	V1.0	Initial version	Karen Stoyles Antenatal Ward and DAU Lead Midwife
4th August 2016	V1.1	• Amendments to information surrounding assessment face to face and telephone. • Addition of minimum time required to conduct assessment. • Addition of Appendix 1 to list risk factors.	Rob Holmes Obs and Gynae Consultant Sarah Harvey-Hurst Antenatal Ward and DAU Deputy Ward Sister
4 August 2016	V1.2	Amended to include the recommendation of one hour minimum stay post VE in hospital.	Sarah-Jane Pedler Practice Development Midwife
3 November 2016	V1.3	Updated post SI.	Karen Stoyles, Bereavement Specialist Midwife

Date	Version Number	Summary of Changes	Changes Made by
July 2019	V2.0	Full review to incorporate NICE recommendations 2017.	Sarah Harvey-Hurst, Truro Birth Centre Lead Midwife
December 2019	V2.1	2.5.3.6 Following a statement by Professor Redman. Dawes Redman analysis is not valid for Latent phase or early labour.	Sally Budgen Fetal Monitoring Lead midwife
July 2020	V2.2	GDPR updated template. 1.3. Inclusion statemen.t 2.5.5.2. the word 'even' removed. Appendix 1 updated Governance template. Appendix 2 updated EIA template.	Sophie Haynes Consultant Obstetrician
November 2022	V3.0	Full version update. New trust template added. All amendments noted in text as 'NEW 2022', including 2.4.1.3 which is a change in response to patient feedback.	Sarah Harvey Hurst, Clinical Matron
June 2023	V3.1	Amendment to 2.6.3	Jane Pascoe, Fetal Wellbeing Lead Midwife

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:	Latent Phase of Labour Management Clinical Guideline V3.1
Directorate and service area:	Obstetrics and Midwifery
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):	Sarah Harvey Hurst, Clinical Matron
Contact details:	01872 252684

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)	To provide a framework for the best possible care, including consistency of advice and self –management for women during the latent phase of labour.
2. Policy Objectives	Appropriate and timely management of women presenting or contacting midwives for advice when in the latent phase of labour.
3. Policy Intended Outcomes	Reduction in unnecessary hospital attendances and improve patient experience for pregnant women.
4. How will you measure each outcome?	Compliance Monitoring Tool.
5. Who is intended to benefit from the policy?	All pregnant women.

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 approved
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: Yes**

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	Any information provided should be in an accessible format for the patient / carer's needs- i.e., available in different languages if required/access to an interpreter if required.

Protected Characteristic	(Yes or No)	Rationale
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	Those patient / carer's with any identified additional needs will be referred for additional support as appropriate- i.e., to the Liaison team or for specialised equipment. Written information will be provided in a format to meet the family's needs e.g., easy read, audio etc.
Religion or belief	No	All staff should be aware of any beliefs that may impact on the decision to treat and should respond accordingly.
Marriage and civil partnership	No	
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