University Hospitals Sussex
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# TRUST CLINICAL GUIDELINE

# Assisted Vaginal Birth

**Overview**

- To provide evidence-based guidance on the management of pregnant women and birthing people requiring the use of forceps and vacuum extraction for both rotational and non-rotational assisted vaginal births, and to ensure that their care is safe, consistent and of a high quality.
- Guidance on use of sequential instruments and when to abandon the procedure.

| | |
|---|---|
| **Owner** | Clinical Director |
| **Author/further information** | Surajit Das, Obstetric Consultant<br>H. Al-Abdali, Obstetric Registrar |
| **Guideline version** | v7.0 |
| **Related policies** | None |
| **Related protocols/procedures** | **UH Sussex (SRH & WH) Maternity Guidelines:** Caesarean Section Birth, Diabetes in pregnancy, Shoulder Dystocia, Bladder Care, Venous Thromboembolism, Severely ill pregnant woman and person, Postpartum Haemorrhage |
| **Standards** | NICE NG235 Intrapartum care (2023)<br>RCOG (2020) Green-top guideline no.26 |
| **Superseded documents** | N/A |
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| **Approval** | | |
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| JOGG | Date approved | 20th March 2024 |
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# Assisted Vaginal Birth

## 1.0 Introduction

This guideline is for use at SRH & WH. It aims to provide:

- Evidence-based guidance on the management of pregnant women and birthing people requiring the use of forceps and vacuum extraction for both rotational and non-rotational assisted vaginal births, and to ensure that their care is safe, consistent and of a high quality.
- Guidance on use of sequential instruments and when to abandon the procedure.

## 2.0 Definitions and abbreviations used in this document

| | |
|---|---|
| **CPD** Cephalopelvic Disproportion | **FBS** Fetal Blood Sample |
| **OASI** Obstetric and Sphincter Injury | **PPH** Postpartum Haemorrhage |
| **RCOG** Royal College of Obstetricians and Gynaecologists | **VTE** venous thromboembolism |
| **WHO** World Health Organisation | |

## 3.0 Duties and Responsibilities

| | |
|---|---|
| All staff working in the Trust | • To access, read, understand and follow this guideline.<br>• To use their professional judgement in application of this guideline. |
| Managers | • To ensure the guideline is reviewed three yearly and aligns with national standards.<br>• To ensure the guideline is accessible to all relevant staff. |

## 4.0 Background

In 2022-2023 Assisted birth rates were12% in the UK. (NHS Maternity Statistics 2022-2023) Pregnant women and birthing people who have an assisted birth are more likely to have an uncomplicated birth subsequently, though there has been increasing awareness of the potential for mother or birthing parent and baby morbidity associated with assisted vaginal birth, however, with careful practice, overall rates of morbidity remain low. Rare neonatal complications such as sub-galeal and intracranial haemorrhage, spinal cord injury and skull fracture are more common with rotational deliveries and failed attempts. Complex decision-making is required when weighing up these risks with the significant maternal and birthing parent and birthing parent and perinatal morbidity of a second stage caesarean birth.

### 4.1 Reducing the risk of assisted birth

- Continuous support in labour upright or lateral positions in the second stage of labour without epidural.
- With epidural - adopt lying down lateral positions rather than upright positions in the second stage of labour.
- Delay pushing for 1–2 hours in nulliparous women and birthing people with epidural analgesia as this may reduce the need for rotational and mid-pelvic assisted vaginal birth.
- Epidural in the latent phase of labour compared to the active phase of labour does not increase the risk of assisted vaginal birth.
- Discontinuing epidural anaesthesia in active second stage is not recommended as it does not decrease the risk of assisted vaginal birth.
- There is insufficient evidence to recommend routine oxytocin augmentation for pregnant women and birthing people with epidural analgesia as a strategy to reduce the incidence of assisted vaginal birth.
- There is insufficient evidence to recommend routine prophylactic manual rotation of fetal malposition in the second stage of labour to reduce the risk of assisted vaginal birth. (RCOG 2020)

### 4.2 Classification for assisted vaginal birth

| Outlet | Low | Mid cavity |
|---|---|---|
| Fetal scalp visible without separating the labia | Fetal skull is at station + 2 cm, but not on the perineum | Mid Fetal head is no more than one-fifth palpable per abdomen |
| Fetal skull has reached the perineum | Non-rotational ≤ 45° | Leading point of the skull is at station 0 or + 1 cm |
| Rotation does not exceed 45 | Rotational > 45° | Non-rotational ≤ 45° |
| | | Rotational > 45 |

## 5.0 Indication

No indication is absolute, and each case should be considered individually. Threshold to intervene may be lower where several co-factors exist.

### 5.1 Fetal Indications

- Presumed/suspected fetal compromise
- Abnormal FBS
- Thick meconium

### 5.2 Maternal and birthing parent Indications

- Maternal and birthing parent fatigue/exhaustion.
- Medical conditions requiring shortening of the second stage e.g.
  - cardiac disease class III or IV,
  - severe hypertensive disease,
  - cerebral vascular disease or malformation,
  - myasthenia gravis,
  - spinal cord injury patients
  - proliferative retinopathy

### 5.3 Delay in the second stage

Maternal and birthing parent morbidity increases significantly after 3 hours of the second stage and again further after 4 hours, however, with appropriate fetal surveillance and timely intervention, neonatal morbidity is not increased. The timing of intervention for delay in second stage is therefore about balancing the risks of continued pushing against those of assisted birth and alongside the labouring woman or birthing person's choice.

The use of oxytocin, with the offer of regional analgesia, should be considered for nulliparous women and birthing people if contractions are ineffective at the onset and throughout the second stage. This decision should be made on an individual patient basis and documented by an obstetrician.

### 5.4 Duration of the active second stage and definition of delay (NICE 2023)

Delay in progress is defined as a lack of continuing progress in the second stage of labour with effective contractions. Consider maternal or birthing person position to aid descent and active pushing.

| | WITHOUT EPIDURAL | | WITH EPIDURAL | |
|---|---|---|---|---|
| | **Nulliparous** | **Multiparous** | **Nulliparous** | **Multiparous** |
| **Passive** | 1 hour, unless urge to push | 1 hour, unless urge to push | Up to 2 hours | 1 hour |
| **Active** | • Birth should be expected within 3 hours of the start of active second stage in most women and birthing people.<br>• After 1 hour of active pushing, reassess and offer vaginal examination and consider amniotomy if the membranes are intact.<br>• If birth not imminent after 2 hours of pushing, refer woman or birthing person for a senior review and a decision on place and mode of birth. | • Birth would be expected to take place within 2 hours of the start of the active second stage in most women and birthing people.<br>• After 30 minutes of active pushing, reassess if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact.<br>• If birth is not imminent after 1 hour of pushing, refer the woman or birthing person for senior review and decision on place and mode of birth. | • Birth would be expected to take place within 3 hours of the start of the active second stage in most women and birthing people but be aware that these women and birthing people may have had a passive stage of up to 2 hours after full dilatation before commencing active pushing.<br>• After 1 hour of active pushing reassess and offer vaginal examination and consider amniotomy if the membranes are intact.<br>• If birth not imminent after 2 hours of pushing, refer the woman or birthing person for a senior review and a decision on place and mode of birth. | • Birth would be expected to take place within 2 hours of the start of the active second stage in most women and birthing people but be aware that these women and birthing people may have had a passive stage of up to 1 hour after full dilatation before commencing active pushing.<br>• After 30 minutes of active pushing, reassess if there are no signs of progress, offer vaginal examination and consider amniotomy if the membranes are intact.<br>• If birth is not imminent after 1 hour of pushing, refer the woman or birthing person for senior review and decision on place and mode of birth. |

## 6.0 Contraindications

Some contraindications are relative, and the risks and benefits should be assessed individually and in partnership with the birthing woman or birthing person.

### 6.1 Absolute contraindications

- Ventouse at less than 32 weeks
- Ventouse for face presentation
- Ventouse for known or suspected immune thrombocytopenic purpura
- Brow presentation
- Cervix not fully dilated
- Failure to meet criteria for safe birth.

### 6.2 Relative contraindications

- Fetal bleeding disorders (e.g. alloimmune thrombocytopaenia). Avoid ventouse, low forceps may be acceptable. Balance with risk of abdominal birth.
- Fetal predisposition to fracture (e.g. osteogenesis imperfecta).
- Ventouse use with caution between 32-36 weeks.
- For known or suspected blood-borne maternal or birthing parent infection (including immune thrombocytopenic purpura) use mid-cavity or rotational forceps with caution.

## 7.0 Choice of instrument

The choice of instrument depends on clinical circumstances and practitioner experience. As the use of more than one instrument should be avoided the operator should choose the most appropriate instrument for facilitating successful birth with the first attempt. Operators should be aware that forceps and vacuum extraction are associated with different benefits and risks; failure to complete the birth with a single instrument is more likely with vacuum extraction, but maternal and birthing parent perineal trauma is more likely with forceps.

### 7.1 Vacuum comparison with forceps

- More likely to fail to achieve vaginal birth.
- More often associated with cephalohematoma.
- More often associated with retinal haemorrhage.
- More often associated with maternal and birthing parent concerns regarding baby.
- Less significant maternal and birthing parent perineal and vaginal trauma.
- No more likely to be associated with caesarean birth.
- No more likely to be associated with low 5-minute Apgar.
- No more likely to increase need for phototherapy.

Risk-based and occurrence information can be summarised as follows:

| Maternal and birthing parent outcomes | Vacuum | Forceps |
|---|---|---|
| Episiotomy | 50-60% | ≥ 90% |
| Significant vulvo-vaginal tear | 10% | 20% |
| OASI | 1-4% | 8-12% |
| PPH | 10-40% | |
| Urinary or bowel incontinence | Common at 6 weeks- improves over time | |

| Perinatal outcomes | Occurrence |
|---|---|
| Cephalohematoma | **1-12%** Predominantly vacuum |
| Facial or scalp lacerations | **10%** |
| Retinal haemorrhage | **17–38%** More common with vacuum, variable |
| Jaundice or hyperbilirubinemia | **5–15%.** |
| Subgaleal haemorrhage | **3-6 in 1000** Predominantly vacuum |
| Intracranial haemorrhage | **5-15 in 10,000** |
| Cervical spine injury | **Rare** Mainly Kielland's rotational forceps. |
| Skull fracture | **Rare** Mainly forceps |
| Facial nerve palsy | **Rare** Mainly forceps |
| Fetal death | **Very rare** |

## 8.0 Risk Factors for failed assisted vaginal birth - Choice of place of birth

The following are associated with higher rates of failure of assisted birth and the operating theatre may be more suitable situations where there may be increased need to resort to birth by immediate caesarean section (CS) birth.

- Mid-cavity or rotational birth or when 1/5$^{th}$ palpable per abdomen.
- Maternal and birthing parent obesity (BMI > 30).
- Estimated fetal weight greater than 4000g or clinically large baby.
- Occipito-posterior position.
- Short maternal and birthing parent stature.
- Fetal head circumference above 95$^{th}$ centile.

## 9.0 Categorisation of assisted vaginal birth in theatre

| Category | Definition | Decision to delivery interval |
|---|---|---|
| **Category 1** | Involves an immediate threat to the life of the mother or birthing parent and/or fetus. | Within 30 minutes. |
| **Category 2** | Maternal or birthing parent or fetal compromise which is not immediately life-threatening. | Within 75 minutes |

## 10.0 Requirements for safe assisted vaginal birth

Adequate planning and preparation is important. Pregnant women and birthing people should be informed about assisted vaginal birth in the antenatal period, especially during their first pregnancy. If they indicate specific restrictions or preferences then this should be explored with an experienced obstetrician, ideally in advance of labour.

### 10.1 Full abdominal and vaginal examination

- Head is ≤ 1/5 palpable per abdomen (in most cases not palpable).
- Cervix is fully dilated, and the membranes ruptured.
- Station at level of ischial spines or below.
- Position of the fetal head has been determined.
- Caput and moulding are no more than moderate (or +2) Moderate moulding or +2 moulding is where the parietal bones are overlapped but easily reduced; severe moulding or +3 is where the parietal bones have overlapped and are irreducible indicating cephalopelvic disproportion.
- Pelvis is deemed adequate.

### 10.2 Preparation for assisted birth

- Consider the birth preferences of the woman or birthing person for choice of instrument and where possible discuss – ideally antenatally but at least before 2nd stage of labour.
- Trust and agreement with pregnant woman or birthing person established document discussion.
- Verbal consent in labour room or written in theatre.
- For mid-pelvic or rotational births, the risks and benefits of assisted birth should be compared with second stage caesarean.
- Appropriate analgesia
  - Mid-pelvic or rotational birth, usually regional block; a pudendal block may be acceptable depending on urgency.
  - Perineal block may be sufficient for low or outlet birth.
- Maternal or birthing parent bladder has been emptied.
- Indwelling catheter has been removed or balloon deflated.
- Aseptic technique.

### 10.3 Preparation of staff and supervision of trainees

- Operator must have the knowledge, experience and skill necessary to complete procedure and manage any complications that may arise.
- For all mid pelvic or rotational assisted births an experienced operator should be either in theatre or immediately available if a trainee has not been signed off as competent.
- For mid-pelvic births, theatre facilities should be available to allow a caesarean birth to be performed without delay; a senior obstetrician should be present if an inexperienced obstetrician is conducting the birth.
- Anticipation of complications that may arise (e.g. shoulder dystocia, perineal trauma, postpartum haemorrhage).
- Personnel present who are trained in neonatal resuscitation.
- WHO Surgical Checklist should be used for any births being carried out in theatre due to risk of progressing to caesarean birth.

## 11.0 Role of ultrasound

Ultrasound assessment of the fetal head position prior to assisted vaginal birth is recommended where uncertainty exists following clinical examination.

There is insufficient evidence to recommend the routine use of abdominal or perineal ultrasound for assessment of the station, flexion and descent of the fetal head in the second stage of labour. (RCOG 2020)

## 12.0 When to discontinue vacuum assisted birth

- No evidence of progressive descent with moderate traction during each pull of a correctly applied instrument by an experienced operator.
- After x2 two ‘pop-offs’ (less experienced operators should seek senior support after 1x ‘pop-off’ for the best chance of a successful assisted vaginal birth).
- If there is minimal descent after 2 pulls consider suboptimal application, incorrect diagnosis of fetal position or CPD. (Less experienced operators should stop and seek senior opinion).
- Vacuum-assisted birth should bring the fetal head to the perineum in 3 pulls in the majority of cases; three additional gentle pulls can be used to ease the head out of the perineum.
- The rapid negative pressure application for vacuum-assisted birth is recommended as it reduces the duration of the procedure with no difference in maternal or birthing parent and neonatal outcomes.

## 13.0 When to discontinue forceps birth

- When forceps cannot be applied easily.
- Handles do not approximate easily.
- Lack of progressive descent with moderate traction.
- Birth is not imminent following three pulls of a correctly applied instrument by an experienced operator.

- Discontinue rotational forceps birth if rotation is not easily achieved with gentle pressure.
- If there is minimal descent with the first one or two pulls consider suboptimal application, incorrectly diagnosed position or CPD. Less experienced operators should stop and seek a second opinion.
- Experienced operators should re-evaluate the clinical findings and either change approach or discontinue the procedure.
- Inform neonatal team in event of failed forceps.
- Be aware of the increased risk of fetal head impaction at caesarean birth following a failed forceps and be prepared to disimpact the fetal head using recognised manoeuvres.

## 14.0 Morbidity and USE OF sequential instruments

The use of forceps following failed vacuum extraction must only be attempted in exceptional circumstances and by an experienced operator, or under expert supervision. This should be avoided whenever possible. This is due to an increased risk of trauma to the infant. However, the operator needs to balance the risks of a caesarean birth following failed vacuum extraction with the risks of forceps birth following failed vacuum extraction.

There is increased neonatal morbidity following failed vacuum assisted birth and/or sequential use of instruments. The neonatal team should be informed.

## 15.0 Obstetric anal sphincter injuries OASI and episiotomy

- There is an increased risk of OASI following sequential use of instruments.
- Manual perineal protection should be used for all instrumental births to reduce the risk of OASI.
- Though there is no robust evidence to support routine or restrictive use of mediolateral episiotomy the evidence is strongest for nulliparous and forceps delivery in preventing OASI. This may require an assistant.
- The decision should consider the circumstances at the time and the woman or birthing person's preference.
- The risk of post-partum haemorrhage (PPH) is higher with episiotomy
- When performing a mediolateral episiotomy, the cut should be at a 60° angle initiated when the head is distending the perineum.

## 16.0 Care following assisted vaginal birth

### 16.1 Antibiotics

Single dose IV antibiotics should be given as it significantly reduces maternal and birthing parent infection.

Refer to Eolas Medical. Ensure antibiotic prescriptions are documented appropriately on the electronic prescribing system and on BadgerNet Maternity.

| | Antibiotic | Dose | Rate |
|---|---|---|---|
| **First line** | Co-amoxiclav | 1.2grams | STAT |
| **Penicillin allergy** | Cefuroxime + Metronidazole | 1.5grams 500milligrams | |
| **Severe penicillin Allergy** | Clindamycin + Gentamicin | 900 milligrams 240 milligrams | |

- Make an individualised risk assessment for PPH.
- Ensure paired cord blood samples are taken and documented.
- At the end of the procedure, it should be ensured that all instruments, swabs and sharps are complete (checked with 2nd staff member) and both should document on Maternity BadgerNet. If in theatre complete the WHO surgical checklist.
- Information on assessment including timings, decision-making and procedure.
- Standardised proformas in Maternity BadgerNet (examination prior to instrumental birth, instrumental birth and perineal repair section) should be completed, and any additional notes documented in the additional details section. This is the responsibility of the obstetrician undertaking the procedure.
- Clear postnatal plan.
- Debrief/discussion regarding future pregnancies ideally by the person who performed the birth.
- Women and people who had an uncomplicated assisted birth should be encouraged to aim for a spontaneous birth in a subsequent pregnancy as even of those who had a complicated assisted birth in theatre have an 80% chance of a successful spontaneous vaginal birth subsequently.
- Additional support should be offered to establish infant feeding and with baby care. Consideration should be made for paediatric review for pain relief for infants who appear in pain from the birth who are unable to latch despite support and who cry excessively when handled.
- Pelvic floor exercises should be recommended to all women and birthing people to reduce the risk of urinary incontinence. Physiotherapy directed strategy at 3 months reduces risk of urinary incontinence (31-38%). Physiotherapy-directed postnatal women and birthing people regardless of mode of birth should be advised about pelvic floor exercises and conversation recorded in the records.

### 16.2 Bladder care

Following instrumental birth, women and birthing people should have a fluid balance chart until catheter is removed to detect post-partum urinary retention and the first two voids following birth or removal of an indwelling urinary catheter should be measured and recorded on Maternity BadgerNet. (See*:* Bladder Care Guideline and Maternity Fluid Management Guideline)

- Women and birthing people should be educated about the risk of urinary retention so that they are aware of the importance of bladder emptying in the postpartum period.
- Post void residual should be measured if urinary retention is suspected.

- Women and birthing people who have had regional analgesia for a trial of assisted vaginal birth should be offered an indwelling catheter for 6–12 hours after birth to prevent asymptomatic bladder overfilling, to ensure good voiding volumes.
- Fluid balance should be documented on Maternity BadgerNet.

### 16.3 Thromboprophylaxis

Following birth, all women and birthing people should be re-assessed for risk factors for venous thromboembolism (VTE) and a VTE score re-calculated and recorded on Maternity BadgerNet. Where thromboprophylaxis is required, referral to the obstetrician should be made and appropriate prescription arranged.

### 16.4 Analgesia

Regular paracetamol and ibuprofen (in the absence of contraindications) should be considered for all postnatal women and birthing people.

## 17.0 Reducing psychological effects of assisted birth

- Shared decision making, good communication, and positive continuous support during labour and birth have the potential to reduce psychological morbidity following birth. In addition, careful use of language should be observed in the medical record, avoiding the term ‘failure to progress’ in favour of ‘delay’ due to the recognised impact this has on the parent’s view of their birth and their body.
- Offer referral to in-house midwife counsellor for advice and support to parents who have had a traumatic birth and wish to talk about their experience. The effect on the birth partner should also be considered.
- Do not offer single session, high-intensity psychological interventions with an explicit focus on ‘reliving’ the trauma.

## 18.0 Patient information

Please refer women and birthing people to the following webpages for further written information on assisted vaginal birth (these can be printed and in other languages as required):

- RCOG patient information leaflet: An Assisted Vaginal Birth (ventouse or forceps)

## 19.0 Clinical incident reporting

Maternity units should provide a safe and supportive framework to support women and birthing people, their families and staff when serious adverse events occur. All staff should adhere to duty of candour; a professional responsibility to be honest with patients when things go wrong.

A clinical incident form (Datix) must be completed in the following circumstances:

- Instrumental birth is unsuccessful, and CS is required.
- More than one instrument is used.
- Third/fourth degree perineal tear is sustained.

- Low Apgar (less than 7 at 5 mins), cord pH less than 7.1 or neonatal trauma.
- Major obstetric haemorrhage.
- Shoulder dystocia.
- Event reporting, regular reviews and audits.

## 20.0 Monitoring

Auditable standards as recommended by RCOG guideline:

- Proportion of assisted vaginal births; the UK average is between 10%-15%.
- Proportion of unsuccessful assisted vaginal births.
- Proportion of sequential instrument use.
- Case notes review to audit appropriate care of woman or birthing person with failed assisted vaginal birth or sequential instrument use for:
  - Use of ultrasound scan to confirm fetal position.
  - Proportion of third- and fourth-degree perineal tears (1-4% for vacuum and 8–12% for forceps).
  - Proportion of neonatal morbidity (composite trauma, including subgaleal haemorrhage, brachial plexus injury, fracture, facial nerve palsy, or cerebral haemorrhage), low Apgar score less than 7 at 5 minutes and cord arterial pH less than 7.10 (refer RCOG consent).
  - Completeness of documentation (100%).
- Proportion of women and birthing people after assisted vaginal birth receiving a postnatal review explaining the birth and discussing birth options in future pregnancy (100%).

| Issue being monitored | Monitoring method | Responsibility | Frequency | Reviewed by and actions arising followed up by |
|---|---|---|---|---|
| Administration of IV antibiotics with instrumental birth | Audit of EPMA | CE Team in combination with Pharmacy team. | Yearly or more frequently if clinically indicated | Maternity Q&S Meeting |

## Guideline Version Control Log

**Change Log – Assisted Vaginal Birth**

| Version | Date | Author(s) | Status | Comment |
|---|---|---|---|---|
| 1.0 | June 2010 | Consultant Obstetrician/ IT Audit and CE Midwife | Archived | Original new Trust wide guideline |
| 2.0 | Feb 2011 | Consultant Obstetrician/ IT Audit and CE Midwife | Archived | Minor administrative amendment |
| 3.0 | Aug 2013 | Consultant Obstetrician/ IT Audit and CE Midwife | Archived | Version 2 expired-minor updates only required |
| 4.0 | July 2017 | Obstetric Registrar and Consultant | Archived | Guideline review and update |
| 5.0 | Oct 2017 | Consultant Obstetrician | Archived | Addition of consent discussion |
| 6.0 | Feb 2020 | Specialist trainee (R.Sexton) /consultant obstetrician (S.Das) | Archived | Full review based upon RCOG and NICE recommendations:<br>NICE Guidance (updated 2017) CG190 Clinical Guideline -Intrapartum Care<br>RCOG (2020) Green-top guideline no.26 |
| 7.0 | Mar 2024 | H. Aladali, Obstetric Registrar<br>S. Das, Obstetric Consultants | LIVE | 3 year review:<br>• Definition of ineffective progress updated.<br>• Use of USS where there is uncertainty over position. |

## Due Regard Assessment Tool

To be completed and attached to any guideline when submitted to the appropriate committee for consideration and approval.

| | | Yes/No | Comments |
|---|---|---|---|
| **1.** | **Does the document/guidance affect one group less or more favourably than another on the basis of:** | | |
| | Age | *No* | |
| | · Disability | *No* | |
| | · Gender (Sex) | *No* | |
| | · Gender Identity | *No* | |
| | · Marriage and civil partnership | *No* | |
| | · Pregnancy and maternity | *No* | |
| | · Race (ethnicity, nationality, colour) | *No* | |
| | · Religion or Belief | *No* | |
| | · Sexual orientation, including lesbian, gay and bisexual people | *No* | |
| ***2.*** | **Is there any evidence that some groups are affected differently and what is/are the evidence source(s)?** | *No* | |
| ***3.*** | **If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?** | *NA* | |
| ***4.*** | **Is the impact of the document likely to be negative?** | *No* | |
| ***5.*** | **If so, can the impact be avoided?** | *NA* | |
| ***6.*** | **What alternative is there to achieving the intent of the document without the impact?** | *NA* | |
| ***7.*** | **Can we reduce the impact by taking different action and, if not, what, if any, are the reasons why the guideline should continue in its current form?** | *NA* | |
| ***8.*** | **Has the document been assessed to ensure service users, staff and other stakeholders are treated in line with Human Rights FREDA principles (fairness, respect, equality, dignity and autonomy)?** | *Yes* | |

If you have identified a potential discriminatory impact of this guideline, please refer it to [Insert Name], together with any suggestions as to the action required to avoid/reduce this impact. For advice in respect of answering the above questions, please contact uhsussex.equality@nhs.net 01273 664685).

## Template Dissemination, Implementation and Access Plan

To be completed and attached to any guideline when submitted to Corporate Governance for consideration and TMB approval.

| | Dissemination Plan | Comments |
|---|---|---|
| 1. | Identify: | |
| | Which members of staff or staff groups will be affected by this guideline? | Midwives and obstetricians |
| | How will you confirm that they have received the guideline and understood its implications? | Dissemination through the usual Communication channels and highlighted at Safety Huddles. |
| | How have you linked the dissemination of the guideline with induction training, continuous professional development and clinical supervision as appropriate? | All new members of staff shown where to access Clinical documents that are relevant to their area of practice. |
| 2. | How and where will staff access the document (at operational level)? | Accessed by staff via Sharepoint |

| | | Yes/No | Comments |
|---|---|---|---|
| 3. | Have you made any plans to remove old versions of the guideline or related documents from circulation? | Yes | Previous versions will be archived as part of the uploading to SharePoint process. |
| 4. | Have you ensured staff are aware the document is logged on the organisation's register? | Yes | Dissemination plan includes notifying staff via email, safety noticeboards, departmental newsletter and social media. |

## Additional guidance and information

Bohren MA, Hofmeyr GJ, Sakala C, Fukuzawa RK, Cuthbert A. Continuous support for women during childbirth. Cochrane Database of Syst Rev 2017;7:CD003766.

Care Quality Commission. Regulation 20: Duty of Candour. Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare. London: CQC; 2015.

Committee on Practice Bulletins—Obstetrics. ACOG Practice Bulletin No. 154: Assisted vaginal birth. Obstet Gynecol 2015;126:e56–65.

Demissie K, Rhoads GG, Smulian JC, Balasubramanian BA, Gandhi K, Joseph KS, et al. Assisted vaginal birth and neonatal and infant adverse outcomes: population based retrospective analysis. BMJ 2004;329:24–9

Grady. K, Howell. C and Cox.C (2007) Managing Obstetric Emergencies and Trauma – the MOET Course Manual.

Gupta JK, Sood A, Hofmeyr GJ, Vogel JP. Position in the second stage of labour for women without epidural analgesia. Cochrane Database Syst Rev 2017;5:CD002006

Knight M, Chiocchia V, Partlett C, Rivero-Arias O, Hua X, Hinshaw K, et al. on behalf of the ANODE collaborative group*. Prophylactic antibiotics in the prevention of infection after assisted vaginal birth (ANODE): a multicentre randomised controlled trial. Lancet 2019;393:2395–403

National Safety Standards for Invasive Procedures (NatSSIPs), NHS England, 2014

NICE Intrapartum Care (2023) https://www.nice.org.uk/guidance/ng235

NHS Litigation Authority (2010) Clinical Negligence Scheme for Trusts, Maternity Clinical Risk Management Standards, April 2010, London, NHSLA.

NHS Maternity Statistics, NHS Maternity Statistics, England, 2022-23 - NHS Digital

Pavord S, Rayment R, Madan B, Cumming T, Lester W, Chalmers E, et al. on behalf of the Royal College of Obstetricians and Gynaecologists. Management of inherited bleeding disorders in pregnancy. Green-top Guideline No. 71. BJOG 2017;124:e193–e263.32

Ramphul M, Kennelly M, Murphy DJ. Establishing the accuracy and acceptability of abdominal ultrasound to identify the foetal head position in the second stage of labour: a validation study. Eur J Obstet Gynecol Reprod Biol 2012;164:35–9.

Royal College of Obstetricians and Gynaecologists (2020) Assisted Vaginal Birth. Green-top No.26.

Royal College of Obstetricians and Gynaecologists. Assisted vaginal birth. Consent Advice No. 11. London: RCOG; 2010.

Towner D, Castro MA, Eby-Wilkens E, Gilbert WM. Effect of mode of delivery in nulliparous women on neonatal intracranial injury. N Engl J Med 1999;341:1709–14.

Tuuli MG, Frey HA, Odibo AO, Macones GA, Cahill AG. Immediate compared with delayed pushing in the second stage of labour: a systematic review and meta-analysis. Obstet Gynecol 2012;120:660–8

Wassen MM, Zuijlen J, Roumen FJ, Smits LJ, Marcus MA, Nijhuis JG. Early versus late epidural analgesia and risk of instrumental delivery in nulliparous women: a systematic review. BJOG 2011;118:655–61.