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TRUST CLINICAL GUIDELINE

Latent phase of labour

Overview

This guideline provides evidence-based guidance for providing care to women and birthing people in the latent phase of labour.

First, second and third stages of labour are covered in the [Care in Labour guideline](#).

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Latent phase of labour

1.0 Introduction

Clinically the latent phase of labour is poorly understood and can be hard to define (Hundley et al., 2017). The concept of the latent phase has significance in understanding childbirth because labour is considerably longer when a latent phase is included. The management of a woman or birthing person's care during this phase of labour has implications for their entire labour experience. Moreover, the latent phase of labour is considered to be more sensitive to external influences such as lighting, language and emotional support, than the active phase of labour; especially with regard to its duration.

Accordingly, the care provided to women and birthing people in the latent phase of labour should focus on allaying their fears, giving them information, and providing reassurance, emotional and physical support. It is therefore vital that healthcare professionals understand the physiology behind this stage and the psychological impact that care in the latent phase can have on women and birthing people and the length of their overall labour.

This guideline is intended for women and birthing people at low risk of complications. If women and birthing people with risk factors present in the latent phase, they should be reviewed by a senior obstetrician (ST3 or above) and an individualised plan made, however the principles of care within this guideline should still be considered, particular in regards to ongoing monitoring during admission and identifying progression to active labour.

2.0 Scope

This guideline applies to the following:

- Midwives
- Obstetricians

3.0 Responsibilities

Midwives & obstetricians:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this guideline.

Management:

- To ensure the guideline is reviewed as required in line with Trust and National recommendations.
- To ensure the guideline is accessible to all relevant staff.

4.0 Definitions and abbreviations used within this guideline

BP, P, RR, T Blood pressure, pulse, respiration rate, temperature	cm centimeters
MLU Midwife led unit	OP Occipital position
VE Vaginal examination	

Definitions:

The latent phase or early stage of labour is defined a period of time, not necessarily continuous, when women and birthing people experience painful contractions and there is some cervical change, including cervical effacement and dilatation up to 4 cm (NICE, 2023).

Some women and birthing people have pain without cervical change. Although they are described as not being in established labour, they may well consider themselves 'in labour' by their own definition and it may help someone to be acknowledged that they are in early labour.

5.0 Antenatal Conversations

It is good practice for midwives to discuss with all pregnant women and birthing people, and ideally their birth partners, what to expect during the latent phase of labour when the woman or birthing person's birth preferences are considered (NICE, 2023).

Information should include:

- Coping strategies (such as use of water, mobilisation and maternal positioning) and nutrition and hydration advice.
- Management of pain and pain relief options.
- How and when to contact the telephone triage.
- 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.
- What signs and symptoms to report to us and what to do in an emergency.

Pregnant women and birthing people should be signposted to online maternity information to help them during early labour.

6.0 Management of latent phase of labour

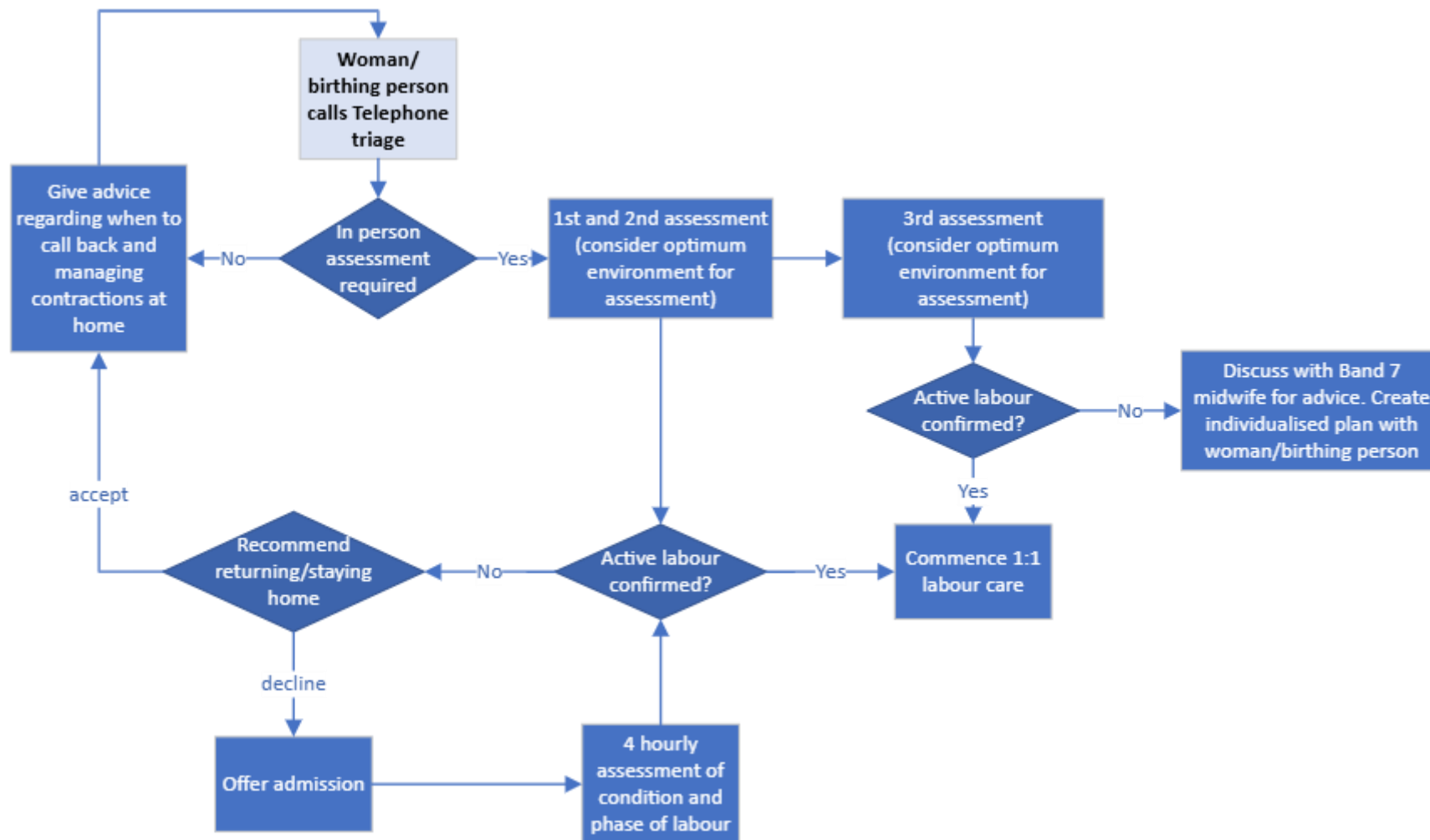


Figure 1: Flowchart for the management of the latent phase of labour

6.1 Telephone Triage

Women and birthing people should be advised to call Telephone Triage if they think they are in labour. Please see Telephone Triage and [Care in Labour guideline](#).

6.2 Initial assessment

See [Care in Labour guideline](#) for guidance on in-person initial assessment of women and birthing people in suspected labour.

If women and birthing people with risk factors are to be admitted in the latent phase, they should be reviewed by a senior obstetrician (ST3 or above) and an individualised plan made.

6.3 Diagnosed latent phase

Woman and birthing people confirmed to be in the latent phase of labour should be encouraged to return home or stay home as long as possible if having an at home assessment. Studies have shown that early admission to hospital is associated with increased labour augmentation with oxytocin, epidural analgesia and caesarean birth (Kjerulff et al., 2023).

If discharging women and birthing people home in the latent phase, midwives should discuss different strategies for managing contractions at home, and give safety netting advice, including when to call telephone triage again.

In some circumstances it may be more appropriate to offer admission, for example multiparous women and birthing people who are contracting regularly (more than 1 in 5), or women and birthing people who have risk factors.

It is important when planning care in the latent phase to create a personalised care plan with the woman or birthing person, taking into consideration clinical, psychological and social factors. For example, low station of the fetal head is a sign that progress in labour may be very quick. For multiparous women and birthing people who are contracting (more than 1 in 5) consideration should be given to admitting them to the labour ward rather than the antenatal ward as they may progress quickly (Impey et al., 2023).

In some cases, women and birthing people may decline to go home after being given all the information on the benefits of being at home. This may be because they feel safer in the hospital and their labour may not become established until they feel safe and relaxed in the place they want to birth in. Or this may be because they do not feel as though they are able to cope at home. Staff should explore the reasons why they do not wish to go home. If a woman or birthing person declines to go home, they should be supported in their decision. If they prefer not to be at home at this stage, they can be offered the option of staying on an antenatal ward or within the MLU for a few hours.

6.4 Latent phase care in hospital

Low risk women and birthing people should be reviewed at least 4 hourly to ensure they are coping and assess if established labour may have started; if the birthing woman or pregnant person is awake, this review should include a full assessment of maternal and fetal wellbeing, including:

- Maternal observations (BP, P, RR, T).
- Auscultation of the fetal heart.
- Discussion of fetal movements.
- Assessment of uterine contractions, including frequency, length and strength and how they are managing with their contractions.
- Assess the woman or birthing person's behaviour including her position, movements, and emotional wellbeing.
- Review of any new or evolving risk factors.

If the woman or birthing person raises concerns or is very anxious, it may be appropriate to check on them more frequently. High risk women or birthing people may need review more often, the frequency of which should be based on clinical judgement and existing risk factors.

This review may include a vaginal examination (VE), but they should not be routinely offered every 4 hours in the latent phase of labour due to the increased risk of infection associated with multiple examinations (Gluck et al., 2020). VEs should only be offered if there is a clear indication, for example, a change in behaviour or contractions that indicate progression. If a woman or birthing person requests a VE but there is no clinical indication, healthcare professionals should ensure they are aware of the risks to support informed decision making.

If the woman or birthing person remains in hospital, birthing parent satisfaction and probability of spontaneous vaginal birth may increase if:

- The environment is free from medical equipment and facilitates self-comforting behaviour. They should be encouraged to adapt the space for their own needs.
- Physical positions are encouraged that promote fetal head rotations and relieve pain; such as standing, leaning forward, sitting upright, leaning forward with support, kneeling on all fours and side lying positions. This may include positions and methods used by midwives trained in biomechanics for birth techniques.
- Promote strategies to cope with pain (See [section 8.0](#)).
- Use interventions to reduce emotional distress such as reframing negative thoughts to positive ones, discussing the importance of relaxation, rhythm and visualisation techniques. Avoid the use of negative language such as "you are not in labour".
- Encourage support from birth partners. Good support in labour has been shown to reduce pain, stress and anxiety and increase satisfaction (UHL, 2024).

After a period of time, birthing women and people may feel confident to return home if still in the latent phase of labour. If after 4 hours the birthing woman or person remains in the latent phase,

with no new risk factors and with normal clinical observations and able to cope, another conversation should be held to explore the advantages of returning home.

6.5 Recognising progression of labour

Not recognising when labour is progressing has been identified at a local and national level as a contributing factor to some adverse outcomes (MBRRACE-UK et al., 2017). In part, this is due to a lack of appropriate 1:1 labour care provision and fetal monitoring during undiagnosed labour. Not being believed or not being listened to are common themes in the Birth Trauma Report, the Ockenden Report, Kirkup report and local service user feedback (APPG, 2024; Kirkup, 2022; Ockenden, 2022).

It is important to recognise early when a woman or birthing person has transitioned to the active phase of labour, particularly when they are in a setting where 1:1 labour care cannot be provided, e.g. AN ward, in order to provide safe and timely transfer. Delayed transfer when women and birthing people are in advanced labour can make them feel vulnerable, out of control and exposed and this can lead to adverse maternal and neonatal outcomes (MBRRACE-UK et al., 2017).

Vaginal examinations can be a useful tool when assessing labour progress but should be considered as only one aspect of the holistic assessment and they are not predictive of future labour progress. Women and birthing people could progress to active labour shortly after a VE has confirmed the latent phase and it is important to be able to recognise this transition. The desire to confirm active labour by a VE must be balanced against the additional risk of infection from multiple vaginal examinations. If active labour is strongly suspected, but it has been less than four hours since the last examination, consider commencing active labour care pathway without a VE. If at the next examination the woman or birthing person is found to still be in the latent phase, then care can revert to latent phase care.

The absence of a VE confirming active labour should not restrict access to appropriate care or pain relief. (see section on '*Diagnosing labour in the absence of vaginal examination*' in the [Care in Labour guideline](#)).

6.5.1 Modified Burvill Score

One tool that can be used to support midwives in recognising transition to active labour is the Burvill Score. External signs are often visible and can support midwives to diagnose the onset of established labour (Fumagalli et al., 2022). The Modified Burvill Score is a standardised assessment tool which can be used to capture these external signs. It is not intended to replace clinical assessment but is to enhance the assessment process of labouring women and birthing people, particularly when VEs have been declined or are not recommended. For example:

- A woman or birthing person has declined a VE
- There is a change in maternal or birthing parent behaviour during the latent phase, indicating progress, when it has been less than 4 hours since the last examination and there are no maternal or fetal concerns.
- Considering whether a VE is indicated as part of the 4 hourly assessments during latent phase admissions.

Score	0	1	2
Themes	Signs may indicate Early Labour	Signs may indicate established labour	Signs may indicate advanced established labour
Breathing	Exaggerated, pain like breathing	Deeper breathing, controlled, pronounced, like a sigh	Not shallow, cannot talk, focused on breathing slow with contractions; grunting sounds, cries out with expiration
Conversation	Chatty, excitable, speaks quickly	Speaks less	Becomes quiet, conversation stops with each contraction, takes 20 seconds or more to resume talking; focus goes inward
Mood	Excitement/anxiety, happy, slightly agitated	Ceases to worry about external concerns	Withdraws, focus is on self
Energy	Wants to sort out practicalities	Becoming still. Inward focus on self	Still. Withdrawn into self
Movement & Posture	Grasps abdomen and bends forward with contractions	Less mobile. Stops for contractions and holds onto something/one	Stays in one position with or without contraction. Sways hips during contraction
Contractions without palpation	20 - 40 seconds	50 seconds or more - at least 4 minutes apart	50 seconds or more, 2-3 minutes apart

Table 1: Modified Burvill Score

It is suggested that where the Burvill score is 5 or more one to one care should be commenced. For women and birthing people on the antenatal ward (in early labour or undergoing an induction of labour), a score of 5 or more should be discussed with the labour ward coordinator. A high score may indicate prompt transfer to the labour ward without further VE to avoid delay in transfer, particularly in the presence of multiparity/previous precipitate birth.

If the Modified Burvill Score is used, it should be recorded on BadgerNet Maternity using the appropriate form ([Appendix 1](#)).

7.0 Prolonged Latent Phase

There is no agreed definition for a prolonged latent phase within the literature and anecdotally it can last for 2-3 days (Ängeby et al., 2015). Every woman or birthing person's experience of the latent phase is different, some women and birthing people need minimal input from their midwives,

and others may find the irregularity of contractions and disturbed sleep challenging and seek more support from maternity services.

Research shows that women and birthing people admitted with a prolonged latent phase are more likely to receive obstetric interventions, with increased rates of instrumental deliveries for nulliparous women, and increase rates of emergency caesareans for both nulliparous and primiparous women and birthing people (Ängeby et al., 2018).

Mal-positions, especially the occipital position (OP), may lead to a prolonged latent phase (Tilden et al., 2019). Women and birthing people should be reassured that OP positions are normal and most babies rotate during labour. However, if there is a suspicion of malposition affecting labour, early support and advice from the midwife on how to cope and for promoting optimal fetal positioning should be given (See [section 8.1.2](#)).

A prolonged latent phase of labour can be a discouraging and exhausting experience for women and birthing people. If a woman or birthing person remains in the latent phase of labour on a third assessment, a review by a senior midwife is recommended where an individualised plan of care incorporating the woman or birthing person's preferences should be created. This may be a third attendance of a midwife at home for planned homebirths, or a third attendance to the unit, but also includes if women and birthing people have a third vaginal examination as an inpatient. If there are any additional risk factors identified at any assessment, referral to the obstetric team may be indicated (see [Care in Labour](#)).

8.0 Techniques to support with early labour contractions

There are many ways to support women and birthing people manage their contractions, both pharmaceutical and non-pharmaceutical.

8.1 Non-pharmaceutical techniques

The following table summarises a number of different non-pharmaceutical techniques and their proposed mechanisms of actions that women and birthing people may find beneficial.

Methods	Mechanism of Action	Benefits
Massage	Reduces discomfort and triggers endorphin release, an endogenous hormone with analgesic properties. Promotes subjective sense of psychological relief.	Combining oil with massage: <ul style="list-style-type: none"> • Decrease pain • Reduces labour duration • Improved satisfaction.
Acupressure	Gate control theory- blocking pain signals. Regulation of oxytocin.	Improve women and birthing people's satisfaction. Decrease labour pain. Reduces labour duration.
TENS	Gate control theory- blocking pain signals.	Reduce pain. Improves satisfaction.

Water immersion	Water can induce relaxation, reduce pain perception and facilitate smoother movement during labour.	Improves physical and psychological comfort. Reduces need for pain relief.
Heat therapy	Enhances blood circulation, induces muscle relaxation.	Reduces pain. Reduces labour duration. Reduces pain post-labour.
Breathing Techniques	Diverts attention from pain and facilitates state of relaxation.	Reduces pain. Reduces labour duration.
Hypnobirthing	Modulates pain intensity caused in the primary somatosensory cortex. Relaxes and distracts attention from the pain sensation.	Reduces use of analgesia.
Music	Modulates pain responses in Central nervous system.	Reduces stress. Reduces pain. Increases pain tolerance.
Distraction	Minds occupied by excitement are distracted from the excitement of the pain senses.	Reduces pain. Reduces stress.
Dancing	Combines the benefits of music and the effects of upright positioning and movement.	Reduces pain. Improved satisfaction.
Support	Supports autonomy and decision-making, promoting feelings of control and confidence.	Reduces pain. Reduces stress and anxiety. Increased satisfaction.

Table 2: Non-pharmaceutical support (Nori et al., 2023)

Presence of birth supporters in the birth room is protective against birth trauma and is associated with improved physical outcomes (Bohren et al., 2019). However, birth partners often do not feel included and can feel very vulnerable and stressed (Schmitt et al., 2022). Enabling birth partners to support their partners through some of the strategies outlined in the table above may improve the birth experience for the whole family. This can be particularly effective on the antenatal ward where a midwife may not be able to provide continuous emotional support.

8.1.1 Supported rest

As the length of the latent phase of labour can vary considerably, it is important to emphasise to women and birthing people the importance of rest at this time. Historically, women and birthing people have been advised to remain active and are often recommended to continuously walk during this stage to bring on contractions. While activity is important, it must be recognised that active labour is expected to last up to 18 hours for primiparous women and birthing people, and up to 12 hours for multiparous women and birthing people, therefore preservation of energy in the latent phase can be crucial (NICE, 2023). The importance of rest in this stage should be discussed.

Supported rest refers to resting in dynamic positions that support the physiology of birth by creating space in the pelvis. In the latent phase, positions that open the inlet of the pelvis may encourage fetal descent and labour to become established. Consider the use of peanut balls, pillows and blankets to facilitate these positions.

8.1.2 Biomechanics

Biomechanics is the study of biology and the mechanisms of movement. Biomechanics and maternal positional changes in any stage of pregnancy and labour encourages optimal fetal positioning and its associated benefits. Different maternal or birthing parent positions may be used by a midwife or health professional, both preventatively and responsively to support labour physiology. On suspicion of a malposition, early support and advice regarding biomechanics may be of benefit. The use of these techniques should not delay or replace escalations of concerns. The aim of biomechanics in labour is to provide additional choice and holistic care to women and birthing people.

There is an increasing number of research studies to support the use of other biomechanic techniques to resolve malposition. By adopting these positions, the pelvic and uterine ligaments are stretched, and this may create space and encourage the baby to rotate into a more favourable position for labour. At an Irish maternity unit, introduction of the biomechanics toolkit increased the rate of spontaneous onset of labour and reduced the caesarean birth rate, without any reported adverse outcomes (Lennon, 2024). A biomechanical approach is being adopted by many NHS trusts across the UK.

Some benefits that have been identified in these studies include:

- Improved birth experience and maternal satisfaction (Iversen et al., 2017; Mahmoud Mahmoud Saadoon, Yousif and Fouad Mohammed, 2023; Farag, Ibrahim and Alam, 2024; Tandoğan and Oskay, 2024).
- Reduce pain and anxiety (Mahmoud Mahmoud Saadoon, Yousif and Fouad Mohammed, 2023; Farag, Ibrahim and Alam, 2024).
- Reduction in caesarean section rate (Barrera & Acosta, 2022; Funk, 2024; Lennon, 2024; Zwillinger & Burke, 2023).
- Shortened second stage of labour (Sears, 2023; Tandoğan and Oskay, 2024).
- Increased rate of spontaneous onset of labour (Lennon, 2024).
- Decrease in persistent OP position (Fumagalli et al., 2024).
- Increased feeling of being active participant in their labour and feelings of safety (Tandoğan and Oskay, 2024).

8.2 Pharmacological Options

If a woman or birthing person is requesting additional pain relief, consideration should be given to if their labour is progressing to the active phase of labour

Drug	Details
Paracetamol	<p>1 gram 4 hourly (500 milligrams if woman or birthing person weighs less than 50 kilograms) with no more than 4 doses within 24 hours.</p> <p>Midwives should check if the woman or birthing person has already self-medicated at home.</p>
Dihydrocodeine	<p>Dihydrocodeine 30 milligrams 4-6 hourly. Maximum dose 120 milligrams within 24 hours.</p> <p>If the woman or birthing person has had dihydrocodeine before moving on to oral morphine (30 milligrams of dihydrocodeine is equivalent to 3 milligrams morphine sulfate) – this needs to be taken account of and documented accordingly.</p>
Oral Morphine	<p>Morphine sulfate 10 milligrams PO, each dose should be prescribed as a once-only medication and a maximum of two doses four hours apart.</p> <p>Midwives may administer this under PGD if they meet the criteria for PGD (requiring analgesia while in the latent phase of labour before they are fully admitted to the trust who remain onsite for clinical assessment prior to admission). Morphine sulfate must be prescribed for inpatients.</p>
Sedatives	<p>Consider use of sedatives (temazepam 10-20 mg, 10mg is sufficient for benzodiazepine naive patients) if lack of sleep main factor for woman or birthing person's perception of not coping with early labour, in liaison with (and prescription from) an obstetrician.</p>
IM Morphine	<p>10 mg Morphine sulfate 4-6 hourly.</p> <p>It should be given with an antiemetic e.g. prochlorperazine 12.5mg PO/IM (NICE, 2023).</p> <p>Morphine and prochlorperazine may be given under Midwives Exemptions.</p> <p>Wait a minimum of 1 hour post oral administration of morphine, ideally 2, before administering IM morphine and monitor for signs of toxicity.</p> <p>Inform the woman or birthing person that this will provide limited pain relief during labour and may have significant side effects for both them (for example, drowsiness, nausea and vomiting) and their baby (for example, short-term respiratory depression and drowsiness, which may last several days and may make it more difficult to breastfeed).</p> <p>Women and birthing people should not enter water (a birthing pool or bath) within 2 hours of opioid administration or if they feel drowsy.</p>

Table 3: Pharmaceutical options available in the latent phase of labour

9.0 Monitoring

Issue being monitored	Monitoring method	Responsibility	Frequency	Reviewed by and actions arising followed up by
Clinical incidents relating to management of labour Service User experience	Datix/Incident review process, Service user feedback via MNVP, complaints and Friends and Family Test.	Patient Safety/ Governance/ Clinical Effectiveness Team	On-going	Maternity Quality and Safety

Appendix 1: Modified Burvill Score Documentation

Modified Burvill Score form on BadgerNet Maternity:

Modified Burvill Score

Date and Time of Assessment12 May 25at 13:18Gestation 39Weeks, 2Days

Completed By

Use current user...

Answer each of the following.

The first option will score 0 and may indicate Early Labour. The second option will score 1 and may indicate Early Active labour. The third option will score 2 and may indicate Active labour.

Breathing

Conversation

Mood

Energy

Movement & Posture

Contractions without palpation

Total Score

The Burvill score is not intended to replace clinical assessment but is to enhance the assessment process of labouring women.

It is suggested that where the Burvill score is 5 or more one to one care should be commenced. Escalate if necessary

Audit trail...

Save & Close

Cancel

Appendix 2: Guideline Version Control Log

Version	Date	Author	Comment
1.0	June 2025	S. McCambridge, Consultant Midwife Z. Brice, Audit & Guideline Midwife	New Trust wide guideline replacing: <ul style="list-style-type: none">• MP030 Latent Phase of Labour (PRH&RSCH)• CG1106 Care During Latent Phase of Labour (SRH&WH)

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).

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 are 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 onto 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, departmental noticeboards, and safety huddles.

Additional guidance and information

Ängeby, K., Wilde-Larsson, B., Hildingsson, I., & Sandin-Bojö, A. K. (2015). Primiparous women's preferences for care during a prolonged latent phase of labour. *Sexual and Reproductive Healthcare*, 6(3), 145–150. <https://doi.org/10.1016/j.srhc.2015.02.003>

Ängeby, K., Wilde-Larsson, B., Hildingsson, I., & Sandin-Bojö, A. K. (2018). Prevalence of Prolonged Latent Phase and Labor Outcomes: Review of Birth Records in a Swedish Population. *Journal of Midwifery and Women's Health*, 63(1), 33–44. <https://doi.org/10.1111/jmwh.12704>

APPG. (2024). *Listen to Mums: Ending the Postcode Lottery on Perinatal Care*.

Barrera, E., & Acosta, L. (2022). Spinning Babies® a Professional Development Program for Birth Workers to Reduce C-Section Rates. *SMH Best Practice Fair*.

Bohren, M. A., Berger, B. O., Munthe-Kaas, H., & Tunçalp, Ö. (2019). Perceptions and experiences of labour companionship: A qualitative evidence synthesis. In *Cochrane Database of Systematic Reviews* (Vol. 2019, Issue 3). John Wiley and Sons Ltd. <https://doi.org/10.1002/14651858.CD012449.pub2>

Farag, W. K. A., Ibrahim, H. I., & Alam, T. H. M. (2024). Effect of Rebozo Techniques on Pain Intensity, Anxiety and birth experience among Primiparous Women during the Active Phase of Labor. *Menoufia Nursing Journal*, 9(4), 281–300. <https://doi.org/10.21608/menj.2024.414770>

Fumagalli, S., Antolini, L., Cosmai, G., Gramegna, T., Nespoli, A., Pedranzini, A., Colciago, E., Valsecchi, M. G., Vergani, P., & Locatelli, A. (2022). Development and validation of a predictive model to identify the active phase of labor. *BMC Pregnancy and Childbirth*, 22(1). <https://doi.org/10.1186/s12884-022-04946-y>

Fumagalli, S., Antolini, L., Nespoli, A., Panzeri, M., Terenghi, T., Ferrini, S., Spandrio, R., Maini, I. M., Locatelli, A., & Ornaghi, S. (2024). Rebozo and advanced maternal postures: A promising set of intrapartum interventions to reduce persistent occiput posterior position of the fetal head. *European Journal of Midwifery*, 8(61). <https://doi.org/10.18332/EJM/191511>

Funk, B. (2024). The effects of spinning babies® on nulliparous, term, singleton, vertex (NTSV) cesarean rates: A clinical trial. *International Journal of Obstetrics and Gynaecological Nursing*, 6(2), 101–106. <https://doi.org/10.33545/26642298.2024.v6.i2b.165>

Gluck, O., Mizrachi, Y., Ganer Herman, H., Bar, J., Kovo, M., & Weiner, E. (2020). The correlation between the number of vaginal examinations during active labor and febrile morbidity, a retrospective cohort study. *BMC Pregnancy and Childbirth*, 20(1). <https://doi.org/10.1186/s12884-020-02925-9>

Hundley, V. A., Susan Way, R., Cheyne, R. H., Janssen, R. P., Mechthild Gross, B., Spiby, H., & Mphil, S. (2017). Defining the latent phase of labour: is it important? *Evidence Based Midwifery*, 3(15), 89–94.

- Impey, L., Health Innovation Oxford & Thames Valley, & Maternity and Newborn Safety Investigations. (2023). *The diagnosis of labour and improving the safety of the latent phase of labour. A framework to support best practice.*
- Iversen, M. L., Midtgaard, J., Ekelin, M., & Hegaard, H. K. (2017). Danish women's experiences of the rebozo technique during labour: A qualitative explorative study. *Sexual and Reproductive Healthcare*, 11, 79–85. <https://doi.org/10.1016/j.srhc.2016.10.005>
- Kirkup, B. (2022). *Reading the signals - Maternity and neonatal services in East Kent – the Report of the Independent Investigation.*
- Kjerulff, K. H., Attanasio, L. B., Vanderlaan, J., & Sznajder, K. K. (2023). Timing of hospital admission at first childbirth: A prospective cohort study. *PLoS ONE*, 18(2 February). <https://doi.org/10.1371/journal.pone.0281707>
- Lennon, R. (2024). Bouncing your way to labour and birth using biomechanics and fetal optimal positioning. *British Journal of Midwifery*, 32(5), 226–232. <https://doi.org/https://doi.org/10.12968/bjom.2024.32.5.226>
- Mahmoud Mahmoud Saadoun, O. H., Yousif, A., & Fouad Mohammed, S. (2023). Effect of Applying Rebozo Techniques on Pain Intensity and Anxiety among Primiparous Women during the Active Phase of Labor. *Egyptian Journal of Health Care*, 14(2), 476. <https://doi.org/10.21608/ejhc.2023.297805>
- MBRRACE-UK, Draper, E. S., Kurinczuk, J. J., & Kenyon, S. (2017). *Maternal, Newborn and Infant Clinical Outcome Review Programme MBRRACE-UK Perinatal Confidential Enquiry Executive Summary and Lay Report.* www.hqip.org.uk/national-programmes
- NICE. (2023). *NG235 Intrapartum care.* www.nice.org.uk/guidance/ng235
- Nori, W., Kassim, M. A. K., Helmi, Z. R., Pantazi, A. C., Brezeanu, D., Brezeanu, A. M., Penciu, R. C., & Serbanescu, L. (2023). Non-Pharmacological Pain Management in Labor: A Systematic Review. In *Journal of Clinical Medicine* (Vol. 12, Issue 23). Multidisciplinary Digital Publishing Institute (MDPI). <https://doi.org/10.3390/jcm12237203>
- Ockenden, D. (2022). *Findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust.* [Dandy Booksellers Ltd].
- Schmitt, N., Striebich, S., Meyer, G., Berg, A., & Ayerle, G. M. (2022). The partner's experiences of childbirth in countries with a highly developed clinical setting: a scoping review. *BMC Pregnancy and Childbirth*, 22(1). <https://doi.org/10.1186/s12884-022-05014-1>
- Sears, D. (2023). *The Impact of the Spinning Babies Method on Labor Duration and The Impact of the Spinning Babies Method on Labor Duration and Delivery Outcome Delivery Outcome* [PhD Thesis, Walden University]. <https://scholarworks.waldenu.edu/dissertations>
- Tandoğan, Ö., & Oskay, Ü. (2024). The effect of Rebozo technique on perceived labour pain and childbirth experience A randomized controlled trial. *Medicine*, 103(35). <https://doi.org/10.1097/MD.00000000000039346>

Tilden, E. L., Phillippi, J. C., Ahlberg, M., King, T. L., Dissanayake, M., Lee, C. S., Snowden, J. M., & Caughey, A. B. (2019). Describing latent phase duration and associated characteristics among 1281 low-risk women in spontaneous labor. *Birth*, 46(4), 592–601.
<https://doi.org/10.1111/birt.12428>

University Hospitals of Leicester. (2024). *Care in the Latent Phase of Labour Guideline*.

Zwillinger, E., & Burke, J. (2023). Cesarean birth reduction: EBP in action. *American Nurse Journal*, 18(9), 50–54.