



TITLE: Latent Phase of Labour – The Care of Women Guideline

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| Sponsor: | W&C, Head of Midwifery and Nursing | | |
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Remain at Home

If contractions are infrequent and mild, the woman is coping well at home, and there are no risk factors requiring admission:

Provide reassurance and information

- Explain what the contractions are doing (effacement, softening, and dilatation).
- Discuss the expected duration of the latent phase.

Encourage comfort measures and normal activity

- Maintain usual daily activity as tolerated.
- Eat nutritious, high-energy foods.
- Drink according to thirst.
- Rest when possible.

Supportive measures for comfort and coping

- Use the birth partner for back massage.
- Use a birthing ball for comfort and mobility.
- Take a warm bath or shower, directing water onto the lower back if helpful.
- Focus on relaxed shoulders and deep breathing techniques.
- Mobilise and change positions frequently.
- Consider using a TENS machine.

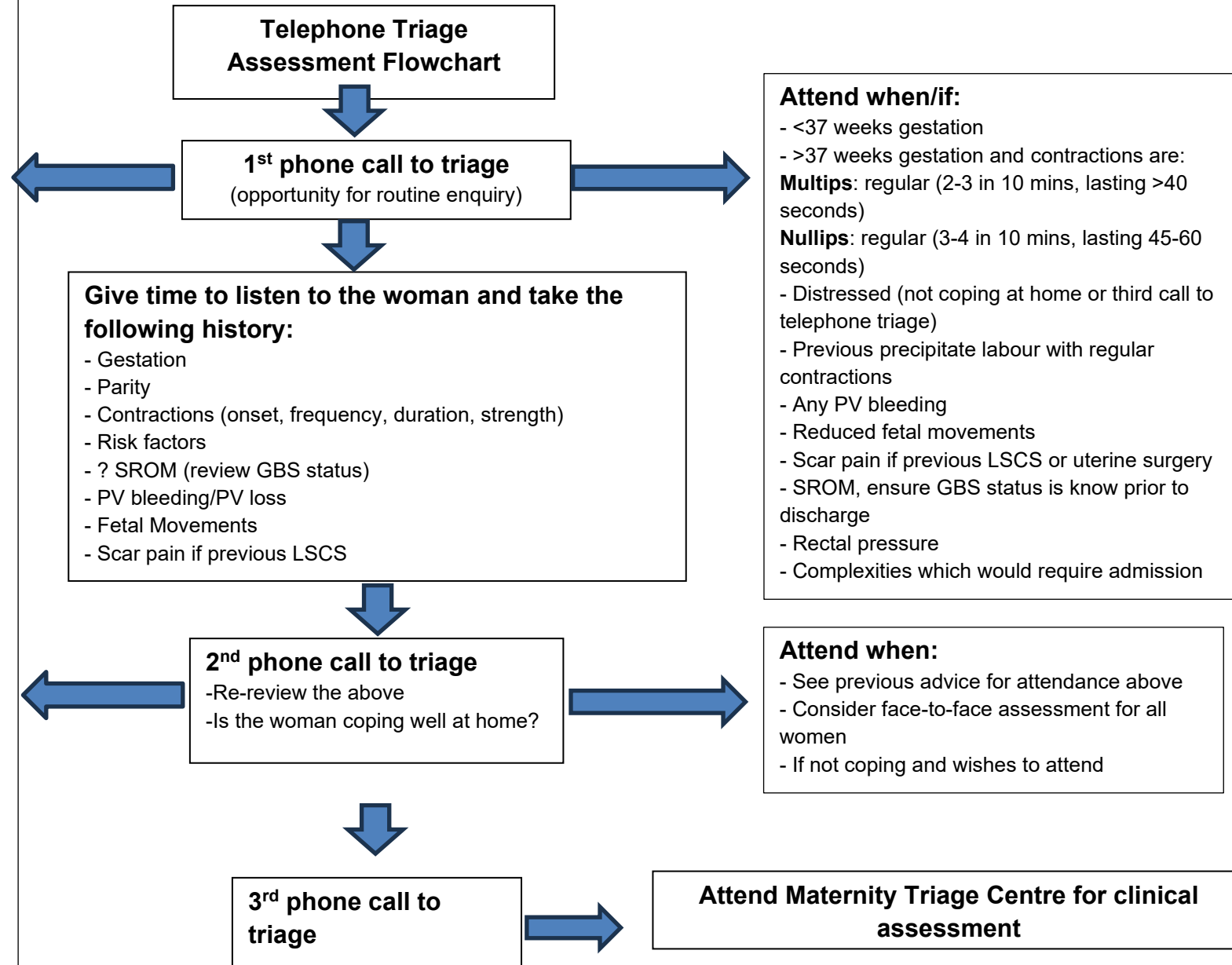
Monitoring and observations at home

- Monitor fetal movements and call back if they change.
- If spontaneous rupture of membranes has been confirmed, monitor the liquor for any changes (colour, odour).
- Observe any PV loss.
- Reinforce important signs and symptoms that should prompt further assessment.

Follow-up Advice

- If the woman is happy with the advice, encourage her to call back when contractions become more regular and/or stronger, or if any concerns arise.

Guideline



Attendance in Latent Stage of Labour Flowchart

Complete and document full labour assessment to determine maternal and fetal wellbeing and identify stage of labour (NB: a vaginal examination is not always necessary):

- Maternal observations and fetal heart assessment (including fetal movements)
- Urinalysis
- Contractions (strength, frequency, length, pain)
- PV Loss

NB: The woman should receive midwifery care for at least 1 hour.

Maternal and/or fetal observations abnormal

Seek medical review and determine plan of care

Maternal and fetal observations normal

Woman can be discharged home, consider analgesia options, give latent stage of labour advice as outline on 'Telephone Triage Assessment Flowchart'. Present again if contractions become regular, cannot cope at home or if concerns arise.

Prior to discharge home, all women should be reviewed one hour following admission to reassessed contraction frequency, length and strength to determine if labour is progressing.

Woman declines discharge home

- Following discussion with the labour ward coordinator, admit to the maternity ward or SBU and individualise care based on relevant background and history
- Provide analgesia where required
- Seek medical review if any abnormalities
- Contact should be made with the woman a minimum of 2 hourly to assess clinical and/or emotional needs. As a minimum, a FULL labour assessment of the woman and fetus should occur every 4 hours
- At each contact with the woman consider if a medical review is required

2nd presentation to triage – full labour assessment, consider analgesia options, and determine plan of care.

3rd presentation to triage – full labour assessment, if not in established labour seek medical review and determine plan of care which should include admission.

NB: Consider face-to-face assessment for all women at every contact; consider routine enquiry

1 INTRODUCTION/ BACKGROUND

The latent phase of labour is a normal physiological process, but it is highly variable both in duration and women's experiences which, therefore, makes it difficult to measure and predict. Timely recognition of active labour can be problematic for both women and their caregivers and it is important that midwives and clinicians, are thorough in their assessment, considering factors such as maternal behaviour, clinical assessment, and clinical judgement prior to diagnosing the 'Active Phase' of labour. Failing this, a mistaken assessment can lead to a subsequent diagnosis of labour dystocia and a consequent cascade of interventions (Hanada et al., 2015). The onset of labour is usually identified by women from various signs, including, painful contractions, back ache, and a blood-tinged mucus vaginal loss (bloody show). It is common for women at this point, to seek advice from health professionals about progress of their labour and for reassurance. It is also not unusual for progress in early labour to be slow. Women may feel anxious or distressed in early labour and lose confidence, which may slow progress and result in women being less likely to experience a spontaneous vaginal birth (Kobayashi et al., 2017). To ensure that women feel supported, it is therefore crucial that Midwives' communications with women in early labour should be clear, friendly, and compassionate (Royal College of Midwives (RCM), 2018).

It is also important to remain professional curiosity and, when safe to do so, ask routine enquiry questions where the recurrent phone call or attendance may be associated with the woman not feeling safe in the home environment or with those around her.

NB: Pregnant women includes any women who are pregnant as well as transgender or non-binary people who are pregnant. This terminology is used to maintain consistency with NHS documents and websites.

2 AIMS/ OBJECTIVES/ PURPOSE (including Related Trust Documents)

Aim

This guideline has been developed to support midwives and obstetricians in recognising the latent phase of labour, enabling accurate clinical risk assessment and effective planning of individualised care for women during this period.

Objectives

- To ensure staff provide consistent, evidence-based care, advice, and reassurance to women and their birth partners during the latent phase of labour.
- To promote effective pain management, ensuring women receive timely, appropriate, and individualised support to optimise comfort and coping.
- To encourage women, where clinically appropriate, to remain at home during the latent phase to enhance physiological oxytocin release and support the natural progression into established labour.
- To standardise clinical practice, ensuring all staff are familiar with the content of this guideline and implement it in accordance with national and local recommendations.

- To enhance maternal and fetal wellbeing through timely recognition of deviation from the expected latent phase and appropriate escalation where required.
- To support shared decision-making, ensuring women are fully informed about the latent phase, available options, and when to seek further assessment.

This clinical guideline applies to:

Staff group(s)

- Midwives
- Obstetricians

Clinical area(s)

- Maternity Triage Centre
- Sherwood Birthing Unit (SBU)
- Maternity Ward
- Community Midwifery
- Continuity of carer Teams

Patient group(s)

- Women in latent phase of labour

Related Trust Documents

- Other maternity guidelines as applicable

3 EVIDENCE BASE/REFERENCES [Type here]

Baillit, J.L., Dierker, L., Blanchard, M.H. and Mercer, B.M. (2005) 'Outcomes of women presenting in active versus latent phase of spontaneous labour', *Obstetrics & Gynecology*, 105:77.

Birmingham Women's and Children's NHS Foundation Trust. (2023) *Guideline for the management of the latent phase of labour*. Internal document. Available to staff via local trust network (Accessed: 10 December 2025).

Kobayashi, S., Hanada, N., Matsuzaki, M., Takehara, K., Ota, E., Sasaki, H., Nagata, C. and Mori, R. (2017) *Assessment and support during early labour for improving birth outcomes*. *Cochrane Database of Systematic Reviews*, Issue 4, Art. No.: CD011516. Available at: <https://doi.org/10.1002/14651858.CD011516.pub2>

National Institute for Health and Care Excellence (NICE) (2025) *Intrapartum care for healthy women and babies (NG235)*. Available at: <https://www.nice.org.uk/guidance/ng235/resources/intrapartum-care-pdf-66143897812933> (Accessed: 10 December 2025).

Royal College of Midwives (RCM) (2018) *Midwifery care in labour: Guidance for all women in all settings*. London: RCM.

4 ROLES AND RESPONSIBILITIES

It is the responsibility of maternity service care providers to ensure the provision of care and support to all women in latent phase of labour.

5 GUIDELINE DETAILS (including Flowcharts)

5.1 Definitions

The latent phase of labour is the time between the beginning of uterine contraction and the onset of the active phase. National Institute for Health and Care Excellence (NICE) (2025) define the latent first stage of labour as a period of time, which may not necessarily be continuous, when there are painful contractions experienced with some cervical changes including cervical effacement and dilatation up to 4cm.

Established Labour should be identified when there are regular painful contractions with progressive dilatation of the cervix from 4cm (NICE 2017). This definition should be used as a guide and must not exclude the importance of individualised clinical decision making when diagnosing established labour.

Preterm labour is defined as labour before 37 completed weeks of gestation

5.2 Antenatal Education

It is important to educate women and their birth partners by providing realistic information about what to expect in the latent phase of labour, how it may be recognised and experienced and when to travel to their planned place of birth (RCM, 2018). It is fundamental that loved ones are involved in antenatal education, as seeing women in pain may cause anxiety amongst some birth partners/companions, which may encourage her to go to hospital sooner than necessary. The information provided must be realistic as whilst accessing a range of sources of information including web-based materials, textbooks, and antenatal classes, can be beneficial to women, they may be less so if their labour does not follow the 'normal' pattern (RCM, 2018).

It is the responsibility of the staff providing antenatal care whether in community, a clinic setting or birth preparation classes to educate women on:

- What to expect in the latent phase of labour
- Differentiating between Braxton Hick's contractions and the latent phase of labour
- The expected frequency of contractions and how long they last
- Recognition of rupture of membranes (colour and odour)
- Description of normal vaginal loss
- Explaining to the woman that a reduction of fetal movements is not normal in the latent or established phase of labour
- How to work with any pain they may be experiencing
- How to contact their midwifery care team (relevant contact number depending on place of birth; home, SBU) and what to do in an emergency
- What they can expect when they access care (i.e., first contact will be a telephone triage early labour assessment)

- That if found not to be in established labour that she should expect to be encouraged to return home

NB: please signpost women to the 'Am I in Labour'. This leaflet is also available in triage, Pregnancy Day Care, Antenatal Clinic, Maternity ward and available on the internet.

5.3 Telephone Triage Assessment

An early assessment of labour by telephone triage provided by a dedicated triage midwife should be carried out on all women who contact SFH in the latent phase of labour. For most women, home is the preferred environment in early labour, so this is an opportunity to give verbal support, reassurance, and encouragement to remain at home and continue normal activity. The midwife should document the discussion and guidance given to the woman using the telephone triage assessment, which in the case of SFH is the BSOTS triage form. It is fundamental that any advice given, including remaining at home, is accompanied by the rationale (RCM, 2018).

During the telephone assessment consider the following:

- If English is not her first language and there is difficulty with communication then a face-to-face assessment is recommended
- Consider a face-to-face early assessment of labour for all low-risk nulliparous women, either: at home (regardless of planned place of birth) or in maternity triage centred, comprising one-to-one midwifery care for at least 1 hour (NICE, 2025)
- Women may be uncertain about their labour having started and ability to cope; therefore, all women who call for advice during the latent phase should be given sufficient time to explain their symptoms during each telephone call so that the triaging midwife can make an accurate assessment of their needs and determine how they cope during a contraction

Speak with the woman directly and gather the following information as a minimum:

- How she is feeling, and about her wishes, expectations, and any concerns she has
- Ask her about the current pregnancy and previous pregnancies including any risk factors
 - Gestation
 - PV loss (if SRM suspected refer to the Pre Labour Spontaneous Rupture of Membranes (at term) guideline)
 - Scar Pain if previous LSCS
- The possible signs of labour which she is experiencing
- Strength, frequency, length and onset of contractions and how she copes with them – a woman's ability to 'talk through her contractions' should not be used as a measure to assess whether a woman is in established labour. Every woman and labour is different and applying this measure risks missing the opportunity to recognise when a woman is in established labour
- Strategies used so far to help her cope
- Consider previous triage admissions that may indicate a prolonged latent phase.

Advise the woman to attend if:

- Distressed - not coping at home or third call to SFH
- Previous Precipitate Labour with regular contractions
- Reduced fetal movements
- PV bleeding
- Scar Pain if previous LSCS or uterine surgery
- SRM- ensure GBS status is Known prior to discharge.
- Rectal Pressure
- Complexities which would require admission
- She is <37 weeks gestation
- She is >37 weeks gestation and contractions are:
 - **Multiples:** Regular (2-3 in 10 mins lasting >40 seconds)
 - **Nullips:** Regular (3-4 in 10 mins lasting 45-60 seconds)
- Or if in your clinical judgement you feel she may be in the active stage of labour.

Based upon the midwife's clinical judgement, if she is considered suitable to remain at home, provide reassurance (see telephone triage flow chart), and specific advice that she needs to access further information or assessment if:

- SRM
- Change in fetal movements
- PV bleeding
- Constant pain or unable to cope at home
- Give information about what the woman can expect in the latent first stage of labour and how to work with any pain she experiences (NICE, 2025)
- Give information about what to expect when she accesses care (NICE, 2025)
- Agree the plan of care with the woman, including guidance about who she should contact next and when (NICE, 2025)

NB: If a woman makes a third phone call within 24 hours then invite her in for a face-to-face assessment. If following the assessment, they are found to be in the latent phase they can still return home. It is important to consider at each contact with all women whether a face-to-face assessment is necessary and to remain professionally curious at all times. If safe to do so, routine enquiry question should be asked at all contacts, affording opportunity, and seeking to identify women who may be experiencing domestic abuse or feeling unsafe to remain in the home environment.

5.4 Assessment

5.4.1 Triage:

If labour has not fully established and no risks have been identified on the risk assessment, the woman should be encouraged to return home. There is some low-quality evidence that women receiving early labour advice and support at home are less likely to receive oxytocin for labour augmentation and are less likely to have an epidural compared to women who have an immediate admission. Women may also

be more satisfied with their care and spend less of their labour duration in hospital (RCM, 2018). Women should be reminded of this and the rationale behind the advice should be explained. For those women who are Consultant led, if the admission has been solely related to labour, and no other risks are detected, the woman can be transferred home by a midwife.

The initial face to face assessment should comprise the following and be used to thoroughly risk assess each woman. This should be repeated during each presentation to SFH or if any changes occur during her time there:

Observations of the woman:

- Review the antenatal notes on BadgerNet
- Ask the woman how they are, and about wishes, expectations or any concerns they may have
- Ask her about the length, strength and frequency and onset of her contractions – a woman's ability to 'talk through her contractions' should not be used as a measure to assess whether a woman is in established labour. Every woman and labour is different and applying this measure risks missing the opportunity to recognise when a woman is in established labour
- Record her pulse, blood pressure and temperature, oxygen saturations, respirations, and carry out urinalysis
- Record if she has had any vaginal loss
- Do not use Dawes Redman criteria as this is not valid during the latent phase of labour. Use traditional CTG and categorisation
- Ask her about any pain she is experiencing and offer analgesia if needed, see section on Analgesia in the Latent Phase.

If there is uncertainty about whether the woman is in established labour, a vaginal examination may be helpful after a period of assessment but is not always necessary. If the woman appears to be in established labour, offer a vaginal examination (NICE, 2025) but please ensure the following:

- Be sure that the examination is necessary and will add important information to the decision-making process
- 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
- Explain the reason for the examination and what will be involved
- Ensure the woman's informed consent, privacy, dignity and comfort
- Explain sensitively the findings of the examination and any impact on the birth plan to the woman and her birth companion(s) (NICE, 2025).

Observations of the unborn baby:

- Ask the woman about the baby's movements in the last 24 hours
- Palpate the woman's abdomen to determine the baby's lie, presentation, position, engagement of the presenting part, and frequency and duration of contractions. Review the fundal height measurements/serial USS on the GROW chart (BadgerNet)
- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction using a pinard stethoscope or hand-help Doppler. Palpate the woman's pulse to differentiate

between the heartbeats of the woman and the baby

- Do not routinely offer Cardiotocography (CTG) monitoring to women on a low-risk pathway as part of their initial assessment
- Do offer CTG monitoring if any maternal or fetal risk factors requiring obstetric review (as outlined in this guideline) are identified, or if pre-existing complexities mean that CTG monitoring is recommended.

Maternal observations requiring obstetric review:

- Pulse over 120 beats/minute on 2 occasions 30 minutes apart
- A single reading of either raised diastolic blood pressure of 110 mmHg or more or raised systolic blood pressure of 160 mmHg or more
- Either raised diastolic blood pressure of 90 mmHg or more or raised systolic blood pressure of 140 mmHg or more on 2 consecutive readings taken 30 minutes apart
- A reading of 2+ of protein on urinalysis and a single reading of either raised diastolic blood pressure (90 mmHg or more) or raised systolic blood pressure (140 mmHg or more)
- Ketonuria: 3+ or 2+ if not improved with oral diet and fluids over 4 hours.
- Temperature of 38°C or above on a single reading, or 37.5°C or above on 2 consecutive readings 1 hour apart
- Any vaginal blood loss other than a show
- Rupture of membranes more than 24 hours before the onset of established labour
- The presence of significant meconium
- Pain reported by the woman that differs from the pain normally associated with contractions (being extra vigilant where there is a uterine scar)
- Any risk factors recorded in the woman's notes that indicate the need for obstetric led care
- Duration of latent phase of labour indicating prolonged duration.

Fetal observations requiring obstetric review:

- Pre-term <37 weeks gestation
- Any abnormal presentation including cord presentation
- Suspected SGA or macrosomia
- Suspected anhydramnios or moderate or severe polyhydramnios
- Abnormality of fetal heart on auscultation / CTG (remember accelerations should continue during the early/latent phases of labour where there is sufficient resting tone between tightening/contractions for full reperfusion of the placenta to occur)
- Reduced fetal movements within the last 24 hours.

5.4.2 Communication

- Recognise that a woman may experience painful contractions without cervical change, and although they may be described as “not in labour”, they may well believe they are “in labour” by their own definition. Therefore, ensure appropriate language is used to reassure them that you acknowledge the pain they are experiencing and reassure them it is normal
- Avoiding referring to women as “only” being in the latent phase or “not in labour” as this can devalue their experiences
- Avoid focusing only on objective measures such as frequency of contractions. Instead explain that effacement and movement of the cervix may occur prior to dilation. Consideration and focus on a woman's experience may help them to be less anxious

- Ensure women feel supported in their decision making
- The Midwife should document the guidance and advice they give and the agreed plan of care, taking into consideration the woman's wishes and birth plan

5.4.3 Multiparous women

The latent phase of labour is usually considerably shorter for multiparous women. Therefore, all multiparous women who have presented to triage in the latent phase of labour must be encouraged to mobilise within the hospital grounds for 1 hour post assessment. Following this, they should return to triage, where the midwife (preferably the same midwife as before) should review them. This should include assessing whether the contractions have changed in intensity or frequency, any fetal concerns, and how the woman now perceives the pain, including whether she feels that she is progressing to established labour. This information, along with the woman's obstetric history and preferences should be used to co-ordinate an individualised plan of care.

5.3.4 Analgesia during Latent Phase of Labour

Women who come to the hospital for a labour check may be offered analgesia before being sent home. These analgesics include:

- Paracetamol – women can also self-medicate this at home. Midwives must ensure women are aware of dosage and frequency of administration.
- Morphine sulphate oral solution (10 mg/5 ml) may be used for analgesia in the latent phase of labour when clinically appropriate:

- **Dose:** 10–20 mg orally every 4 hours, with a maximum total dose of 120 mg within a 24-hour period.
- **Prescribing requirements:** All doses must be prescribed by a medical practitioner.
- **Further dosing:** If ongoing analgesia is required beyond the initial dose(s), this must be reviewed and prescribed by a medical practitioner following reassessment.
- **Post-administration observation:** Women may return home one hour after administration, provided that the midwife has completed and documented an assessment confirming reassuring:
 - maternal pulse
 - fetal heart rate
 - frequency and strength of uterine contractions

The midwife must identify any known drug allergies before giving women any analgesics and ensure all drugs given are charted on the woman's drug chart as well as documented on Nervecentre.

5.3.5 Care at Home following Initial Assessment

After completing a thorough risk assessment, if the woman seeks advice with painful contractions but is not in established labour:

- Advise the woman she can return home, unless doing so leads to a significant risk that she could give birth without a midwife present or become distressed
- Discuss the importance of hydration and nutrition for energy needed in established labour
- Suggest relaxation techniques such as making a nest/all fours over a bean bag/ rocking on a birthing ball/dim lights and calming music or a warm bath
- Suggest using gentle breathing techniques or Hypnobirthing techniques that have been learnt
- If the woman's cervix is 4cm dilated, but she is not experiencing painful contractions (regular or irregular) invite her to be admitted for observation. Do not routinely encourage her

to return home

- Consider teaching positions to encourage optimal fetal positioning and aid rest
- Offer leaflet 'Am I in Labour', with advice and tips on how to cope in early labour, including what to expect in the latent phase of labour and how to work with any sensations that may be experienced
- Reassure the woman that she can phone for further advice/support at any time
- Agree a plan of care with the woman, ensure that appropriate follow up is arranged and provide relevant contact numbers
- If analgesia given and woman is undecided on whether she feels comfortable returning home, encourage her to mobilise but remain on hospital grounds for one hour. After this period the woman should be reviewed again (preferably by the same midwife) and an individualised plan of care co-ordinated and documented
- Provide guidance and support to the woman's birth companion (NICE, 2025).

NB: See section 5.4.1 Telephone Triage Assessment/Telephone Triage Assessment Flowchart for advice to be given to help cope with latent phase of labour, and information outlining when women should attend, including important signs and symptoms.

5.3.6 Early Labour Care in Hospital

Midwives should use their expertise when planning optimal care in partnership with the woman and her partner. This care should be continually assessed with the aim of enabling the woman to feel confident to return home. If a woman is being transferred from triage to either the maternity ward or SBU in the latent phase of labour, ensure that an SBAR handover is given to the midwife taking over her care and document this on BadgerNet.

If the woman is an in-patient in early labour e.g., during Induction of labour (IOL), or if she does not feel comfortable returning home provide reassurance, explanation of the physiology of early labour and specific early labour advice:

- Have a warm bath in a comfortable position and take simple analgesia
- Eat and drink regularly
- Rest in a comfortable position whenever possible e.g., birth balls
- Change position/walk around if uncomfortable and maintain everyday activities

Prompt recognition of the transition from the latent phase of labour into established labour is important to ensure timely commencement of fetal and maternal monitoring that is required throughout established labour. The midwife should consider whether the woman may have transitioned at all contacts, particularly if the woman is requesting analgesia or reporting changes to contractions. Contact should be made with the woman a minimum of 2 hourly to assess clinical and/or emotional needs. As a minimum, a FULL labour assessment of the woman and fetus should occur every 4 hours. The midwife should ensure that this is documented on BadgerNet and use this information to form a risk assessment based on the following information:

- Ask how she is feeling and assess if the woman looks well or unwell
- Record her pulse, blood pressure, temperature, oxygen saturations and her respirations
- Ensure that adequate time is taken to observe and palpate (if consent obtained) the length, strength, and frequency of her contractions
- Palpate the woman's abdomen to determine the baby's lie, presentation, position, engagement of the presenting part
- Ask her about any pain she is experiencing
- When she last passed urine
- Record if she has had any vaginal loss
- Ask the woman about her baby's movements
- Auscultate the fetal heart rate for a minimum of 1 minute immediately after a contraction

using a pinard stethoscope or hand-held Doppler (a CTG may be required for women on a high-risk pathway, or if concerns are identified)

- Administer analgesia accordingly
- Consider offering vaginal assessment if warranted, but do not rely solely on the dilation of the cervix to diagnose established labour
- Assess whether the woman appears to remain in the latent phase of labour or if she has transitioned to established labour. If any concerns are identified then the midwife should refer the woman for a medical review. The woman's birth partner(s) should be involved in her care and updated on the findings and outcome of each risk assessment. Early labour pain can often be short, sharp, and very painful, irregular yet frequent, preventing adequate rest. Diamorphine may be administered a maximum of 2 times. If after this the woman feels that further doses are required or that the pain is still severe then a medical review is required.

Liaise with SBU if the woman needs to be transferred, ensuring that the SBAR handover tool is completed on BadgerNet.

6.4 Prolonged latent phase of labour

It is common for early labour to last for 2-3 days. This is usually considerably shorter for second and subsequent labours and a prolonged latent phase has been suggested as >20 hours in primigravid women and >14 hours in multiparous women (Bailit et al., 2005).

A prolonged latent phase can be exhausting and discouraging for women. If a woman presents to triage for a THIRD time and following maternal and fetal clinical assessment, remains in the latent phase of labour, a review should be carried out by a member of the obstetric team. An individualised plan of care, taking into account the woman's preferences and wishes should be developed, which should involve an offer of admission to the maternity ward or SBU for further observation. For women where the latent phase lasts longer than 24 hours (or sooner if she is struggling to cope), where there are concerns identified from the risk assessment, or if she presents to triage 3 times and is not in established labour, arrange for a medical review and it may be reasonable to offer artificial rupture of membranes (ARM) and augmentation. Women should be informed that IOL for prolonged labour shortens the time in which she is in labour, but does not reduce caesarean birth rate or intervention, although satisfaction levels are found to be the same. Women must be included in decisions relating to their care, and her birth partner also involved and asked about their feelings.

5.5 Pre-term latent phase

Premature birth is a leading cause of perinatal mortality and morbidity and therefore careful and thorough management is required. Management of women in pre-term latent phase of labour will vary dependent on gestation and clinical picture.

- Diagnosis and Management must be in line with the Preterm Labour guideline- see trust intranet for guidance.

NB: Abdominal pain can also be caused by other factors, most commonly urinary tract infection (UTI). Symptoms of a UTI should be elicited and urinalysis carried out. If this is positive for nitrates, protein, blood or leucocytes then an MSU should be taken, and antibiotic treatment commenced as per the Preterm birth prevention guideline.

5.6 Induction of Labour

For women in the latent phase of labour who are booked for IOL, if labour has not established by the time of her planned IOL, discuss continuing with the plan for ARM and Oxytocin and a time frame for this to take place. It is important that the woman's wishes, and preferences are considered when making this decision. If the woman is considered high risk of complications, and she is currently in her home environment, admission may be required sooner, but this should be risk-assessed on an

individual basis. If the woman reports SROM during the latent phase of labour discuss options of expectant management with a view that 60-70% women will establish in labour within the next 24 hours. IOL at the earliest opportunity does not need to be routinely recommended if the woman is already contracting. An individualised discussion, risk and clinical assessment should be performed, and a plan of care made based on findings and the woman's wishes.

6 EDUCATION AND TRAINING

No education and training is required for the implementation of this guideline, however it is recommended that new starters make themselves familiar with the guidance.

7 MONITORING COMPLIANCE AND EFFECTIVENESS

A prospective audit will be carried out three yearly through review of case notes over a 12-month period for all cases meeting the definition of normal labour. The audit report with conclusions, recommendations and an action plan will be submitted to the Maternity and Gynaecology Clinical Governance group where the action plan will be monitored.

8 EQUALITY IMPACT ASSESSMENT

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

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| Name EIA Assessor: Sam Todd | | Date of EIA completion: 2 April 2026 |
| Department: Maternity | | Division: Women’s and Children’s |
| Name of service/policy/procedure being reviewed or created: Latent Phase of Labour Guideline | | |
| Name of person responsible for service/policy/procedure: Sam Todd, Consultant Midwife | | |
| <p>Brief summary of policy, procedure or service being assessed:</p> <p>The Latent Phase of Labour Guideline provides evidence-based guidance for midwives and obstetricians in assessing, supporting, and managing women during the latent phase of labour. It outlines approaches to telephone triage, face-to-face assessment, risk assessment, pain management, and decision-making regarding admission or remaining at home.</p> <p>The guideline emphasises compassionate, individualised care, clear communication, and shared decision-making, ensuring women feel supported, informed, and confident during early labour. It promotes physiological labour where appropriate, while ensuring timely recognition of complications and escalation when required. It also supports involvement of birth partners and reinforces the importance of dignity, consent, and personalised care planning.</p> | | |
| <p>Please state who this policy will affect: Staff, Patients</p> <p>(Please delete as appropriate)</p> | | |
| Protected Characteristic | Considering data and supporting information, could protected characteristic groups’ face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No) | <p>Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening.</p> <p>Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.</p> |

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| Race and Ethnicity | No | <p>The guideline promotes equitable access to care through an emphasis on individualised assessment, clear communication, and flexible care pathways. It supports women to access care in a way that meets their needs, including both telephone triage and face-to-face assessment, with explicit recommendation for in-person review where communication barriers exist (e.g. where English is not a first language or where there are concerns about understanding).</p> <p>To reduce inequalities, the guideline reinforces the importance of compassionate, respectful communication, ensuring women are given sufficient time to express concerns and are actively involved in decision-making. It promotes inclusive practice, including recognition of birth partners and an explicit statement within the guideline that “pregnant women” includes transgender and non-binary people who are pregnant, ensuring clarity and inclusivity while maintaining alignment with NHS terminology.</p> <p>The guideline also supports reasonable adjustments for those with additional needs, including adapting communication approaches, offering repeated contact, and enabling access to face-to-face assessment where remaining at home may not be appropriate due to social, psychological, or environmental factors. It acknowledges that some women may not feel safe or supported at home and encourages professional curiosity, including routine enquiry, to identify safeguarding concerns such as domestic abuse.</p> <p>Data and supporting information used to inform this assessment includes national evidence (e.g. NICE guidance and RCM guidance on early labour), local maternity data (including BadgerNet), patient experience data, complaints and compliments, and feedback from service user groups (MNVP). Consideration has also been given to known national maternity inequalities (e.g. MBRRACE</p> |
| Sex | No | |
| Age | No | |
| Religion and Belief | No | |
| Disability | No | |
| Sexuality | No | |
| Pregnancy and Maternity | No | |
| Gender Reassignment | No | |
| Marriage and Civil Partnership | No | |
| Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation) | No | |

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| | | data relating to ethnicity and deprivation) and local population demographics to ensure the guideline does not inadvertently disadvantage specific groups. |
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What consultation with protected characteristic groups including patient groups have you carried out?

- Service user voice (MNVP feedback)
- Patient experience data, complaints and compliments
- Consultation with Senior Midwifery Team, Specialist Midwives, PMAs, Obstetric Consultants
- Local demographic data via BadgerNet
- CQC survey findings

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

No new or specific human rights concerns identified. The guideline supports autonomy, dignity, informed consent, and non-discrimination.

The inclusion of an explicit terminology statement recognising transgender and non-binary people who are pregnant supports respect for individual identity and equitable access to care. The guideline also promotes compassionate communication and shared decision-making, supporting fundamental human rights principles.

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)

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| Positive | | | | | |
| Low | | | | | |

If you identified positive impact, please outline the details here:

No negative impacts identified, and this volunteer policy promotes good practise around all equality aspects. Only positive impacts identified. No requirement for stage 2 EIA.

Signature: Sam Todd

I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form

Date:

2 April 2026