Royal Cornwall Hospitals
NHS Trust

Preterm Prevention Clinical Guideline

V1.0

January 2024

1. Aim/Purpose of this Guideline

1.1. Preterm labour is defined as labour after 22 weeks gestation and before 37 weeks gestation and is a major cause of perinatal morbidity and mortality. This guideline gives guidance to Obstetricians and Midwives on identifying those at risk of preterm labour and measures taken to prevent preterm delivery.

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

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

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

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

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

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

2. The Guidance

2.1. Prevention of Preterm Birth in a Singleton Pregnancy

2.1.1. Initial booking

Complete preterm labour risk assessment to identify women at HIGH and INTERMEDIATE risk of preterm birth (page 4 in the handheld notes).

All women should be screened for risk factors for Preterm birth. Risk factors for the general population to be aware of include smoking, maternal age under 18 years, domestic violence, urinary tract infections, vaginal infections. To help reduce the risk of preterm labour in these patient groups, ensure that they are offered the appropriate pathways e.g.

- **Smoking cessation** – inform the woman that smoking doubles the risk of preterm delivery and therefore they should be encouraged to stop and offered referral to Smoking Cessation Team.

- **Women <18 years** should be informed that they have a higher risk of preterm birth and should be offered support and advice and a referral to WILD made.

- **Domestic violence** – sensitive questioning regarding possible domestic violence and offer referral to IDVA's if DV is disclosed.

- **Urinary tract infections** – Any woman identified as INTERMEDIATE or HIGH risk should have a routine MSU sent at booking. All other women should have a booking urine dipstick and MSU sent if positive. If an MSU is sent ensure the results are checked, and any UTI treated. After treatment a further MSU should be sent. Any women with a history of recurrent UTI's should be referred to their area consultant for a plan.

- **Vaginal infections**, gonorrhoea and chlamydia are associated with preterm birth and screening should be offered to at risk women and the results followed up and acted upon.

2.1.2. High risk group

- Previous preterm birth or mid-trimester loss (16 to 34 weeks gestation).

- Previous preterm rupture of membranes <34 weeks.

- Previous cervical cerclage

- History or trachelectomy.

- Known uterine variant (unicornuate uterus, significant bicornuate uterus or uterine septum).

- Ashermann's syndrome.

2.1.3. Intermediate risk group

- Previous caesarean section at full dilatation.

- History of single LLETZ with depth >15mm depth.

- More than one LLETZ (irrespective of depth).

- Cone biopsy (by knife of laser, irrespective of depth).

2.1.4. Women identified as HIGH risk

Women identified as **HIGH** risk should be referred at booking to the PREM prevention clinic via email (rcht.prempreventionclinic@nhs.net).

These women will also need to be referred to their area consultant if there are additional risk factors.

These women will be seen by a consultant and midwife sonographer at 16 weeks where they will have an individualised plan based on their previous history. After discussion of the implications and possible interventions of a shortened cervix, they will be offered a cervical length scan at this appointment and repeated every 2-4 weeks until 24 weeks.

Women with a history of previous cerclage or trachelectomy will be seen after their dating scan and offered either repeat cerclage or cervical length surveillance.

Women with a history of previous preterm birth/second trimester loss 14-34/40 should be assessed as to whether this was associated with placental disease at booking. If so, they should be advised to take aspirin 150mg from 12 weeks gestation and growth scans booked from 28 weeks.

Additional investigations (e.g., swabs for infection) or interventions such as prophylactic progesterone will be considered on an individual basis.

2.1.5. **Women identified as INTERMEDIATE Risk**

Women identified as **INTERMIDEATE** risk should be referred to the Preterm Prevention Clinic via email; if their cervical treatment was out of county, please include the hospital in the referral. The preterm birth team will check histopathology and only offer an appointment if the LLETZ was 15mm or more.

These women will also need to be referred to their area consultant if there are additional risk factors that require an obstetrician.

Women will be seen in clinic and offered single cervical length between 18-22 weeks.

If this cervical length is greater than 30mm they will be discharged from the Preterm Prevention clinic back to routine care. If the cervical length is 25-30mm a further scan will be organised in 2 weeks.

Additional use of fetal fibronectin alongside cervical length scanning in asymptomatic women will be decided by the Preterm Prevention team.

All women seen in the preterm prevention clinic will be advised of symptoms and signs of preterm labour and advised to contact maternity triage if she experiences any of them.

Women who have required an intervention should remain under consultant led care for the duration of the pregnancy. Women who have had normal cervical length scans, who are otherwise low risk (other than the preterm loss/birth), can be discharged back to midwifery led care.

Complex cases should be discussed at the Southwest regional preterm prevention MDT.

2.1.6. **Vaginal Progesterone**

Consider vaginal progesterone in women who have had a previous preterm delivery or mid trimester loss (16-34 weeks gestation). Noting the evidence for this in women with a cervical length >30mm is uncertain.

Consider vaginal progesterone to high-risk women, without a history of previous preterm birth, with a shortened cervix (<25mm) on ultrasound scan.

Commence progesterone between 16-24 weeks and continue until 34-36 weeks.

2.1.7. **Cervical suture**

Offer:

- Previous delivery 16-34 weeks and cervical length <25mm.
- Women who have had 3 or more losses/births (16-34 weeks).
- Women who have had a previous cervical cerclage.
- NB. women who have a previous failed cervical suture (i.e., delivery <28 weeks) should be considered for an abdominal cervical cerclage.

Consider:

- For women who have a history of preterm rupture of membranes <34 weeks or cervical surgery and cervix <25mm. Offer a choice of vaginal progesterone or cervical suture.
- For women without a history of previous preterm birth/mid-trimester who have been commenced on progesterone due to a cervical length less than 25mm, whom further cervical shortening is seen.
- Women who have had 2 losses/preterm births (16-34 weeks).

Low risk women who have a coincidental finding of a short cervical length should not automatically be offered a cervical suture as there is limited data to support the use of a cervical suture in this situation. Each case should be individualised, and the options discussed with the woman.

It is not known whether a cervical suture is beneficial for women who have had a Caesarean section at full dilatation and a short cervix in a subsequent pregnancy. The CRAFT study has been designed to prove the evidence regarding this. In the meantime, there needs to be a discussion with the woman about the potential advantages and disadvantages of cervical suture, prophylactic vaginal progesterone, or conservative management so that an informed decision can be made.

2.1.8. Rescue Cervical Cerclage

- Do not offer this if signs of infection, active bleeding, or uterine contractions.
- Consider a rescue cervical cerclage in women from 16 weeks up until 27+6 weeks who have a dilated cervix and exposed, unruptured fetal membranes.
- This needs to be a consultant decision only considering gestation age and extent of dilatation.
- If presenting after 21+5 discuss with the neonatal consultant as transfer to a hospital providing tertiary neonatal care; pre or post insertion may be indicated.
- Risks of the procedure (rupture of membranes, infection, delivery) along with the benefits (aims to delay the birth to increase the likelihood of survival and reduce the risk of serious neonatal morbidity) should be discussed with the woman and an informed choice made.
- If a rescue suture is inserted, please refer to the Preterm Prevention Clinic for ongoing follow up (rcht.prempreventionclinic@nhs.net).

2.1.9. Operative Considerations

The outcomes of the C-Stich trial have shown a monofilament suture to be non-superior to a braided suture in preventing pregnancy loss or preterm birth. Therefore, the choice of suture material can be at the preference of the surgeon.

The use of peri operative antibiotics should be at the decision of the operating team.

Routine use of perioperative tocolytics should not be used.

Anaesthetic choice is at the choice of the operating team in conjunction with the woman's preferences.

2.1.10. Women with a Cervical Suture

For all women who have had a cervical cerclage, a clear plan for suture removal needs to be made and documented in the patient records.

Removal of the suture does not require anaesthetic and can usually be performed in a delivery room.

Suture removal should occur if:

- The pregnancy has reached 37 weeks.
- There is active bleeding.
- There is cervical dilation on speculum/VE or active signs of labour.

- There are ruptured membranes.
- There is evidence of chorioamnionitis.
- Induction of labour is required for another reason.

NB. Abdominal sutures are not removed.

The decision to leave the suture in place to allow transfer to a tertiary centre should only be made by a consultant obstetrician in conjunction with the receiving unit.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Appropriate referral to Preterm Prevention Clinic.
Lead	Obstetric Audit Lead/Perinatal team.
Tool	Periprem database.
Frequency	Every birth <34/40 ongoing.
Reporting arrangements	Periprem report to safety Champions. Presented and discussed quarterly at the Perinatal Safety MDT meeting.
Acting on recommendations and Lead(s)	Any deficiencies identified will be discussed at the Patient Safety Meeting and clinical audit forum and an action plan developed.
Change in practice and lessons to be shared	• Required changes to practice will be identified and actioned within a time frame agreed on the action plan. • A lead member of the forum will be identified to take each change forward where appropriate. • The results will be distributed to all staff through the Patient Safety newsletter/audit forum as per the action plan.

4. Equality and Diversity

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

4.2. Equality Impact Assessment

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

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Preterm Prevention Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	December 2023
Date Valid From:	January 2024
Date Valid To:	January 2027
Directorate / Department responsible (author/owner):	Helen Le Grys, Obstetric Consultant Jane Pascoe, Fetal Wellbeing Lead Midwife
Contact details:	01872 252270
Brief summary of contents:	This guideline gives guidance to Obstetricians and Midwives on identifying those at risk of preterm labour, and prevention of preterm delivery.
Suggested Keywords:	Preterm, Prevention, Cervical suture
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Mel Gilbert
Links to key external standards:	CNST / Saving Babies Lives v3/ MatNeoSip
Related Documents:	• RCOG Clinical guideline No 75 (2022). Cervical Cerclage. • NICE guidance (NG25) Preterm Labour and Birth. 2022. • FIGO. Progesterone and preterm birth (2020)

Information Category	Detailed Information
	• FIGO. Good practice guidance recommendations on cervical cerclage for prevention of preterm birth (2020).
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
December 2023	V1.0	Initial issue	Helen Le Grys Obstetric Consultant

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

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

This document is only valid on the day of printing.

Controlled Document.

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

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

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

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

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Preterm Prevention Clinical Guideline V1.0
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	New
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Helen Le Grys, Consultant Obstetrician
Contact details:	01872 252270

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	This guideline gives guidance to Obstetricians and Midwives on the recognition of women at risk of preterm delivery and their antenatal management.
2. Policy Objectives	To ensure women at risk of pre-term labour is managed in line with current evidence-based practice.
3. Policy Intended Outcomes	To identify women at risk of pre-term labour early enough to arrest it and to achieve the best possible outcome for the pre-term baby.
4. How will you measure each outcome?	Compliance Monitoring Tool.
5. Who is intended to benefit from the policy?	Women at risk of preterm delivery.

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

7. The Impact

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

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

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

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

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

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

Name of person confirming result of initial impact assessment: Helen Le Grys, Consultant Obstetrician

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

Appendix 3. Preterm Labour Risk Assessment

No risks identified ☐

- Previous spontaneous birth or loss between 16 and 34 weeks.
- Previous PPROM <34/40.
- Ashermanns (intrauterine scarring).
- Uterine variant (unicornuate, septum, significant bicornuate).
- Previous cerclage.
- Previous trachelectomy (removal of cervix).

Any Risk Factor identified:

HIGH RISK will be seen at 16/40

Refer to the Preterm prevention clinic by 12 weeks with the indication for referral via the email rcht.prempreventionclinic@nhs.net

Send booking MSU ☐

Date:

Sign:

- Previous LLETZ.
- Previous cone biopsy.
- Previous LSCS at fully dilated.

Any Risk Factor identified:

INTERMEDIATE RISK

Refer to clinic rcht.prempreventionclinic@nhs.net

Please inform these women that their notes will be reviewed*, and an appointment will ONLY be sent if it is confirmed that they are at increased risk of preterm birth.

Send booking MSU ☐

Date:

Sign:

*if the LLETZ occurred in another hospital please ensure which hospital is included in the referral

Assess everyone with a history of preterm birth <34 weeks to determine whether this was associated with placental dysfunction (may have letter on Maxims). If yes, then advise Aspirin 150mg daily and discuss scan pathway.

If unclear review previous placental histology/contact obstetrician.

Inform the patient that they will be seen in Preterm Prevention clinic at 16/40 where they will meet a doctor for an individualised plan; this will include a cervical length scan.

Patients with a previous cerclarge or trachelectomy will be seen at 12/40.

Patients identified as high risk of preterm birth with additional obstetric risk factors (e.g., medical condition/previous caesarean section) will also need to be referred to their area consultant as the Preterm Prevention clinic does not replace the consultant review.