**FOI Ref: 6100**

**Category(ies): Clinical Service - Activity**

**Subject: Preterm Prevention**

**Date Received: 16/11/2021**

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| **Your request:** | **Our response:** |
| I would like to know if your Trust offers a Preterm Prevention Clinic for pregnant women. If so, what inclusion criteria is it set against? | There is a pre-term prevention clinic, currently led by a Consultant (there will be a change to the Lead Professional – awaiting confirmation of new Consultant Lead)  All women are screened at booking for any risk factors of pre-term birth. This also includes a routine mid-stream urine sample, screening for chlamydia and other sexually transmitted infections is offered to women <18years or <25 years who may be at risk. Furthermore; women who smoke are offered routine Carbon Monoxide screening; are given very brief advice re smoking and pregnancy and offered referral to the specialist Smoking in Pregnancy team.  Any women who are screened with any risk factors for preterm birth will be referred, and ideally seen by 12 weeks gestation within the preterm prevention clinic.  The criteria is set within The Rotherham NHS Foundation Trust, Guideline for the Prevention and Management of preterm labour is researched evidence and national guidance; including Saving Babies Lives V.2. And NICE (2015), preterm labour and birth [NG25].  High Risk factors for preterm birth include :-   * Previous preterm birth or mid-trimester pregnancy loss between 16 and 34 weeks gestation weeks * Previous preterm labour rupture of membranes < 34 weeks gestation * Previous cervical cerclage * Known uterine variant (i.e. unicornuate/bicornuate uterus or uterine septum) * Intrauterine adhesions (Ashermann’s syndrome) * History of trachelectomy (treatment following cervical cancer)   Intermediate risk factors for preterm birth include:-   * Previous caesarean section at full dilatation * History of significant cervical excisional event i.e. LLETZ >10mm depth removed * >1 LLETZ procedure carried out * Cone biopsy (knife or laser) |
| What is the caseload capacity | There is no specific set caseload capacity; all women who have risk factors are referred to the preterm prevention clinic.  Where there are specific difficulties with capacity within the specialist clinic; individual case by case discussion will take place with the Consultant Lead (or other Consultant if not available). This may include a review within an alternative Consultant Obstetric clinic; however the same guidelines are considered and the woman would be seen within the preterm prevention clinic where possible, at a later date. |
| Do you have any data on success rate supporting this intervention? | This data is not currently collected |
| Is this in addition to the implementation of Continuity of Care model which was requested by government? | Continuity of Care model is offered for Rotherham women separately to the preterm birth clinic. This currently means that some women will receive CoC whilst others may not. However we have plans to make CoC our default offer of care for the majority of women who are cared for at Rotherham maternity unit. |
| Do you have information on the interventions being used together for reducing preterm birth? | Women who have a high risk factors for preterm birth will be offered cervical length scans every 2 weeks from 16 weeks to approx. 24 weeks gestation; along with biomarker testing (a quantitative fetal fibronectin(fFN) and QuiPP risk score at/around 22-24 weeks gestation).  Any women screened, who have intermediate risks of preterm birth will be offered at least one cervical length scan as a minimum between 18 and 22 weeks gestation; currently they are offered scans 4 weekly from around 16 weeks to 24 weeks gestation.  Vaginal progesterone pessaries (200 – 400mg daily) are offered from 16 weeks gestation to women who meet the following criteria:-   * Previous preterm birth <34 weeks or a mid trimester pregnancy loss (this is in accordance with NICE guidline; preterm labour and birth (2015). * All women with a cervical length of </= 25mm on transvaginal ultrasound (with NICE guideline – as above) * All women with recurrent vaginal bleeding prior to 20 weeks gestation.   Cervical cerclage is offered to all women with singleton pregnancies who meet the following criteria:-   * Cervical length </= 25mm on ultrasound scan * Previous obstetric history of cervical cerclage * Cervix < 3cms dilated on examination </= 24 weeks gestation.   The information above is in relation to prevention strategies for preterm labour where preterm labour is not suspected within the current pregnancy.  Where preterm labour is suspected, dependent upon individual circumstances; women who present with contractions with no cervical effacement or dilatation between 23-35 weeks gestation and where there is no evidence of rupture of membranes are offered biomarker testing (a quantitative fetal fibronectin (fFN) and utilizing the QuiPP to calculate an individualized % risk score of delivery. This supports accurate diagnosis to enable shared planning and decision making between the obstetric team and woman.  Where the risk of preterm labour is confirmed; women are offered antenatal steroids to reduce the risk of neonatal respiratory distress, intraventricular haemorrhage and neonatal death. Tocolysis is offered for women between 24+0 and 33+6 weeks with intact membranes, suspected or diagnosed preterm labour – to allow steroid administration/ in utero transfer.  All women in preterm labour are also offered antibiotic prophylaxis against Group B streptococcus.  Magnesium sulphate is also offered for neuroprotection of the baby to women between 24+0 and 29+6 weeks gestation in established labour or who have a planned preterm birth within the following 24 hours.  Magnesium sulphate is also considered for women between 33+0 and 33+6 weeks, in established preterm labour or having a planned preterm birth within the following 24 hours.  For women between 23+0 and 23+6 weeks gestation magnesium sulphate is offered if antenatal steroids and tocolysis is being administered. |