NICE National Institute for Health and Care Excellence

NICE quality standard

Preterm labour and birth

Quality standard
Published: 19 October 2016
Last updated: 2 August 2019

www.nice.org.uk/guidance/qs135

Contents

This standard is based on NG25.

This standard should be read in conjunction with QS121, QS120, QS109, QS75, QS60, QS35, QS32, QS15, QS105, QS162, QS169, QS192, QS193 and QS57.

Quality statements

Statement 1 Pregnant women at increased risk of preterm labour are given information about the potential signs and symptoms.

Statement 2 Women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage.

Statement 3 Women having a planned preterm birth are given information about the risks and potential outcomes.

Statement 4 Women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour are offered tocolysis.

Statement 5 Women between 24+0 and 33+6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have preterm prelabour rupture of membranes (P-PROM) are offered maternal corticosteroids.

Statement 6 Women between 24+0 and 29+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours are offered magnesium sulfate.

Quality statement 1: Providing information about potential signs and symptoms of preterm labour

Quality statement

Pregnant women at increased risk of preterm labour are given information about the potential signs and symptoms.

Rationale

Not all pregnant women at increased risk of preterm labour know what symptoms and signs to look out for. At such a vulnerable time in their lives, women and their families need information about the potential signs and symptoms of preterm labour and the care available that meets their needs and supports shared decision making, without causing unnecessary anxiety.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and clinical protocols to ensure that pregnant women at increased risk of preterm labour are given information about the potential signs and symptoms.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications and clinical protocols.

Process

Proportion of pregnant women at increased risk of preterm labour who are given information about the potential signs and symptoms.

Numerator – the number in the denominator who are given information about the potential signs and symptoms.

Denominator – the number of pregnant women at increased risk of preterm labour.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Pregnant women's satisfaction with the information provided.

Data source: No routinely collected national data has been identified for this measure. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from maternity surveys.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that pregnant women at increased risk of preterm labour are given written information about the potential signs and symptoms by healthcare professionals, who also discuss this with them.

Healthcare professionals (such as midwives and obstetricians) give written information to pregnant women at increased risk of preterm labour about the potential signs and symptoms, and discuss this with them.

Commissioners (clinical commissioning groups or integrated care systems) commission services that ensure that pregnant women at increased risk of preterm labour are given written information about the potential signs and symptoms by healthcare professionals, who also discuss this with them.

Pregnant women at increased risk of preterm labour(that is, going into labour before the 37th week of pregnancy) are given written information about the signs and symptoms that might suggest preterm labour. A healthcare professional also talks to them about this and the care available.

Source guidance

Preterm labour and birth. NICE guideline NG25 (2015, updated 2022), recommendation 1.1.1

Definitions of terms used in this quality statement

Pregnant women at increased risk of preterm labour

Pregnant women who:

- have a history of:
  - spontaneous preterm birth
  - preterm prelabour rupture of membranes (P-PROM)
  - loss (from 16+0 weeks of pregnancy onwards)
  - cervical trauma (including surgery – for example, previous cone biopsy [cold knife or laser], large loop excision of the transformation zone [LLETZ – any number] and radical diathermy)
- are considered to be at risk of preterm labour and birth because they have a short cervix (25 mm or less) that has been identified on a transvaginal ultrasound scan and/or bulging membranes in the current pregnancy
- have P-PROM.

[Adapted from NICE's full guideline on preterm labour and birth]

Information

Pregnant women should be given oral and written information, and be directed to

organisations that can provide further support. [Adapted from NICE's full guideline on preterm labour and birth]

Potential signs of preterm labour

Potential signs could include:

- watery, mucosal or bloody vaginal discharge
- regular or frequent (often painless) contractions or uterine tightening
- P-PROM.

[Expert opinion]

Potential symptoms of preterm labour

Potential symptoms could include:

- pelvic or lower abdominal pressure
- constant low, dull backache
- mild abdominal cramps, with or without diarrhoea.

[Expert opinion]

Equality and diversity considerations

Pregnant women at increased risk of preterm labour should have access to information that is understandable if they:

- have additional needs, such as physical, sensory or learning disabilities
- do not speak or read English
- have religious, ethnic or cultural needs.

Interpreters and advocates should be provided if needed.

For women with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 2: Prophylactic vaginal progesterone and prophylactic cervical cerclage

Quality statement

Women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage.

Rationale

Preterm birth causes significant neonatal morbidity and mortality, as well as long-term disability. Therefore, strategies for preventing preterm birth are important. Both prophylactic cervical cerclage and prophylactic vaginal progesterone are effective in preventing or delaying preterm birth in women with a short cervix and a history of spontaneous preterm birth (up to 34+0 weeks of pregnancy) or loss (from 16+0 weeks of pregnancy onwards). Which treatment is best for each woman will depend on her individual preferences and circumstances, and women should be given information as part of shared decision making.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications and clinical protocols.

Process

Proportion of women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy who are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage.

Numerator – the number in the denominator who are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage.

Denominator – the number of women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

Outcome

Timing of labour and birth.

Data source:NHS Maternity Statistics include data from Hospital Episode Statistics (HES) on the number of 'delivery episodes' with a number of breakdowns including by method of onset of labour, delivery method and place of delivery.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage, with the choice of treatment depending on

the woman's preferences and circumstances.

Healthcare professionals (such as obstetricians) offer women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage, with the choice of treatment depending on the woman's preferences and circumstances.

Commissioners (clinical commissioning groups or integrated care systems) commission services that ensure that women who have had a previous preterm birth or loss and have a cervical length of 25 mm or less measured between 16+0 and 24+0 weeks of pregnancy are offered a choice of either prophylactic vaginal progesterone or prophylactic cervical cerclage, with the choice of treatment depending on the woman's preferences and circumstances.

Women at increased risk of preterm labour in whom an ultrasound scan has shown that they have a short cervix are offered a treatment to stop the cervix (neck of the womb) opening early and so delay labour and birth. This could be either progesterone (a natural female sex hormone) inserted into the vagina or a stitch in the cervix, with the choice of treatment depending on the woman's preferences and circumstances.

Source guidance

Preterm labour and birth. NICE guideline NG25 (2015, updated 2022), recommendation 1.2.1

Definitions of terms used in this quality statement

Prophylactic vaginal progesterone

Progesterone by vaginal suppository to reduce the incidence of spontaneous preterm birth.

In August 2019, this was an off-label use of vaginal progesterone. See NICE's information on prescribing medicines. [NICE's full guideline on preterm labour and birth]

Prophylactic cervical cerclage

A treatment for cervical weakness (also termed cervical incompetence or insufficiency) to prevent preterm birth and miscarriage. [Adapted from NICE's full guideline on preterm labour and birth]

Quality statement 3: Information for women having a planned preterm birth

Quality statement

Women having a planned preterm birth are given information about the risks and potential outcomes.

Rationale

Women who are having a planned preterm birth need information about the level and nature of the risks, including how likely it is that their baby will survive. This should be given as early as possible in the antenatal period. It can help the woman and her family to understand what neonatal care their baby might need and inform their discussions with their neonatologist or paediatrician. The woman and her family should also be offered a tour of the neonatal unit.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and clinical protocols to ensure that women having a planned preterm birth are given information about the risks and potential outcomes.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications and clinical protocols.

Process

Proportion of women having a planned preterm birth who are given information about the risks and potential outcomes.

Numerator – the number in the denominator who are given information about the risks and potential outcomes.

Denominator – the number of women having a planned preterm birth.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Women's awareness of the risks and potential outcomes of having a planned preterm birth.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from maternity surveys.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that women having a planned preterm birth are given information about the risks and potential outcomes and the care available.

Healthcare professionals (such as obstetricians, neonatologists and paediatricians) give information to women having a planned preterm birth about the risks and potential outcomes and the care available.

Commissioners (clinical commissioning groups or integrated care systems) commission services that ensure that women having a planned preterm birth are given information about the risks and potential outcomes and the care available.

Women who are having a planned preterm birth (before the 37th week of pregnancy) for medical reasons are told about what may happen. This should include:

- information about the care that the woman and her baby might need, and whether this might include being transferred to another hospital for specialist care
- information about the types of problems that a preterm baby might have, both at birth and as they grow up, including how likely these are
- offering to show the woman round the neonatal unit, and an opportunity for her to talk with a neonatologist or paediatrician.

Source guidance

Preterm labour and birth. NICE guideline NG25 (2015, updated 2022), recommendation 1.1.2

Definitions of terms used in this quality statement

Planned preterm birth

A planned birth before 37+0 weeks of pregnancy because of medical complications. [NICE's full guideline on preterm labour and birth]

Information

Women should be given oral and written information, and directed to organisations that can provide further support. [Adapted from NICE's full guideline on preterm labour and birth]

Potential outcomes

These include the likelihood of the baby surviving and long-term neurodevelopmental outcomes. [Adapted from NICE's full guideline on preterm labour and birth]

Equality and diversity considerations

Women having a planned preterm labour should have access to information that is understandable if they:

- have additional needs, such as physical, sensory or learning disabilities
- do not speak or read English
- have religious, ethnic or cultural needs.

Interpreters and advocates should be provided if needed.

For women with additional needs, disability, impairment or sensory loss information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

Quality statement 4: Tocolysis for women between 26+0 and 33+6 weeks of pregnancy

Quality statement

Women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour are offered tocolysis.

Rationale

For women in suspected preterm labour, tocolysis may delay the birth and reduce the risk of problems such as cerebral palsy and of neonatal death. Not all women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour are currently offered this treatment. It is important that the potential benefits and risks of this treatment are discussed with the woman and her family members. Tocolysis is appropriate only under particular circumstances, and a range of factors need to be taken into account.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour are offered tocolysis.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications and

clinical protocols.

Process

Proportion of women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour who receive tocolysis.

Numerator – the number in the denominator who receive tocolysis.

Denominator – the number of women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Neonatal death.

Data source: The Office for National Statistics provides annual statistics on child and infant mortality in England and Wales.

b) Intraventricular haemorrhage.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

c) Incidence of neonatal sepsis.

Data source:NHS Maternity Statistics include data from Hospital Episode Statistics (HES) on the number of 'delivery episodes' where bacterial sepsis of newborn is recorded as a birth complication.

d) Use of antibiotics.

Data source: No routinely collected national data for this measure has been identified.

Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

e) Ventilation.

Data source:NHS Maternity Statistics include data on neonatal critical care.

What the quality statement means for different audiences

Service providers (such as secondary or tertiary care services) ensure that women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour are offered tocolysis as appropriate.

Healthcare professionals (such as midwives and obstetricians) offer tocolysis as appropriate to women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour.

Commissioners (clinical commissioning groups or integrated care systems) commission services that ensure that women between 26+0 and 33+6 weeks of pregnancy who have intact membranes and are in suspected or diagnosed preterm labour are offered tocolysis as appropriate.

Women who are more than 26 weeks but less than 34 weeks pregnant andin suspected or diagnosed preterm labour are offered tocolytics (medicines that slow down or stop labour) if these medicines are likely to help their baby. The benefits and risks of this treatment are explained to them.

Source guidance

Preterm labour and birth. NICE guideline NG25 (2015, updated 2022), recommendation 1.8.3

Definitions of terms used in this quality statement

Suspected preterm labour

A woman is in suspected preterm labour if she has reported symptoms of preterm labour and has had a clinical assessment (including a speculum or digital vaginal examination) that confirms the possibility of preterm labour but rules out established labour. [NICE's guideline on preterm labour and birth, terms used in this guideline]

Diagnosed preterm labour

A woman is in diagnosed preterm labour if she is in suspected preterm labour and has had a positive diagnostic test for preterm labour. [NICE's guideline on preterm labour and birth, terms used in this guideline]

Tocolysis

Drugs used to stop or delay the progress of labour. The NICE guideline recommends nifedipine as the first choice, or oxytocin receptor antagonists if nifedipine is contraindicated.

In November 2015, this was an off-label use of nifedipine. See NICE's information on prescribing medicines. [Adapted from NICE's full guideline on preterm labour and birth]

Quality statement 5: Corticosteroids for women between 24+0 and 33+6 weeks of pregnancy

Quality statement

Women between 24+0 and 33+6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have preterm prelabour rupture of membranes (P-PROM) are offered maternal corticosteroids.

Rationale

Giving corticosteroids to a woman before a preterm birth reduces the severity of lung disease of prematurity and of other associated complications for her baby. Maternal corticosteroids also have the potential to reduce the number of days that the baby needs to be on a ventilator.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that women between 24+0 and 33+6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have P-PROM are offered maternal corticosteroids.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications and clinical protocols.

Process

a) Proportion of women between 24+0 and 33+6 weeks of pregnancy in suspected, diagnosed or established preterm labour who receive maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women between 24+0 and 33+6 weeks of pregnancy in suspected, diagnosed or established preterm labour.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of women between 24+0 and 33+6 weeks of pregnancy having a planned preterm birth who receive maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women between 24+0 and 33+6 weeks of pregnancy who are having a planned preterm birth.

Data source: Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

c) Proportion of women between 24+0 and 33+6 weeks of pregnancy with P-PROM who receive maternal corticosteroids.

Numerator – the number in the denominator who receive maternal corticosteroids.

Denominator – the number of women between 24+0 and 33+6 weeks of pregnancy with P-PROM.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

a) Ventilation.

Data source:NHS Maternity Statistics include data on neonatal critical care.

b) Incidence of neonatal sepsis.

Data source:NHS Maternity Statistics include data from Hospital Episode Statistics (HES) on the number of 'delivery episodes' where bacterial sepsis of newborn is recorded as a birth complication.

c) Use of antibiotics.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

What the quality statement means for different audiences

Service providers (secondary care services) ensure that women between 24+0 and 33+6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have P-PROM are offered maternal corticosteroids by healthcare professionals.

Healthcare professionals (such as obstetricians and midwives) offer maternal corticosteroids to women between 24+0 and 33+6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have P-PROM.

Commissioners (clinical commissioning groups or integrated care systems) commission services that ensure that women between 24+0 and 33+6 weeks of pregnancy who are in suspected, diagnosed or established preterm labour, are having a planned preterm birth or have P-PROM are offered maternal corticosteroids.

Women over 24 weeks and under 34 weeks of pregnancy are offered corticosteroid

injections to help their baby's lungs develop if:

- they are in suspected preterm labour **or**
- they are in diagnosed preterm labour (they have had a test that shows they are in labour) **or**
- they are in established preterm labour **or**
- they are having a planned preterm birth **or**
- they have P-PROM – this is when a woman's waters break early but labour hasn't started.

Source guidance

Preterm labour and birth. NICE guideline NG25 (2015, updated 2022), recommendation 1.9.2

Definitions of terms used in this quality statement

Suspected preterm labour

A woman is in suspected preterm labour if she has reported symptoms of preterm labour and has had a clinical assessment (including a speculum or digital vaginal examination) that confirms the possibility of preterm labour but rules out established labour. [NICE's guideline on preterm labour and birth, terms used in this guideline]

Diagnosed preterm labour

A woman is in diagnosed preterm labour if she is in suspected preterm labour and has had a positive diagnostic test for preterm labour. [NICE's guideline on preterm labour and birth, terms used in this guideline]

Established preterm labour

A woman is in established preterm labour if she has progressive cervical dilation from 4 cm with regular contractions. [NICE's guideline on preterm labour and birth, terms used in this

guideline]

Planned preterm birth

A planned birth before 37+0 weeks of pregnancy because of medical complications. [NICE's full guideline on preterm labour and birth]

Preterm prelabour rupture of membranes (P-PROM)

A woman is described as having P-PROM if she has ruptured membranes before 37+0 weeks of pregnancy but is not in established labour. [NICE's guideline on preterm labour and birth, terms used in this guideline]

Maternal corticosteroids

Corticosteroids (glucocorticosteroids) are anti-inflammatory medicines given to the woman (usually by intramuscular injection) which cross the placenta and accelerate fetal lung maturation.

In June 2022, this was an off-label use of bethamethasone and desamethasone. See NICE's information on prescribing medicines. [Adapted from NICE's full guideline on preterm labour and birth]

Quality statement 6: Magnesium sulfate for women between 24+0 and 29+6 weeks of pregnancy

Quality statement

Women between 24+0 and 29+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours are offered magnesium sulfate.

Rationale

With advances in neonatal care in recent years, more babies born preterm are surviving. These children frequently have long-term complications associated with preterm birth. Neurological effects are common and may cause severe disability. Magnesium sulfate can protect the developing fetal brain and so has significant potential to reduce disability.

Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

Structure

Evidence of local arrangements and written clinical protocols to ensure that women between 24+0 and 29+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours are offered magnesium sulfate.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from service specifications and clinical protocols.

Process

a) Proportion of women between 24+0 and 29+6 weeks of pregnancy in established preterm labour who receive magnesium sulfate.

Numerator – the number in the denominator who receive magnesium sulfate.

Denominator – the number of women between 24+0 and 29+6 weeks of pregnancy in established preterm labour.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

b) Proportion of women between 24+0 and 29+6 weeks of pregnancy who are having a planned preterm birth within 24 hours who receive magnesium sulfate.

Numerator – the number in the denominator who receive magnesium sulfate in the 24 hours before the birth.

Denominator – the number of women between 24+0 and 29+6 weeks of pregnancy who have a planned preterm birth.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example, from patient records.

Outcome

Incidence of cerebral palsy.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

What the quality statement means for different audiences

Service providers (such as secondary or tertiary care services) ensure that women between 24+0 and 29+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours are offered magnesium sulfate.

Healthcare professionals (such as midwives, obstetricians and neonatologists) offer magnesium sulfate to women between 24+0 and 29+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours.

Commissioners (clinical commissioning groups or integrated care systems) commission services that ensure that women between 24+0 and 29+6 weeks of pregnancy who are in established preterm labour or having a planned preterm birth within 24 hours are offered magnesium sulfate.

Women who are more than 24 weeks but less than 30 weeks pregnant andin established preterm labour, or having a planned preterm birth within 24 hours, are offered magnesium sulfate, as this medicine is likely to help their baby. The benefits and risks of this treatment are explained to them.

Source guidance

Preterm labour and birth. NICE guideline NG25 (2015, updated 2022), recommendation 1.10.2

Definitions of terms used in this quality statement

Established preterm labour

A woman is in established preterm labour if she has progressive cervical dilatation from 4 cm with regular contractions. [NICE's guideline on preterm labour and birth, terms used in this guideline]

Planned preterm birth

A planned birth before 37+0 weeks of pregnancy because of medical complications. [NICE's full guideline on preterm labour and birth]

Magnesium sulfate

Intravenous magnesium sulfate is offered to women in established preterm labour or who are having a planned preterm birth within 24 hours for neuroprotection of the baby. Women having this treatment should be monitored for magnesium toxicity.

In August 2019, this was an off-label use of intravenous magnesium sulfate. See NICE's information on prescribing medicines. Magnesium sulfate is not recommended beyond 24 hours, but if uncertainty around the exact timing of delivery results in repeat administration, follow the Medicines and Healthcare products Regulatory Agency (MHRA) safety advice on the prolonged or repeated use of magnesium sulfate in pregnancy. [Adapted from NICE's guideline on preterm labour and birth, section 1.10]

Update information

August 2019: Changes have been made to align this quality standard with the updated NICE guideline on preterm labour and birth. Statements 2, 4 and 5 have been updated to reflect changes to the guidance on prophylactic vaginal progesterone and prophylactic cervical cerclage, and the timing for corticosteroids for women with preterm labour. Licensing information, references and source guidance sections have also been updated throughout.

Minor changes since publication

June 2022: Changes have been made to align this quality standard with the updated NICE guideline on preterm labour and birth. Statement 2 has been amended to ensure consistency with guideline terminology. Links, definitions and source guidance references have been updated throughout.

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource

impact work for the source guidance. Organisations are encouraged to use the resource impact statement for the NICE guideline on preterm labour and birth to help estimate local costs.

Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN: 978-1-4731-2118-8

Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Royal College of General Practitioners (RCGP)
- Bliss
- Royal College of Midwives
- Royal College of Obstetricians and Gynaecologists