

MATERNITY GUIDELINES

Screening for Infectious Disease (HIV, Hep B, Syphilis)

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1. Introduction

The UK National Screening Committee (UK NSC) has responsibility for setting screening policy. It recommends systematic population screening in pregnancy for HIV, hepatitis B and syphilis. The Infectious Diseases in Pregnancy Screening Programme (IDPS) is responsible for implementing this policy ensuring that women with hepatitis B, HIV and syphilis infection are identified in early pregnancy. The programme is an essential component of strategies to prevent mother to child transmission of hepatitis B, HIV and syphilis. Women who decline screening for any of the infections should be formally reoffered screening and counselled about the benefits by a member of the multidisciplinary team. The screening team should be informed they liaise with the health advisors within the Sexual Health in Plymouth department (SHIP) who offer further risk assessment and counselling.

Maternity services are responsible for delivering the IDPS programme, the midwife therefore has responsibility for ensuring that information on maternal disease status and treatment outcomes is available to facilitate communication across professional groups.

All pregnant women, booking for pregnancy care should be given the National Screening Committee booklet “Screening tests for you and your baby” prior to or at the booking visit.

An interpreter should be arranged for women whom for whom English is not their first language. Support may also be necessary for those women with learning, communication or physical disabilities.

1.1 The Offer of Screening

All pregnant women should be offered screening for all three conditions.

The Midwife should discuss and ensure that:

- The woman has seen the written information “Screening tests for you and your baby”

- Written information is backed up with verbal explanation.
- The tests are offered individually not as a suite.
- The woman has been informed about the process of receiving both negative and positive results.
- Women are informed that they will be contacted directly if the hepatitis B, HIV or syphilis test is positive or needs repeating for any reason.
- Documentation of the date of the offer.
- Accepted/declined for each infection.
- Known to be HIV or hepatitis B positive has been documented as prior diagnosis not a decline.
- A blood sample taken for screening.
- The date of the test is documented.

Verbal information should be backed up with supporting literature in appropriate languages allowing women ample opportunity to make an informed decision on whether or not to opt out of these recommended tests as part of their antenatal care package.

Every woman should receive and have time to read the National booklet **SCREENING TESTS FOR YOU AND YOUR BABY**. (Available in English, Arabic, Bengali, Chinese, French, Latvian, Lithuanian, Polish, Portuguese, Punjabi, Romanian, Somali, Urdu).

If the woman requires more information or there are identified risk factors requiring more extensive counselling, referral should be made to the Health Advisers in SHIP. Midwives can contact the Health Advisors by phone, email or via the Screening Midwives however the screening midwives should be informed of any women who decline screening.

1.2 Declining Screening

If the offer of any infectious disease screening is declined at booking, the community midwife should repeat the offer at the next appointment and the woman should be informed that it will be reoffered by 20 weeks of pregnancy. If the woman further declines this should again, be recorded on page 7 of her hand held notes. Details of the discussion should be included in the 'comments' box. The Screening midwives will identify women who decline, record the decline on the Maternity booking database and provide SHIP with patient details, not to coerce the woman into having the test but to ensure she is making an informed choice (Appendix 3).

1.3 Taking samples

If the offer of screening is accepted, the laboratory should receive a fit for purpose antenatal blood sample within **one working day** of the sample being taken. A record of the date and time the specimen was taken should be kept. It is necessary to indicate the tests being requested and, if relevant, those declined.

1.4 Unacceptable Samples/inconclusive results

The requestor will be contacted and informed that a repeat sample is required by the laboratory. The requestor is responsible for informing the woman, action the request and

sending a repeat sample to the laboratory **within 10 working days** of the request being received by the maternity unit. The laboratory will monitor the turnaround of these requests.

1.5 Women who book late for antenatal care

Women who have not had any antenatal care, have come from out-of-area and have no antenatal notes with them, are to be offered screening for all three conditions as soon as possible. Specimens taken at 24 weeks of gestation or later should be marked “urgent”, the laboratory informed with a result available within 24 hours of receipt by the laboratory. If positive, the woman should be referred immediately to the relevant specialist service for further assessment.

1.6 Women presenting in labour with no available results

Women who have not had any antenatal care or have come from out-of-area and have no antenatal notes with them need to be offered screening for all three conditions as soon as possible. They should be marked “urgent”, the laboratory informed and a result should be received by the requestor within 24 hours of the sample being received by the laboratory – see guideline antenatal 42.

1.7 Repeat testing

Midwives should inform women that she can have repeat testing in pregnancy if she feels she may be at risk of any if the screening conditions or other sexually transmitted infection. Advice on safe sex may be appropriate.

1.8 Diagnostic tests

Infectious Diseases screening results are an indicator of current infection status. No invasive tests, amniocentesis or chorionic villus sampling (CVS) should be carried out until the results of screening for all the infections are received.

1.9 Negative Result

Negative results are available in the hospital ICM (Isoft Clinical Manager) system within 7 working days of receipt in the laboratory. The midwife (community or ANC) is responsible for checking the woman’s result, communicating this information to the woman and documenting the result within the handheld notes. The result is usually available and given to the woman at the time of the 1st trimester scan.

Failsafe: A further check for the results is made after 1 working week. Where results are available these are sent to the woman for her to file in the pregnancy handheld notes. A request for repeat bloods is sent to the community midwife at this point if results are still

not available. It is the responsibility of the community midwife to ensure the result is available at the 16 week appointment. The screening midwives also maintain a monthly booking spreadsheet to ensure all women have a result. Where there is no result the community midwife is asked to follow up and recommend the woman has screening.

1.10 Women who miscarry or terminate their pregnancy

Screen positive – the laboratory should notify the screening coordinator/team to facilitate appropriate onward referral into specialist services and close the maternity care episode

Screen negative – Community midwives are informed of any women who miscarry. The IDPS blood results are copied to the General Practitioners and therefore are available to the community midwives. The community midwives should make contact with women who have a pregnancy loss to inform them of a negative result and may offer support information at this time.

2. Documentation

2.1 The Maternity notes

The offer of infectious diseases screening should be clearly documented in **the woman's handheld maternity notes**. Verbal consent must be obtained and documented in the notes declines should be clearly indicated.

2.2 The laboratory request form

The form must be signed and the name of the requestor clearly printed. Appropriate clinical information should be included. If any of the routine antenatal blood tests are declined this must be clearly indicated on the request form.

3. Hepatitis B

Hepatitis B is an infectious disease of the liver caused by the hepatitis B virus, resulting in both acute and chronic infection. Transmission is through sexual contact, contaminated blood (e.g. needle sharing) or by vertical transmission i.e. mother to baby.

The risk of perinatal transmission is dependent on the status of the maternal infection. HBV e-antigen (HBeAg) positive women (found in the blood when HBV virus is actively replicating) are at a higher risk of transmitting the infection to the baby. Anti-HBe is present in women who have recovered from an acute hepatitis B infection.

If the infection is transmitted there is risk of the child developing chronic infection which may result in liver cirrhosis or liver cancer in later life. The earlier in life the infection occurs, the greater the risk that it will lead to chronic infection or premature death.

Presence of hepatitis B surface antigen (HBsAg) is often used for screening as it is the earliest indicator of infection and frequently identifies people before symptoms appear.

All pregnant women should be recommended to have screening for Hepatitis B in each pregnancy unless previously diagnosed. Women have the right to refuse the test. The offer of Hepatitis screening should be clearly documented in the woman's notes. The midwife must write '**declined**' on the antenatal blood form so that the laboratory is aware that it is not an administrative error.

The midwife offering the test is responsible for informing the Antenatal Screening Coordinator if a woman declines infectious diseases screening. A woman who declines Hepatitis B screening may be referred to a Sexual Health specialist for further counselling. The midwife must offer screening again no later than 28 weeks' gestation. For those women who are previously diagnosed at a different hospital, the test must be offered and repeated.

3.1 Women with known Hep B status

Where a prior positive diagnosis of Hep B is documented and known, a prompt consultant appointment should be made for clinical evaluation. The woman's infection status should be recorded as "screening not required – prior diagnosis" rather than "declined" in the patient record. All other screening tests should be offered as normal.

3.2 Pathway for all women with Hepatitis B positive result

- The Lead Microbiologist informs GP/requestor and Screening Midwives by phone or email.
- It is the GP's responsibility to give the woman the result within 10 working days and arrange a Consultant obstetrician appointment.
- The lead Microbiologist generates a letter to advise the need for neonatal vaccination to obstetric consultant, GP, community midwife and screening midwife

Partners and families of infected women should be offered screening and vaccination for HBV.

All Hep B positive women are managed by a multidisciplinary team. The lead obstetrician will make a care plan, in accordance with BHIVA guidelines, which will include:

- Counselling and formation of a plan of care regarding the giving of Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) to the baby. This should be clearly documented in the woman's obstetric notes.

- Liver function tests should be performed. If the results are abnormal, refer the woman to a gastroenterologist.
- A neonatal alert form should be completed and sent to the neonatal secretaries for the attention of a neonatologist. The neonatologist will write a management plan for care of newborn. The form will be filed in maternal hospital notes and transferred to the neonatal notes following birth.
- In the antenatal period a plan for delivery must be clearly documented within the patient maternity handheld notes.
- Give leaflet “Hepatitis B – What does my positive screening result mean” to the woman, available in English and 12 other languages and can be downloaded. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/520329/Hep_B_screening_leaflet_2016.pdf
- Inform hepatology specialist nurse phone using proforma (appendix 2). The woman should be seen within **6 weeks** of the referral.
- All positive women have a named consultant and are aware that if appropriate their case will be discussed at the viral hepatitis MDT.

Non-attendance at any appointment should be reviewed and a management/action plan developed.

3.3 Vaccine and Immunoglobulin

- Vaccine should be ordered from 36 weeks gestation.
- Vaccine should be administered within 24 hours of birth.
- The microbiologist at Derriford Hospital will obtain the Hepatitis B Vaccine and Hepatitis B Immunoglobulin (HBIG) from the Communicable Diseases Surveillance Centre (CDSC) as required.
- These can be ordered from pharmacy on admission and labelled with the woman’s name and hospital number and placed in the DRUG FRIDGE on Central Delivery Suite.
- For unplanned admissions during ‘working hours’ contact the Microbiology Department, as they keep a small stock.
- For unplanned admissions during ‘out of hours’ contact the Emergency Dept as they keep a small stock of adult doses. The neonatologist will calculate the correct dose for the baby.

Failsafe: Antenatal screening team inform the child health department of all hepatitis positive women who have booked for maternity care on a monthly basis.

3.4 Intrapartum Care

Avoid:

- ARM.
- Applying a fetal scalp electrode.
- Performing fetal blood sampling.

3.5 Neonatal care

Neonatologist to be informed when the woman is in labour.

For protection of babies born to hepatitis B carrier mothers – Please refer to neonatal GBS guideline. In addition:

The neonatologist should prescribe the appropriate treatment depending on the mother’s status and birth weight of the baby. The treatment will have already been supplied by the Microbiology Department at Derriford Hospital.

MOTHERS STATUS	TREATMENT FOR BABY (INITIAL)	FOLLOW-UP VACCINATIONS
HBsAg positive and HBeAg positive +/- Anti-HBe negative 'HIGH RISK CARRIER'	Hepatitis vaccine PLUS Human Hepatitis B Immunoglobulin	Hepatitis vaccine at 1 month, 2 months and 12 months
HBsAg positive and Anti-HBe +ve 'LOW RISK CARRIER'	Hepatitis B vaccine alone	Hepatitis B vaccine at 1 month, 2 months and 12 months

- The Hepatitis B Immunoglobulin (HBIG) should be given as a deep intramuscular injection into the anterolateral aspect of the baby’s thigh.
- The Hepatitis B Vaccine should be given as a deep intramuscular injection into the anterolateral aspect of the baby’s opposite thigh.
- This procedure should be performed before the mother and baby leave the Central Delivery Suite.
- Clearly documented in the baby’s care plan.
- Follow up is via the GP who will prescribe the Hepatitis B vaccine at 1 month, 2 months and 12 months.
- The baby will have a blood test at 12 months to check immunity.

3.6 Postnatal Care

- Breastfeeding is not contraindicated as there have been no reported cases of transmission from mother to baby via breast milk.

3.7 On Discharge

- Ensure the mother’s discharge address and contact numbers are correct.
- Discuss with the mother the baby’s immunisation schedule and the importance of completion.
- Record the woman’s hepatitis B status and the baby’s vaccination schedule on the discharge letter as well as in the Personal Child Health Record.

- A notification form that the infant has received vaccine +/- immunoglobulin will be given to the mother and a copy must be sent to the GP and to Plymouth Child Health Team via the screening team.

All infants born to Hepatitis B positive women will require serology to be taken at 12 months (arranged through the GP). If the infant is positive for hepatitis, he/she is then referred back to the Paediatric team at hospital.

3.8 Responsibilities

Consultant Obstetrician - responsible for the woman's antenatal plan of care and ensures all appropriate follow up.

The Paediatric Registrar / SHO - administer the first dose of the vaccine +/- immunoglobulin to the baby.

The Antenatal Screening Co-ordinator - facilitating communication between all members of the Multidisciplinary Team. The ANSC will refer all positive women to the specialist hepatology nurse (to be seen within 6 weeks).

The midwife is the lead carer for maternity issues, ANC staff for out of area women.

The Sexual Health Clinic - screening and vaccinating family members, partner tracing and education for women on public health issues. The Sexual Health Clinic will provide ongoing support and counselling. The team will arrange the programme of care for the woman's individual.

4. HIV (Refer to antenatal guideline No.25 HIV screening and Management of HIV positive women).

The human immunodeficiency virus (HIV) is a blood borne, retrovirus that attacks and destroys T-lymphocytes, resulting in immune suppression that eventually leads to acquired immune deficiency syndrome (AIDS).

HIV is transmitted through:

- Sexual contact.
- Contaminated blood e.g. needle sharing.
- Transmission from mother to child, which can occur in utero, during delivery or through breast feeding.

All pregnant women should be offered and recommended testing for HIV in each pregnancy, unless they are already known to be HIV positive. HIV screening should be recommended alongside the other antenatal booking blood tests.

Pregnant women are offered screening for HIV infection so that the interventions can be offered to reduce the risk of mother-to-child transmission of the virus, as well as to safeguard the woman's own health.

Antiretroviral therapy, appropriate management of delivery and the avoidance of breast feeding can reduce the risk of mother-to-child transmission to 1% or less. This rationale should be explained to women.

The aim of the antenatal screening and management pathway is to prevent neonatal HIV infection.

The objectives of the screening programme are to:

- Identify all HIV positive women and those with positive test results.
- Ensure rapid referral of all HIV positive women for assessment and management within a multi-disciplinary team.

Women are recommended to have serology screening as part of routine antenatal care- includes; HIV, Syphilis, Hepatitis B. These blood tests must occur at the 1st booking visit with the community midwife (recommended by 10 weeks' gestation).

At booking, a pre-test discussion with the woman is an integral part of their antenatal care and should include information about the benefits of testing and interventions that are available to women following a positive result.

Women have the right to refuse the blood test. If a woman declines the offer of HIV screening, this should be clearly documented in the woman's notes. Document 'declined' on the antenatal blood form so the laboratory is aware that it is not an administrative error.

- For those who decline HIV screening, a referral to SHIP should be sent for further counseling and risk assessment. The midwife should offer HIV screening again no later than 28 weeks' gestation.
- If women book later in pregnancy, HIV screening should still be offered regardless of gestation and the Microbiology Consultant should be informed.
- For women who present in labour and have no UK result - PHNT rapid testing should be offered. A reactive result in labour must be acted upon accordingly.
- All women must be informed of the results procedure, including how they will be informed of the result

Failsafe: A further check for the results is made after 1 working week and where results are available these are sent to the woman for her to file in the pregnancy handled notes a request for repeat bloods is sent to the community midwife at this point if results are still not available. It is the responsibility of the community midwife to ensure the result is available at the 16 week appointment. The screening midwives also maintain a monthly booking spreadsheet to ensure all women have a result. Where there is no result the community midwife is asked to follow up and recommend the woman has screening.

4.1 Women with known HIV status

Where a prior positive diagnosis of HIV is documented and known, a prompt consultant appointment should be made for clinical evaluation. The woman's infection status should be recorded as "screening not required – prior diagnosis" rather than "declined" on page 7 of the hand held notes. All other screening tests should be offered as normal.

4.2 Pathway for all women with HIV positive result

All results will be given on a laboratory report, in a format which clearly specifies the result.

The Lead microbiologist will contact SHIP, who will inform the GP and provide an urgent appointment for the woman and her partner and the screening team. It is the GP's responsibility to give the women the results together with the SHIP appointment **within 10 working days**.

After a confirmed positive result SHIP will:

- inform the lead obstetrician **and**
- make an appointment for the woman with the lead obstetrician.

A leaflet has been developed to help women understand a positive result. It is available in English and 12 other languages and can be downloaded.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/520331/HIV_screening_leaflet_2016.pdf

Care following a confirmed positive result should include input from a multidisciplinary team including obstetrician, neonatologist, midwife, specialist counsellor and specialist in genitourinary medicine. The specialist obstetrician will liaise with the HIV consultant to formulate an individualised management plan to be written in the patients handheld notes (a copy is also available on the inpatient areas with patient consent) to ensure the plan is followed).

The patient will be added to the Fetal Medicine MDT spreadsheet for information and further discussion if required.

A neonatal alert form will be completed and sent to the neonatal secretaries for the attention of a neonatologist. The neonatologist will write a management plan for care of the newborn. The form will be filed in maternal hospital notes and transferred to the neonatal notes following birth.

4.3 Combined Screening

Where there is a raised combined test risk and a referral for a diagnostic test is requested serology results must be available prior to the appointment.

Invasive testing such as CVS and amniocentesis may increase vertical transmission of HIV to the baby and the woman would need careful counselling before making a decision. The HIV specialist may feel that it is pertinent to start prophylactic anti-retroviral treatment before the diagnostic test is done. Amniocentesis would be the preferred test for this reason.

The lead obstetrician will make a care plan, in accordance with BHIVA guidelines, which will include:

- Maternal infection status.
- Maternal treatment history and any requirement for care and treatment during labour and delivery.
- The need to avoid both fetal blood sampling and use of fetal scalp electrode in most circumstances.

- Requirement for neonatal assessment and management after delivery.

The lead neonatologist and team will be informed, in writing, and details of mode and timing of delivery will be discussed at MDT meetings.

The neonatologists will provide a plan of care for the baby following birth. This will be filed in the maternal hospital notes and transferred to the baby notes at birth.

Any non-attendance at any appointment should be reviewed and a management/action plan developed.

5. Syphilis

Syphilis is an infectious disease caused by the *Treponema pallidum* bacterium. It is transmitted primarily through sexual contact but can be transmitted from mother to baby. The risk of transmission from mother to baby declines as maternal syphilis infection progresses. Risk ranges from 70 – 100% in primary syphilis, 40% in early latent syphilis and 10% in late latent syphilis.

Maternal syphilis infection can result in a range of adverse pregnancy and neonatal outcomes. These include late miscarriage, stillbirth, hydrops and low birth weight. If left untreated congenital syphilis can result in physical and neurological impairments affecting the child's bones, teeth, vision and hearing.

Congenital syphilis is a preventable condition but this depends on correct diagnosis and adequate treatment of the mother. There has been an increase in syphilis diagnosis in the adult population in recent years. Against this background the need to review and improve the arrangements for identification and management of syphilis in pregnancy has been emphasised.

The purpose of screening is to identify women who are infected and treat accordingly in the antenatal period thus reducing the risk of the baby being born with the infection.

All pregnant women should be offered and recommended screening for syphilis in each pregnancy. The screening tests are over 99% accurate.

For those who decline Syphilis screening, referral to a Sexual Health Clinic for further counselling may be appropriate. The midwife should offer Syphilis screening again no later than 28 weeks gestation.

For women who book later in pregnancy, Syphilis screening should still be offered regardless of gestation and the gestation of the pregnancy is to be recorded on the laboratory request form.

All women must be informed of the results procedure including how they will be informed of the result

5.1 Pathway for all women with positive result for Syphilis

The Lead Microbiologist contacts GP /requestor & informs Screening Midwives who will alert GUM.

GP phones SHIP for an urgent appointment - (01752) 763924.

It is the GPs responsibility to give the woman the result & the arranged urgent appointment with SHIP within 10 working days.

The Health Advisors discuss the following with the woman in accordance with the British Association for Sexual Health and HIV (BASHH) guidelines:

- need for further assessment to provide a diagnostic evaluation, confirm identity and evaluate maternal treatment needs
- the significance of syphilis infection for maternal health, the pregnancy and the baby's health,
- the potential benefits of multi-disciplinary management for the pregnancy, the woman's health and that of the baby
- practical arrangements for further assessment eg date options for appointments with an appropriate specialist.

The urgency to complete the assessment is because:

- not all positive screening test results will be confirmed as a syphilis diagnosis or as an infection requiring treatment,
- treatment, when indicated, needs to be instituted as early as possible to avoid adverse outcomes of pregnancy

All Syphilis positive women who require treatment are managed within a multidisciplinary framework. Management plans will be designed by the lead obstetrician and neonatologist in consultant with woman and her family and be clearly documented within the patient healthcare record. A leaflet has been developed to help women understand a positive result. It is available in English and 12 other languages and can be downloaded. <https://www.gov.uk/government/publications/syphilis-explaining-the-screening-result>

A neonatal alert form will be completed and sent to the neonatal secretaries for the attention of a neonatologist. The neonatologist will write a management plan for care of the newborn. The form will be filed in maternal hospital notes and transferred to the neonatal notes following birth.

5.2 Intrapartum care

It is essential that the relevant information is available to the delivery team

This should include:

- Final diagnosis and staging of maternal disease if known.
- Maternal treatment during the pregnancy.
- Maternal treatment outcome / titre of final follow up blood test if known at delivery.
- Fetal medicine assessment if relevant.
- Requirement for postnatal tests for mother and baby.
- Requirement for neonatal assessment.
- Confirmation that neonatal treatment has been ordered and is available.

The neonatal team should be informed during delivery to ensure prompt transfer of care.

5.3 Neonatal management

Postnatal management of the mother and baby should be undertaken in accordance with the BASHH guideline.

6. Rash illness in pregnancy

Information and advice to pregnant women regarding rash illness should reflect the “Guidance on Viral Rash in Pregnancy”.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/322688/Viral_rash_in_pregnancy_guidance.pdf

This sets out the investigation, diagnosis and management of pregnant women who have, or have been exposed to, a rash illness. All pregnant women with rash illness, or contact with rash illness, should be referred for medical management and laboratory investigation in line with the HPA guidance document.

At booking, midwives should use the new national leaflet to:

- discuss the vaccinations to protect women and their babies
- raise awareness of rash illness or contact with rash illness in the current pregnancy
- advise women to inform their midwife, GP or obstetrician urgently if they develop a rash or are in contact with someone who has a rash, at any time in pregnancy
- advise women who develop a rash or are in contact with someone who has a rash to avoid any antenatal clinic or maternity setting until clinically assessed, to avoid exposing other pregnant women

7. Data Collection

The Screening midwives will be informed by the lead microbiologist of any positive results from the infectious disease screening programme. Accurate data collection is required at Trust level & is the responsibility of the Screening midwives to co-ordinate this. All infectious disease screen positives are inputted into the Infectious Disease Screen Positive Database for follow up.

The Screening midwives submit data, quarterly, to the Health Protection Agency & the National Screening Committee publish Key performance indicators that include the coverage of antenatal HIV screening. This is collated at regional and national level for reporting. The testing laboratory is responsible for notifying and reporting positive Hepatitis B, HIV and Syphilis cases.

Cases of HIV positive women will be included in the Fetal Medicine database on the shared Maternity drive.

Babies born to Hep B positive women are notified to Child Health Information Team after the first vaccine is given to enable the schedule of appointments to be generated.

8. Regional Screening team

Sharon Webb, Programme Manager, NHS Infectious Diseases in Pregnancy Screening Programme.

Siobhan O'Callaghan Senior Quality Assurance Advisor 07976770296

Wendy Ring Quality Assurance Advisor 07841067240

Maggie Denholm Quality Assurance Advisor 07887986416

Andrea Arnott Screening & Immunisation Coordinator PHE / NHS England – South (South West) 01138248957

Plymouth Infectious Disease Screening team

Alison Mackenzie Consultant in Public Health Medicine - Screening and Immunisation Lead 01138248760

Dr Richard Cunningham Lead Microbiology Consultant

Miss Imogen Montague Lead Obstetrician Pager 89511

Dr Alex Allwood Lead Neonatologist 01752 432333

SHIP Health Advisors 01752 431804

Amanda Clements Hepatology Nurse Consultant 433174

Ruth Rice Antenatal and Newborn Screening Coordinator 01752 430090,

Jackie Craner Antenatal and Newborn Screening Deputy 01752 439792

Denise Edgecombe Lead Health Visitor 01752 434428

Helen Finnie Child Health Information Team Manager 01752 437281

Appendix 1. Pathway for antenatal infectious disease screen results

Booking bloods taken early in pregnancy 8-10 weeks allow time for screen positives to be identified & reported as below prior to 12 week scan appointment

Screening midwives check all Infectious Disease Screening booking blood results prior to 12 week scan appointment & **Scanning midwives** give all negative results to the woman
Screening midwives follow up any outstanding results & send to the woman by post.
Any results missing from 16 weeks will need to have samples repeated

Hepatitis B Positive
Lead Microbiologist informs GP/requestor and Screening Midwives by phone/email
GP gives the woman the result & arranges Consultant appointment within 10 working days
Lead Microbiologist generates a letter to advise the need for neonatal vaccination to Obstetric Consultant

HIV Positive
Lead Microbiologist contacts **GP /requestor** & informs Screening Midwives who **alert SHIP**
GP phones **SHIP** for appt & gives the woman the result within 10 working days and an arranged appointment with **SHIP**
Screening Midwives arrange obstetric appointment

Syphilis positive
Lead Microbiologist contacts **GP /requestor** and informs Screening Midwives who **alert SHIP**
GP phones **SHIP** gives the woman the result within 10 working days & an arranged appointment with **SHIP Health Advisor 01752763924**
SHIP provide rapid assessment of women
 Obstetric appointment made for lead Consultant with results of diagnostic evaluation.

Screening Midwives/CMW refer patient to **Hepatology Nurse Consultant**
Hepatology provide appointment for the woman to be seen within 6 weeks
Women booking late need urgent referral
 Consider ordering and storage of vaccine +/- HBIG in advance
 Baby needs 1st dose within 24hrs
Medical team administering vaccine notifies GP, HV, Screening Midwife and parents of vaccination.
Screening Midwives notify CHIT of babies having had 1st dose
CHIT generates appointments for primary care and notifies immunisation Co-ordinator to co-ordinate follow up for serology and **CYPOD** appt at 12 months

Screening Midwives
 Checks that neonatal alert has been provided
 Care planned by **Obstetric Consultant and Neonatologist**
 Information provided at the Multi disciplinary team meetings

**Appendix 2. Referral form for women with positive
Hepatitis B result**

Viral Hepatitis Referral to: Amanda Clements, Hepatology Nurse
Specialist Level 9, Derriford Hospital, PL6 8DH Ext 57665 bleep 276
From Midwifery services

Can we please refer the following person to you:(please PRINT)

NAME: **DoB**...../...../.....

Address & mob. phone number (or care of address)

.....

.....

..... **Postcode:**.....

Expected delivery date:.....

GP:

GP Address:.....

GP informed of referral:

Reason for referral:.....

.....

.....

Name of Obstetric Consultant:.....

What blood tests have been done? (if any).....

.....

Does patient require an interpreter; for which language:.....

.....

Name & tel. No. drug worker.....

Any other information that may be helpful:.....

.....

.....

Signed:..... **contact no:**..... **Date:**.....

**Appendix 3. Antenatal Serology Decline Referral to
SHIP**

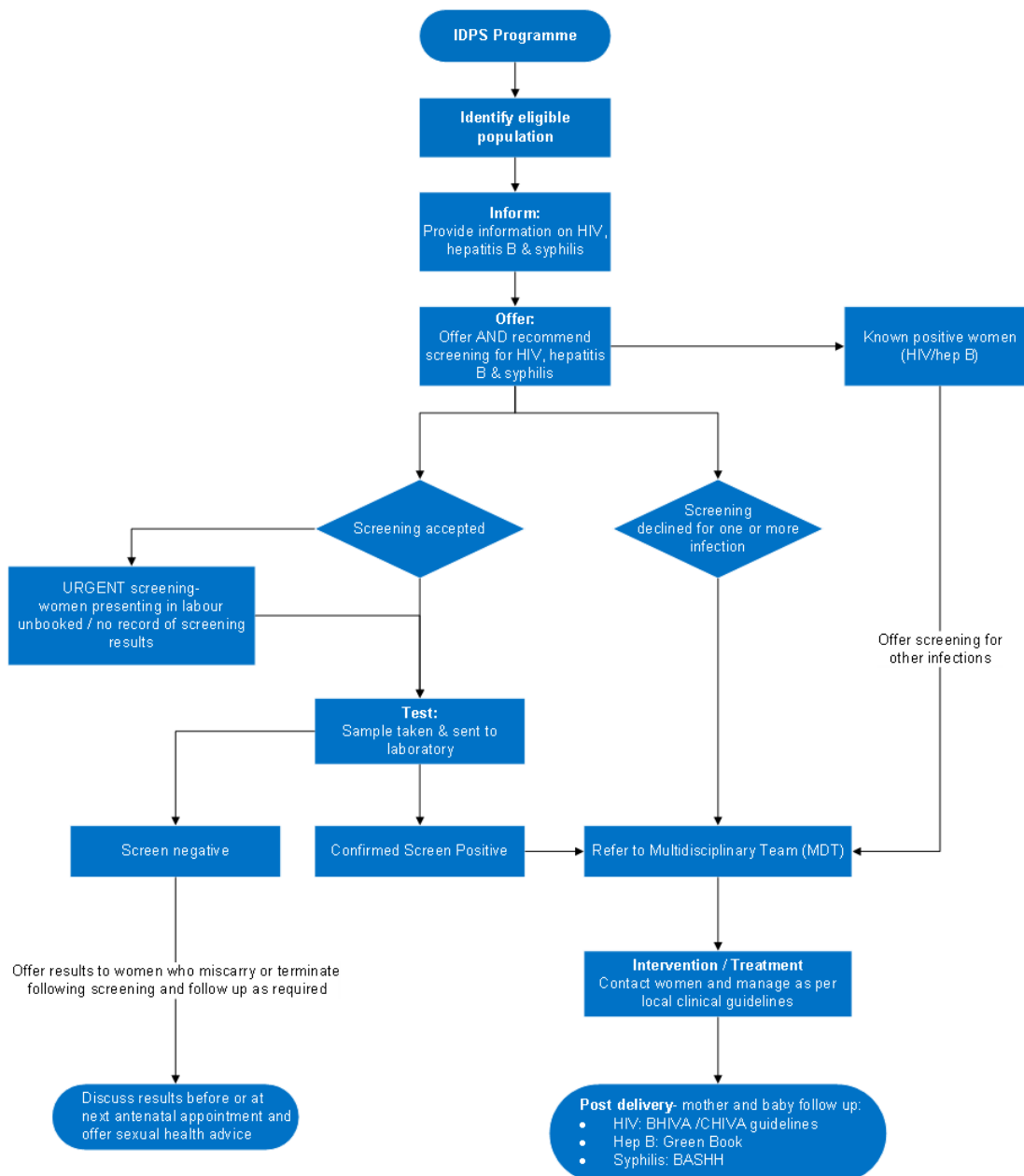
Antenatal Serology Decline

Date of Referral	
Name of Patient	
Date of Birth	
Hospital Number N H S Number	
Gestation at Referral	
Address	
Postcode	
Telephone Number Mobile Number	
GP	
GP Address	
Postcode	
Partners Name	
Partners Date of Birth	

LMP	
EDD	
Blood Tests done PRIOR to pregnancy / during this pregnancy	
Date of Contact with GUM	
Name of Health Advisor	
Discussion	

Referrer		
Contact Number		DERRIFORD HOSPITAL

Appendix 4. IDPS Screening pathway



Monitoring and Audit

Auditable standards:

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines

Reports to:

Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit

Clinical Governance & Risk Management Committee

Frequency of audit:

Annual

Responsible person:

Antenatal and Newborn Screening Team

Cross references

Local guidelines for :

AN 17 Dating Scans

AN 19 Antenatal Screening for Downs Syndrome

AN 24 Sickle Cell and Thalassaemia Screening (please rename Haemoglobinopathies)

AN 25 HIV screening and Management of HIV positive women

AN 27 Screening for Infectious Diseases in Pregnancy

AN 31 Maternity Hand Held Notes, Hospital Records and Record Keeping

AN 37 Antenatal & Newborn Screening guidelines

AN 42 Women who are unbooked or have moved from another area

AN 44 Guideline development within the maternity services

AN 45 When Fetal abnormality is detected

Neonatal guidelines:

Immunisation of Infants at Risk of Hepatitis B

Management of Infants Born to Low Risk HIV +ve Mothers

Training requirements

Audit of training needs compliance – please refer to TNA policy

Annual Screening Update on Maternity Mandatory Training Week

Please refer to 'Training Needs Analysis' guideline together with training attendance database for all staff

References

Infectious Diseases in Pregnancy Screening Programme handbook PHE 2016-2017 July 2016
<https://www.gov.uk/government/publications/infectious-diseases-in-pregnancy-screening-programme-handbook>
 NHS public health functions agreement 2016-17 Service specification no.15 NHS Infectious Diseases in Pregnancy Screening Programme. Updated Feb 2016
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/02/serv-spec-15.pdf>
 NHS Infectious Diseases in Pregnancy Screening Programme Standards 2016 to 2017. Updated March 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/529070/IDPS_Programme_Standards_2016_to_2017.pdf
 NICE clinical guideline 62 Antenatal care Routine care for the healthy pregnant woman March 2008 updated March 2016 (www.nice.org.uk/Guidance/CG62)
 For HIV refer to the British HIV Association guideline:
<http://www.bhiva.org/documents/Guidelines/Pregnancy/2012/BHIVA-Pregnancy-guidelines-update-2014.pdf>
 For hepatitis B refer to the DH Green Book: March 3013 Updated February 2016
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/503768/2905115_Green_Book_Chapter_18_v3_0W.PDF
 For Syphilis refer to British Association of Sexual Health and HIV (BASHH) **Guidelines** 2015
www.bashh.org/guidelines

Author	<i>Ruth Rice (Ante-Natal Screening Co-ordinator)</i>	
Work Address	<i>Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH</i>	
Version	6	
Changes	Parvovirus removed, Links to patient information Rash awareness added Failsafes added	
Date Ratified	<i>Jan 2017</i>	Valid Until Date <i>Feb 2020</i>