Brighton and Sussex University Hospitals NHS Trust

Antenatal screening for infectious diseases: Human Immunodeficiency Virus (HIV)

Maternity Protocol: MP004

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Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

Scope

This protocol applies to:
All women booking at any stage of pregnancy

Responsibilities

Midwives & Obstetricians:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this protocol.

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations.
- To ensure the protocol is accessible to all relevant staff.

1 Antenatal Screening for HIV

Background to the screening programme is given in Appendix B.

For Designated programme lead for maternity services and Link speciality staff please see Appendix A

1.1 Aims

The NHS infectious Disease in Pregnancy Screening Programme ensures that all pregnancy women are offered and recommended screening for HIV [public Health England (PHE) 2018b]

1.2 Objectives

1.2.1 To ensure that women with HIV are identified early in pregnancy to facilitate appropriate assessment and management for their health

1.2.2 To reduce the risk of mother -to-child transmission of HIV

1.2.3 To facilitate appropriate neonatal referral and management [PHE 2018b]

1.3 Expected Health Outcomes

Our aim is to reduce the risk of a mother-to-child transmission of HIV and safeguard the woman own health [PHE 2018b.

2 Screening for HIV In Pregnancy

2.1 Pre-Screening information: enabling informed choice

2.1.1 At the first antenatal contact with the midwife, the woman should be given verbal and written information about HIV. This should include the benefits of screening for both the woman and unborn baby [National Institute for Health and Care Excellence (NICE) 2008, PHE 2018b].

2.1.2 Screening should be offered and recommended.

2.1.3 Trust uses the NHS Screening Programmes information booklet: 'Screening tests for you and your baby'. This includes the section 'Infectious Diseases' This leaflet may be sent to the woman by post prior to the first appointment or given out at the first appointment. The midwife must document in the hand held notes that the leaflet has been received by the woman.

2.1.4 Copies of 'Screening tests for you and your baby' are available in some other languages and can be downloaded via the Public Health England website: https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief If the leaflet is not available in the language required from the national website, it is possible to ask for the leaflet to be translated via the trust's Equality and Diversity Team.

2.1.5 Interpreting services (including sign language) should be used for communicating with parents who are not fluent in English at all stages of the screening pathway.

2.1.6 Where there are specific communication requirements (e.g. English is not the woman's first language, visual/ hearing impairment) appropriate interpretation services should be used at booking and all subsequent stages in the screening pathway. For further guidance see also the trusts Accessible Communications Guidelines via the Equality and Diversity team.

2.1.7 If the midwife or doctor feels unable to answer all questions or the woman requests further advice/information about any aspect of HIV, then a direct referral can be made to the Specialist Midwife for Reproductive Health and Wellbeing (SMRHW) for specialist counselling [See contact list Appendix A.

3 Offering Screening in Pregnancy

3.1 The Eligible Population
All women and people should be offered screening for HIV early in each pregnancy regardless of the results of HIV screening in previous pregnancies [NICE 2008, PHE 2018b, PHE 2019]

3.2 The midwife or doctor should discuss the reasons why screening for HIV is recommended, the results process and follow-up if diagnosed with HIV infection.

3.3 Screening should be offered early in pregnancy, ideally by 10 weeks [NICE 2008]. The aim is to offer and screen all women before 10 weeks, however, screening can be offered at any point during the pregnancy.

3.4 Women booking late or who arrive unbooked in labour should still be offered screening at the first available opportunity (see sections 4.0 and 5.0).

3.5 Testing should also be available on request at any stage of pregnancy should a woman consider herself to be at risk of infection [PHE 2018b]. However advice should be sought immediately from the GUM team if a woman thinks she have been in contact with HIV infection during pregnancy.

3.6 Women who have booked elsewhere and transferred care to BSUH NHS TRUST should be offered repeat screening. This ensures a result is available in-house for all staff to access electronically if the hand held notes are not available and for completion of cohort data. If a woman or person declines repeat testing having been screened elsewhere, then a copy of the original result from the previous booking unit must be inserted in the hand held notes and a further copy sent to the Antenatal Screening Co-ordinator and SMRHW. A booking test declined form (Appendix C) should be completed and the declines process should be implemented)

3.7 The midwife should document in the hand held notes that discussion has taken place and the woman's decision to accept or decline screening. Screening should only be performed after documented informed consent; this does not require a signature from the woman.

3.8 There is currently no national policy to offer repeat HIV screening later in pregnancy. However, in the following circumstances, the midwife should consider a repeat test at 28 weeks if:

- If a woman or person changes their sexual partner/s or continues to engage in at risk behaviour during the pregnancy including injecting recreational drugs, sex work, having a partner that is known to be bisexual, having a partner that is known to have HIV, or if either partner is diagnosed with an STI
- If the woman is from a high risk group and/ or her partner is from a high risk group with HIV status is unknown. E.g. if they are from a sub-Saharan country
- If symptomatic for sero-conversion (rash, flu-like symptoms, sore throat, diarrhoea) at any stage
- If the woman discloses that her partner is HIV positive [PHE 2018b]

These cases should be considered on an individual basis. Advice can be sought from the SMRHW as necessary (see Appendix A).

4 Women Booking Late

4.1 Women booking late must be offered screening at the first appointment with the midwife. Short interval between treatment for maternal infection and delivery are associated with an increased risk of vertical transmission. Therefore for women booking at 24 weeks gestation or later, the blood specimens should be marked urgent and positive results reported within 24 hours (1 working day) of the sample being received in the laboratory [Royal College of Pathologists (RCP) 2013]

4.2 In such cases it is the responsibility of the midwife booking the woman to follow up results within 5 working days of the sample being taken. The midwife must agree a plan with the woman to communicate the results to her. This plan must be documented in the maternal hand held notes [RCP 2013].

5 Women Who Arrive Un-booked or Without Screening Results in

5.1 Labour

5.1.1 Women who arrive unbooked or without screening results in labour must be offered screening on admission by the midwife responsible for her care. Consideration should be given to the stage of labour, woman's condition and specific risk factors for HIV. The midwife should document all discussions that have taken place in the hand held notes [PHE 2018b].

5.1.2 If the woman is considered to be at increased risk of HIV infection and delivery is imminent or maternal health compromised then it may be necessary to consider urgent or rapid screening. If in doubt as to whether urgent screening is necessary, discuss with the SMRHW or on-call doctor for HIV.

5.1.3 During normal working hours results can normally be obtained within an hour from the laboratory. These cases should be discussed with laboratory staff BEFORE the sample is taken, informing them that the result is urgent. Out of normal working hours, the case should be discussed with the on-call microbiologist and on-call doctor for HIV [PHE 2016a, PHE 2018b].

5.1.4 Where a rapid test is required at the point of care (POCT – point of care test) in urgent cases (for example if delivery is imminent or baby has been born before maternal HIV testing), the case must be discussed with the on-call microbiology consultant and SMRHW or on call doctor for HIV. Where it is agreed that a POCT is appropriate, this will be carried out by either the on-call doctor for HIV, SMRHW or laboratory staff.

5.1.5 Presumptive action should be taken on a preliminary positive result taken on a woman in labour until such time as the result is confirmed.

5.1.6 If consent is withheld for screening during labour the midwife caring for the woman should re-offer screening after delivery and document discussions/ decisions in hand held maternity notes, and refer to the SMRHW for follow up [PHE 2018b](DoH 2003).

5.1.7 The midwife caring for the woman in labour should inform the on-call neonatal doctor when either:

- consent to screening is withheld during labour
- a woman has been screened but delivery is likely before the result is available

In either of these situations, the midwife should alert the on-call neonatal consultant who, in conjunction with the on-call HIV doctor, will consider screening the infant. Breast feeding should be avoided until an HIV negative result is obtained. For further information refer to BSUH neonatal policy: HIV testing of babies of untested mothers.

5.1.8 In all cases blood results must be obtained before discharge from the hospital / maternity services and documented in the hand held notes by the midwife responsible for the woman's care [PHE2018b]

5.1.9 The Antenatal Screening Co-ordinator and SMRHW should both be informed of any woman or person screened on delivery suite/postnatal wards to ensure appropriate tracking and follow up [PHE 2018].

6 Women Known To Be Living with HIV Prior To Screening

6.1 Where a positive diagnosis of HIV is documented and known to the health professional, they should refer the woman to the Specialist Midwife for Reproductive Health and Wellbeing (SMRHW) by phone immediately (see Appendix A) to ensure appropriate management. Management for these women is the same as for women diagnosed via antenatal screening and detailed in section 10.0

6.2 Known women living with HIV should still be re-screened for HIV as they may not be known to local GUM services and the positive result triggers the laboratory to inform the SMRHW which acts as an additional failsafe to ensure follow-up. When completing the request form write 'HIV positive status known' and include date of prior diagnosis and where it was performed.

6.3 If the woman declines a re-screen for HIV then this should be recorded as 'HIV screening test not required – positive status known' rather than declined. All other antenatal screening tests should be offered as routine.

7 7.0 Declining Screening

7.1 Screening is optional. All women have the right to decline screening. In these cases the midwife should complete a booking blood test declined form (see Appendix C) and return to the SMRHW.

7.2 The decision to decline screening must be clearly documented by the midwife in the hand held notes. The 'decline' box must also be ticked on the booking blood request form.

7.3 Where women decline screening, the midwife should ensure that the woman is aware she can opt for screening at any stage later in her pregnancy and is aware how to arrange this [PHE 2018b].

7.1 The woman should also be informed that as they have declined HIV screening, they will be contacted by the SMRHW to further discuss their choices. This contact will usually be within 10 working days of receipt of the decline form and ideally by 20 weeks. Ideally this discussion takes place in person. At this contact the SMRHW will:

- discuss the woman or person's decision to decline and ensure that they are fully aware of the benefits of screening for both themselves and their baby
- reoffer the screening test and where this is accepted arrange testing of all booking bloods and follow up of the result
- offer and where accepted arrange needle prick point of care tests or oral swabs to women and people who are severely needlephobic [PHE 2018b]

7.2 If the woman remains unscreened at 28 weeks the midwife should re-offer screening at the 28 week visit along with the other blood test routinely offered at this appointment. The midwife should document in the hand held notes any discussions that take place and the woman or person's decision to accept or decline screening after re-offer.

7.3 The SMRHW will follow up at 32 weeks and if the woman remains unscreened, the SMRHW will inform the following staff by email:

- Link Neonatal Consultant
- Link GUM consultant
- Link Obstetric Consultants
- Consultant Virologist
- Antenatal Screening Co-ordinator
- Neonatal secretary
- Consultant Neonatologist (who will co-ordinate a team meeting to formulate a postnatal management plan individual to the woman or person's circumstances) [PHE 2018b]

7.4 For further information refer to BSUH neonatal policy: HIV testing of babies of untested mothers.

8 Taking the Sample

8.1 The sample may be taken at booking by the midwife or practice nurse or phlebotomist according to local arrangements:

- A 5 ml sample of blood is required in a gold topped (clotted) bottle. This same sample can be used for Syphilis and Hepatitis B screening.
- The requestor (midwife or doctor) should complete all fields on the Antenatal Booking Blood Request Form. The request from is in triplicate, and the requestor must ensure that all hand writing has transferred through and is legible on all three sheets of the form.

Where adhesive patient labels are used, a label must be affixed onto each of the three sheets of the request form. The form includes tick boxes for 'accept' or 'decline' of HIV screening as well as boxes to indicate whether this is a 'first booking', 'urgent' or 'repeat' sample.

8.2 The sample must be labelled according to laboratory guidelines. The minimum acceptable identifiers include forename, surname (no abbreviations), plus date of birth and NHS number or hospital ID number. The NHS number is the preferred number to use [PHE 2016a].

8.3 Additional information should be included on the request form if relevant: For example: family origins, recent immigration (if lived in an area of world where HIV is endemic), known prior positive result and first language (if not English) to assist the SMRHW in follow-up of positive results.

8.4 Samples are sent to Brighton Pathology for processing and should arrive within one working day of sample collection.

9 Unacceptable Samples

9.1 Where the sample is deemed to be unacceptable by the laboratory because of insufficient blood, incomplete data on the request form, mislabelling of sample bottle or for any other reason, the laboratory will inform the sample requestor to request a repeat. In such cases, a repeat sample should ideally be taken within 10 working days of the request being received by the maternity unit [PHE 2016a, PHE 2018b].

9.2 Where repeat samples take longer than 10 working days to arrange (for example the woman is away or declines to attend for repeat sampling within 10 days), the midwife should document reasons why there has been a delay.

9.3 The midwife must always follow up the results of repeated samples and arrange a plan (documented in the hand held notes) being mindful that there has already been a delay in obtaining a result because of the need to repeat.

10 Results Processes

10.1 Accessing result

(Including failsafes to ensure all women who accept screening receive a result)

10.1.1 Results will be available to staff within 5 working days on ICE (the electronic results reporting programme) or by phoning the virology laboratory at RSCH on 01273 696955 ext 4627 [PHE 2016a].

10.1.2 **Failsafe- 10 day check:**

It is the responsibility of the sample requestor to follow up results within 10 working days of the sample being taken (see also 9.1.3 for situations where this is not possible). The sample requestor should ensure positive results have been acted upon (by contacting the SMRHW) and follow up missing results or laboratory requests for a repeat sample. The sample requestor must document that results were followed up and acted on. An example proforma that can be used for recording that results were followed up is given in Appendix D

10.1.3 It is recognised that some community clinics do not have facilities for venepuncture and therefore women attend hospital phlebotomy to have bloods taken. In such cases, the sample requestor will not know when the bloods were actually taken and so cannot follow up results at 10 days. In such cases it is essential that the requestor follows up results as per 9.1.4.

10.1.4 **Failsafe- check at follow up antenatal appointment:**

It is the responsibility of the health professional (midwife or doctor) providing care at the next antenatal appointment (usually at the 16 weeks of pregnancy appointment) to check the results. If the result is negative then, document results (with informed consent) in the hand held notes and inform the woman of the results during the appointment [PHE 2018b].If the result is positive please liaise with the SMRHW to confirm the woman or person is already known to the SMRHW, and the woman or person has been informed of the result.

10.1.5 **Failsafe- Check at time of dating scan**

As an additional failsafe, the Antenatal Screening Support Worker (ASSW) will ensure a full set of booking blood results are available at the time women attend dating scan. This allows early identification of missing results that can be actioned after the scan. With consent, missing bloods will be repeated at this point of contact by the ASSW. The ASSW will then inform, via email, the Antenatal Screening Team and named community midwife. It is then the responsibility of the named community midwife to follow up results within 10 working days and inform the woman or person as per 9.1.2. all women and people should be notified of their results following testing and this includes women and people who terminate or miscarry following screening. This is especially important with screen positive results to ensure women and people are referred and seen for specialist follow up within the timeframe detailed in section 10.0 [PHE 2016a, PHE 2018b]

10.1.6 It is recognised that not all women will be attending for dating scan. This might include women booking late or transferring in from another trust or women who decline scans. Therefore this is will not capture all women which is why the failsafe checks as detailed in this section are mandatory.

10.1.7 **Women who terminate or miscarry**:

All women should be notified of their results following testing and this includes women who terminate or miscarry following screening. This is especially important with screen positive results to ensure women are referred and seen for specialist follow up as per section 10.0 [PHE 2016a, PHE 2018b].

10.1.8 **Missing Antenatal Screening Results:**

Results should be documented in all cases at the next antenatal appointment [PHE 2018b]. In rare circumstances, a result may not be available at the next appointment. The midwife or doctor should phone the laboratory to try and ascertain how long results will take and agree with the woman or person, a plan to communicate the results to them.

10.1.9 If having phoned the laboratory it is apparent that there is no result, then a repeat screening test should be recommended and where accepted, taken that day or within 10 working days maximum [PHE 2016a, PHE 2018b].

10.1.10 Where a repeat sample is taken, the midwife or doctor taking the sample must agree a plan with the woman for communicating the result to her within a specified time frame.

10.1.11 Full documentation of the above should be made in the hand held notes by health professional offering the test.

11 Negative Result

Where a result is negative, the health professional (midwife or doctor) informing the woman of the result should explain the following:

11.1 A negative result does not confer protection on the woman. If a woman (or her partner) engages in high risk behaviour there is a risk of acquiring HIV during pregnancy [PHE 2018a]Informing a woman of a negative test result should be used as an opportunity for general sexual health promotion and for the dangers of becoming infected during pregnancy or lactation [PHE 2016b, PHE 2018b].

11.2 There is a 'window period' of 6-8 weeks between acquiring the infection and testing HIV antibody positive. Therefore there is a small possibility of infection going undetected. The option for a repeat test later in the pregnancy should be offered in cases where the woman is anxious about her status or if she is unaware of her partner's HIV status and he is from a higher risk group (for example IV drug user / from HIV endemic area).

11.3 Women can also request repeat screening at any stage of the pregnancy if she requests to do so or deems herself at risk or changes her sexual partner [PHE 2016b, PHE 2018b]

12 Follow Up For Women with an HIV Positive Result

12.1 All confirmatory testing is performed in Brighton pathology laboratory.

12.2 The virology laboratory staff will inform the Specialist Midwife for Reproductive Health and Wellbeing (SMRHW) and designated Health Advisors (HA - who provide cover if the SMRHW is absent) by email of a HIV positive or equivocal result. This email is sent to a dedicated email account (bsuh.womens.health.advisor@nhs.net) which is checked daily by the designated specialist staff (SMRHW/HAs). This failsafe ensures results are communicated and actioned within the appropriate timeframe as per 10.6.

12.3 The following members of staff are also informed about an HIV positive result

- Manager of SMRHW
- Nominated Health advisor
- Consultant for HIV in pregnancy
- Consultant obstetrician
- Consultant neonatologist
- Antenatal Screening Co-ordinator

12.4 The laboratory also informs the Health Protection Agency's Communicable Disease Surveillance Centre on line with national policy (DoH 2003). Note all HIV positive samples undergo confirmatory testing within BSUH pathology at the RSCH laboratory

12.5 All positive results will be actioned within 48 working hours of the result being received by the Health Advisor team.

12.6 The SMRHW (or HA in her absence) will first attempt to contact the woman by phone offering an appointment at the Claude Nicol Centre, RSCH, to discuss antenatal screening blood test results. Women will be offered an appointment within 10 working days of the result. If there is no response from the letter then attempts will be made to contact the woman by phone.

12.7 At this first appointment, the SMRHW will inform the women of the results and meet her immediate support needs according to each individual case. This will vary according to whether this was a prior diagnosis or new diagnosis. In addition the following will take place (either at this appointment or subsequent appointments according to the individual circumstances):

- Baseline CD4/Viral load test taken. Process agreed with the women for communicating results
- The SMRHW asks patients for consent to inform all relevant parties

12.8 The SMRHW asks patient for consent to inform all relevant

12.9 The SMRHW co-ordinates ongoing care and support as well as partner notification with the woman's consent. Testing of partner/ other children arranged as appropriate.

12.10 The SMRHW arranges an appointment at the Lawson Unit to see the HIV consultant. Pregnant Women who are diagnosed with an HIV infection are managed and treated by the appropriate specialist teams (NICE 2009). See trust policy: MP009 Management of HIV in pregnancy and Neonatal Period.

12.11 The SMRHW will arrange referral to other agencies as required according to individual client need.

12.12 The SMRHW will document all discussions that have taken place with the women in the GUM notes.

13 Documentation/ Liaison with Other Members of the Healthcare Team

13.1 Women have a right to confidentiality regarding an HIV positive result. Thus other staff involved in her care can only be informed and a result can only be documented in the hand held notes, with informed consent. Women who decline documentation of their HIV status should be encouraged to inform staff on admission in labour. Failure to do so could adversely affect care and interventions may take place that unwittingly increase the risk of vertical transmission.

13.2 The SMRHW has responsibility to inform the following staff (once informed consent has been obtained):

- Community midwife by email
- Consultant for HIV in Pregnancy in person (arranges appointment for the woman to be seen)

13.3 The Consultant for HIV in Pregnancy has responsibility to liaise with the following staff re –ongoing treatment (once informed consent has been obtained):

- Consultant Neonatologist by letter
- Consultant Obstetrician by letter

14 On-Going Care of Women Living With HIV In Pregnancy

Refer to the following BSUH protocols for further guidance on management:

14.1 See Maternity protocol: MP008 Infections in Pregnancy

14.2 See trust policy: MP009 Management of HIV in Pregnancy and Neonatal period

15 Audit and monitoring

15.1 Minimum auditable standards
Public Health England requires that the following data is collected on a quarterly basis and reported annually (see Public Health England 2016 for full details of current standards and all definitions):

15.1.1 Number of women booking

15.1.2 Number of women eligible for screening

15.1.3 Number of women tested (Coverage: Standard 1)

15.1.4 Number of women declining screening

15.1.5 Number of women diagnosed with newly diagnosed HIV infection

15.1.6 Number of women diagnosed with old HIV infection (ie diagnosis made before current pregnancy) who were re-screened in the current pregnancy

15.1.7 Number of women attending for specialist assessment within 10 working days of a positive result (Standard 5)

15.2 Current data requirements of the Key Performance Indicators for screening are available at http://www.screening.nhs.uk/kpi : Data for the trust is submitted quarterly.

15.3 An annual audit of women's notes will take place to review documentation processes.

15.4 Data and audit findings will be included in the BSUH Trust Annual Antenatal and Neonatal Screening Report compiled by the Antenatal Screening Co-ordinator which is circulated to board level with in the trust and to the following (see contact list in Appendix A):

- Regional Public Health England lead
- Regional Screening and Immunisation Lead
- Regional Quality Assurance Screening Lead

16 Training

16.1 All midwives must attend a yearly update on antenatal screening for infectious diseases as part of their mandatory education update sessions

16.2 All midwives new to the trust should complete the Antenatal & Newborn Screening eLearning Module available at www.e-lfh.org.uk .This includes a section on antenatal screening for infectious diseases.

16.3 It is recommended that all staff involved in antenatal screening for infectious diseases complete the Antenatal & Newborn Screening eLearning Module annually.

16.4 All band 5 midwives must complete the Antenatal & Newborn Screening eLearning Module as part of their competencies before they can apply for a band 6.

17 Governance

17.1 All incidents related to antenatal screening for HIV are reported via the trusts internal reporting system known as DATIX.

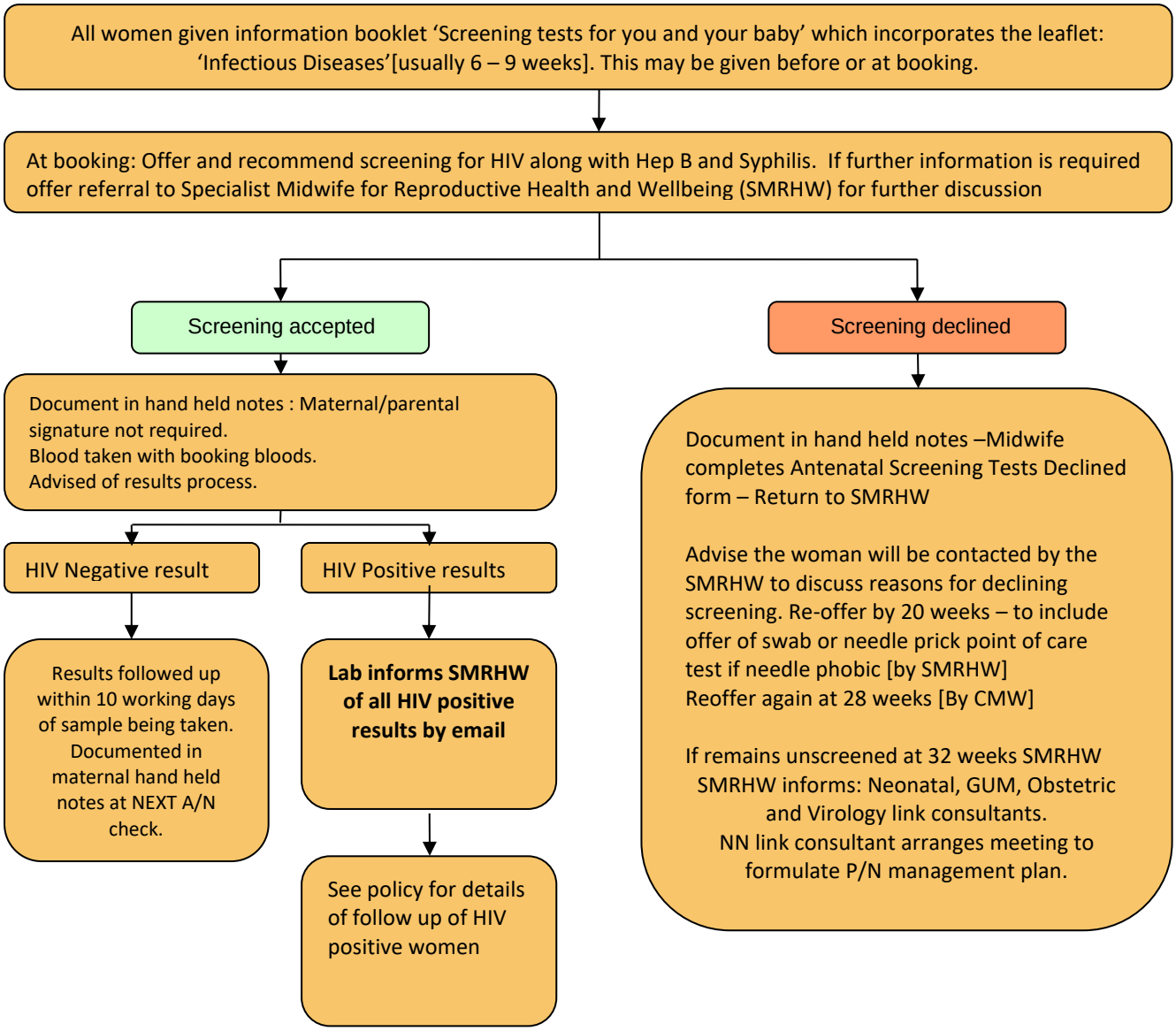
17.2 All incidents related to screening for HIV should also be reported to the Antenatal Screening Co-ordinator who will liaise with the Maternity Risk Manager and where necessary complete a SIAF (Screening incident assessment form) in order to notify the Regional QA screening team and the Screening and Immunisations lead.

17.3 Where relevant incidents should also be reported to the Laboratory Lead and Pathology Quality Team as well as the SMRHW and GUM lead consultant.

17.4 For further information relating to management of incidents please refer to the protocol: MP085 Maternity & Gynaecology Risk Management Strategy.

17.5 The Antenatal Screening for Infectious Diseases Steering Group meets quarterly and will address all issues pertaining to HIV screening.

18 Care Pathway: Antenatal screening for infectious diseases HIV screening



19 References

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Public Health England [2018b] NHS public health functions agreement 2018-19: Service specification no.15: NHS Infectious Diseases in Pregnancy Screening Programme. 2018 September (2018b). Available from: https://www.england.nhs.uk/wp-content/uploads/2017/04/Gateway-ref-07836-180913-Service-specification-No.-15-NHS-IDPS.pdf

The Royal College of Pathologists. Key performance indicators-proposals for implementation. 2013 July. Available from: https://www.rcpath.org/asset/A428B2AF-7AE9-42DA-BF9343E184EE05CF.2DBFC9CA-A72A-479B-ACE8B1150A7C1BC2/

20 Patient information

Public Health England [2019] 'Screening Tests for You and Your Baby'. Click on this link to view/download a copy of the information leaflet including the section 'Infectious Diseases'. Patient information: https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief

Further information about the NHS Infectious Diseases in Pregnancy Screening Programme is available from: https://www.gov.uk/topic/population-screening-programmes/infectious-diseases-in-pregnancy

Relevant BSUH NHS TRUST Maternity protocols:

Maternity protocol MP014: Infections in pregnancy; GBS, Herpes, Varicella and HIV (Aug 2009): Available to read or download on the intranet under Maternity/ Labour ward protocols.

Gilleece Y, D Utting, Bomont R (February 2017) BSUH Guidelines MP009 Management of HIV in Pregnancy and Neonatal period: available to read or download on the intranet under Specialised Teams / HIV.

21 Appendix A – Key Personnel and Contact Information

Designated Programme Lead for Maternity Services

Karen Gregory- Antenatal Screening Co-ordinator

Link Speciality Staff

David Utting	Consultant Lead for Obstetrics
Yvonne Gilleece	Consultant Lead for GUM
Rob Bomont	Consultant Lead for Neonatology
Karen Gregory	Antenatal Screening Co-ordinator
Rosie Jennings	Specialist Midwife for Reproductive Health and Wellbeing

Laboratory Team

Dr Mohammed Osman Hassan-Ibrahim	Consultant Virologist
Nick O'Flanagan	Blood Sciences Manager
Graham Terrey / Clare Reynolds	Laboratory Leads
Jackie Longbone	Laboratory Quality Officer
John Mcbride	Pathology Quality Manager

Antenatal Screening Coordinator at BSUH (cross site)	Karen Gregory	Karen.gregory@bsuh.nhs.uk Mobile: 07876 357 423 Office RSCH 01273 696955 X 67477 Office PRH: 01444 441 881 X 5404 FAX: 01273 664732
Antenatal Screening Support Midwife	RSCH: Angela Jones	Office RSCH 01273 696955 X 67477 Office PRH: 01444 441 881 X 5404 FAX: 01273 664732
	PRH: Melanie Sanders	Office: 01444 441881 X 5404 FAX: 01444 415865
Fetal Medicine Consultants at BSUH	RSCH: David Utting	David.Utting@bsuh.nhs.uk Secretary: 01273 696955 X 4031
	PRH: Jo Sinclair	Jo.Sinclair@bsuh.nhs.uk Secretary: 01444 441881 X 8069
Laboratory Service Leads for Virology/Microbiology	Lead consultant: John Paul	John.Paul@bsuh.nhs.uk 01273 696955 X 4627
	Dr Mohammed Osman Hassan-Ibrahim Consultant Virologist	MohammedOsman.HassanIbrahim@bsuh.nhs.uk Virology Section Department of Microbiology & Infection Tel. 01273696955 ext 3584 Pager: 07623809015 Mobile: 07940 933 197
	Sarah Bastow Blood sciences Manager	Sarah.Bastow@bsuh.nhs.uk RSCH Ext 7422 PRH Ext 8216
Link Neonatal Consultant	Rob Bomont, Consultant Neonatologist	Rob.Bomont@bsuh.nhs.uk Trevor Mann Baby Unit, RSCH Tel 01273 696955 X 4188

Specialist Midwife for Reproductive Health and Wellbeing	Rosie Jennings	Rosie.Jennings@bsuh.nhs.uk Address: Claude Nicol Clinic RSCH, Eastern Road Brighton, East Sussex, BN2 5BE Tel: 07919627603 Internal extension: X 4716 or X 4725
Link GUM Consultant	Yvonne Gilleece	Yvonne.gilleece@bsuh.nhs.uk Tel: 01273 664707
Antenatal and Newborn Screening Programmes (South East) Quality Assurance Service	Emma Proctor Quality Assurance Advisor	emmaproctor@nhs.net 07919691456
Public Health England South East Link	Jennie Thomas Screening and Immunisations Manager Public Health England South East	Public Health England South East York House 18-20 Massetts Road Horley RH6 7DE Direct Line: 0113 825 4694 Mobile: 07795644708

22 Appendix B - Background to Antenatal screening for HIV

1.0 **Human immunodeficiency Virus (HIV)** is a blood borne virus. It is a retrovirus that infects and damages T-lymphocytes, resulting in immune suppression that may lead to Acquire Immune Deficiency Syndrome (AIDS). Two forms of the virus have been identified, HIV-1 and HIV-2. The commonest and most virulent form is HIV-1 with HIV-2 being relatively uncommon in western countries

1.1 HIV is transmitted through: sexual contact, contact with contaminated blood products e.g. needle sharing, vertical transmission during pregnancy, birth or breastfeeding [PHE 2016b]

1.2 The risk of mother/parent-to-child HIV transmission in an untreated woman or person in pregnancy is around 25%. However, with early diagnosis, effective treatment and subsequent viral suppression, the risk of transmission is now very low (under 0.5%) [PHE 2016b].

1.3 Pregnant women are offered screening for HIV infection so that interventions can be offered to reduce the risk of mother to child transmission of the virus, as well as safeguard the mother's own health [PHE 2018b].

23 Appendix C: Blood Test Declined Form

Antenatal Booking Bloods – Screening Declined Form

Form to be completed by the booking midwife for every woman or person who declines some or all of the screening tests for infectious diseases and emailed to rosie.jennings@nhs.net. These statistics are required for Public Health England.

Midwife's name:	**Date of decline:**			
Midwife's contact no:	**Team:** *(circle)*	North	East	West

Patient Details: *(Use label if available)*

Name:	**EDD:**			
DOB:	**Gestation:**			
Hospital no.:	**Site booked at:** *(circle)*		RSCH	PRH
NHS no.:				
Address:		**Ethnicity:**	**Nationality:**	**Language:**
	Mother:			
	Father:			
Contact number: *(for Specialist Midwife for Reproductive Health and Wellbeing to call)*				

Which Tests Declined? *(circle)*	**HIV**	**HEP B**	**Syphilis**	**ALL**

Reason(s) for decline?	✓	**Comments**
Anxious about testing generally. Why?		
Anxious as feels may be at risk. Why?		
Feels testing is unnecessary? Why? If tested previously state where and when:		
Other [e.g. needle phobic]		

Please advise that the Specialist Midwife for Reproductive Health and Wellbeing will contact all women and people who decline screening for infectious diseases to discuss and offer further advice / support. If you have a specific concern you would like to discuss, please contact the Specialist Midwife for Reproductive Health and Wellbeing using the details below. Women or people who wish to discuss screening further can also self-refer by phone.

Return form to:	
Rosie Jennings Specialist Midwife for Reproductive Health and Wellbeing	**Email:** Rosie.Jennings@bsuh.nhs.uk **Phone:** 07919 627603 / 01273 523388 (option 2)

Updated October 2019 (RJ)

24 Appendix D – Hepatitis B Notification form

Notification Form for Baby who has commenced a course of Hepatitis B vaccination at birth (from 01/08/2017)

MIDWIFE: Following delivery, please complete this form, email it to CHRD **AND** pass to the Screening Coordinator who will return it by email to the Public Health Protection Team at phe.sshpu@nhs.net	**CHRD Office** esh-tr.childhealth@nhs.net	
Hospital / Unit:	Trust:	
Patient Details (Mother)	Address:	Telephone No:
Forename:		
Surname:		
DOB:		
NHS Number:		

Reason for baby commencing Hepatitis B course *(please tick)*
Mother Hepatitis B + ☐ Hepatitis B + household member ☐

Patient Details (Baby)	Address (if different from above):	Contact no:
Forename:		
Surname:		
NHS Number:	Sex of baby: *(please circle)* Male / Female	
Date of birth:	Time of Delivery:	

GP Details: Name:	Address:	Telephone No:

Informed Consent for Hepatitis B Vaccine Obtained *(please circle)* Yes / No
Please send this notification form even if consent is NOT obtained.

Date Hepatitis B Vaccine given:	Time vaccine given:	Batch no:
Name of Midwife / Doctor: *(please print)*		Telephone no. (incl. beep):

Hepatitis B Specific Immunoglobulin (HBIG) given? *(please circle)* Yes / No

Date HBIG given:	Time HBIG given:	Batch no:
Name of Midwife / Doctor: *(please print)*		Telephone no. (incl. beep):

Please pass completed form to your screening coordinator AND email a copy to CHRD (as shown at top right of page) – Thank you

25 APPENDIX E– Proforma for recording results at 10 days

BOOKING BLOOD RESULTS TO BE CHECKED 2 WEEKS AFTER TAKEN: Clinic _____[surgery / children's centre]

Name, DOB, ID number					Accepted /declined	Result	Date result	MW checking	Comments: results missing/ repeat required/ decline form sent/ referrals made?
				Group & Rhesus					
				Hb					
				Sickle and thal					
				Rubella					
				Syphilis					
Gest at booking		MW at booking		**HIV**					
				Hep B					
Date booked		Date booking bloods taken							
				Downs screen	Accepted / Declined		Tick if transfer booking:		
				Anomaly scan	Accepted / Declined				

Name, DOB, ID number					Accepted /declined	Result	Date result	MW checking	Comments: results missing/ repeat required/ decline form sent/ referrals made?
				Group & Rhesus					
				Hb					
				Sickle and thal					
				Rubella					
				Syphilis					
Gest at booking		MW at booking		**HIV**					
				Hep B					
Date booked		Date booking bloods taken							
				Downs screen	Accepted / Declined		Tick if transfer booking:		
				Anomaly scan	Accepted / Declined				