NHS public health functions agreement 2018-19

Service specification no.15
NHS Infectious Diseases in Pregnancy Screening Programme
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Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic and those who do not share it (as required under the Equality Act 2010); and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities (in accordance with the duties under sections 13G and 13N of the NHS Act 2006, as amended).
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Service specification No.15

This is a service specification to accompany the ‘NHS public health functions agreement 2018-19 (the ‘2018-19 agreement’).

This service specification is to be applied by NHS England in accordance with the 2018-19 agreement. This service specification is not intended to replicate, duplicate or supersede any other legislative provisions that may apply.

Where a specification refers to any other published document or standard, it refers to the document or standard as it existed at the date when the 2018-19 agreement was made between the Secretary of State and NHS England Board, unless otherwise specified. Any changes in other published documents or standards may have effect for the purposes of the 2018-19 agreement in accordance with the procedures described in Chapter 3 of the 2018-19 agreement.

Service specifications should be downloaded in order to ensure that commissioners and providers refer to the latest document that is in effect.

The 2018-19 agreement is available at www.gov.uk (search for ‘commissioning public health’).

All current service specifications are available at www.england.nhs.uk (search for ‘commissioning public health’).
Section 1: Purpose of Screening Programme

1.1. Purpose of the specification

A common national service specification must be used to provide, monitor and govern the NHS Infectious Diseases in Pregnancy Screening Programme (IDPS) Programme. This enables a consistent and equitable approach across England.

The purpose of the service specification for the IDPS Programme is to outline the service and quality indicators expected by NHS England for the population for whom it is responsible and which meets the policies, recommendations and standards of the NHS Screening Programmes.

The service specification is not designed to replicate, duplicate or supersede any relevant legislative provisions which may apply, e.g. the Health and Social Care Act 2008 or the work undertaken by the Care Quality Commission. The specification will be reviewed and amended in line with any new guidance as quickly as possible.

This specification should be read in conjunction with:

- NHS Infectious diseases in pregnancy screening standards

- Guidance and updates on Key Performance Indicators (KPIs)

- IDPS programme laboratory handbook

- IDPS: programme handbook

- Managing Safety Incidents in the NHS Screening Programmes

- Infectious diseases in pregnancy screening programme: checks and audits

- PHE Immunisation against Infectious Disease – the green book

- PHE Guidance on viral rash in pregnancy

- PHE Pregnancy: How to protect you and your baby


- UK national guidelines on the management of syphilis 2015 (British Association of Sexual Health and HIV – BASHH) https://www.bashh.org/guidelines

1.2. Aims

The NHS Infectious Diseases in Pregnancy Screening Programme ensures that all pregnant women are offered AND recommended screening for hepatitis B, HIV and syphilis.

1.3 Objectives

The objectives of the NHS IDPS Programme are:

- to reduce the risk of mother-to-child transmission of hepatitis B, HIV and syphilis
- to ensure that women with hepatitis B, HIV and syphilis are identified early in pregnancy to facilitate appropriate assessment and management of their health
- to facilitate appropriate neonatal referral and management

1.4. Expected health outcomes

The expected health outcome is a reduction in the risk of a mother-to-child transmission of HIV, hepatitis B and syphilis and to safeguard the woman’s own health.

1.5. Principles

The NHS IDPS Programme will ensure that:

- all individuals will be treated with courtesy, respect and an understanding of their needs
- all those participating in the IDPS programme will have adequate information on the benefits and risks to allow an informed decision to be made before participating
- the target population will have equitable access to screening
- screening will be effectively integrated across a pathway with clear lines of communication between the different providers of services in screening centres, primary care and secondary care
1.6. Equality

Delivery of the NHS IDPS Programme contributes to reducing health inequalities and should include the following deliverables:

- screening should be delivered in a way which addresses local health inequalities, tailoring and targeting interventions when necessary
- a Health Equity Audit should be undertaken as part of both the commissioning and review of this screening programme, including equality characteristics, socio-economic factors and local vulnerable populations
- the service should be delivered in a culturally sensitive way to meet the needs of local diverse populations
- user involvement should include representation from service users with equality characteristics reflecting the local community including those with protected characteristics
- providers should exercise high levels of diligence when considering excluding people with protected characteristics in their population from the programme and follow equality, health inequality and screening guidance when making such decisions

Service providers will demonstrate they have systems in place to address health inequalities and make sure there is equity of access to screening, subsequent diagnostic testing and outcomes. This will include, for example, how the services are designed to make sure that there are no obstacles to access on the grounds of the nine protected characteristics as defined in the Equality Act 2010.

Service providers will have procedures in place to identify and support those persons who are considered vulnerable/hard-to-reach, including but not exclusive to, those who are not registered with a GP; homeless people and rough sleepers, asylum seekers, gypsy and traveller groups and sex workers; those in prison; those with mental health problems; those with drug or alcohol harm issues; those with learning disabilities, physical disabilities or communications difficulties. Service providers will comply with safeguarding policies and good practice recommendations for such persons.

Service providers are expected to meet the public sector Equality Duty which means that public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees

https://www.gov.uk/equality-act-2010-guidance

It also requires that public bodies:
- have due regard to the need to eliminate discrimination
- advance equality of opportunity
- foster good relations between different people when carrying out their activities

Classification: official
Section 2: Scope of Screening Programme

2.1. Description of screening programme

Screening for HIV, hepatitis B, and syphilis is part of the NHS Infectious Diseases in Pregnancy Screening (IDPS) Programme. In delivering a national screening programme and to ensure national consistency, the local provider is expected to fulfill the following, in conjunction with guidance from the national screening programme as detailed in the screening standards and policies: https://www.gov.uk/government/collections/nhs-population-screening-programme-standards and https://www.gov.uk/guidance/evidence-and-recommendations-nhs-population-screening

- work to national screening standards
- provide data and reports against programme standards and key performance indicators (KPIs) and other measures as requested by the national screening programme
- provide data on screening outcomes as required by the national screening programme
- ensure appropriate governance structures are in place
- take part in quality assurance processes and implement changes recommended by quality assurance (QA) including urgent suspension of services if required
- implement and monitor failsafe procedures and continuously ensure quality
- work with NHS England and the Screening Quality Assurance Service (SQAS) in reporting, investigating and managing screening safety incidents
- respond to national action/lessons, for example change of software, equipment or equipment supplier or new technologies
- ensure all health care professionals access appropriate training to maintain continuous professional development and competency
- use materials provided by the national screening programme, for example leaflets, e-learning resources and operational guidance
- implement and support national IT developments

2.2. Care pathway

Each condition has a screening pathway that describes a woman’s ‘step by step’ journey from booking to delivery. The pathway goes from identification of the eligible population and the offer of screening through to timely referral and entry into care and specialist services. The pathway correlates with the themes of the screening standards. Healthcare professionals must be familiar with these pathways and the timeframes in which to refer women (Figure 1). https://www.gov.uk/government/collections/nhs-population-screening-care-pathways

Classification: official
• **Identify population** – the eligible population is all pregnant women identified through maternity antenatal care services. Women presenting after 20 weeks gestation; unbooked in labour or with no documented laboratory record of screening results should be included. All trusts should have a process in place in all departments, such as maternity assessment units, gynaecology wards and delivery suites to manage women who book late or present with no reliable documentation of their screening status.

• **Inform** – during the first antenatal contact or booking visit with the midwife, verbal and written information about the three infections and the benefits of screening for the woman and her unborn baby should be given to the woman using the Public Health England (PHE) booklet ‘Screening Tests for You and Your Baby’ to enable her to make an informed choice [https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief](https://www.gov.uk/government/publications/screening-tests-for-you-and-your-baby-description-in-brief)

• **Offer** – all women booking for antenatal care should be offered AND recommended screening for EACH of the three infections. The screening tests should not be offered as a suite of tests. Acceptance or decline for each of the individual screening tests should be documented in the patient held record / maternity notes (paper or electronic) and on the laboratory request form

  - **Women who accept screening for all infections** – a blood sample should be taken as soon as possible in line with local protocols and sent to the laboratory with completed request form (paper or electronic) for analyses (in line with the [IDPS Laboratory Handbook](#)). Taking of the sample must not be delayed to coincide with other appointments or scan visits

  - **Management of women who decline one or more screening tests** – there should be a local protocol in place to notify the screening coordinator/team directly if a woman declines any of the three infections offered to facilitate prompt follow up. This notification must be acknowledged on receipt.

    - the midwife who offered the initial screen should inform the woman that she will be contacted by a specialist midwife by 20 weeks at a face-to-face meeting to discuss their choices (in line with the [IDPS Screening Programme Handbook](#)).

    - the midwife should ensure a blood sample is taken for the test(s) accepted and sent to the laboratory with a complete request form, paper or electronic, clearly identifying the infections she has declined screening for.

    - the woman should be contacted by the MDT (Screening Coordinator/team) as soon as possible to facilitate the formal reoffer by 20 weeks gestation (or as soon as possible if after 20 weeks gestation) at a face-to-face meeting to:

      - discuss her decision to decline and ensure that she is fully apprised of the benefits of screening for IDPS for her and her baby.
      - reoffer the screening test(s) and if accepted arrange testing and follow up of the result.
      - if the woman declines the second formal reoffer of screening the local multidisciplinary team will be responsible for further management in line with
local clinical protocols.

- the onus of the reoffer is to facilitate an informed choice and not to coerce women to accept screening.

- **Known positive women (Hepatitis B or HIV)** IVwomen who disclose that they are positive for HIV or hepatitis B do not require screening. They should be referred directly to the Multidisciplinary Team (MDT) and seen for specialist assessment within 10 working day of the known status being reported to maternity services (in line with IDPS screening standards and Programme and Laboratory Handbooks)

  - screening should be offered for the other infections and a blood sample taken if accepted and sent to the laboratory with completed request form (paper or electronic) for analyses (in line with IDPS Laboratory Handbook and screening algorithms).
  - some trusts may have a local protocol to retest all known positive women. If so, this must be recorded as known positive on the laboratory request form and reported accordingly to ensure timely referral to the MDT.
  - all women should be offered screening for syphilis in every pregnancy regardless of previous testing and/or treatment.

- **Sexual health and prevention of infections in pregnancy**

  - women should be advised on the availability of sexual health testing at any stage of pregnancy and to report any symptoms of genitourinal infection as soon as possible.
  - repeat tests should be recommended if women change their sexual partner, inject recreational drugs, are a sex worker, have a partner that is known to be bisexual, have a partner that is known to have HIV or Hepatitis, or if either partner is diagnosed with an STI or requests a test.
  - there should be a local protocol in place to ensure midwives utilise the PHE leaflet on vaccinations in pregnancy ‘Pregnancy: How to protect you and your baby’.
  - at the booking visit midwives should discuss and promote vaccinations for pertussis and influenza and advise women to ensure they check their MMR status post-delivery.
  - midwives should advise women to report any rash or rash-like illness to their midwife or GP as soon as possible to facilitate appropriate management of viral rash in pregnancy as per PHE guidance. The woman should be advised to avoid any clinic setting or other pregnant women until she has been assessed.

- **Women who present in labour or unbooked**

  - there should be a system in place to ensure that tests for HIV, hepatitis B and syphilis are offered and performed for all women who present in labour either unbooked or with no reliable laboratory evidence of screening results.
  - the midwives on delivery suite offering screening should ensure women are able to understand the offer and recommendation of screening for infections and are in a position to consent.
  - where this has not happened, screening should be offered and recommended prior to discharge from maternity services.
  - the maternity service should liaise directly with the laboratory to ensure the laboratory has the clinical information to prompt analyses and an initial screening result dispatched as soon as possible to inform clinical care (see Classification: official).
- point of care tests should not be used for routine screening purposes.
- there should be robust processes in place to ensure all results are obtained, reported and managed appropriately
- the Screening Coordinator / Specialist Midwives should be informed of any woman screened on delivery suite/postnatal wards to ensure appropriate tracking and follow-up.

- **Test** – laboratories should comply with British Standards Institution EN ISO 15189:2012 and the IDPS Screening Laboratory Handbook. Screening laboratories must be able to identify antenatal samples as distinct from other samples they receive and should be able to match these samples to a specific maternity service:
  - the specimen should be clearly identified as an antenatal screening sample
  - the request form or electronic data fields should be compliant to the minimum dataset as indicated in the IDPS Laboratory Handbook.
  - a local failsafe protocol must be in place to ensure that all women who accept screening complete the testing pathway
  - local protocols should be in place between the laboratory and maternity service to facilitate communications and management of
  - incorrect or incomplete information on the request form so that necessary changes can be made by the originator and improvements to practice made
  - requests for repeat samples- either inadequate samples or those requiring a two week repeat second sample to exclude recent infection
  - identified declines for one or more screening tests
  - known positive status women with HIV and hepatitis B.

  Analysis should be undertaken in line with nationally agreed screening protocols and testing algorithms:

  - provisional results should not be reported to maternity services before the full confirmatory testing has been undertaken.
  - all confirmed screening test results should be issued by the laboratory and received by maternity services within specified timescales as per IDPS Standards.
  - processes should be in place locally to identify and follow-up results that have not been received within the specified time period
  - a report should be issued for every screening request form received by the laboratory
  - the format of the laboratory report (whether written or verbal) should clearly specify whether the result is ‘screen positive’; ‘screen negative’; known positive or decline
  - local protocols should be in place between the laboratory and maternity services to ensure results are communicated within nationally set timescales/standards. NHS England should check these local protocols, as they are critical to ensure adequate and timely follow up of results

- **Management of results**

  **Screen negative results:**
  - all women should be notified of their screening test result before or at the next antenatal visit, according to local protocol. The result should be recorded in the
health records
- the healthcare professional notifying the woman of her negative result should inform the woman that she was negative at the time of testing and offer the woman sexual health advice. She should be informed that she can request screening at any stage in her pregnancy if she deems herself at risk or changes her sexual partner (see IDPS Programme Handbook)

**Confirmed screen positive results:**
- results should not be communicated to the maternity service, either written or electronic, until confirmatory tests are completed on the screening sample
- the laboratory should directly inform the designated lead within the IDPS Multidisciplinary Team (e.g. Screening Coordinator / Specialist Midwife) of the screen positive result
- a local protocol should be in place between the laboratory and maternity service to log receipt of screen positive results

**Inconclusive results:**
- There should be an agreed process in place between the laboratory and screening coordinator/team to directly alert them to an inconclusive result and the need for a repeat sample within 2 weeks after the initial sample was taken to exclude recent infection (see Laboratory and Programme Handbooks)

- **Women who miscarry or terminate their pregnancy following screening** – There should be a local protocol in place to ensure that all women who miscarry or terminate their pregnancy after screening receive their results and followed up as required:
  - screen positive- the Screening Coordinator/team should liaise with the woman within 10 working days of the positive result to facilitate appropriate onward referral into specialist services and close the maternity care episode
  - screen negative- arrangements should be in place to notify the woman of her result by maternity services and close the maternity care episode (see Programme Handbook)

- **Intervention /Treatment**

  **Generic** – for the three infections
  - women who are known positive (HIV or hepatitis B) or who have a confirmed screened positive result for any of the three infections should be invited and attend for specialist assessment within 10 working days of the positive report being received from the laboratory, or known positive status reported to the screening coordinator (IDPS Standard 4)
  - the time between initial contact with the woman and the appointment should be as short as possible to minimise the duration of any anxiety she is likely to experience
  - results should be discussed at a face-to-face consultation with a member of the MDT (Screening Coordinator / Specialist Midwife / Clinical Nurse Specialist) at an appointment made for that purpose within agreed timescales (see IDPS standards)
  - a comprehensive assessment of the history of care for known positive women should be taken to ensure continuity of care and appropriate onward referral
  - all women should have a full assessment of their needs including social circumstances and status of possible co-infections to ensure appropriate involvement of clinical expertise and other support agencies

Classification: official
non-attendance at the MDT appointment should be reviewed within a multidisciplinary framework and a management/action plan developed

Condition specific – a triage process should be in place in line with national clinical guidelines and locally agreed multidisciplinary protocols and pathways (see Programme Handbook)

HIV – appropriate referral to the specialist team coordinating the woman’s HIV care in accordance with the BHIVA Guidelines

Hepatitis B
- further tests should be taken to assess hepatitis infectivity status according to local MDT protocol to facilitate appropriate timely referral into specialist care.
- local arrangements should be in place to inform the Proper Officer in the Field Epidemiology Teams; the woman’s GP and the Child Health Record Department of the woman’s positive status and requirements for follow on care and scheduling of newborn vaccinations in line with ‘Green Book’ requirements. The woman must be informed of this notification.
- ordering of the immunoglobulin, if required, should be coordinated by the MDT in line with local protocols. The immunoglobulin should be stored appropriately as a blood product, and be accessible and available when the woman is in labour to ensure administration to the neonate within 24 hours of birth (see IDPS standards). Administration or non-use of immunoglobulin should be recorded in the woman’s records and notified to the MDT and the supplying laboratory at PHE Colindale.

Syphilis - further tests may be undertaken by the MDT according to local protocols prior to referral to the GUM team for clinical assessment and review of test results to determine true syphilis status and requirement for treatment in accordance with BASHH Guidelines.

- Postnatal/Newborn Care – the neonate should be followed up in line with clinical guidelines and as highlighted in agreed MDT paediatric alerts and care plans
  - HIV- see BHIVA and CHIVA guidelines regarding follow up procedures
  - Hepatitis B
    - ensure the vaccine (+/- HBIG) is given within 24 hours of birth and recorded in the specific Hep B page of the Parent Child Health record (PCHR)
    - ensure a mechanism is in place to inform Proper Officer in the Field

Epidemiology Teams and Child Health Information Services (CHIS) should be informed of the administration of the initial vaccine/immunoglobulin and the need to schedule further vaccinations/serology in line with Green Book guidance. Service providers should ensure:

- there is a process in place to notify the GP/Primary Care Team of the administration of the initial hepatitis B vaccine/immunoglobulin and the need to schedule further vaccinations/serology in line with Green Book guidance (see Screening Handbook)
- the mother is aware of the importance of the immunisation schedule
  - for cases of syphilis, there is a neonatal alert and plan in place for paediatric assessment for babies born to women treated for syphilis in pregnancy before

Classification: official
discharge from hospital in line with BASHH guidelines and that a follow up care pathway is in place.

All service providers are expected to review and risk assess local screening pathways in the light of national IDPS Programme guidance and work with PHE’s Quality Assurance teams, and NHS England’s Screening and Immunisation Leads and Teams to develop, implement and maintain appropriate risk reduction measures. This should involve mechanisms to audit implementation, report incidents, ensure staff training and development and competencies, and have appropriate links with internal governance arrangements.
Figure 1: NHS IDPS Screening Pathway

IDPS Programme

Identify eligible population

Inform:
Provide information on HIV, hepatitis B & syphilis

Offer:
Offer AND recommend screening for HIV, hepatitis B & syphilis

Known positive women (HIV/Hep B)

Screening accepted

Screening declined for one or more infection

URGENT screening: women presenting in labour unbooked/no record of screening results

Test:
Sample taken & sent to laboratory

Screen negative

Confirmed Screen Positive

Refer to Multidisciplinary Team (MDT)

Screening accepted

Screening declined for other infections

Offer screening for other infections

Offer results to women who miscarry or terminate following screening and follow up as required

Discuss results before or at next antenatal appointment and offer sexual health advice

Intervention/Treatment
Contact women and manage as per local clinical guidelines

Post delivery: mother and baby follow-up:
- HIV BHIVA/CHIVA guidelines
- Hep B: Green Book
- Syphilis: BASHH

Public Health England is responsible for the NHS Screening Programmes

Classification: official
2.3. Roles and accountabilities through the screening pathway

The NHS IDPS programme is dependent on systematic specified relationships between stakeholders. Stakeholders include maternity services, the screening laboratory, reference laboratory, primary care/GPs/immunisation teams, Child Health Record Department, specialist services, and professional bodies who set guidance for management of infectious diseases in pregnancy.

NHS England will be expected to ensure that the whole pathway is robust. The provider will be expected to fully contribute to ensuring that systems are in place to maintain the quality of the whole screening pathway in their organisation. This will include, but is not limited to:

- providing robust screening coordination
- ensuring that midwifery services are supported to facilitate early booking for maternity care, agreeing and documenting roles and responsibilities relating to all elements of the screening pathway across organisations and organisational boundaries
- developing joint audit and monitoring processes
- operation of an escalation process for screening incidents
- agreeing joint checks and audit where required to ensure safe and timely processes across the whole screening pathway
- contributing to any NHS England and Public Health England initiatives in screening pathway development in line with NHS Screening Programmes expectations
- providing or seeking to provide robust electronic links with relevant organisations
- links with primary, secondary and tertiary care
- the need for robust IT systems across the screening pathway.

All service providers should have the following posts in place:

- A screening midwife/coordinator (and deputy) to oversee the screening programme and act as a link between other members of the IDPS Multidisciplinary Team

For further specific staffing requirements refer to Section 3.15

2.4. Commissioning arrangements

The NHS IDPS Programme is commissioned by NHS England Public Health Commissioning Team. Some elements of the pathway will be commissioned by other parties, including CCGs, NHS England specialised commissioners and maternity services themselves. The NHS England Public Health Commissioning Team will collaborate with any co-commissioners to ensure the seamlessness of the pathway.

Refer to ‘Who pays for what? Aspects of Maternity Pathway Payment for the Screening and Immunisation Programmes’

2.5. Links between screening programme and national programme expertise

PHE, through the national screening programmes, is responsible for leading high-quality, uniform screening, and providing accessible information to both the public and health care professionals, and developing and monitoring standards. It is also responsible for the delivery of national quality assurance, based at regional level, and for ensuring training and education for all those providing screening is developed, commissioned and delivered through appropriate partner organisations. PHE will be responsible for delivery of the essential elements of screening programmes best done once at a national level. These include setting clear specifications for equipment, IT and data.
Section 3: Delivery of Screening Programme

3.1. Service model summary

The model of delivery for the screening programme is primarily through maternity services care. See section 2.2 Care Pathway for further details.

3.2. Programme co-ordination

The service provider will be responsible for ensuring that the part of the programme they deliver is coordinated and interfaces seamlessly with other parts of the programme with which they collaborate, in relation to timeliness and data sharing.

The service provider will ensure that there is one or more named individuals responsible for the coordination of the delivery and planning of the programme, with appropriate administrative support to ensure timely reporting and response to requests for information. Where there is only one named coordinator, the provider will ensure that there are adequate cover arrangements in place to ensure sustainability and consistency of programme.

The service provider and NHS England should meet at regular intervals to monitor and review the local screening pathway. The meetings should include representatives from programme coordination, clinical services, laboratory services and service management.

3.3. Governance and Leadership

The provider will:

- cooperate with and have representation on local oversight arrangements as agreed with NHS England commissioners
- identify a trust director who is responsible for the screening programme
- ensure internal clinical oversight and governance by an identified clinical lead and a programme manager
- provide documented evidence of clinical governance that includes:
  - compliance with the NHS Trust and NHS England information governance/records management
  - user involvement, experience and complaints
  - failsafe procedures
  - risks and mitigation plans
- ensure that there is regular monitoring and audit of the screening programme, and as part of the organisation’s clinical governance arrangements, the board is assured of the quality and integrity of the screening programme
• produce an annual report of screening services, which is signed off by the board
• ensure the programme is delivered by trained workforce that meet national requirements

3.4. Definition, identification and invitation of cohort/eligibility

The target population is all pregnant women, irrespective of whether they have been screened in previous pregnancies.

3.5. Location(s) of programme delivery

The provider will ensure appropriate and accessible service provision for the population whilst assuring that all locations where IDPS screening occurs fully comply with the policies, standards and guidelines referenced in this service specification.

3.6. Days/Hours of operation

The days and hours of operation are to be determined locally and must ensure sufficient resources are in place to meet screening demand within required timescales without compromising relevant standards and guidelines. However, timeliness is essential and is a key criterion of quality along all parts of the screening pathway.

3.7. Entry into the screening programme

All women will be identified through maternity services. While there is nothing specific in the general practitioner (GP) contract regarding the IDPS screening programme, GPs have a key role in ensuring that pregnant women presenting to them are referred on as soon as possible to midwifery services. Providers will ensure timely access for women to all aspects of the screening programme.

3.8. Working across interfaces between departments and organisations

The screening programme is dependent on strong functioning working relationships, both formal and informal, between primary care, the hospital trust (maternity services), the screening and referral laboratories, specialist Genitourinary Medicine (GUM); Hepatology and HIV specialties; paediatrics, Field Epidemiology Services and PHE Centres and laboratories and other appropriate clinical services.

Accurate and timely communication and handover across these interfaces is essential to reduce the potential for errors and ensure a seamless pathway for service users. It is essential that there remains clear named clinical responsibility at all times and at handover of care the clinical responsibility is clarified.

The provider will be expected to fully contribute to ensuring that cross organisational systems are in place to maintain the quality of the entire screening pathway.
3.9. Information on Test/Screening Programme

Prior to any screening offer, the midwife will provide verbal and written information regarding screening utilising the PHE booklet ‘Screening Tests for You and Your Baby’ as a guide for discussion.

Where there are specific communication requirements, for example, English is not the woman’s first language or she has a visual/hearing impairment, appropriate interpretation services should be used during the booking appointment and appropriate information provided. All women, including those with special requirements, will be fully informed of the choices regarding all antenatal screening programmes.

The information should be impartially presented and should include an explanation of the limitations of the screening test. The decision to accept or decline to the offer of should be recorded.

3.10. Testing (laboratory service, performance of test by individuals)

See Section 4 for further detail.

3.11. Results giving, reporting and recording

Screening results should be explained to women by appropriately trained staff and recorded in the woman’s health records / IT system.

See section 2.2 care pathway for further detail.

3.12. Transfer of and discharge from care obligations

Active inclusion in the screening programme ends depending on the woman’s result:

- when the screening result is negative for HIV, hepatitis B and syphilis

- when the woman has a screen positive result for HIV, hepatitis B or syphilis and arrangements have been made for referral to an appropriate specialist and they have been seen by the specialist team. Non-attendance at the specialist appointment should be reviewed within a multi-disciplinary framework and a management/action plan developed

3.13. Public information

Providers must always use the nationally-developed public information leaflets at all stages of the screening pathway to ensure accurate messages about the risks and benefits of screening and any subsequent surveillance or treatment are provided and should involve the national screening team before developing any other materials. For local awareness campaigns, local contact details must be used.
3.14. Exclusion criteria

All pregnant women should be offered screening for the three infections.

3.15. Staffing

Providers will have in place a dedicated screening coordinator/screening midwife (with appropriate deputy and administrative support arrangements to ensure continual cover) to oversee the implementation, delivery and monitoring of the screening programme in the antenatal, intrapartum and postnatal settings. These staff are also responsible for ensuring there is an on-going educational programme for health professionals involved in screening.

Providers are responsible for funding minimum training requirements to maintain an effective screening workforce including CPD where necessary. Training requirements are detailed in the screening programme handbook.

Providers should ensure training is completed satisfactorily and recorded and that there is a system in place to assess on-going competency.

3.16. User involvement

The provider(s) will be expected to:

- demonstrate that they regularly seek out the views of service users, families and others in respect of planning, implementing and delivering services
- demonstrate how those views will influence service delivery for the purposes of raising standards
- make results of any user surveys/questionnaires available to NHS England on request

3.17. Premises and equipment

The provider will:

- ensure that suitable premises and equipment are provided for the screening programme
- have appropriate polices in place for equipment calibration and electronic safety checks, maintenance, repair and replacement in accordance with manufacturer specification to ensure programme sustainability
- ensure that equipment meets the European Council Directive, enforced by the Medicines and Healthcare Regulatory Agency, to ensure that it is safe and effective to use
3.18. Safety & Safeguarding

The provider should refer to and comply with the safety and safeguarding requirements as set out in the NHS Standard Contract.
Section 4: National standards, risks and quality assurance

Service providers will:


- maintain a register of risks, working with NHS England and quality assurance teams within Public Health England to identify key areas of risk in the screening pathway, and — make sure these points are reviewed in contracting and peer review processes

- participate fully in national quality assurance (QA) processes which includes:
  - submitting agreed minimum data sets and reports from external quality assurance schemes
  - undertaking ad-hoc audits and reviews as requested
  - completing self-assessment questionnaires / tools and associated evidence
  - responding to SQAS recommendations within agreed timescales providing specified evidence
  - producing with agreement of commissioners of the service an action plan to address areas for improvement that are identified in recommendations

- ensure that all screening laboratories are
  - accredited by the UK Accreditation Service (UKAS) to ISO. 'Medical laboratories – Requirements for quality and competence (ISO 15189)' or be CPA accredited and actively transitioning towards ISO 15189
  - participating in EQA schemes accredited to ISO. 'Conformity assessment. General requirements for proficiency testing schemes (ISO 17043)'
  - meeting the screening programme quality assurance requirements mapped to ISO 15189
  - using ISO 15189 accredited reference laboratories

The UK Accreditation Service (UKAS) will look at both ISO 15189 and the screening requirements on behalf of PHE Screening Quality Assurance Services and the national screening programme

Service improvement:

The service provider will develop and agree with NHS England commissioners a CSIP (continual service improvement plan) in cases where national recommendations and/or screening standards are not fully met. The CSIP will include the following:

- action plans specifying changes and improvements that will be made during the contracting period
- defined timescales for actions

Classification: official
• roles and responsibilities for actions
• performance issues highlighted by the commissioners
• concerns raised by service users

New technologies:

New technologies should not be used for screening unless approved by the UK National Screening Committee.
Section 5: Data Monitoring

5.1. Key performance indicators


5.2. Data collection monitoring

Service providers should:

- ensure that appropriate systems are in place to support programme delivery including audit and monitoring functions
- continually monitor and collect data regarding its delivery of the service
- comply with the timely data requirements of the national screening programmes, commissioners and Screening Quality Assurance Service. This will include reporting quarterly against the programme KPIs, annually against the screening standards (except those reported as KPIs) and the production of annual reports. The current dataset can be accessed from the National Screening programme website.

IDPS Programme specific measures:

For quality and monitoring, information should be shared with:

- IDPS Programme national standards annual data collection process
- IDPS Programme commissioned national screening outcomes audits e.g. :
  - National Study of HIV in Pregnancy and Childhood (NSHPC) www.ucl.ac.uk/nshpc
  - British Paediatric Surveillance Unit http://www.rcpch.ac.uk/what-we-do/british-paediatric-surveillance-unit/british-paediatric-surveillance-unit

5.3. Public Health Outcomes Framework Indicators

The IDPS Programme contributes to the Public Health Outcomes Framework indicator on the uptake of screening for national screening programmes.

Indicator 2.21i: HIV coverage: percentage of pregnant women eligible for infectious disease screening who are tested for HIV, leading to a conclusive result.
Indicator 2.21ii): Syphilis and hepatitis B uptake: The percentage of women booked for antenatal care, as reported by maternity services, who have a screening test for syphilis and hepatitis B leading to a conclusive result. (Note the IDPS programme now collates coverage key performance indicators for syphilis and hepatitis B)

The 2016 Standards set a coverage target of ≥ 95% as a reference point for all infectious diseases screened in pregnancy (HIV, hepatitis B and syphilis).

- Acceptable level: ≥ 95.0%
- Achievable level: ≥ 99.0%

Key Deliverable:
Completeness: All maternity services should return complete and robust coverage and uptake data. Achievable = 100%