Group B Strep Support

Preventing Group B Strep infections in babies: failure to turn national recommendations into local guidelines

Contents

Acknowledgements

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We are grateful to everyone who has given us invaluable advice and support in developing the questions and interpreting the results. Particular thanks go to Ben Hillman at the ONS, Professor Philip Steer, Dr Edward Morris, Christopher Johnston QC and Dr Gopal Rao for their help.

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Foreword

Group B Strep is the UK's most common cause of severe infection in newborn babies, causing sepsis, pneumonia, and meningitis. Approximately 800 babies a year in the UK develop group B Strep infection in their first 3 months of life, 50 babies will die, with another 70 survivors left with life-changing disabilities. Most of these infections could be prevented.

There have been welcome improvements to the Royal College of Obstetricians & Gynaecologists' Green-top guideline on group B Strep, with key new recommendations introduced in September 2017. If implemented, these recommendations would protect more babies from group B Strep infection, saving time and money that would otherwise be spent treating these sick babies and providing for their long-term care.

However, our report has found significant evidence that the new recommendations are not being implemented. Only a tiny number of NHS Trusts are following the key new recommendations around information provision for pregnant women, offering of testing to some pregnant women, and following Public Health England guidelines when testing for group B Strep carriage. As a result, pregnant women face a postcode lottery, potentially receiving significantly different care from recommended practice. Even worse, babies will suffer group B Strep infections that could have and should have been prevented.

Group B Strep Support recommends that the NHS prioritises the prevention of group B Strep infection in newborn babies. A key step towards this would be to ensure published national guidance from recognised expert bodies is adopted and implemented in a timely manner.

Group B Strep Support recommends that:

1. All NHS Trusts/Boards adopt and implement the Royal College of Obstetricians & Gynaecologists' Green-top guideline on group B Strep promptly.

2. All pregnant women are provided with a high-quality information leaflet on group B Strep as a routine part of their antenatal care.

3. Pregnant women who had a positive test result for group B Strep in a previous pregnancy are offered the option of testing for group B Strep in the current pregnancy, or of being treated as a carrier this pregnancy.

4. Where pregnant women are offered testing for group B Strep carriage, the GBS-specific enriched culture medium (ECM) test is offered late in pregnancy.

5. All pregnant women with one or more recognised risk factors present are offered intrapartum antimicrobial prophylaxis which, when accepted by the pregnant women, is administered as soon as possible once labour has started.

6. All new parents are informed about the key signs of group B Strep infection in babies to empower them to seek vital early treatment, which can save lives.

Implementing these six key recommendations would be a significant step forward in reducing the harms caused by group B Strep infections in newborn babies.

This report should be a wake-up call for NHS organisations providing maternity services, who need to assess what more can be done to reduce these life-changing, yet largely preventable, infections.

Jane Plumb MBE
Chief Executive

Background and Introduction

Group B Streptococcus (group B Strep, Strep B or GBS) is the UK's most common cause of severe infection in newborn babies. Approximately 800 babies a year in the UK develop group B Strep infection in their first 3 months of life. The most common presentations of GBS infection in babies are sepsis, meningitis and pneumonia.

On average, in the UK:

- Two babies a day develop group B Strep infection.
- One baby a week dies as a result of GBS infection.
- One survivor a week is left with long term disability following their GBS infection.

The GBS bacteria live in the intestines, rectum and vagina of around 2-4 in every 10 women in the UK (20-40%). This is often referred to as 'carrying' or being 'colonised with' GBS. Most women carrying GBS will have no symptoms, and carrying GBS is not harmful to them, but it can affect their baby around the time of birth.

GBS can occasionally cause serious infection in young babies and, very rarely, during pregnancy before labour.

Most GBS infections presenting in the first 6 days of life (early-onset GBS or EOGBS infections) could be prevented, yet the rate of these infections has been increasing in the UK. The less common late-onset GBS infections, which present after the first week of life and up to age 3 months, are not yet preventable.

Incidence in the UK & Republic of Ireland

The 2000-2001 enhanced surveillance study throughout the UK and Republic of Ireland, undertaken through the British Paediatric Surveillance Unit (BPSU), found a rate of 0.48 babies developing early-onset GBS infection per 1,000 live births (Heath et al., 2004). In the 2014-2015 enhanced surveillance study undertaken by the BPSU, this had increased by 18.8% to 0.57 per 1,000 live births (O'Sullivan et al., 2018), despite the introduction of national prevention guidelines in the intervening years.

Preventing early-onset GBS infection

Since 2003, the UK National Screening Committee has recommended against offering all pregnant women testing for GBS carriage. In a screening programme, those testing positive and those with other key risk factors would be offered intravenous antibiotics in labour to protect against their babies developing EOGBS infection. This is the approach followed by most developed countries.

That same year, the Royal College of Obstetricians and Gynaecologists (RCOG) produced their first Green-top guideline on group B Strep, based on published evidence and expert

opinion, for obstetricians, gynaecologists and other relevant health professionals. This described a risk-based approach to preventing early-onset GBS infections whereby risk factors identified during pregnancy and labour are used to trigger the offer of protective intravenous antibiotics in labour (also referred to as intrapartum antibiotic prophylaxis or IAP).

There have been two updates to the RCOG's Green-top guideline for the prevention of early onset GBS disease in the UK, one in 2012 and the latest version published in 2017 (Hughes et al., 2017).

The RCOG's 2017 Green-top guideline on GBS makes several new recommendations compared to previous editions. Key changes included:

- All pregnant women should be provided with a patient information leaflet on group B Strep.
- Women who carried GBS in a previous pregnancy should be offered either an Enriched Culture Medium test (ECM test), following Public Health England's UK Standards for Microbiology Investigations B58 late in her next pregnancy, or antibiotics in labour if she declines a test.
- Women who are in preterm labour should be recommended to have IV antibiotics in labour to protect against group B Strep.

Group B Strep Support worked closely with the RCOG to co-produce a joint information leaflet on group B Strep, following the updated 2017 Green-top guideline, that both would recommend be provided to all pregnant women. This leaflet (Group B Strep Support and Royal College of Obstetricians and Gynaecologists, 2017) is available to download from both organisations' websites, with hard copies also available on request for families and the NHS from Group B Strep Support.

Up-to-date, expert-produced and evidence-based guidelines are important to improve practice, as are clear and accessible patient information materials that reflect such guidelines. However, guidelines can only play a part - they also need to be embedded into both national and local practice for patients to benefit from them.

The Impact of the Royal College of Obstetricians and Gynaecologists' Green-top guideline on GBS

In mid-2019, Group B Strep Support sought to establish the extent to which the updated RCOG Green-top guideline on GBS had been adopted and was being followed, and to understand any barriers to its implementation. We made requests to NHS Trusts and Boards with maternity services throughout the United Kingdom under the Freedom of Information Act (FOIA).

Some Trusts/Boards took a long time to respond to the FOI requests, well beyond the 20-working day limit set by the FOIA. The final responses from Trusts/Boards were received in late 2019. The disruption caused by the Covid-19 outbreak in 2020 led to capacity issues within GBSS, and this report is published later than initially intended.

Methodology

Using the Freedom of Information Act (FOIA), the charity requested information from NHS Trusts and Boards with maternity services throughout the United Kingdom.

These requests asked 14 separate questions and asked for copies of the information materials given to pregnant women about GBS and the Trust/Board's local guideline on preventing early-onset group B Strep infection.

GBSS received a response from all 151 organisations approached, a 100% response rate: 125 organisations in England, 15 in Scotland, six in Wales, and five in Northern Ireland.

GBSS is grateful to all the Trusts/Boards for responding to its request for information and recognises the time and effort that went into providing the information.

Results

Local Group B Strep guideline

Question 1: Please supply a copy of your guideline(s) relating to group B Strep during pregnancy, labour, and in newborn babies.

Guidelines provided	Guidelines not provided	Invalid response
148	1	2*

*Two Trusts did not have local guidelines, and simply signposted to the RCOG's GBS guideline itself.

The overwhelming majority of Trusts/Boards had created local guidelines on group B Strep, based on RCOG's Green-top guideline on GBS. The one Trust that did not provide a copy of its guideline had stated 'Attached' in their response to the question, so we assume that this was a clerical oversight.

Question 2: Please provide the date when your guideline relating to group B Strep during pregnancy and labour was last updated.

Year GBS guideline was last updated	Number updating that year
Between 2012 and 2015	8
During 2016	8
During 2017 (before GBS guideline published on 13 Sept 2017)	12
During 2017 (on/after GBS guideline published on 13 Sept 2017)	11
During 2018	69
During 2019	42
Total	**150**

Of the 151 Trusts/Boards across the UK who responded to the FOI request, 150 provided information on when their GBS guideline had last been updated.

122 (81%) Trusts/Boards had updated their GBS guideline after the RCOG's Green-top guideline on GBS was published on 13 September 2017.

28 (19%) Trusts/Boards had not updated their guidelines since the 2017 update, meaning they are out of step with recommended clinical best practice. They may be leaving themselves vulnerable to legal challenge.

Question 3: Please provide the date when your guideline relating to group B Strep during pregnancy and labour is due to be updated.

Year GBS guideline next due to be updated	Number updating that year
During 2019	17
During 2020	32
During 2021	58
During 2022	24
During 2023	5

136 Trusts/Boards provided information on when their GBS guideline was next scheduled to be updated. Five Trusts/Boards reported that their local guideline was currently being updated.

Many Trusts/Boards seemed to follow a three year review cycle, which matches with most guidelines being updated in 2018 and due for review in 2021.

Providing information on group B Strep to pregnant women

An important new recommendation in the RCOG's Green-top guideline on GBS was that all pregnant women should be provided with an appropriate information leaflet, such as the RCOG patient information leaflet, *Group B Streptococcus (GBS) in pregnancy and newborn babies*. The RCOG Green-top guideline includes as an auditable topic "Proportion of pregnant women given high-quality patient information".

Question 4: Do you provide information materials routinely to pregnant women about group B Strep as a routine part of antenatal care?

Yes	No
73	76

Just over half (51% n=76/149) of the Trusts/Boards who responded did not provide information to at least some pregnant women as a routine part of their antenatal care, contrary to the RCOG Green-top guideline on GBS recommendation.

Question 5: Do you provide ALL pregnant women with information materials about group B Strep? If not to all pregnant women, do you provide them to women:

- who have previously had a baby with GBS infection?
- where GBS has been detected during the current pregnancy (swab or urine)?
- who are in preterm labour?
- whose waters break early?
- who request information?

Situations in which information materials about GBS would be provided to the pregnant woman	Number	Percentage*
All pregnant women	67	46%
GBS detected in current pregnancy (swab or urine)	76	92%
On request	73	89%
Previously baby developed GBS infection	61	73%
Waters break early	18	22%
Preterm labour	17	21%

*greater than 100% since multiple answers were allowed.

11% (n=9/82) of Trusts/Boards would not provide information even where a woman specifically asked for it. This could open them up to legal challenge if there is an adverse outcome.

Question 6: Please supply copies of the information materials (physical and/or digital) which are given to women about GBS as a routine part of antenatal care.

Type of information provided	Number	Percentage*
RCOG / GBSS co-produced leaflet	99	74%
Local leaflet	19	14%
Maternity notes/pregnancy book or equivalent	26	19%
Total	**144**	

*greater than 100% since multiple answers were allowed.

The co-produced RCOG-GBSS patient information leaflet was widely used, with nearly three-quarters of Trusts/Boards stating they provided it (74% n=99/144).

Around one in five Trusts/Boards stated that information on GBS was provided in their maternity notes, a pregnancy book or equivalent. However, this is not adequate as an alternative to the RCOG-GBSS leaflet, which provides much more detailed and useful information. One set of maternity notes, for example, had one short paragraph in small font about GBS on the 22nd page of the notes, alongside many other pregnancy conditions of less clinical importance.

Data collected on the incidence of early-onset and late-onset group B Strep infection

Question 7: What was the Trust/Board's recorded number of early-onset GBS infections (EOGBS infections develop in babies aged 0-6 days) and late-onset GBS infection (LOGBS infections develop in babies aged 7-90 days) for 2017 and 2018. This may include those who developed GBS infection while in hospital, and those who were brought to hospital (i.e. fell ill after going home). Please also supply your declared total number of births within your Trust/Board for each year.

Many Trusts/Boards reported that the data on EOGBS and LOGBS were either not collected or held by their organisation. Sometimes the data were collected, but only held on individual patient records, making them inaccessible within the work-time limit set by the FOIA.

One Trust explained:

"The Trust does not hold the GBS data electronically. To complete this request the Trust will need to go through thousands of sets of patient notes. This would take the Trust more than 18 hours to complete and is therefore exempt from disclosure under Section 12 of the Freedom of Information Act."

In view of the low response rate to this question, we have not published the data received.

Testing pregnant women for group B Strep carriage

A new recommendation in RCOG's Green-top guideline on GBS was that all pregnant women who carried GBS in a previous pregnancy should be offered the option of an Enriched Culture Medium swab test for GBS carriage at 35-37 weeks of pregnancy or of being treated as a carrier this pregnancy and offered IAP. In the RCOG's Green-top guideline on GBS, the proportion of pregnant women who were colonised in a previous pregnancy who are offered testing and/or IAP is listed as one of the 5 auditable topics.

The ECM test is different from a standard swab for vaginal discharge – swabs should be taken from both the low vagina and rectum, and samples cultured using enriched culture media. The RCOG's Green-top guideline on GBS states that Public Health England's Standards for Microbiology Investigations B58 (Public Health England, 2018) should be followed when testing for GBS carriage.

The ECM test is known to be far more predictive of GBS carriage status than direct plating methods, which have a high false-negative rate. Sites using standard testing processes will lead to falsely negative results, and babies left at higher risk of developing GBS infection than if ECM tests were being used.

Question 8: Does the Trust/Board offer culture-based GBS testing for GBS carriage in late pregnancy to women where GBS was detected in a previous pregnancy?

Offer testing in accordance with new RCOG recommendation	Number	Percentage
Yes	74	51%
No	72	49%
Total	**146**	

Nearly half (49%) of Trusts/Boards did not offer testing to pregnant women who carried GBS in a previous pregnancy, and therefore did not follow the RCOG's Green-top guideline on GBS recommendation.

Question 9: Does the Trust/Board offer culture-based GBS testing for GBS carriage in late pregnancy to women in any other circumstances?

Offer testing in other circumstances	Number	Percentage
Yes	49	35%
No	91	65%
Total	**150**	

Over a third (35% n=49/150) of Trusts/Boards offered GBS testing in circumstances other than previous carriage.

Question 10: If the Trust/Board undertakes GBS testing for GBS carriage to women in late pregnancy, which of the following specimen types do you collect?

If the Trust/Board undertakes GBS testing for GBS carriage in women in late pregnancy, which of the following specimen types do you collect?	Number	Percentage
Vaginal Swab	90	66%
Rectal Swab	3	2%
Both Vaginal and Rectal Swab	43	32%
Total	**136**	

The majority of Trusts/Boards (66% n=90/136) are still using standard vaginal swabs to detect GBS carriage. This is not in line with RCOG's Green-top guideline on GBS recommendations, which state that both vaginal and rectal swabs should be taken.

Question 11: If the Trust/Board undertakes GBS testing for GBS carriage in women in late pregnancy, which detection method is used by the Microbiology laboratory?

If the Trust/Board undertakes GBS testing for GBS carriage in women in late pregnancy, which detection method is used by the Microbiology laboratory?	Number	Percentage*
Direct Culture		
Direct culture on non-selective, non-chromogenic media	57	49%
Direct culture on selective &/or indicator media	61	54%
Broth enrichment step [ECM methodology]		
Broth enrichment with subculture onto selective or non-selective, chromogenic or non-chromogenic media	20	13%
Other	1	4%

*greater than 100% since multiple answers were allowed.

13% of Trusts/Boards are using broth enrichment in their testing process, in line with RCOG and PHE recommendations. Many Trusts/Boards are still using direct culture for their testing methodology, and are out of step with RCOG's Green-top guideline on GBS recommendations.

Question 12: Is testing for GBS carriage within the accredited scope of the Microbiology laboratory?

Is testing for GBS carriage within the accredited scope of the Microbiology laboratory?	Number	Percentage
Yes	90	70%
No	39	30%
Total	**129**	

70% (n=90/129) of Trusts/Boards have testing for GBS carriage within the accredited scope of their Microbiology laboratory.

Question 13: Does the Microbiology laboratory use an automated specimen processor (e.g. WASP)?

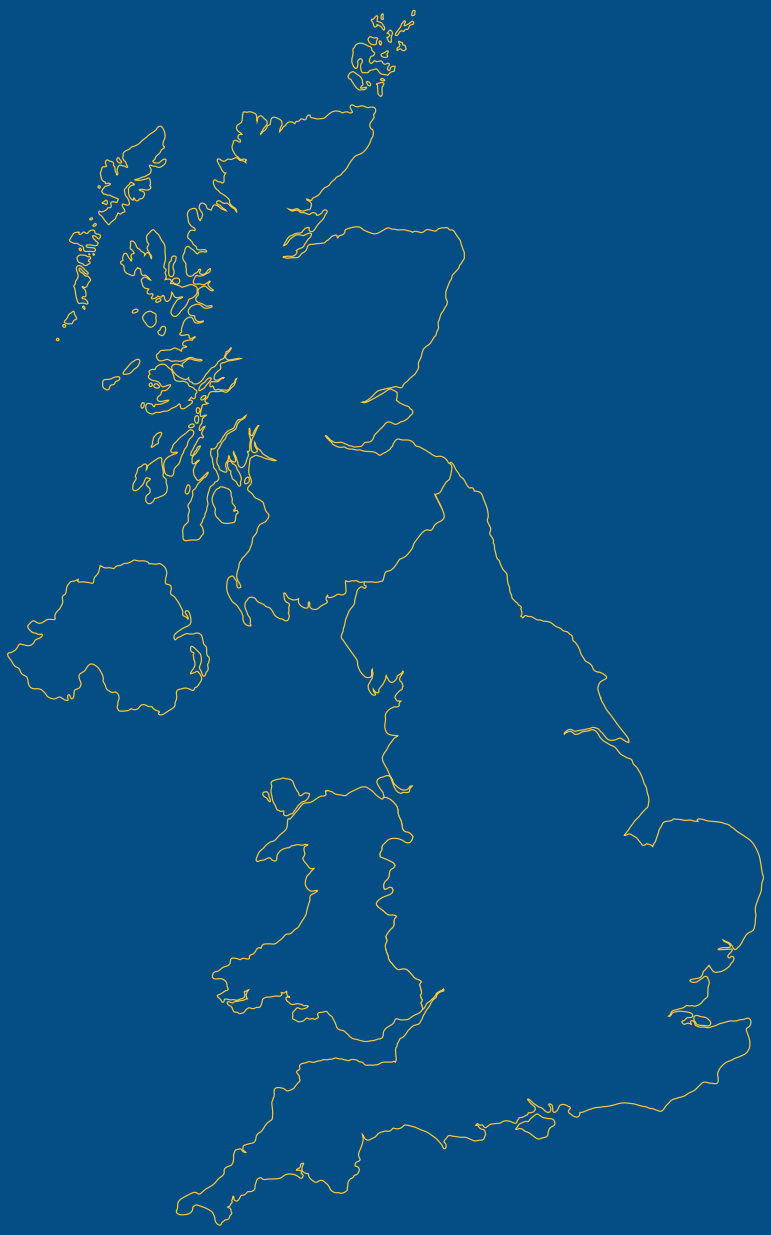
Does the Microbiology laboratory use an automated specimen processor (e.g. WASP)?	Number	Percentage
Yes	37	28%
No	97	72%
Total	**134**	

Nearly three quarters of Trusts/Boards (72% n=97/134) did not use automated specimen processors such as Walk Away Specimen Processor (WASP).

Question 14: If the Microbiology lab uses an automated specimen processor, does it allow enrichment broth inoculation?

If the Microbiology lab uses an automated specimen processor, does it allow enrichment broth inoculation?	Number	Percentage
Yes	18	49%
No	19	51%
Total	**37**	

Just under half of the Microbiology labs using automated specimen processors were able to allow enrichment broth inoculation – i.e. were able to automate some part of the ECM methodology.



Devolved Nations

England

NHS Trusts in England made up 83% of the respondents (125/151). Most Trusts had updated their guidelines since the RCOG's Green-top guideline on GBS update in 2017, with only 20 Trusts having outdated guidance (16%, 20/125)

Under half (46%, 58/125) of Trusts routinely provided pregnant women with information on GBS, with two-thirds using the joint GBSS/RCOG patient information leaflet (66%, 83/125).

Just under half (47%, 59/125) of Trusts offered testing to pregnant women who had carried GBS in a previous pregnancy. England had 19 of the 20 Trusts/Boards which used ECM methodology for testing, making up 15% of their responses (19/125).

Scotland

The 14 regional NHS Boards in Scotland made up a small proportion of overall responses (9%,14/151). Most Boards had updated their guidelines since the RCOG's Green-top guideline on GBS update in 2017, with only five Trusts having outdated guidance (38%, 5/14).

The majority of the Boards routinely provide pregnancy women with information on GBS (64% 9/14) with the same proportion using the joint GBSS/RCOG patient information leaflet (64%, 9/14).

Twelve Boards (85%, 12/14) stated that they offered testing to pregnant women who had carried GBS in a previous pregnancy, with one reporting that it used ECM methodology for testing (7%, 1/14).

Wales

Health Boards in Wales made up a small proportion of the responses, with only seven Health Boards (5%, 7/151). Most Boards had updated their guidelines since the RCOG's Green-top guideline on GBS update in 2017, with only two Boards having outdated guidance (28%, 2/7).

One of the Health Boards (14%, 1/7) reported that they routinely provided pregnant women with information on GBS, though all Health Boards used the joint GBSS/RCOG patient information leaflet to some degree (100%, 7/7).

Only two Boards (27%, 2/7) reported that they offered testing to pregnant women who had carried GBS in a previous pregnancy, and none reported that they used ECM methodology for testing (0%, 0/7).

Northern Ireland

There were five Health and Social Care Trusts in Northern Ireland which provided data (3%, 5/151). Most Trusts had updated their guidelines since the RCOG's Green-top guideline on GBS update in 2017, with two Trusts having outdated guidance (40%, 2/5).

All of these Trusts (100%, 5/5) reported that they routinely provided pregnant women with information on GBS, however only one (20%, 1/5) stated that they used the joint GBSS/RCOG patient information leaflet with the remainder using pregnancy notes or the PHA Pregnancy Book[1].

One Trust (20%, 1/5) reported that they offered testing to pregnant women who had carried GBS in a previous pregnancy, and none reported that they used ECM methodology for testing (0%, 0/5).

[1] As stated in our comment on Question 6 (see page 8), we do not consider the pregnancy notes to be an adequate method of informing women about GBS. They are for general pregnancy information, not specifically about GBS.

Group B Strep testing – the legal position

In late 2019, Group B Strep Support had received anecdotal reports of NHS Trusts & Boards not using ECM methodology when performing testing for group B Strep carriage. This was concerning because it meant a less accurate test was being provided on the NHS (the standard swab and direct plating test is far less reliable than the ECM test). The charity was also concerned that not offering ECM testing might leave a Trust or Board open to a clinical negligence claim were a baby then to develop early-onset GBS infection.

With this in mind, we approached leading clinical negligence barrister, Christopher Johnston QC of Serjeants' Inn Chambers, who kindly provided his legal opinion pro bono. We asked Mr Johnston QC to consider whether a hospital would be negligent for failing to offer ECM testing when a test for GBS carriage is recommended for a pregnant woman. N.B This legal advice reflects the situation in England and Wales, it does not extend to the legal systems of Scotland or Northern Ireland.

We asked him to consider three circumstances:	**Mr Johnston QC's opinion was that, with the important caveats that all cases must turn on their own particular facts, be supported by independent expert evidence and that both factual and medical causation would have to be established in any individual case:**
A) A pregnant woman carried GBS in a previous pregnancy, and is offered a test for GBS carriage in her current pregnancy. However, the test offered to her is not an ECM test but a standard swab test. The woman carries GBS but the standard swab test does not detect it. The mother and/or baby goes on to develop GBS infection with consequent injury.	**1. In this scenario –** "It is very likely that a claimant would establish breach of duty in a consent (Montgomery) claim here", noting that the "RCOG guidelines support ECM testing."
B) The facts are the same as A) but the pregnant woman is offered no testing at all.	**2. In this scenario** – "A breach of duty in a consent (Montgomery) claim would almost certainly be established here. A reasonable patient would want to know about the existence of testing given the potentially severe injury which might result."
C) The facts are the same as B) but testing is requested by the mother but refused by the hospital on the basis that it is not indicated, but then no guidance is offered to her about private alternatives.	**3. In this scenario** – "A breach of duty in a consent (Montgomery) claim would almost certainly be established here. Whilst the patient could be advised that the hospital does not consider it to be indicated, she should be advised that it can be obtained cheaply privately and (if this is the case) that other NHS hospitals and doctors do provide it for free (and – presumably – that her GP could refer her to such a NHS resource)."

The conclusion Mr Johnston QC reached was that:

"The simple solution here is for hospital trusts to follow the RCOG guidance and offer ECM testing in appropriate circumstances. The ECM test is inexpensive and offering it to all affected prospective mothers makes the most sense ethically, legally and financially (given the potential exposure to expensive litigation and the financial burden imposed on the State by those injured by the failure to provide the ECM test).

Further, without knowing the detail of individual trusts reporting obligations to NHS Resolution, it would seem to accord with standard risk management practices for NHS Trusts to inform NHS Resolution (as effectively an insurer) if they are not offering the ECM test given the litigation risk exposure this decision creates."

Commentary and Recommendations

The 2017 update of the RCOG's Green-top guideline on GBS has been mostly adopted across the UK, at least in part, with 81% of the Trusts/Boards surveyed having updated their local guidelines since the 2017 national guidelines were published.

We strongly recommend the remaining 19% of Trusts/Boards update their clinical guidelines in line with the RCOG's Green-top guideline on GBS. These organisations are currently out of step with recommended clinical best practice and may be leaving themselves vulnerable to legal challenge.

An important new recommendation in the RCOG's Green-top guideline on GBS was that all pregnant women should be provided with an appropriate information leaflet on GBS. Under half (46% n=67/147) of the Trusts/Boards who responded provided information to all pregnant women as a routine part of antenatal care. 11% (n=9/82) of Trusts/Boards reported that they would not provide information on GBS even to a woman who specifically asked for it.

We strongly recommend Trusts/Boards follow the RCOG recommendation to provide all pregnant women with an information leaflet on group B Strep. The joint RCOG-GBSS patient information leaflet is freely available to download from both organisations' websites, and paper copies are available from the charity free of charge to the NHS.

Where women are provided with information on GBS, we are pleased to see such good usage of the jointly produced RCOG-GBSS patient information leaflet. Nearly three-quarters of Trusts/Boards who provide women with information use this leaflet.

We recommend that the remaining quarter of Trusts/Boards adopt the jointly produced RCOG-GBSS patient information leaflet.

Many Trusts/Boards reported that data on numbers of EOGBS and LOGBS infections were either not collected or held by their organisation.

We strongly recommend that Trusts/Boards routinely collect data on GBS infection in babies at a local level, so that they can track local rates of GBS infection and how their hospitals are performing in terms of reducing early-onset GBS infection.

Nearly half (49%) of Trusts/Boards did not offer the option of testing to pregnant women who carried GBS in a previous pregnancy, and therefore did not follow the RCOG's Green-top guideline on GBS.

We strongly recommend Trusts/Boards follow the RCOG guidelines to offer women who carried GBS in a previous pregnancy the option of testing.

Non-compliance around testing may be partially explained by the fact that many Trusts/Boards are still not using the ECM methodology for GBS testing. Most Trusts/Boards (66% n=90/136) are still using standard vaginal swabs to detect GBS carriage, and only 13% (n=20/151) of Trusts/Boards are using broth enrichment in their testing process, in line with RCOG and PHE recommendations.

We strongly recommend that all Trusts/Boards implement ECM testing within their Microbiology laboratories.

As Mr Johnston QC's legal opinion sets out, organisations which are not using the ECM testing methodology may be leaving themselves vulnerable to legal challenge. Group B Strep clinical negligence claims can be very expensive. Our report **The cost of group B Strep infection** (Group B Strep Support, 2019) found that claims could reach more than £20m in value.

More than two years after the September 2017 update to the RCOG's Green-top guideline on GBS, very few Trusts/Boards have updated their local guidelines to reflect fully these recommendations. Only five (3% n=5/151) Trusts/Boards report that they follow the key recommendations from the RCOG's Green-top guideline on GBS to provide information to pregnant women, offer testing to appropriate groups, and use ECM methodology for GBS testing.

This needs to change.

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GROUP B STREP SUPPORT

Group B Strep Support is the only UK charity dedicated to eradicating group B Strep infections in babies.

We provide up-to-date, evidence based information on GBS to families and health professionals, and support to affected families.

We want every pregnant woman to be given information on group B Strep during routine antenatal care, and offered the opportunity to have a GBS- specific test late in pregnancy.

Ultimately, GBSS wants GBS infections in babies to be eradicated.

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