Reference Number: UHBOBS052 Version Number: 11	Date of Next Review: 13/1/2029 Previous Trust/LHB Reference Number:

Group B Streptococcus, Management of colonisation in pregnancy

Introduction and Aims

The Lancefield group B beta-haemolytic streptococcus infection (*Streptococcus agalactiae*) is recognised as the most frequent cause of severe early-onset (less than 7 days of age) infection in newborn infants. GBS is present in the bowel flora of 20–40% of adults (this is called 'colonisation'). Around 1 in every 1750 newborn babies in the UK is diagnosed with early-onset GBS infection (EOGBS), most commonly pneumonia, meningitis or sepsis. Of these babies with EOGBS 5.2% will die and of the survivors 7.4% will have long term disability.

Objectives

The purpose of this guideline is to provide guidance for obstetricians, midwives and neonatologists on the prevention of early-onset neonatal group B streptococcal (EOGBS) disease and the information to be provided to women, their partners and family.

Scope

This policy applies to all healthcare professionals in all locations including those with honorary contracts.

Equality Health Impact Assessment	*An Equality Health Impact Assessment (EHIA) has not been completed.*
Documents to read alongside this guideline	Prevention of Early-onset Neonatal Group B Streptococcal Disease | RCOG |Green Top Guidance 36
Approved by	*Maternity Professional Forum*
Accountable Executive or Clinical Board Director	Abigal Holmes Director of Midwifery
Author(s)	Anne Lloyd

Disclaimer

If the review date of this document has passed, please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments			
Version Number	**Date of Review Approved**	**Date Published**	**Summary of Amendments**
1	Dec 2005	Dec 2005	
2	Dec 2008	Dec 2008	Alex Rees, Julia Sanders
3	Nov 2011	Dec 2011	Pina Amin
4	Sept 2013	Nov 2013	Sybil Barr, Julia Sanders, Alex Rees
5	July 2014	July 2014	Sybil Barr, Julia Sanders, Alex Rees
6	October 2018	Feb 2019	Louise Dowler, Abi Holmes
7	2020	2020	Amendment to antibiotics January 2020
8	May 2023	2023	Updated to include GBS3 trail, Maternity section updated by Sarah James, consultant midwife. Neonatal section updated by Alok Sharma, neonatologist
9	October 2023	2023	Further updates to neonatal section by Alok Sharma, Neonatal Consultant. All babies born to GBS women will require SRC. Babies born by ELCS will not require SRC.

			Not linked to neonatal SharePoint guideline as refers to NICE, this is not used in C&V
10	March 2024	2024	Information about GBS Study removed as Study now complete
11	Jan 2026	2026	Refer to RCOG Green Top Guidance with Cardiff and Vale Variations

Contents

National Guidance

Care will be provided in accordance with the most recent version of the following National Guidance, with the exception of the variations outlined below:

Prevention of Early-onset Neonatal Group B Streptococcal Disease | RCOG |GTG 36

https://obgyn.onlinelibrary.wiley.com/doi/epdf/10.1111/1471-0528.14821 (Press control and click on link)

Variations from above National Guidance

1. **"How should a newborn baby be managed?"**
   Instead of referring to this section of the RCOG GTG, please refer to the CAV Specific Guidance as outlined below (Care and Management of the Neonate).

2. **Management of PPROM in a known GBS carrier**
   Women with PPROM and known GBS carrier status in the current pregnancy should be offered immediate birth via either induction of labour or caesarean section from 34 weeks gestation (NICE, NG195, Neonatal Infection: Antibiotics for Prevention and Treatment, 2021)

CAV Specific Guidance

Assessment following term SROM (≥37 weeks)

All women presenting with a confirmed rupture of membranes should have their Welsh Clinical Portal record checked, to identify women who are GBS positive.

Please remember that if a pregnant patient is GBS positive, but is otherwise low risk, they can be safely manged on the Midwifery Led Unit (MLU).

Women who are allergic to Penicillin CANNOT receive their intrapartum care on the MLU and should be advised to give birth on the Consultant Led Unit.

Assessment following pre-term SROM (<37 weeks)

All women presenting with a confirmed rupture of membranes should have their Welsh Clinical Portal record checked, to identify women who are GBS positive.

Women who have a confirmed pre-term SROM and GBS status is unknown or negative on standard HVS should have screening performed as detailed below.

This is because preterm SROM in context of GBS alters recommendations for timing of birth.

GBS screening (only if GBS carrier in previous pregnancy, or pre-term SROM)

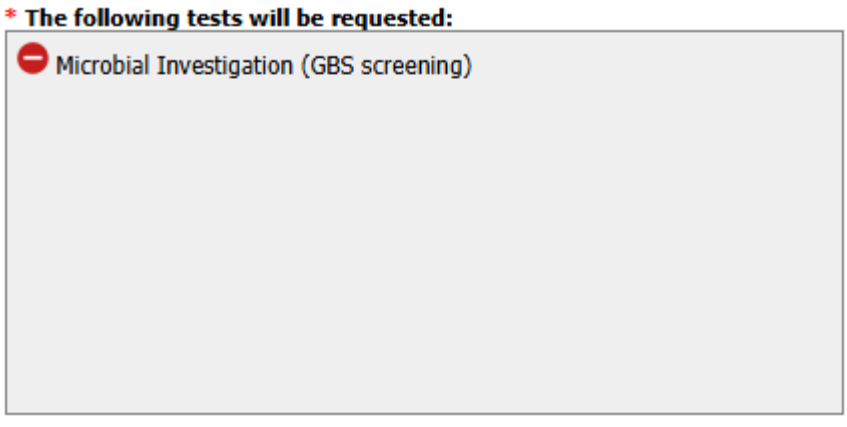
This should always be offered in the following circumstances:

i. Known GBS carrier in previous pregnancy
ii. Preterm SROM, with unknown GBS carrier status, or negative result on standard HVS

The swabs should ideally be low vaginal and rectal (either 2 separate swabs or 1 swab, sampling the low vagina first). A routine HVS swab will NOT be able to accurately exclude GBS colonisation, and these screening swabs require a specific culture medium (ECM – Enriched Culture Medium).

Requesting on WCP

Please request “GBS Screening” from the dropdown menu:



Requesting on a handwritten form

Please write “GBS Screening. For ECM” on the handwritten form.

Care and management of the Neonate

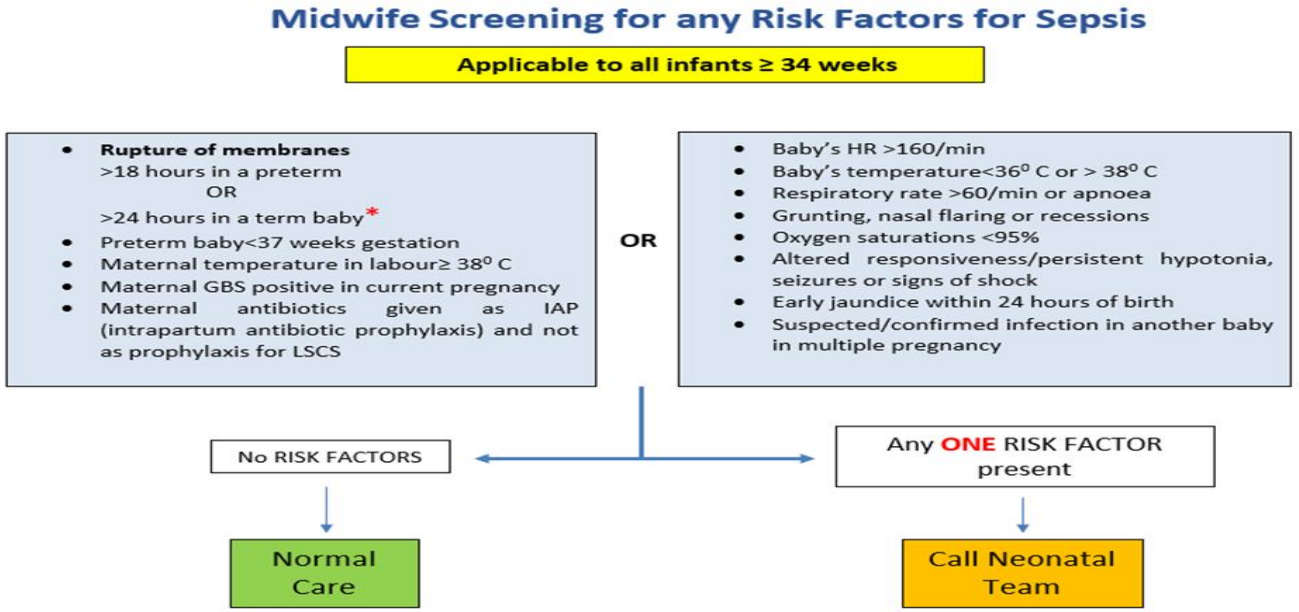
All babies born via VAGINAL BIRTH who have been exposed to GBS should be referred to the Neonatal Team. This is the case for ALL postnatal ward areas (Consultant Led Unit, Midwifery Led Unit, Transitional Care). The Neonatal Team will review the baby and perform the Sepsis Risk Calculator (SRC).

NB – babies born via caesarean section before labour and with intact membranes do NOT require referral to a Neonatologist and should receive routine care

The following generic principles apply in all situations and supersede any sepsis algorithm.

1. All infants symptomatic of sepsis must be investigated and treated promptly with antibiotics within 1 hour of the decision to treat. This is irrespective of their sepsis risk score. If you are unsure seek senior help.
2. Investigations for sepsis should include a blood culture **(a minimum of 1ml of blood must be inoculated into the blood culture bottle)**, FBC and a CRP. The latter should be repeated in 18- 24 hours.
3. Where there is a history of confirmed Group B Streptococcal sepsis or death of a neonate in previous pregnancy, **AND** the mother **has not** received adequate intrapartum prophylaxis in this pregnancy, the newborn infant should be screened and presumptively treated irrespective of the sepsis risk score.

Midwife Screening for any Risk Factors for Sepsis



Antibiotic choice

Please refer to our local Micro guide/Eolas for our most up to date antimicrobial advice on

Eolas Medical (Press Control and click on link to access)