Guidance

Blood - Borne Infection Testing

For all Children and Young People In Local Authority Care within Devon.

Colleague Guidance

This is a guide to support colleagues in Virgin Care Integrated Children's Services in conjunction with the acute trust. The Guidance will also support colleagues in Devon Local Authority Children's Services.

This guidance applies to the following group(s) of colleagues: All staff in Integrated Children's Services,

Paediatricians, Social Workers / Managers

Domain	Final		
Number	V7.5	**Lead author**	Gwyneth Nightingale Designated Nurse Children in Care
Date written	November 2016	**Review date**	November 2019
Responsible committee	Completed on behalf of Devon Local Authority (Children and Young People's Services), New Devon Clinical Commissioning Group and Virgin Care Limited.		

Version number:	Date distributed:	Supersedes Version No:
Draft V1	April 2008	
Draft 2 – Draft 6	May – December 2008	Draft V1
V7 Final	December 2010	Draft 2 – Draft 6
Draft V7.1 - Draft 3	September -November 2016	V7 Final
V7. 4 Draft	November 2016	Draft V7.1 - Draft 4
V7.5 Final	December 2016	Final Draft V7.4

Colleague group	Required level of acceptance	
	Awareness	Read
Virgin Care corporate colleagues	✓	
Clinical colleagues	✓	
Non-clinical colleagues in business units/ clinical services	x	
All colleagues	x	
Specific colleague group(s) (if applicable, please state)		

Signed on behalf of Integrated Children's Services, Devon:

Amir Qureshy, Head of Operations Date: December 2016

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1.0 Introduction

This guidance has been produced by utilising research from National Children's Bureau (NCB), Unaccompanied Asylum Seeking Children and Young people (Kent UASC), British Adoption and Fostering (BAAF) and Public Health Devon.

The guidance offers brief explanation to specific blood borne infections although does not offer comprehensive information regarding the illnesses, the management or practical implications for foster carers, residential staff or adopters. However, universal safe practices for prevention of transmission are detailed.

Additional information can be found by accessing Coram British Adoption & Fostering (BAAF) related articles and BAAF Practice Note 53: 'Guidelines for the testing of Looked After Children who are at risk of Blood-borne viruses' and or British Association for sexual Health and HIV guidelines.

2.0 Duties and Responsibilities

The corporate parenting responsibilities of local authorities include having a duty under section 22(3) (a) of the Children Act 1989 to safeguard and promote the welfare of the children they look after. This includes the promotion of the child's physical, emotional and mental health and acting on any early signs of health issues which may have a detrimental impact upon their health and well-being.

Blood borne infections such as Hepatitis B, Hepatitis C, Human Immunodeficiency Virus (HIV) and Syphilis (amongst others) cause diseases which are considered to be infectious i.e. transmitted from person to person. It is important to note that transmission is not through everyday social contact and this misconception can increase anxiety and fear in both professionals and lay people, creating a stigma, discrimination and social exclusion of those affected including their families.

Opportunistic contact between health professionals and a young person may present itself at any time and health professionals should have the awareness and knowledge to ascertain if a child / young person has been exposed to a potential risk of BBI. If risk of exposure is identified action must be taken in the best interest of the child / young person.

For teenagers that have been sexually active / exploited, the health professional may decide a referral to a sexual health clinic may be more appropriate (than arranging the blood test) as continuity of follow up care will be consistent.

For other young people information leaflets are provided with request to see their GP and a referral letter is sent to GP.

This guidance aims to address issues that may arise and clarify process related to

- Testing of children in care for blood-borne infections 0-18 years of age
- Consent to medical treatment for children in local authority care
- Services available to assist young people in relation to BBVs as they go through the transition into adulthood.

3.0 What is a blood borne Infection (BBI)?

For the purpose of this document the blood borne infections are viruses specific to: Hepatitis B, Hepatitis C, Human immunodeficiency Virus (HIV) and non-viral Syphilis.

Hepatitis B: Is a blood-borne virus which is highly infectious and can cause acute and chronic liver disease. The majority of people infected in adulthood are able to fight off the virus and recover within one to three months – some of these people will have life-long immunity but some continue to carry the virus. However, children infected at birth or as young children are at a much higher risk of developing chronic infection (90% of babies and 20% of older children) and there is also a higher risk of developing liver cancer. The main routes for transmission are; sexual, blood to blood and mother to child.

[In the South West there were a total of 27 cases of acute Hepatitis B in 2015 (from a total of 457 in England.

The South West incidence was 0.49 cases per 100,000 population - England rate was 0.83.

The prevalence of chronic Hepatitis B infection would be much higher as many acute infections are sub-clinical and also many are acquired abroad, in many cases, infection persists through life. The rates of new infections are fairly stable].

Hepatitis C: This virus presents itself as a number of different strains causing liver disease and the effects of the virus will vary from one individual to the next. In most cases the acute infection is subclinical. Approximately one quarter of people who acquire Hepatitis C will clear the virus naturally within six months. In others, people remain apparently healthy for long periods of time – even years whilst the virus is active and this chronic infection can cause cirrhosis which can develop into cancer. The main route for transmission is via blood to blood, especially through injecting drug use

In 2014 983 Hepatitis C infections were diagnosed in the South West. The majority of these cases will be in people who use, or have used drugs and therefore the transmission rate is high. It is important to note that there may be a high percentage of the population unaware of their Hep C status and or undiagnosed.

The rate of new infections is fairly stable, as the number diagnosed per year has been fairly consistently around the 1000 mark since 2008].

HIV: This is a retrovirus that attacks the body's immune system. HIV can be asymptomatic for years but left untreated will eventually lead to acquired immunodeficiency syndrome (AIDS), a condition in which the immune system begins to fail, leading to life – threatening opportunistic infections. The main routes for transmission are via sexual, blood to blood and mother to child. There may be a high number of people unaware of their HIV status and or undiagnosed.

[The figures for 2015 report that there were 330 Devon (local authority) residents accessing care with an HIV diagnosis. This gives an HIV prevalence of 0.80 per 1000 people aged between 15 and 59, compared to the national average of 1.9/1000.
Data derived from Public Health England].

Syphilis: this is a bacterial infection that in adults causes sores, rashes and generalised symptoms which left untreated causes serious damage to many of the vital organs of the body. The main route for transmission is via sexual contact.

3.1 Why Test for BBis?

There have been real advances in the treatment of BBVs and there is widespread recognition that early intervention for those exposed to these infections will have improved health outcomes. HIV treatment is highly effective, enabling individuals to stay well long-term if they begin treatment at an early stage. However, it is important to note that younger children often experience faster HIV progression than adults and therefore early diagnosis is essential. If HIV is left untreated, there can be serious implications to health which can ultimately be life threatening.

It is not uncommon for people to have more than one of the blood borne infections and therefore, consideration should be given (where indicated – see risk factors) to testing for all four infections (Hepatitis B, Hepatitis C, HIV and Syphilis). Testing for other infections will be a consideration of the person undertaking the test and they may refer on to specialist services.

The opportunity for a comprehensive Initial Health Assessment (IHA) undertaken by the paediatrician within 20 working days of the child entering care is an ideal opportunity to review the health of the child and consider any potential risk factors that may alert to the potential risk of a BBI infection.

The gathering of information before and at the time of the IHA is essential. This can be via social care documentation, maternal health records – this may indicate risk factors in the mother's pre-birth history that may not have been visible at time of delivery. Other medical records and information disclosed by parents, foster carers at the IHA appointment may also be forthcoming.

It is essential that health professionals act in a sensitive way to take into account what has happened to any child / young person and with particular reference to those children of UASC status. The process of gathering information and careful consideration in relation to what has happened to the individual before entering the UK, en route and at their final destination is essential (RCPCH 2016) cited in NCB 2016. This may include possible experiences of rape and or sexual exploitation.

It is essential to ensure that interpreters are available if required and that any BBI and HIV related information / support is culturally appropriate and relevant

4.0 Risk Factors to consider in relation to potential exposure of BBI's

The following risk factors may be indicative of the need for further investigation and testing:

1. If a mother is known to be positive to any BBI they should be tested.

2. If a mother is considered to be at risk of having a blood-borne infection and has declined testing for herself ***(see sentence marked **)***
3. The child's parents are intra-venous drug users and have a chaotic lifestyle, where a mobile child may have been exposed accidentally to used needles.
4. A child who has come from a country where blood-borne infections are highly prevalent e.g. some parts of Africa, South Asia – Unaccompanied Asylum Seeking Children (UASC) are at high risk
5. Girls and young women who have undergone female genital mutilation (FGM)
6. *Children and young people who have experienced sexual violence, this may include learning or physical disabilities.*
7. There is no background information available on the child; although this will be a rare occurrence, it may happen for children arriving in this country from overseas.
8. It is suspected that the child or young person has injected drugs
9. It is suspected that the child or young person has been involved in unprotected sex, may have had multiple sexual partners, been involved in prostitution or been subject to sexual abuse
10. Boys and young men engaging in same-sex sexual activity
11. Young people who use psychoactive or image and performance enhancing drugs (IPED) *Self-reported condom use is low amongst users of psychoactive drugs and IEPDs and* Transgender young *people*

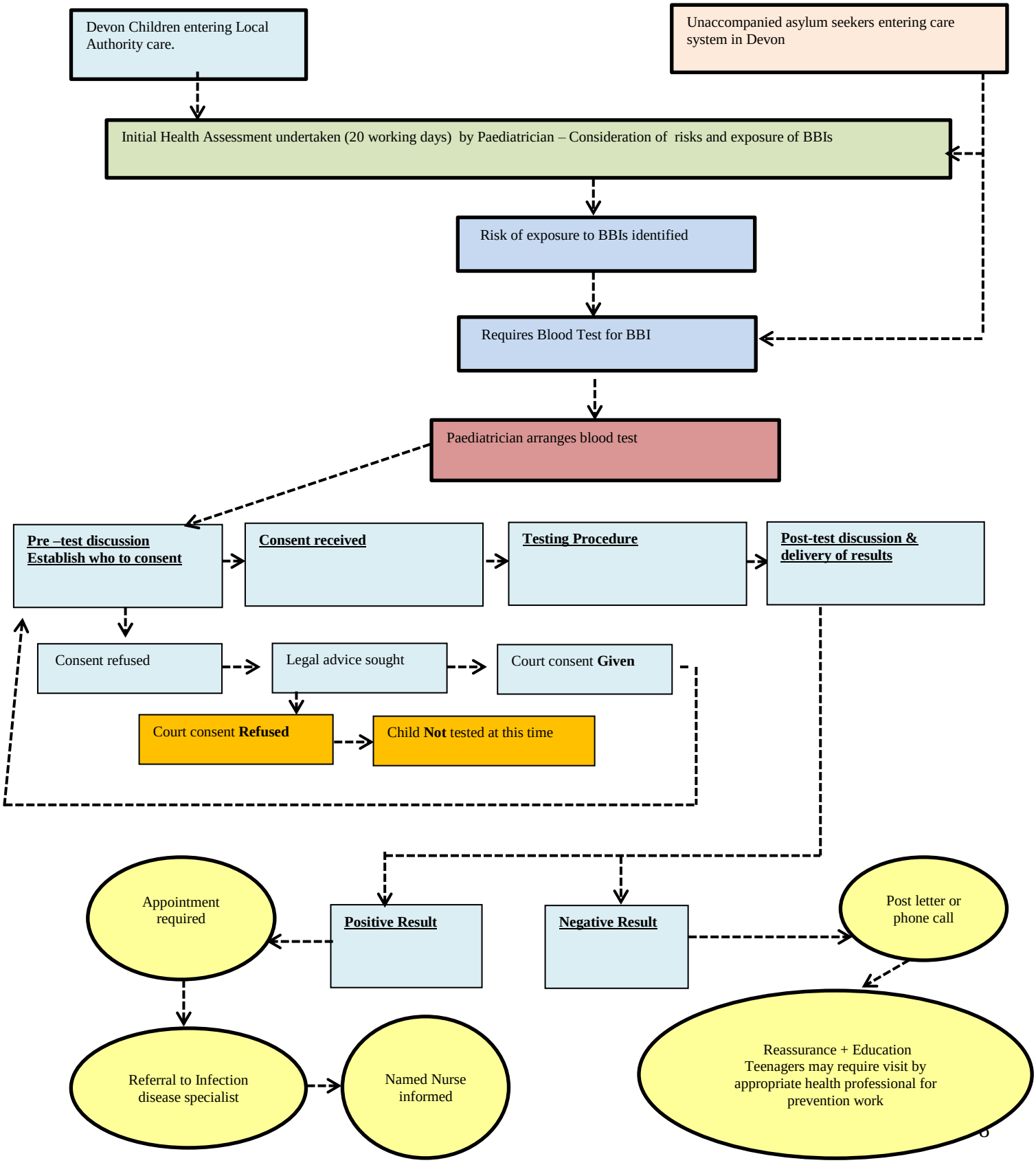
****** *Identifying infection in a child is likely to indicate that the mother is also infected. Therefore, confirming infection in a child has implications for the whole family, as a positive test is likely to mean that the mother is positive and that her partner and other children may also be infected.*

All children with mother and or father known to be living with HIV require testing (regardless of age) and even if they are showing no symptoms (CHIVA 2014) cited in NCB 2016.

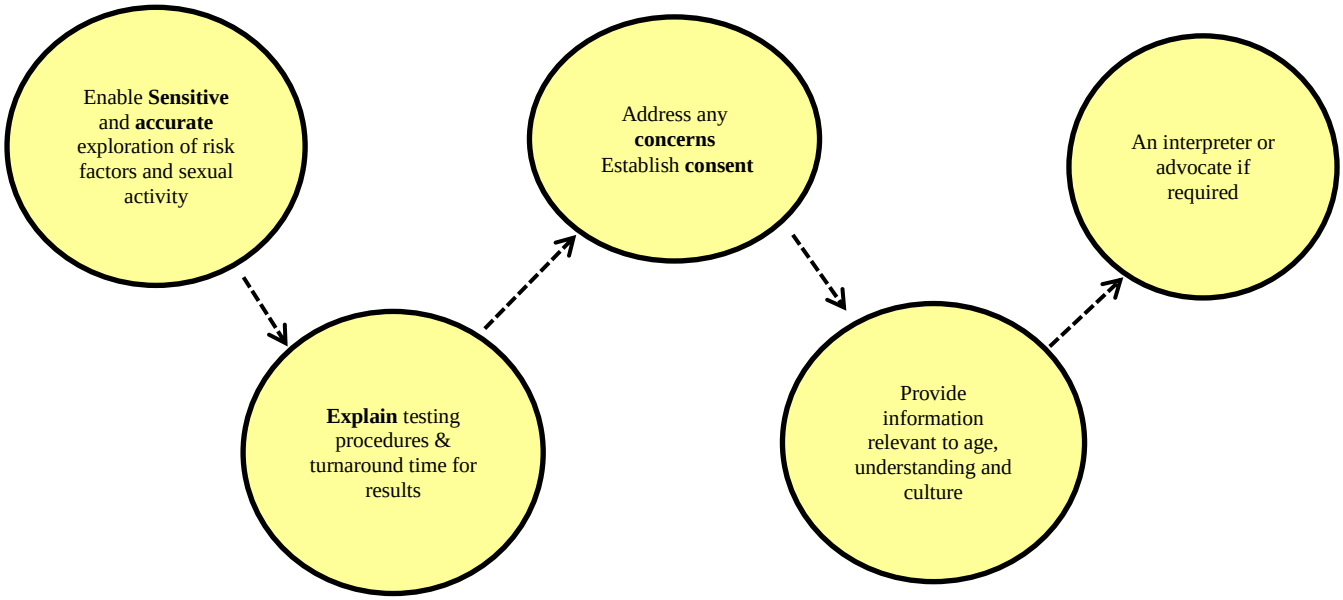
Devon Health Provider Services supports the view that each child's case should be considered on an individual basis, and that there will be no 'routine testing'. Reassurance of carers or prospective adopters is not a reason for testing a child. No child should be tested for blood-borne viruses without a doctors' recommendation to do so.

It is not a social care decision whether or not to test the child. If the factors in the child's circumstances indicate that testing is required, but does not happen, then the local authority and others may have failed to discharge its duty of care towards the child.

5.0 The Local Process for testing children across Devon, Plymouth and Torbay



5.1 Best Practice for the Health Professional undertaking the Test



6.0 Results

Negative results from laboratory tests should be made available by post (letter) or phone call, although face to face meeting with appropriate health professional may be beneficial, particularly, if prevention work around transmission of infections for a young person is indicated.

Positive results for BBIs should always be given to a young person (face to face) in a confidential environment with an appropriate person there to support them. An interpreter should be available if this need has been identified.

It should not be given to a third party, including social worker, personal advisor or other clinical teams unless the young person has specifically agreed to this.

It is essential to explain that these conditions are treatable and provide clear information to support this. A referral to a specialist team should be made for follow on support and treatment.

It is important to identify who will support the young person and help them to think through who else they would like to know about the diagnosis. Contact numbers should be given and an early follow-up arranged with the appropriate specialist.

Non-attendance for positive results - it is essential that all appropriate attempts are made to make contact with the young person and where contact has not been possible, referral to specialist sexual health services will be made to ensure that the young person does receive the information re their BBI status with the appropriate follow on support they will need.

7.0 Universal safe practice to reduce transmission of blood-borne infections

It is essential for health professions to provide reassurance and be able to provide proportionate responses to risks. Carers should take preventative measures for ***all*** children in their care to reduce the chance of any infection being passed on. This includes:

- Wearing gloves when dealing with blood if there is a risk of mixing body fluids (e.g. cuts, abrasions and eczema) and covering cuts with waterproof dressing
- Washing of skin with soap and water following any contact with blood or body fluids
- Avoid sharing items which may be contaminated with blood (e.g. razors, toothbrushes). Offer a separate container for above items as universal practice.
- Careful disposal of sanitary wear prompt clearing up of any spillages of blood or other body fluids (with diluted bleach and disposable tissues)
- Washing soiled clothing in hot water and detergent in a hot wash cycle.
- Advice to young people (age appropriate) re safer sex (always use a condom).
- Advice to young people re sterile equipment i.e. tattooing, ear piercing or body piercing.

8.0 Consent

Capacity to Consent: All young people over the age of 16 years should be assumed to have capacity unless there is a documented reason to suspect that there is doubt about their capacity. Best practice is to have a pre-test discussion to establish informed consent although lengthy counselling is no longer required. In the event where there is uncertainty around capacity – an assessment of capacity under the Mental Health Capacity Act 2005 should be undertaken.

A young person whom has capacity to consent but refuses the test should have the decision respected, unless there are exceptional circumstances. There should be a sensitive discussion (with appropriate health professional) whereby the young person can provide reasons why they do not wish to undertake the test, so that any questions and/or uncertainties can be answered. The case may be referred to the courts for legal advice and the young person should be informed of the course of action and rationale for this.

If there is any doubt as to who has capacity to consent, or dispute between those who can consent, legal advice should be sought.

All discussions and actions should always be documented in the case record.

Children Accommodated under Section 20 of the Children Act 1989 (Voluntary Agreement): The child's parents hold and retain parental responsibility. Young people should be included in the pre-test discussion (dependent upon age) although their birth parents should provide the consent.

Children in the care of the local authority subject to a care order: There will be an arrangement whereby, local authority holds ultimate responsibility for the child, although best practice will be to arrange discussion around consent to medical treatment between the parent and local authority. The local authority can exercise control if this is indicated. A Senior Social Work Manager will provide the consent.

Children placed for adoption: When a placement order is made – the parents do not lose parental responsibility but the local authority can restrict their exercise of it.

Once the child is placed for adoption, Parental Responsibility is shared by the birth parents, prospective adopters and local authority - with the local authority having the ability to decide how far the prospective adopters and birth parents can exercise Parental Responsibility. There would be a placement plan specifying whether the prospective adopters can consent to medical treatment. A partnership approach would be good practice.

Children subject to an Emergency Protection Order or Police protection Order: An Emergency Protection Order gives the local authority the same level of parental responsibility as an Interim Care order.. A police Protection Order does not confer parental responsibility, but will provide authority for the police to obtain emergency medical treatment. If any other form of treatment or assessment is required for the child and parental consent cannot be obtained, this would require an Emergency Protection Order or Interim Order.

Special Guardianship Order: A special guardianship order (SGO) can provide a child with a legally secure and stable relationship.

A SGO lasts until the young person's eighteenth birthday. The Special Guardian may exercise parental responsibility to the exclusion of all others apart from another Special Guardian. .

The intention is that the Special Guardian will have clear responsibility for all day to day decisions about the care of the child.

Whilst birth parents retain their legal rights, their ability to exercise parental responsibility is severely limited.

9.0 Confidentiality

A child's BBI (including HIV status) is confidential to the child / young person.

Respecting the confidentiality of individuals around BBI testing is essential in order to comply with legal duties and responsibilities around information sharing but also to protect the individual from discrimination and potential experiences of stigma.

Ethical issues arise around informing the mother of a positive test result (if she herself has not been tested) as this may have considerable implications for her own health, her partners health and other children. For this reason the child's mother should give consent for the test. In the event that the mother is not competent to give consent consideration needs to be given whether disclosure is justified in the 'public interest', i.e. protecting others outweighs the individual's right to privacy.

The Golden rules and key principles for information sharing: Information sharing should always be necessary, proportionate, relevant, adequate, accurate, timely, secure and recorded.

There is no obligation to automatically inform any other institution, for example, school that a child has a positive BBI result, unless the child is deemed to be at risk of significant harm if disclosure is not made or if disclosure is in the public interest domain – each case will need careful consideration and discussions should be fully documented. Legal advice should be always be sought if there is uncertainty about disclosing information in relation to blood-borne infections.

Conclusion

The organisation should follow best practice for local guidance. This is underpinned by national guidance and also aligns to CQC guidance and regulations.

The values of the CQC standards should be threaded throughout the care delivery process by all those working with children and young people in care.

All professionals working with children and young people should ensure **Safety** is at the forefront of service delivery. Protection and prevention against avoidable harm must be key elements within the care episode.

The treatment and support young people receive should be **Effective**, based on best achievable evidence in order to help them to achieve good outcomes and a good quality of life

Professionals should have a **Caring** approach which involves children, young people and or parents / carers in their care and treat people with compassion, kindness, dignity and respect.

Services should be **Responsive** and proactive so that they are organised in a way that meets individual needs.

The assurance of the above standards will underpin the governance structures that are required to ensure a Well**-led -** organisation with strong leadership and management for the delivery of high quality person centred care and one that supports learning and innovation and promotes an open and fair culture.

Thanks and Acknowledgements to:

Dr Mark Kealy: Consultant in Public Health Devon

Dr Deborah Freedman: Designated Doctor Children in Care and Community Paediatrician (Plymouth).

Dr Wendy Forbes: Consultant Paediatrician – Medical Advisor for Adoption & Fostering and Named Doctor for Children in Care (Exeter).

Dr Myfanwy Giblin: Associate Specialist Paediatrician / Designated Doctor for Looked After Children & Adoption (South Devon &Torbay CCG).

Dr Farah Tanvir Speciality Grade Community Paediatrician (North Devon).
Di Dymond: Designated Nurse Children and Young People in Care (Plymouth).

Document Reference: Care Quality Commission Essential Standards of Quality and Safety

Safe: People are protected from abuse and avoidable harm.

Effective: People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Caring: Staff involve and treat people with compassion, kindness, dignity and respect.
Responsive: Services are organised so that they meet people's need.

Well-led: Leadership, management and governance of the organisation assures the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture.

Linked strategies, policies and other documents

British Association for Adoption & Fostering (BAAF) 2008 Practice Note 53 Guidelines for the testing of looked after children who are at risk of a blood borne infection, London

National Children's Bureau (NCB) May 2016 *Practice guidance: supporting young people with HIV testing and prevention* (Emily Hamblin).

Unaccompanied asylum seeking children and young people (UASC) May 2016 Dr G Siggers

BAAF, Practice Note 53

Appendix B Version Control Sheet

Version	Date	Main author(s)	Individuals/ groups consulted	Significant changes	Legislation/national guidance /best practice etc. reflected
Draft V1	April 2008		Drafted by Service Improvement Manager to working party for comment	Process for testing standardised	(BAAF) 2008 Practice Note 53 Guidelines for the testing of looked after children who are at risk of a blood borne infection, London
Draft 2 – Draft 6	May – December 2008		Viewed, amended and final document agreed	As above	
V7 Final	December 2010		Reviewed & updated by Professional Lead Social Care Andrea Morris & Designated Nurse Children in Care Gwyneth Nightingale	Process agreed for blood testing for BBIs across areas	
Draft V7.1 - Draft 3	September - November 2016		Drafted by Designated Nurse for consultation with Public Health and Named Doctors / Paediatricians for their comment	Process updated in line with national guidance	Unaccompanied asylum seeking children and young people (UASC) May 2016
V7. 4 Final	November 2016		Viewed & amended by working group and final document agreed	As above	DOH 2015 promoting the health and well-being of Looked After Children
V7.5	December 2016		Care Effectiveness & Safeguarding Committee	As above	National Children's Bureau (NCB) May 2016 *Practice guidance: supporting young people with HIV testing and prevention*