



# Management of Respiratory Type Viruses

This procedural document supersedes: PAT/IC 10 v.8 – Management of Respiratory Influenza Type Viruses.



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## Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
9	22 October 2018	<ul style="list-style-type: none"> <li>Updated evidence</li> <li>Added POCT</li> <li>Updated Hyperlinks</li> <li>Added Appendix 1. When to use a surgical face mask or FFP3 respirator, and removed 'Whats the difference between a mask and a respirator'</li> </ul>	Carol Scholey
8	2 March 2016	<ul style="list-style-type: none"> <li>Revised title to take out Influenza heading</li> <li>Expansion on symptom definition</li> <li>Headed section for PPE with integral visor/ mask use</li> <li>Added section on virology diagnostic testing</li> <li>Added section with hyperlink to PHE Influenza Antiviral Prophylaxis and Treatment</li> <li>Added section on the management of Middle East Respiratory Syndrome Coronavirus (MERS-CoV)</li> </ul>	Julie Hartley
7	31 July 2013	<ul style="list-style-type: none"> <li>New style Trust format included.</li> <li>Enhanced guidance on use of FFP3 masks</li> <li>Staff vaccination</li> <li>Sections within the contents page have been 'Booked Marked' to relevant page.</li> </ul>	Maurice Madeo
6	January 2010	<ul style="list-style-type: none"> <li>This policy supersedes and replaces: PAT/IC 10 v.5 – Infection Control Guidelines for Care of Patients Admitted with Suspected Severe Acute Respiratory Syndrome (SARS) – <b>PLEASE READ IN FULL</b></li> </ul>	Maurice Madeo
5	August 2008	<ul style="list-style-type: none"> <li>Universal Precautions changed to Standard Precautions throughout the</li> </ul>	Infection Prevention and Control Team

		<p>policy.</p> <ul style="list-style-type: none"> <li>• Aims, Duties and Education sections added.</li> <li>• PPE list updated – page 13</li> </ul>	
4	August 2006	<ul style="list-style-type: none"> <li>• Page 4 – Communicable Disease Consultants contact numbers updated</li> </ul>	<p>Infection Prevention and Control Team</p>

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## 1. INTRODUCTION

Respiratory infections are common, principally causing colds in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract. However, these can progress and cause more severe infections and even death. There is a wide variety of viral causes of respiratory infection including rhinoviruses, respiratory syncytial virus, influenza viruses A, B and C, para-influenza viruses and coronaviruses. There are also newly emerging respiratory corona viruses such as Severe Acute Respiratory Syndrome (SARS) or more recently MERs Middle eastern respiratory syndrome that may result in a pandemic event. In this event latest guidance would be sought from the Public Health England as advice will change dependant on the infecting agent and mode of spread.

## 2. PURPOSE

The purpose of this document is to provide concise guidance for all staff to minimize the potential risks of infection and to ensure prompt recognition of those patients who are at risk of infection. This document applies to all staff either employed or contracted within in-patient areas in Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust.

## 3. DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues for Trust staff this includes:-

- Employees
- Volunteers
- Agency/Locum/Bank Staff
- Contractors whilst working on the Trust premises

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the standards set out in the Policy to ensure that they adhere to best practice. They need to be aware of their personal responsibilities in preventing the spread of infection. It is the responsibility of Directors and Managers to ensure compliance with this standard.

## 4. INDIVIDUAL AND GROUP RESPONSIBILITIES

Seasonal influenza vaccine is strongly recommended for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients.

### **Trust Board**

The Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manages the risks associated with Infection Control. Their role is to support

the implementation of a Board to Ward culture to support a Zero Tolerance approach to Health Care Associated Infections.

**Director of Infection Prevention and Control:** Is responsible for the development of infection and prevention and control strategies throughout the Trust to ensure best practice.

The Director of Infection Prevention and Control will provide assurance to the board that effective systems are in place.

**The Infection Prevention and Control Team:** is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

**Matrons:** are responsible for ensuring implementation within their area by undertaking regular audits in ward rounds activities. Any deficits identified will be addressed to comply with policy.

**Ward and Department Managers:** are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.

**Consultant Medical Staff:** are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles contained in it at all times.

**On-call Managers:** are responsible for providing senior and executive leadership to ensure implementation of this policy.

## 5. KEY POINTS

Infected healthcare workers and visitors are potential sources of infection by respiratory viruses. Influenza vaccine is recommended for all front line clinical staff each year as stipulated by the Department of Health to reduce risk of staff to patient transmission.

Infection can be acquired by direct and indirect contact and the airborne route. Transmission occurs from person to person by close contact, predominantly by large droplet/airborne respiratory secretions and /or contamination of hands. Standard and respiratory precautions must be maintained at all times.

Patients with a suspected upper respiratory tract infection (URTI), a history of travel and suspected exposure to infection with a new emerging or re-emerging infection and meet the clinical criteria below, must be nursed in a single room and the Infection Prevention Team informed.

Fever 38°C or more plus two or more of the following:

- cough (with or without sputum)
- nasal discharge or congestion
- sneezing
- Sore throat
- headache
- muscle or joint pains
- Chest pain

**Or** severe illness of sudden onset suggestive of an infectious process without another obvious or proven cause.

- On presentation to hospital, if the patient meets the above criteria, they must be isolated immediately (for step by step guidance see **below**).
- All staff should wear surgical face masks when within 3 feet of the patient. Correctly fit tested respirators (FFP3) **must** be worn during **aerosolizing procedures. (Appendix 1)**
- Staff must contact their local clinical educator / Matron for correct fitting of respirators.
- Surgical face masks should be removed and disposed of inside the patient room once more than one metre from the patient and be disposed of in a **closable** pedal operated clinical waste bin.
- FFP3 masks are available via supplies and made available to high risk units during peak activity.

<http://www.hse.gov.uk/respiratory-protective-equipment/>

Visitors with symptoms of respiratory infection must be discouraged from visiting.

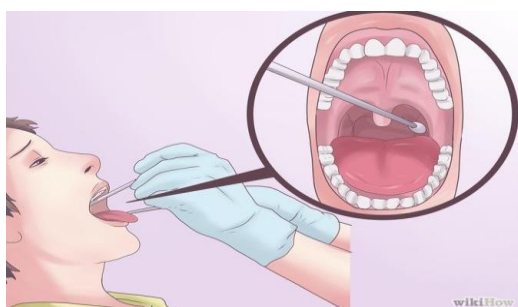
## 6. WHAT TO DO IF YOU HAVE A PATIENT WITH SUSPECTED VIRAL RESPIRATORY INFECTION

This purpose of this policy is to ensure that all staff within Doncaster & Bassetlaw Teaching Hospital takes prompt action in the management of any patient identified (or suspected) of having a RTI, by implementing general principles of infection prevention and control. During normal working hours advice must be sought from the Infection Prevention and Control Team (IPCT) on actions to be implemented, including isolating patients. Out of hours, advice must be sought from the on call Microbiologist. Please note that clinical care must not be compromised and discharge planning and services should continue, for example Dieticians, Therapies, Integrated discharge and Nursing home assessments can be undertaken during the acute phase of a RTI. Any patient admitted with a suspected virus such as influenza or respiratory syncytial virus (RVS) must be nursed immediately in a single room.

During an annual epidemic it may be necessary to cohort nurse symptomatic patients. Obtain relevant investigation to confirm illness at the earliest opportunity, including use of point of care testing (POCT) for influenza A & B and also RSV in children, or viral swab to be sent for diagnosis.

## 7. VIROLOGY DIAGNOSTIC TESTING

To test for influenza or other respiratory viruses **in adults** a green swab must be taken from the throat.

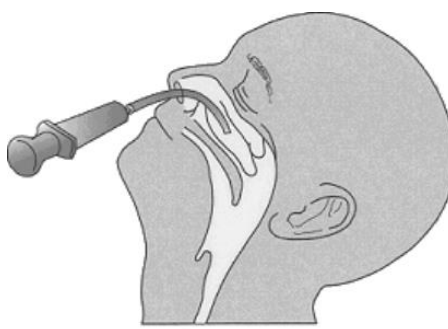


**Take the swab.** Take green virology swab and gently rub it against the back of the throat on the area near the tonsils. This ensures that a proper sample in the area is captured well onto the swab

**In children** to test for respiratory viruses a nasopharyngeal swab or aspirate is taken (commonly for respiratory syncytial virus RSV). The viral medium is in a green swab.

#### **Nasopharyngeal Aspirate Specimen Collection:**

- Insert tubing attached to syringe (or compressed bulb for infants) through nose and direct toward nasopharynx.
- Pull back on syringe (or decompress bulb for infants) to withdraw secretions
- Expel secretions into viral transport media



## **8. MANAGEMENT OF A PATIENT WITH VIRAL RESPIRATORY INFECTION**

### **8.1 Respiratory Isolation**

The patient must be nursed in a single room or cohort bay with the doors closed. Continue isolation for 7 days after the onset of clinical symptoms or until the patient is asymptomatic, if symptoms persist longer than 7 days isolation must be continued until these resolve. N.B. immunocompromised patients' may excrete viruses for a longer period; discuss management with the physician in charge of patient care and with IPC team/microbiologists.

Staff contact should be kept to a reasonable minimum without compromising patient care.

Effective hand hygiene before and after patient contact or contact with the patients' immediate environment. Please refer to the Trust PAT/IC 5 Hand Hygiene Policy.

### **8.2 Respiratory Hygiene/Cough Etiquette**

Actively encourage patients to cover their nose and mouth with disposable tissues when coughing, sneezing, wiping or blowing their nose and dispose of the tissue in a disposal bag on the bedside prior to be disposed of as clinical waste.

Encourage/assist the patient to clean their hands after coughing, sneezing, wiping or blowing their nose.



Restrict patient movement unless clinically indicated, if they need to travel to other areas within the hospital they should wear a surgical mask (if tolerated) at all times.

### 8.3 Personal Protective Equipment (PPE)

Health care workers delivering direct patient care must wear personal protective equipment (PPE):

- An integral combined visor and mask must be worn to protect from the risk of contamination by splashes, aerosols and droplets.
- A disposable apron must be worn whenever there is a risk of contamination by a patient's blood or bodily fluids and during activities that involve close patient contact.
- Long sleeved fluid repellent gowns must be worn if there is risk of excessive soiling.
- Disposable gloves must be worn when in direct contact with blood and body fluids including mucus.

### 8.4 Disposable Respirators (FFP3) for Aerosol Generated Procedures (AGP)

For suspected influenza a FFP3 mask must be worn where there is a risk of aerosolisation of respiratory secretions (**See appendix 3**).

According to PHE - **Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings**. Version 2 - October 2016. The following are classified as aerosol generating procedures (AGP):

- intubation, extubation and related procedures; for example, manual ventilation and open suctioning
- cardiopulmonary resuscitation
- bronchoscopy (unless carried out through a closed circuit ventilation system)
- surgery and post-mortem procedures in which high-speed devices are used
- non-invasive ventilation (NIV) eg bilevel positive airway pressure ventilation (BiPAP)
- continuous positive airway pressure ventilation (CPAP)
- induction of sputum

The following procedures are **not** classified as aerosol generated procedures:

Certain other procedures/equipment may generate an aerosol from material other than patients' secretions but are NOT considered to represent a significant infectious risk. Procedures in this category include:


- obtaining diagnostic nose and throat swabs
- administration of pressurised humidified O<sub>2</sub>
- administration of medication via nebulisation

Chest physiotherapy is **not** considered an AGP but a surgical mask should be worn by the patient if tolerated and Health Care Workers should wear PPE as recommended for routine care (surgical mask) during the procedure.

All PPE must be disposed of as clinical waste in the patient's room, once more than one metre from the patient, dispose of in a **closable** pedal operated clinical waste bin.

### 8.5 Linen

Linen must be treated as infected by placing it in a red soluble bag inside a white plastic bag tied and sealed at the point of use.

<p><b>Infected linen</b></p>	<p>All used and soiled linen including patient wear from patients with known infections or suspected infectious.</p>	<p>Put in to a <b>red soluble (alginate) bag</b> and tie, then into a <b>WHITE</b> polythene bag</p> <p>CFPP 0104 states the <b>outer bag must be tied and secured around the neck of the bag with tape which indicates 'Infected linen'</b></p>	<p><b>Red Soluble Bag</b> <i>Inside a White Polythene Bag</i></p>	
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### 8.6 Environmental Cleaning

All floors and flat surfaces must be cleaned twice daily with the recommended disinfectant, currently this is Difficil S. Communal clinical equipment must be cleaned after each use.

An Isolation door notice must be displayed at all times. The door to the isolation room **must** remain closed at all times.

### 8.7 Ending Isolation

Isolation of the patient may be discontinued after 7 days of the onset of clinical illness providing symptoms are no longer present, if symptoms persist for longer than 7 days isolation should be continued until these resolve.

N.B. Immunocompromised patients (and children) may excrete viruses for a longer period. The IPC team may be contacted for advice.

## 9. INFLUENZA ANTIVIRAL TREATMENT AND PROPHYLAXIS

For the latest PHE guidance on the use of antiviral agents for the treatment and prophylaxis of influenza.

[PHE guidance on the use of antivirals](#)

## 10. MANAGEMENT OF MIDDLE EAST RESPIRATORY SYNDROME CORONAVIRUS (MERS-COV)

Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. They have also been detected in blood, faeces and urine and, under

certain circumstances, airborne transmission is thought to have occurred from aerosolised respiratory secretions and faecal material.

As coronaviruses have a lipid envelope, a wide range of disinfectants and detergents are ineffective. Personal protective equipment and good infection control are extremely useful in preventing the spread of the infection.

If a patient fitting the case definition for possible MERS-CoV is admitted ([see MERS-CoV Case Algorithm](#)), infection control personnel should follow transmission-based precautions (droplet and contact precautions), the full details of which can be found in the Public Health England Document. <https://www.gov.uk/government/publications/merscov-infection-control-for-possible-or-confirmed-cases>

In addition, given that MERS-CoV has been detected in faeces, enteric precautions should also be followed.

Infection control personnel should be notified immediately of any possible or confirmed cases of MERS-CoV admitted or diagnosed whilst in care.

The samples required for the testing for MERS-CoV will be advised by the microbiologist and virologist.

In addition to standard precautions, infection control measures for inpatients should include:

Airborne precautions, e.g.:

- Either an isolation room with negative-pressure relative to the surrounding area or a single room with own bathroom and toilet facilities.
- Use of FFP3 respirators conforming to EN 149:2001 for persons entering the room. Fit testing should be undertaken prior to using this equipment.
- Contact and droplet precautions (including use of long-sleeved fluid-repellent gown and latex or similar non-latex gloves with long tight-fitting cuffs for contact with the patient or their environment).
- Standard precautions to include careful attention to hand washing and hygiene.
- When caring for patients, clinicians should wear eye protection for all patient contact.
- Enteric precautions
- Standard precautions when handling any clinical waste, which must be placed in leak-proof clinical waste bags or bins and disposed of safely.
- Laundry should be classified as infected.

## 11. MEMBERS OF STAFF – STAFF VACINATION

Seasonal influenza vaccine is strongly recommended for all front line clinical staff on an annual basis. It is the responsibility of all front line clinical staff to access this service in order to minimise the risk to patients.

Staff suffering from persistent, unexplained respiratory symptoms, especially following foreign travel, must report to their General Practitioner and should not attend work. Staff suspected and/or diagnosed with a communicable respiratory disease must inform the occupational health service and their line manager immediately.

## 12. VISITORS

All visitors with symptoms of respiratory disease should be discouraged from visiting especially in high risk units such as neonatal unit – see **Appendix 2**

## 13. TRAINING/ SUPPORT

The training requirements of all staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead or nominated person.

IPC must be included in individual Annual Development Appraisal and any training needs for IPC addressed.

Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources:-

- Trust Policies and Procedures available on the intranet
- Infection Prevention & Control web-site on the intranet
- Ward/departmental/line managers
- As part of the mandatory SET training.
- Infection Prevention and Control Educational displays/ posters
- Trust Infection Prevention and Control Team
- Ward link practitioners

## 14. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

It is the responsibility of all department heads/professional leads to ensure that the staff they manage adhere to this policy. The Infection Prevention and Control Team will review this policy in the following circumstances:-

- When new national or international guidance are received.
- When newly published evidence demonstrates need for change to current practice.
- Every three years routinely.

Incidents where non-compliance with this policy is noted and are considered an actual or potential risk should be documented on an Adverse Incident and near miss report form.

Monitoring	Who	Frequency	How Reviewed
The policy will be reviewed in the following circumstances:-	APD Process Group IPCT	Every three years routinely, unless: <ul style="list-style-type: none"> <li>• When new national or international guidance are received.</li> <li>• When newly published evidence demonstrates need for change to current practice.</li> </ul>	Approved Procedural Document (APD) database Policy will be approved and ratified by the

		<ul style="list-style-type: none"> <li>Action required from Root Cause Analysis Serious Incident Investigation Report</li> </ul>	Infection Prevention and Control Committee
Compliance with policy to negate cross-infection	The Infection Prevention and Control Practitioners	Weekly	“Alert organism review” to monitor adherence with the policy.
Effective hand hygiene	Hand hygiene audits completed by ward/ department staff	Monthly	Deficits identified will be addressed via agree action plan to comply with policy.
Environmental cleanliness	Audits completed by domestic teams IPC environmental audits	According to risk category for each ward/ department	Deficits identified will be addressed via agree action plan to comply with policy.
Clinical equipment cleaning and room cleaning check list	Cleaning checklist completed by ward staff. Isolation checklist completed by Hotel service worker	Daily/twice daily while isolation required	Via IPC system (Ward Accreditation Dashboard) and cleaning checklist outside patients room

## 15. DEFINITIONS

URTI – Upper Respiratory Tract Infection

RSV – Respiratory Syncytial Virus

FFP3 respirator – Filter Face Piece Respirator Mask

AGP – Aerosol Generating Procedures e.g. intubation. Open suction

## 16. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Impact Assessment Policy and the Fair Treatment For All Policy – CORP/EMP 27.

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. ( **Appendix 3**).

## 17. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

PAT/IC 5 - [Hand Hygiene](#)

PAT/IC 16 – [Isolation Policy](#)

PAT/IC 19 – [Standard Infection Prevention and Control Precautions Policy](#)

PAT/IC 21 – [Laundry Policy – Bagging Procedure for Linen](#)

PAT/IC 24 – [Cleaning and Disinfection of Ward based Equipment Policy](#)

PAT/PA 19 - [Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards \(DoLS\)](#)

PAT/PA 28 - [Privacy and Dignity Policy](#)

## 18. REFERENCES

Public Health England (2019) PHE guidance on the use of antiviral agents for the treatment and prophylaxis of seasonal influenza

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/773369/PHE\\_guidance\\_antivirals\\_influenza.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/773369/PHE_guidance_antivirals_influenza.pdf)

Public Health England (August 2018) Infection Control Advice Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/732267/Algorithm\\_case\\_v31-Aug2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/732267/Algorithm_case_v31-Aug2018.pdf)

Public health England Middle East Respiratory Syndrome (MERS-CoV) Infection Prevention and Control Guidance September 2016

<https://www.gov.uk/government/publications/merscov-infection-control-for-possible-or-confirmed-cases>

The Use of Face Masks & Respirators during an Influenza Pandemic: Scientific Evidence Base Department of Health 2014.

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/316198/Masks\\_and\\_Respirators\\_Science\\_Review.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/316198/Masks_and_Respirators_Science_Review.pdf)

Public Health England (2013) Latest guidance on pandemic influenza.

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/PandemicInfluenza/>

Public Health England. Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings



Version 2 - October 2016

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/585584/RTI\\_infection\\_control\\_guidance.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585584/RTI_infection_control_guidance.pdf)

## APPENDIX 1

### WHEN TO USE A SURGICAL FACE MASK OR FFP3 RESPIRATOR

When caring for patients with **suspected or confirmed infectious respiratory virus**, all healthcare workers need to – prior to any patient interaction – assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk.

When to use a surgical face mask		When to use an FFP3 respirator
		
In cohorted area (but no patient contact)	Close patient contact (within one metre)	Carrying out potentially infectious aerosol generating procedures Where a patient is known/suspected to have an infection spread via the aerosol route When caring for patients known/suspected to be infected with a newly identified respiratory virus
<b>For example:</b> Cleaning the room, equipment cleaning, discharge patient room cleaning, etc.	<b>For example:</b> Providing patient care, direct home care visit, diagnostic imaging, phlebotomy services, physiotherapy, etc.	<b>For example:</b> bronchoscopy, endotracheal intubation, tracheostomy procedures, cardiopulmonary resuscitation, diagnostic sputum induction;
<b>PPE to be worn</b>	<b>PPE to be worn</b>	<b>PPE to be worn</b>
<ul style="list-style-type: none"> <li>• Surgical face mask (along with other designated PPE for cleaning)</li> </ul>	<ul style="list-style-type: none"> <li>• Surgical face mask</li> <li>• Apron</li> <li>• Gloves</li> <li>• Eye protection (if risk of contamination of eyes by splashes or droplets)</li> </ul>	<ul style="list-style-type: none"> <li>• FFP3 respirator</li> <li>• Gown</li> <li>• Gloves</li> <li>• Eye protection</li> </ul>
		<ul style="list-style-type: none"> <li>• Fit testing should be carried out by a properly trained competent fit tester.</li> </ul>

These images are for illustrative purposes only. Always follow the manufacturer's instructions.

### Remember

- PPE should be put on and removed in an order that minimises the potential for cross-contamination.
- The order for PPE removal is gloves, apron or gown, eye protection, surgical face mask or FFP3 respirator.
- Hand hygiene must always be performed following removal of PPE.
- Healthcare workers who have had influenza vaccination, or confirmed influenza infection, are still advised to use the above infection control precautions.



APPENDIX 2

COUGHS AND SNEEZES SPREAD DISEASES

# Coughs and sneezes spread diseases



always carry  
tissues



cover your  
coughs and  
sneezes



throw used  
tissues in  
a bin



always clean  
your hands

## Stop germs spreading



### APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING

APPENDIX 3 – EQUALITY IMPACT ASSESSMENT - PART 1 INITIAL SCREENING				
Service/Function/Policy/Project/ Strategy	Division/Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
The Management of Respiratory Influenza Type Viruses.	Corporate Nursing, infection Prevention & Control	Carol Scholey, Lead Nurse, Infection Prevention & Control	Existing Policy	September 2018
1) <b>Who is responsible for this policy?</b> Infection Prevention & Control Team				
2) <b>Describe the purpose of the service / function / policy / project/ strategy?</b> Policy Updated using the latest evidence to promote the screening and management of respiratory type viruses				
3) <b>Are there any associated objectives?</b> Public Health England Policy				
4) <b>What factors contribute or detract from achieving intended outcomes?</b> Nil				
5) <b>Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief?</b> No				
<ul style="list-style-type: none"> <li>• <b>If yes, please describe current or planned activities to address the impact</b> [e.g. Monitoring, consultation]</li> </ul>				
6) <b>Is there any scope for new measures which would promote equality?</b> [any actions to be taken]				
7) <b>Are any of the following groups adversely affected by the policy?</b>				
<b>Protected Characteristics</b>	<b>Affected?</b>	<b>Impact</b>		
a) Age	No	Neutral		
b) Disability	No	Neutral		
c) Gender	No	Neutral		
d) Gender Reassignment	No	Neutral		
e) Marriage/Civil Partnership	No	Neutral		
f) Maternity/Pregnancy	No	Neutral		
g) Race	No	Neutral		
h) Religion/Belief	No	Neutral		
i) Sexual Orientation	No	Neutral		
8) <b>Provide the Equality Rating of the service / function /policy / project / strategy</b> – tick (✓) outcome box				
Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4	
Date for next review: September 2021				
Checked by: Kenneth Agwuh			Date: September 2018	