Management of Respiratory Type Viruses

This procedural document supersedes: PAT/IC 10 v.7 – Management of Respiratory Influenza Type Viruses.

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The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.

<table>
<thead>
<tr>
<th>Author/reviewer: (this version)</th>
<th>Julie Hartley</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date written/revised:</td>
<td>December 2015</td>
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<tr>
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<td>Infection Prevention and Control Committee</td>
</tr>
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</tr>
<tr>
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<td>December 2018</td>
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<td>Trust Wide</td>
</tr>
</tbody>
</table>
## Amendment Form

<table>
<thead>
<tr>
<th>Version</th>
<th>Date Issued</th>
<th>Brief Summary of Changes</th>
<th>Author</th>
</tr>
</thead>
</table>
| 8       | 2 March 2016      | • Revised title to take out Influenza heading
• Expansion on symptom definition
• Headed section for PPE with integral visor/ mask use
• Added section on virology diagnostic testing
• Added section with hyperlink to PHE Influenza Antiviral Prophylaxis and Treatment
• Added section on the management of Middle East Respiratory Syndrome Coronavirus (MERS-CoV) | Julie Hartley           |
| 7       | 31 July 2013      | • New style Trust format included.
• Enhanced guidance on use of FFP3 masks
• Staff vaccination
• Sections within the contents page have been ‘Booked Marked’ to relevant page. | Maurice Madeo           |
| 6       | January 2010      | • 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) – PLEASE READ IN FULL | Maurice Madeo           |
| 5       | August 2008       | • Universal Precautions changed to Standard Precautions throughout the policy.
• Aims, Duties and Education sections added.
• PPE list updated – page 13 | Infection Prevention and Control Team |
| 4       | August 2006       | • Page 4 – Communicable Disease Consultants contact numbers updated | Infection Prevention and Control Team |
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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) 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 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 fitted respirators (FFP3) must be worn during aerosolizing procedures.
- Staff must contact their local clinical educator / Matron for correct fitting of respirators.
- All masks are to be removed outside the patient’s room and be disposed of in a designated closable pedal operated clinical waste bin.
- FFP3 masks are available via supplies and made available to high risk units during peak activity.


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

Any patient admitted with a suspected virus such as influenza or respiratory syncytial virus (RVS) must be nursed immediately in a single room.

During a RSV annual epidemic it may be necessary to cohort nurse symptomatic patients.

### 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 Hand Hygiene.

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. The following are classified as AGP by the World Health Organization (2009):
• Intubation and related procedures, e.g. manual ventilation
• Respiratory and airway suctioning (including tracheostomy care and open suctioning with invasive ventilation)
• Cardiopulmonary resuscitation
• Bronchoscopy
• Collection of lower respiratory tract specimens (e.g. bronchial and tracheal aspirates)
• Post mortem procedures

The following procedures are not classified as aerosol generated procedures:
• Mechanical ventilation or respiratory therapy treatment unless an AGP is being performed on an open system
• Closed suctioning with invasive ventilation
• Non-invasive positive pressure ventilation (BiPAP)
• Bi-level positive airway pressure (BPAP)
• Nasopharyngeal aspiration
• Nebulisation (but only if this procedure can be performed in an area physically separate from other patients)

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, except the respirator/surgical mask worn by staff which must be removed outside the room and disposed of in a closable clinical waste bin.

8.5 Linen

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

All floors and flat surfaces must be cleaned twice daily with Difficil S. Communal clinical equipment must be cleaned after each use.

A standard precautions 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 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.

Click here to open link

Advice on management of patients WITH or SUSPECTED of having flu - see attached document: PAT IC 10 v 8 - Flu Management

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 Infection Control Advice Middle East Respiratory Syndrome Coronavirus (MERS-CoV).

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 VACCINATION

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

All clinical staff must undertake Infection Prevention & Control training in line with training department’s guidance.

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

- Trust Induction
• 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 infection control education sessions that Trust staff attend.
• 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.

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Who</th>
<th>Frequency</th>
<th>How Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with policy to negate cross-infection</td>
<td>The Infection Prevention and Control Practitioners</td>
<td>Weekly</td>
<td>“Alert organism review” to monitor adherence with the policy.</td>
</tr>
<tr>
<td>Standard and respiratory precautions maintained at all times</td>
<td>By IPT and dedicated responsible health care worker</td>
<td>For the duration of symptoms</td>
<td>Deficits identified will be addressed to comply with policy.</td>
</tr>
<tr>
<td>Patient to be nursed in single room /cohort bay</td>
<td>By IPT and dedicated responsible health care worker</td>
<td>Duration of isolation</td>
<td>Patient documentation records.</td>
</tr>
<tr>
<td>Effective hand hygiene</td>
<td>Hand hygiene audits completed by ward/ department staff</td>
<td>Monthly</td>
<td>Deficits identified will be addressed via agree action plan to comply with policy.</td>
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<tr>
<td>Environmental cleanliness</td>
<td>Maximiser audits completed by domestic teams IPC environmental audits</td>
<td>According to risk category for each ward/ department</td>
<td>Deficits identified will be addressed via agree action plan to comply with policy.</td>
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</table>
Clinical equipment cleaning

<table>
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<tr>
<th>Cleaning checklist completed by ward staff</th>
<th>Daily</th>
<th>Via IPC system (Ward Accreditation Dashboard)</th>
</tr>
</thead>
</table>

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. (See 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 (June 2013) Infection Control Advice Middle East Respiratory Syndrome Coronavirus (MERS-CoV)

Pandemic (H1N1) influenza: a summary of guidance for infection control in healthcare settings

The Use of Face Masks during an Influenza Pandemic: Scientific Evidence Base Department of Health 2011.

http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/PandemicInfluenza/
APPENDIX 1 –
WHAT IS THE DIFFERENCE BETWEEN A MASK AND A RESPIRATOR?

**Masks** - The main purpose of a mask is to help prevent particles (droplets) being expelled into the environment by the wearer and are also resistant to fluids. They help protect the wearer from splashes of blood or other potentially infectious substances. They are not necessarily designed for filtration efficiency, or to seal tightly to the face.

**Respirators** - are intended to help reduce the wearer’s exposure to airborne particles. They are made to defined national standards, such as the United States NIOSH-approved N99 respirator, or the similar (but not identical) European standard EN149:2001 FFP3 respirator. The standards define the performance required of the respirator, including filtration efficiency. When worn correctly, they seal firmly to the face, thus reducing the risk of leakage. (Source – HPA Guidance Information on Face Masks & Respirators)

European Standard EN 149 defines the following classes of “filtering half masks” (also called “filtering face pieces”) that is, respirators that are entirely or substantially constructed of filtering material:

<table>
<thead>
<tr>
<th>Class</th>
<th>Filter penetration limit (at 95 L/min air flow)</th>
<th>Inward leakage</th>
</tr>
</thead>
<tbody>
<tr>
<td>FFP1</td>
<td>Filters at least 80% of airborne particles</td>
<td>&lt;22%</td>
</tr>
<tr>
<td>FFP2</td>
<td>Filters at least 94% of airborne particles</td>
<td>&lt;8%</td>
</tr>
<tr>
<td>FFP3</td>
<td>Filters at least 99% of airborne particles</td>
<td>&lt;2%</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>Service/Function/Policy/Project/ Strategy</th>
<th>Care Group/Executive Directorate and Department</th>
<th>Assessor(s)</th>
<th>New or Existing Service or Policy?</th>
<th>Date of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Management of Respiratory Influenza Type Viruses.</td>
<td>Corporate Nursing, infection Prevention &amp; Control</td>
<td>Julie Hartley, Infection prevention &amp; Control Practitioner</td>
<td>Existing Policy</td>
<td>11/1/16</td>
</tr>
</tbody>
</table>

1) **Who is responsible for this policy?** Infection Prevention & Control Team

2) **Describe the purpose of the service / function / policy / project/ strategy?** Policy Updated using the latest evidence to promote the screening and management of respiratory type viruses

3) **Are there any associated objectives?** Public Health England Policy

4) **What factors contribute or detract from achieving intended outcomes?** Nil

5) **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?** No

   - If yes, please describe current or planned activities to address the impact [e.g. Monitoring, consultation]

6) **Is there any scope for new measures which would promote equality?** Any actions to be taken

7) **Are any of the following groups adversely affected by the policy?**

<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>Affected?</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Age</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>b) Disability</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>c) Gender</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>d) Gender Reassignment</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>e) Marriage/Civil Partnership</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>f) Maternity/Pregnancy</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>g) Race</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>h) Religion/Belief</td>
<td>No</td>
<td>Neutral</td>
</tr>
<tr>
<td>i) Sexual Orientation</td>
<td>No</td>
<td>Neutral</td>
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</tbody>
</table>

8) **Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box**

<table>
<thead>
<tr>
<th>Outcome 1 ✓</th>
<th>Outcome 2</th>
<th>Outcome 3</th>
<th>Outcome 4</th>
</tr>
</thead>
</table>

   *If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a Detailed Equality Analysis form in Appendix 4

**Date for next review:** December 2018

**Checked by:** J T Hartley **Date:** 11/1/16