Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Hazard Group 4 Viral Haemorrhagic Fevers

This procedural document supersedes: PAT/IC 32 v.5 – Hazard Group 4 Viral Haemorrhagic Fevers

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Author/reviewer: (this version)	Dr A Ellwood – SpR Infectious Diseases Dr P Morris – Consultant in Infectious Diseases
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Approved by:	Infection Prevention and Control Committee
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Next review date:	November 2025
Target audience:	Trust-wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
6	October 2022	• Redrafting of text, update of terminology and contact details.	Dr A Ellwood -Infectious Diseases SpR Dr P Morris - Consultant in Infectious Diseases
5	October 2019	• No new changes	Dr K Agwuh –Consultant Microbiologist
4	December 2016	• Update of Current Trust Structure from clinical Service Units to Care Groups • Update of VHF Algorithm section 7A • Update of cut-off temperature ≥37.5°C	Dr K Agwuh – Consultant Microbiologist
3	August 2014	• Update on the viral Haemorrhagic fevers risk assessment flowchart page:10	Dr K Agwuh – Consultant Microbiologist
2	January 2013	• New style Trust format included • Completely revised policy due to new guidance: • The management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence: Advisory Committee on dangerous Pathogens, July 2012	Dr K Agwuh – Consultant Microbiologist
1	April 2011	• New Policy, please read in full	Dr K Agwuh – Infection Prevention and Control

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1 INTRODUCTION

Viral Haemorrhagic Fevers (VHFs) refers to a group of illnesses that are caused by several distinct families of viruses and are endemic in a number of areas of the world. These include parts of Africa, South America, Eastern Europe and the Middle East. The term VHF is usually applied to disease caused by *Filoviridae* (Ebola and Marburg haemorrhagic fever), *Flaviviridae* (yellow fever, dengue, Kyasanur forest disease, Alkhurma and Omsk haemorrhagic fever), *Arenaviridae* (Lassa fever, Junin and Machupo haemorrhagic fever) and *Bunyaviridae* (Crimean-Congo, Rift Valley and Hantaan haemorrhagic fever).

They can cause severe and life-threatening disease with high case-fatality rates. The incubation period ranges from 2-21 days. Symptoms include fever - up to 41^{o}C, malaise, headache, myalgia and arthralgia. Other symptoms such nausea, diarrhoea, vomiting, shock and haemorrhage can also occur, especially during the latter stages of illness. There is currently no effective treatment for VHFs (although a vaccine is available for yellow fever), the emphasis of care is supportive

The risk of person-to-person transmission of VHF is highest during the latter stages of infection. There is a risk of secondary infection with these diseases, particularly among hospital and laboratory staff. Accidental inoculation may occur from needle stick or contamination with infected blood or body fluids to broken skin or mucous membrane. **Therefore, strict infection control precautions are required to protect those who may be exposed.** Epidemiological studies of VHF on humans indicate that the airborne route does not readily transmit the infection, therefore the Advisory Committee on Dangerous Pathogens (ACDP) now recommend flexibility in the isolation of a patient with a VHF infection within a High-Level Isolation Unit (HLIU) in the UK.

This policy is directed at the ACDP Hazard Group 4 VHF viruses [Table 1]

Table 1: HAZARD GROUP 4 VIRAL HAEMORRHAGIC FEVER VIRUSES:

Family	Virus	Geographical distribution	Transmission routes/vectors
Flaviviridae	**Kyasanur forest disease**	**India, Western districts of Karnataka state.**	Bite of infected tick (*Haemaphysalis spinigera*) contact with infected animals
	Alkhurma haemorrhagic fever	**Saudi Arabia, Mecca, Jeddah, Jizan, Najran regions.**	Contact with infected animal, bite of infected

	Omsk haemorrhagic fever	**Russian Federation, Novosibirsk region of Siberia**	tick or mosquito
			Bite of infected tick (*Dermacentor reticulatus*) Person-to-person

Bunyaviridae		**Crimean Congo haemorrhagic fever**	**Central and Eastern Europe, Central Asia, the Middle East, East and West Africa**	Bite of infected tick (commonly Hyalomma ticks), contact with infected patients, their blood, fluids, and tissues
Filoviridae		**Ebola**	**Western, Central and Eastern Africa**	Contact with an infected animal Contact with infected human blood and body fluid
		Marburg	**Central and Eastern Africa**	As above (animals; fruit bats)
Arena-viridae	**Old world**	**Lassa**	**West and Central Africa**	Contact with excreta or inhalation of aerosols of infected multimammate rat (Mastomys spp.)
		Lujo	**South Africa**	Contact with infected human blood and body fluid, sexual contact

				Transmission to index patient unknown, via blood or body fluids
	New world	**Chapare** **Junin** **Sabia** **Guanarito** **Machupo**	**Bolivia (one case to date)** **Argentina, Pampas region** **Brazil (one case to date)** **Central Venezuela** **North-eastern Bolivia, Beni**	Direct bite of an infected rat or mouse Directed contact with, or contamination of human food by, the excreta of an infected rat or mouse Inhalation of aerosols of the infected excreta of a rat or mouse <u>Muchupo and Guanarito:</u> Contact with blood & body fluids

2 PURPOSE

This policy aims to assist staff working in the emergency department and medical admission units of the hospital, who may assess patients who require “fever in the returning traveller” work up. These patients may have stayed in countries where VHFs are endemic and thus this diagnosis requires consideration at the outset. Whilst clinical assessment remains an important part of the review, epidemiology is essential in guiding appropriate infection control precautions and processing of samples to prevent healthcare workers and lab staff acquiring infection, or putting other inpatients at risk from onward transmission. This Policy should be read in conjunction with other Infection Control Policies, particularly Hand Hygiene (PAT/IC 5), Isolation Policy (PAT/IC 16) and Standard Precautions (PAT/IC 19).

3 DUTIES AND RESPONSIBILITIES

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the standards set out in the Policy. They need to be aware of

their personal responsibilities in preventing the spread of infection and should also continually assess whether they personally meet the required standards.
It is the responsibility of Divisions and Managers to ensure compliance with this standard. Infection Prevention and Control should be included in an individual's Annual Professional Development Appraisal.

Permanent staff groups include:
Managers
Medical Staff
Nursing Staff
Allied Health Professional Hotel and Site Services Staff
Administration Staff

Divisions: Ensuring the policy is adhered to and for ensuring action is taken if staff fail to comply with the policy

Matrons: Policy implementation assurance will be checked by reviewing audit results undertaken by the Infection Prevention and Control (IPC) Team and Ward Staff

Ward and Department Managers: Ensuring all staff have read the policy and implement this within their area. Ward and Department managers will ensure the required number of assurance audits are undertaken as part of the IPC accreditation scheme

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

Director of Infection Prevention and Control: Implementing infection, prevention and control strategies throughout the Trust for embedding best practice

Board of Directors: Ensuring the implementation of a Board to Ward culture and to support a Zero Tolerance approach to Health Care Associated Infections

PATIENTS LACKING CAPACITY
Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which is discriminatory
- Any act done for, or any decision made on behalf of, a patient who lacks capacity must be done, or made, in the person's Best Interest (see definitions page 14)
- Further information can be found in the MCA policy and the Code of Practice, both available on the intranet

There is no single definition of Best Interest. Best Interest is *determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.*

4 MODE OF TRANSMISSION

The following routes can transmit VHF person-to-person:

- Direct contamination with body fluids such as vomit, urine and stool on broken skin or mucous membranes
- Secretions of the respiratory tract if the patient coughs
- Direct contamination with blood on broken skin or mucous membrane or via needle stick injury

5 PATIENT ASSESSMENT AND CATEGORISATION

In the UK the following people are at risk of infection from VHF:

(i) Individuals with a travel history to endemic VHF areas
(ii) Individuals exposed to a patient or animal with VHF (including their blood, body fluids or tissues)

(iii) Workers in a laboratory handling VHF samples

It is a legal obligation to perform a risk assessment for VHF in appropriate patients (see below). The Control of Substances Hazardous to Health (COSHH) regulations require employers to assess risk to their employees in the workplace. The risk to staff may change over time, depending on the symptoms of the patient, diagnostic tests results and/or information from other sources. Patients with confirmed VHF can deteriorate rapidly.

The risk assessment should be done by an Emergency Department or admitting team consultant, in consultation with the duty Microbiologist who can advise on whether a patient can be admitted locally or whether transfer to the Infectious Diseases team in Sheffield is appropriate. A VHF risk assessment should be performed on those who present with a:

- **Temperature** ≥ 37.5°C (or with subjective fever in the previous 24 hours) AND
- **Travel history or epidemiological exposure** AND
- Symptoms began within **21 days** of travel to VHF endemic areas, VHF risk by country can be assessed here: https://www.gov.uk/guidance/high-consequence-infectious-disease-country-specific-risk

The ACDP's VHF risk assessment algorithm (See page 10) assists in categorising cases of VHF as highly unlikely, possible, highly possible or confirmed to have a VHF However, in most cases this can be dismissed on epidemiological grounds alone.

The following information should be obtained from the patient:

- Date of return to the UK
- Date of onset of illness
- Details of illness
- Country and places visited
- Reason for the visit - any visit to rural areas?
- Any contact with illness consistent with VHF?
- Any contact with rodents, in particular rats?
- Any consumption or importation of bush meat into the country?
- Did the patient take anti-malarial prophylaxis regularly? Is malaria endemic in the area travelled?

The categorisation of patients according to level of infectivity and risk is important in the management of suspected case of VHF:

5.1 Highly unlikely to have a VHF:

- Patients who have not travelled to endemic areas before the onset of illness
- Patients who have travelled to endemic areas or had contact with a known or suspected source of VHF (human or animal), but in whom the onset of illness occurred > 21 days after their last contact with this source; (Consider funeral attendees, carers and conservation workers)
- Patients whose malaria screen in the UK is negative, and the patient is apyrexial after more than 24 hours
- Patients whose malaria screen in the UK is positive, and they are responding to anti-malarial therapy appropriately
- Patients who have an alternative diagnosis confirmed and the patient is responding appropriately

The risk of VHF in the following group of patients should be reassessed if there is an adequate exposure history, they are failing to improve and they develop one or more of the following symptoms or complications:

- Bloody diarrhoea
- Epistaxis
- Falling platelet count
- Sudden rise in aspartate transaminase (AST)
- Increasing oxygen requirement in the absence of another diagnosis
- Shock

5.2 Possibility of VHF

Send an urgent malaria screen and local diagnostic investigations e.g. urine, blood cultures, stool MC&S or CXR as normal. The lead clinician should be the responsible physician for managing the patient

Patients who have a negative malaria screen, with ongoing temperatures of ≥ 37.5°C and history of travel to at-risk areas without a diagnosis:

- Initiate a VHF screen
- Continue other investigation and daily assessment
- Contact the Infectious Diseases Unit at Sheffield or HLIU

5.3 High possibility of VHF

The lead clinician should be the responsible physician for managing the patient
Send an urgent malaria and VHF screen in EDTA (purple topped) and clotted (gold topped) blood tubes. Continue with other local investigation as appropriate, but with additional laboratory precautions:

- Informing the laboratory staff before a sample is sent
- Keep the number of specimens sent to the laboratory to the minimum necessary for any investigation

Enhanced infection control measures appropriate to the symptoms of the patient should be in place e.g. bleeding, uncontrolled vomiting or diarrhoea.
See flow chart page 11.

If the malaria test is negative, inform the local health protection team (HPT) about the highly possible case. Check the patient's post code at https://www.gov.uk/health-protection-team to ensure the correct team is rung

York and Humber HPT:

- In hours: 0113 386 0300
  2254 524
- Out of hours: 0151 9091219
  0344 2254 524

East Midlands HPT (BDGH cases):

- In hours: 0344
- Out of Hours:

A positive VHF test will require urgent transfer to a High-Level Isolation Unit (HLIU) formerly known as High Security Infectious Diseases Unit (HSIDU) - see below

5.4 Confirmed VHF

Patients who have a positive VHF screen should be managed in an HLIU except where transfer of the patient is prevented by exceptional circumstances. Discussion with the Infectious Diseases consultant on-call (24-hour phone line) at the HLIU to arrange transfer should be undertaken by the lead physician. See Section 9 page 12 for contact details.

Both The Royal Victoria Infirmary (Newcastle) and The Royal Free (Hampstead) have HLIUs.

Additional advice can be sought from the Imported Fever Service (after discussion with local microbiologist/infectious diseases doctor) on 0844 778 8990.
Full public health action in place (see flow chart page 11)
Testing of specimens after transfer of the patient to be in a dedicated HLIU laboratory.

5.5 Blood Sampling

Prior to taking any blood samples for investigation, please ensure that an appropriate patient risk assessment for VHF has been done. See PPE box in the ED or AMU for VHF risk assessment, or diagram below. Fill out a form to accompany samples to be sent to the laboratory for processing. **NOTE:** samples may not be processed if the form is not signed by a consultant and discussed with a microbiologist.

6 VIRAL HEMORRHAGIC FEVERS RISK ASSESSMENT VERSION 6

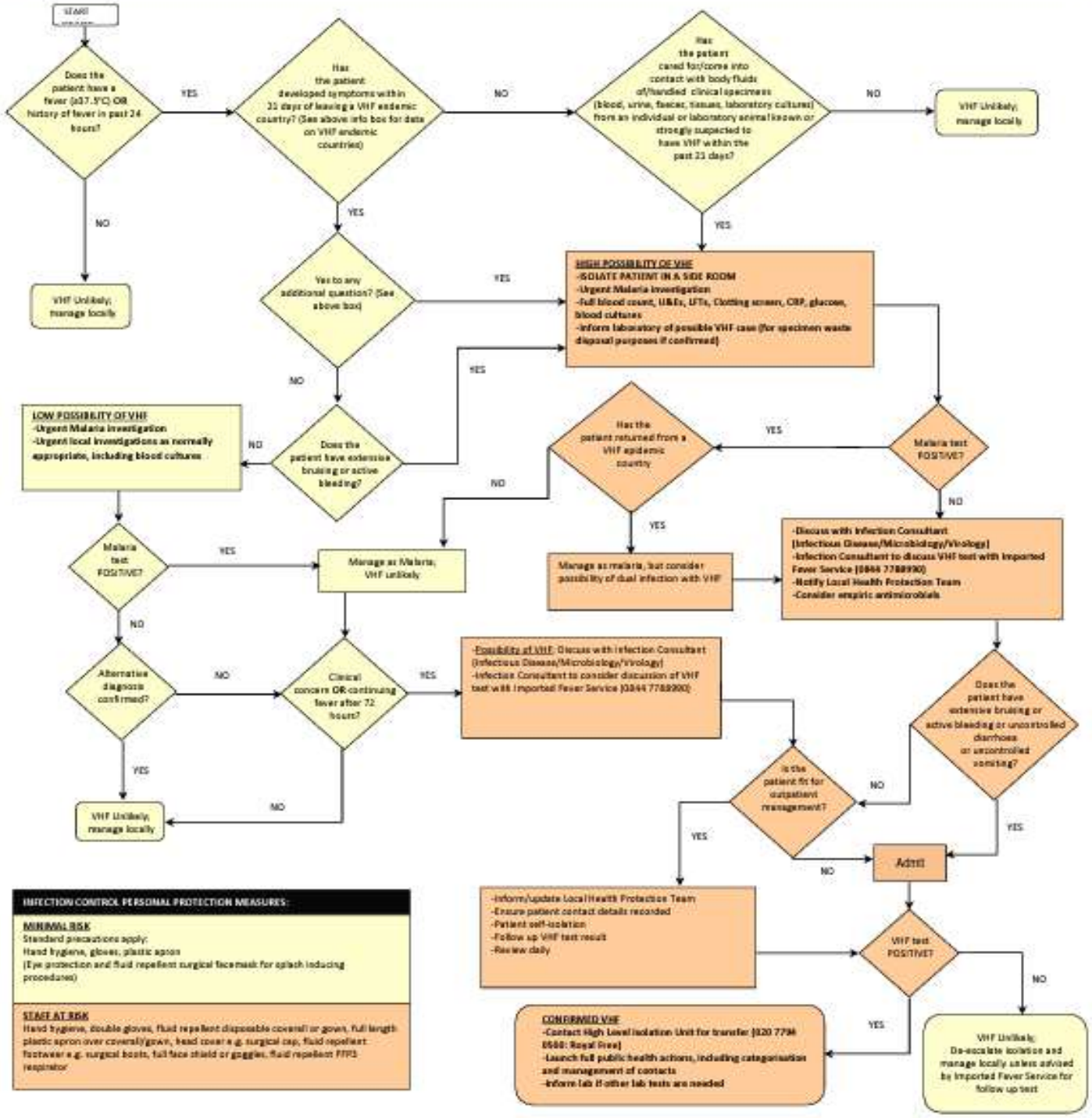
VIRAL HAEMORRHAGIC FEVERS RISK ASSESSMENT (Version 6: 15.11.2015)

VHF ENDEMIC COUNTRIES:

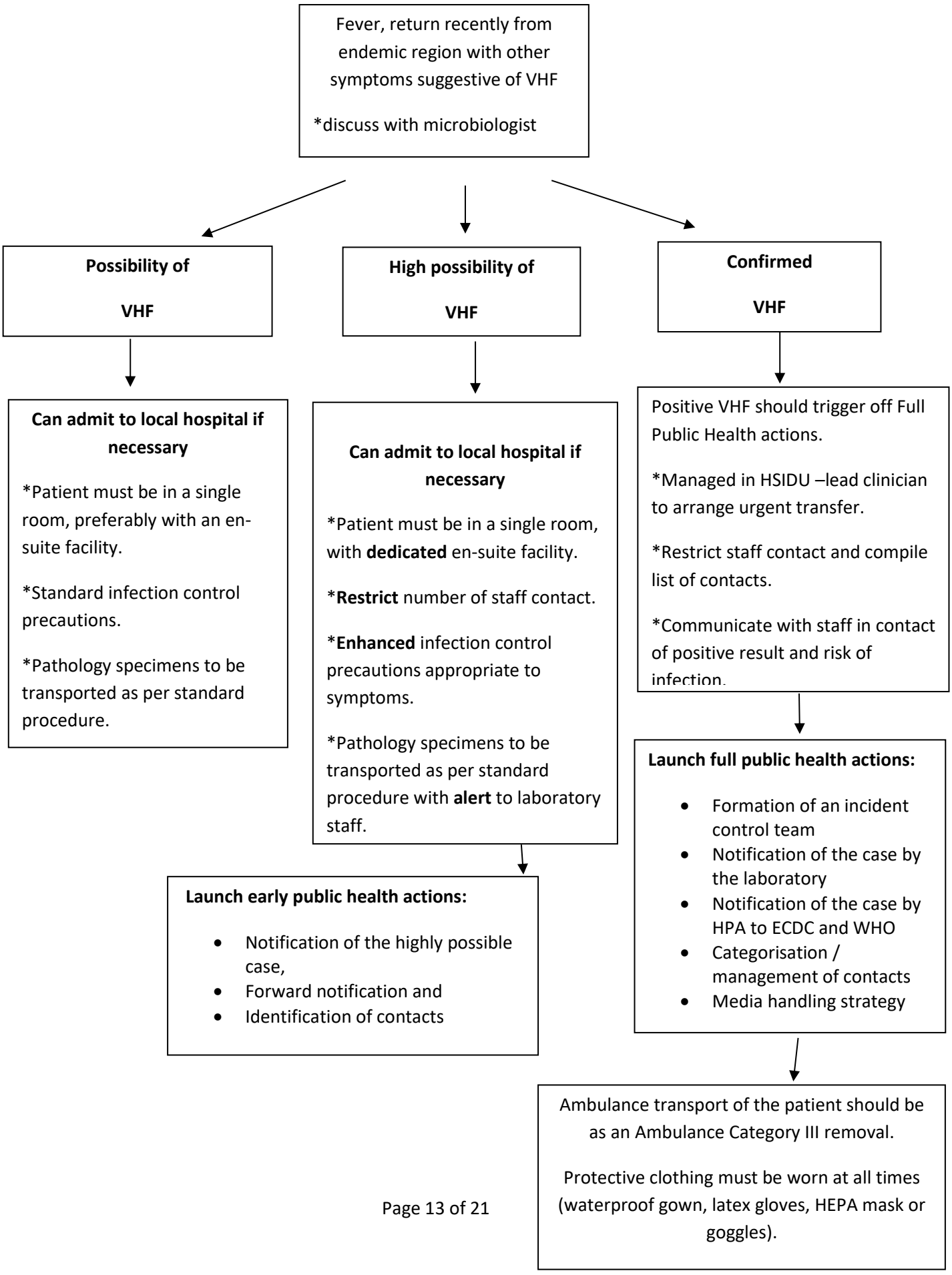
Information on VHF endemic countries can be found at https://www.gov.uk/viral-haemorrhagic-fevers-origins-reservoirs-transmission-and-guidelines
or see VHF in Africa map at http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365845/VHF_Africa_960_640.png

ADDITIONAL QUESTIONS:

-Has the patient travelled to any area where there is a current VHF outbreak? (http://www.promedmail.org/) **OR**
-Has the patient lived or worked in basic rural conditions in an area where Lassa Fever is endemic? (https://www.gov.uk/lassa-fever-origins-reservoirs-transmission-and-guidelines) **OR**
-Has the patient visited caves / mines, or had contact with or eaten primates, antelopes or bats in a Marburg / Ebola-endemic area? (https://www.gov.uk/ebola-and-marburg-haemorrhagic-fevers-outbreaks-and-case-locations) **OR**
-Has the patient travelled in an area where Crimean-Congo Haemorrhagic Fever is endemic (http://www.who.int/csr/disease/crimean_congoHF/Global_CCHFRisk_20080918.png?ua=1) AND sustained a tick bite* or crushed a tick with their bare hands OR had close involvement with animal slaughter? (*If an obvious alternative diagnosis has been made e.g. tick typhus, then manage locally)



7 INFECTION CONTROL MANAGEMENT



8 DISINFECTION AND DECONTAMINATION

Linen from patients with a suspected VHF must be double bagged and treated as "infected" PAT/IC 21. It is anticipated the linen will be incinerated. The disinfectants currently used within the Trust for dealing with blood and body fluids are peracide and a chlorine-based disinfectant: Haz Tabs.

Peracide is an agent that contains peracetic acid as the active chemical and is rapidly effective against viruses, fungi, bacteria and spores. Peracide is used for routine environmental /equipment cleaning on the wards, and high-risk areas such as the emergency department. Peracide may be used on blood spillages, refer to Spillage of Blood and other Body Fluids policy PAT/IC 18.

A chlorine-based disinfectant (Haz Tabs) is used within outpatients departments and communal areas outside the wards. Haz Tabs disinfectant solution is expressed as parts per million (ppm) of available chlorine. A dilution of 10,000 ppm is required for treating blood spillages.

It may be necessary to quarantine the room utilised by High Possibility VHF patients for up to 24 hours if the patient is being tested for any causes of VHF at another hospital. If the diagnosis is confirmed, then specific advice on decontamination and waste disposal will be provided by the IPC team and waste manager. It is advisable to keep used linen and waste within the room until the final result is available or liaise with the waste manager officer.

9 ADDRESSES AND TELEPHONE NUMBERS

High Level Isolation Units (HLIUs)

The Royal Free
Hampstead NHS Foundation Trust
Pond Street
London
NW3 2QG
Tel: 0207 7940500 or 0844 8480700

The Royal Victoria Infirmary
Newcastle Upon Tyne NHS Foundation Trust
Queen Victoria Road
Newcastle
NE1 4LP
Tel: 0191 233 6161

Ask for: Infectious Disease Consultant on-call (this is a 24-hour phone line)

Rare and imported Pathogens Laboratory (RIPL) – for viral screen

UK Health Security Agency
Microbiology Services Division
Manor Farm Road, Porton Down
Wiltshire
SP4 0JG
Tel: +44 (0)1980 612100 (24 hour)

OR in unusual circumstances, where the RIPL lab is not available, samples may be directed to the Viral Reference Department, Colindale:

UK Health Security Agency
Virus Reference Division
61 Colindale Avenue
London
NW9 5HT
Tel: 020 8327 6017 or 020 8200 4400 or (0)20 8200 6868 (24 hour)

10 TRAVEL HEALTH NETWORK

Further information on recent outbreaks of infections around the world can be obtained on the National Travel Health Network http://www.nathnac.org/

11 TRAINING/SUPPORT

It is recommended that Infection Prevention and Control should be included in individual Annual Development Appraisal and any training needs for IPC addressed.

Please note: The training requirements of staff will be identified through a learning needs analysis (LNA). Role specific education will be co-ordinated/ delivered by the topic lead. Alternatively, training may be accessed via an approved e-learning platform where available.

12 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

The Infection Prevention and Control Team will review this policy in the following circumstances:

What is being Monitored	Who will carry out the Monitoring	How often	How Reviewed/ Where Reported to
The policy will be reviewed in the following circumstances	Consultant microbiologist or appropriate other	Every three years routinely, unless When newly published evidence demonstrates need for change to current	Approved Procedural Document (APD) database Policy will be approved and ratified by the Infection Prevention and Control Committee

		practice	
Compliance with policy to negate cross-infection	The Infection Prevention and Control Practitioners	Weekly	"Alert organism review" to monitor adherence with the policy. 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.
Training needs for infection prevention and control	Ward and Department Managers Training and Education Department	Annually	Staffs Professional Development Appraisal. Attendance will be captured by the OLM system.

13 DEFINITIONS

VHF - Viral Haemorrhagic Fevers.
Endemic - (in relation to disease) constantly present to a greater or lesser degree in a particular locality
Incubation Period - from the moment of exposure to an infectious agent until signs and symptoms of the disease appear
Best Interest Assessment - A Best Interest assessment is determined on an individual patient basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision must be in the best interest of the individual. Please see S5 of the MCA code of practice for further information

14 EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and

assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

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 2)

15 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

This policy should be read in conjunction with other Trust Policies and protocols for the prevention and control of HCAI in line with the Health and Social Care Action 2008. In particularly:

- Control of Substances Hazardous to Health (COSHH) Guidance - CORP HSFS 7
- Glove Use Policy - CORP/HSFS 13
- Hand Hygiene - PAT/IC 5
- Health and Safety at Work - Medical Surveillance - CORP/HSFS 2
- Isolation Policy - PAT/IC 16
- Medical Devices Management Policy - CORP/PROC 4
- Medical Equipment Training Policy - CORP/RISK 2
- Mental Capacity Act 2005 Policy and Guidance, including Depravation of Liberty Safeguards (DoLS)- Policy and Guidance including Deprivation of Liberty – PAT/PA 19
- Privacy and Dignity Policy – PAT/PA 28
- Selection and Procurement of Medical Devices Policy - CORP/PROC 3
- Spillage of Blood and other Body Fluids PAT/IC 18
- Standard Infection Prevention and Control Precautions Policy PAT/IC19
- Waste Management Policy - CORP/HSFS 17 (A)
- Waste Management Manual – CORP/HSFS 17 (B)
- Mobile Communications Policy – CORP/HSFS 16
- Fair Treatment For All Policy - CORP/EMP 4
- Equality Analysis Policy - CORP/EMP 27

16 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the UK General Data Protection Regulation (GDPR) 2021.

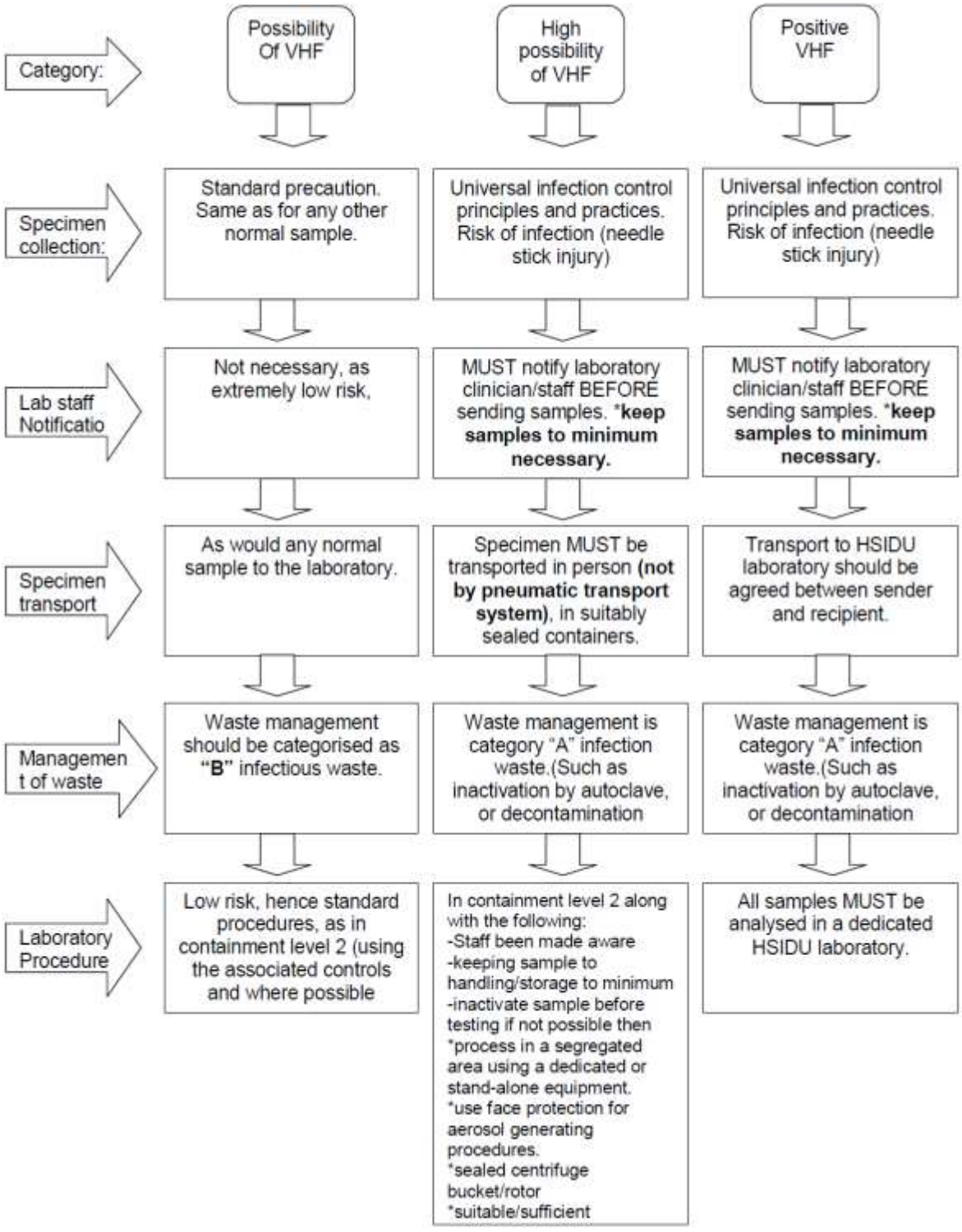
For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:
https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

17 REFERENCES

Department of Constitutional Affairs Mental Capacity Act (2005): Code of Practice, 2007
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/497253/Mental-capacity-act-code-of-practice.pdf

Management of Hazard Group 4 viral haemorrhagic fevers and similar human infectious diseases of high consequence: Advisory Committee on Dangerous Pathogens, November 2015.
https://www.gov.uk/guidance/viral-haemorrhagic-fevers-origins-reservoirs-transmission-and-guidelines
https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid
https://www.gov.uk/government/publications/viral-haemorrhagic-fever-algorithm-and-guidance-on-management-of-patients
https://www.cdc.gov/vhf/index.html
https://wwwnc.cdc.gov/travel/yellowbook/2020/travel-related-infectious-diseases/viral-hemorrhagic-fevers
https://travelhealthpro.org.uk/factsheet/68/viral-haemorrhagic-fever

APPENDIX 1 - SPECIMEN COLLECTION AND HANDLING AND LABORATORY PROCEDURE



APPENDIX 2 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Hazard Group 4 Viral Haemorrhagic Fever	Corporate	Dr Paul Morris	Existing	February 2023

1) Who is responsible for this policy? Name of Division/Directorate: Infection Prevention & Control

2) Describe the purpose of the service / function / policy / project/ strategy? Who is it intended to benefit? What are the intended outcomes? Policy updated using latest evidence to promote the safe management of patients with suspected/ confirmed haemorrhagic fevers. It demonstrates the Trust commitment to provide staff with guidance maintain safe practice.

3) Are there any associated objectives? Legislation, targets national expectation, standards: Public Health England, World Health Organisation.

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? Details: [see Equality Impact Assessment Guidance] - 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] N/A

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

Protected Characteristics	Affected?	Impact
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) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

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 – see CORP/EMP 27.

Date for next review:	**October 2025**		
Checked by:	**Carol Scholey**	**Date:**	**06/04/2023**