Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Multi-Resistant Gram-Negative Bacteria (in particular CPE)

- Prevention and Control Policy

This procedural document supersedes: PAT/IC 28 v.6 – Multi-Resistant Gram-Negative Bacteria – Prevention and Control Policy

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Executive Sponsor(s):	Karen Jessop, Chief Nurse
Reviewer: (this version)	Dr Ken Agwuh, Director of Infection Prevention and Control/Consultant Microbiologist
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Target audience:	Trust Wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 7	December 2023	• Changes to screening • Changes to isolation • Changes to appendix 1 and 3 • New appendix 2	Dr K Agwuh
Version 6	19 April 2021	• Added Executive Sponsor, front page • Duties & Responsibilities updated Section 3 • Added section/s Patients Lacking Capacity and Data Protection • Updated roles and responsibilities on monitoring Compliance section 6	Dr K Agwuh
Version 5	21 February 2017	• Addition of PHE toolkit for Carbapenemase-producing Enterobacteriaceae on appendix 1. • Updating all relevant paragraphs with CPE, making reference to toolkit.	Dr K Agwuh
Version 4	14 January 2015	• Section 6.6 Procedure for taking rectal swab • References updated • Appendix 1 added re EIA form	Dr C Hoy
Version 3	15 October 2013	• Updated to new APD Format • Title change • Screening high risk patients	Dr C Hoy
Version 2	July 2010	• Duties • Individual and Group Responsibilities • Policy Monitoring and Audit	Infection Prevention and Control Team

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1. INTRODUCTION

Multi-resistant gram negative bacteria (MR-GNB) are by definition organisms exhibiting resistance to multiple classes of antimicrobial agents. The organisms most often associated with multi-resistance are, but not limited to, *Acinetobacter sp*, *Enterobacter sp*, *Escherichia coli*, *Klebsiella sp* and *Pseudomonas sp*.

Various resistance patterns are recognised amongst these organisms and form the basis of their classification: The **e**xtended **s**pectrum **b**eta-**l**actamase producing organisms (ESBL- producers) have the ability to hydrolyse, and are therefore resistant to, penicillins and broad-spectrum cephalosporins such as cefuroxime and cefotaxime. The major ESBL producers to date are *Escherichia coli* and *Klebsiella* species.

Multi-resistant *Acinetobacter* are isolates which are resistant to both an aminoglycoside (e.g. gentamicin) and a third generation cephalosporin (e.g. ceftazidime); when this pattern is combined with resistance to carbapenems (e.g. meropenem), such strains are labelled as MRAB-C strains.

Multi-resistant *Pseudomonas* are resistant to varying combinations of anti-pseudomonal antibiotics: ceftazidime, piperacillin/tazobactam, aminoglycoside, ciprofloxacin and carbapenems.

Recent change in taxonomy has included the *Enterobacteriaceae* within the order Enterobacterales. Enterobacterales are a large family of bacteria, including species such as *Escherichia coli*, *Klebsiella* spp and *Enterobacter* spp. that live harmlessly in the gut but are common causes of UTI, intra-abdominal and bloodstream infections. An emerging group of MR-GNB are the carbapenemase-producing Enterobacterales (CPEs). Carbapenems, such as meropenem and ertapenem, are a powerful group of broad spectrum antibiotics which in many cases are the last effective defence against multi-resistant infections. CPEs may occur in patients previously hospitalized in countries where producers are widespread, e.g. Turkey, Israel, Greece, Indian sub-continent and the USA. Over the last 5 years since previous guidelines, new evidence have shown patients are colonised with CPE before developing an invasive infection, with the screening for CPE considered cost effective. There has been a rapid increase in the incidence of infection and colonisation by multi-drug resistant CPEs in the UK, with a number of outbreaks reported. The management of infections with CPE increases not only length of hospital stay, but also as a consequence of morbidity and mortality when compared to bacteria not carrying resistance markers. A framework of actions to contain carbapenemase-producing Enterobacterales for the early detection, management and control of carbapenemase-producing Enterobacterales has been published by Public Health England.

All these multi-resistant gram-negative bacteria are detected by isolation from clinical specimens where they may occur as colonisers (present on skin/wounds etc but not causing infection) or cause true infection. MR-GNB have been implicated in outbreaks of infection in intensive care units, neonatal, and haematology/oncology units. The genes that confer antibiotic resistance can spread to other bacteria. Multi-resistance in these organisms limits the

therapeutic options available when they cause serious infections such as septicaemia and post-surgical sepsis.

2. PURPOSE

The aim of this policy is to prevent the emergence and spread of multi-resistant gram-negative bacteria within this Trust through infection control principles.

3. DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues and applies to all health care workers employed by the Trust that undertake patient care, or who may come into contact with affected patients.

Trust staff this includes:-

- Employees
- Agency/Locum/Bank Staff/Students
- Visiting/honorary consultant/clinicians
- Contractors whilst working on the Trust premises
- Volunteers

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. It is the responsibility of Divisional Directors and Managers to ensure compliance with this standard.

All staff working on Trust premises, outreach clinics and community settings, including Trust employed staff, contractors, agency and locum staff are responsible for adhering to this policy, and for reporting breaches of this policy to the person in charge and to their line manager.

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.

Divisional Management Teams: are responsible for monitoring implementation of this policy and for ensuring action is taken when staff fails to comply with the policy.

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.

Director of Infection Prevention and Control: is responsible for implementing infection and prevention and control strategies throughout the Trust for embedding best practice**.**

Board of Directors: their role is to support the implementation of a Board to Ward culture 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 can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest* see definitions.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

4. RISK FACTORS FOR INFECTION WITH MR-GNB

Risk factors for infection with multi-resistant gram-negative bacteria include:

- Antibiotic usage, particularly broad-spectrum agents
- Prolonged hospital stay
- Admission to ICU, renal or haematology/oncology units.

Endoscope-related transmissions of carbapenem-resistant organisms have been reported in the UK and France.

Transmission within hospitals mainly occurs on the hands of health care workers which have been contaminated by contact with colonised or infected patients, contaminated surfaces or fomites. Gram-negative bacteria may contaminate the environment around a patient and survive there for several days. Environmental contamination is increased when patients have diarrhoea or colonised skin lesions.

5. MANAGEMENT OF PATIENT WITH MR-GNB

Antimicrobial treatment of individual patients is based on clinical assessment and discussion with a Microbiologist who will advise on appropriate therapy whenever required.

- Colonisation with MR-GNB occurs in similar patterns to sensitive strains, superficial wounds, bed sores and decubitus ulcers being usual sites.
- Infection may be associated with intravenous or urinary catheters and management usually entails their removal.

- Isolation of ESBL-producing organisms from urine samples is increasing in frequency from the community.
- CPEs are often multi-resistant with limited therapeutic options for treatment; antibiotic management should be discussed with a Microbiologist. Monotherapy may be recommended for mild to moderate infection. Combination therapy is supported by outcome analysis for treatment of severe infections.

6. INFECTION CONTROL MEASURES

6.1 Isolation

The decision to isolate a patient with MR-GNB or CPE should be based on risk assessment and clinical needs, in full discussion with the Infection Control Team.

- All patients who, in the last 12 months, have been an in-patient in hospital aboard or UK hospitals known to have problems with the spread of CPEs or previous positive case should be isolated on admission. Refer to Appendix 1 and 2.
- Ideally patients with MR-GNB should be isolated in single rooms with en-suite facilities
- If single rooms are not available for every screened or known CPE-positive patient a risk assessment should be undertaken by the IPC and clinical teams to determine where to care for patients.
- Cohorting for CPE is recommended as a second line if isolation is not feasible.
- There is no recognised method of decolonisation for MR-GNB. Therefore isolation should continue whilst the patient is in hospital.
- The decision to de-isolate the patient will be made by a member of the Infection Prevention and Control team (IPCT) following a clinical risk assessment.

6.2 Hand Hygiene

Scrupulous attention to hand hygiene is the most important measure to control the spread of all organisms including antibiotic resistant organisms (Hand Hygiene policy (PAT/IC 5). Outbreaks of MR-GNB have been linked to poor hand hygiene.

- Hands should be decontaminated between each patient contact, including after removal of gloves.
- After contact has finished, staff must decontaminate their hands thoroughly using liquid soap and water followed by alcohol based hand rub.

6.3 Personal Protective Equipment

Health care staff should wear gloves when there is a possibility of direct contact with blood or body fluids, or contact with items in the environment that may be contaminated. Disposable

plastic aprons should be worn for close patient contact or procedures where contamination of clothing may occur (Standard Infection Prevention and Control Precautions Policy (PAT/IC 19).

6.4 Environmental and Equipment Cleaning

The environment around a patient may become contaminated with MR-GNB and this is increased when patients have colonized open wounds or respiratory secretions. Wards should be cleaned on a regular basis in accordance with hospital policy (MRSA Screening and Management of Patients with MRSA (PAT/IC 6)).

- The patient's environment must be kept clean and uncluttered to minimise dust accumulation and to facilitate effective environmental cleaning. Wards should be cleaned on a regular basis in accordance with trust policy.
- Isolation rooms or wards, including all equipment and horizontal surfaces, should be cleaned thoroughly following discharge of patients with MR-GNB.
- Bedding and curtains should be sent to the laundry following patient discharge.
- Where possible equipment should be single use, or should be cleaned in accordance with Trust policy. It is best practice to dedicate equipment to an isolated patient.

- Carbapenemase-producing Enterobacterales can be eliminated from the environment by strict adherence of normal standards of cleaning and decontamination. There must be a terminal decontamination following a patient leaving a specific area/isolation room. The following points are of particular importance:
    - Mattresses are especially important as sheets are not an effective barrier to passage of contamination patient-to-mattress or mattress-to-patient.
    - Bedframes, handrails and mattress covers should be cleaned then disinfected, and the integrity of the cover assessed; if the mattress cover is damaged, the mattress should be condemned. Pillows may also need to be replaced
    - Dynamic mattresses should be disassembled, cleaned and disinfected – usually by specialist external contractors or in specialist facilities within the hospital
    - Privacy curtains should be removed and laundered or be single-patient use only
    - All used or unused single-use items or consumables in the patient's immediate vicinity (that may have become contaminated by hand contact) should be discarded - keeping limited stocks near the patient reduces the need for this
    - Avoid having extraneous equipment in the individual's room
    - Tubes of ointment and lubricant should be discarded
    - Lavatory brushes and their holder should be disposed of as part of the discharge/terminal clean.

6.5 Control of Antibiotic Use

The emergence and spread of MR-GNB is encouraged by the use of broad-spectrum antimicrobials. Units affected by MR-GNB should review their antibiotic policy in conjunction with Microbiology especially in relation to limitation of intravenous therapy and automatic stop dates for antimicrobials.

6.6 Screening

All patients meeting the criteria for screen as stipulated in appendix 1 (page 13) should have a rectal specimen which are most sensitive for detecting the carriage of antibiotic resistant Enterobacterales. A single rectal screening swab is usually sufficient to determine CPE colonisation status on admission. However, in previously colonised patients, the Infection Prevention and Control Team may require additional screening swab if initial swab reported as negative.

Additional screening to identify colonised patients may also be recommended during outbreaks on the advice of the Infection Prevention and Control Team.

Procedure for taking a rectal swab:-

- Moisten swab with normal saline or medium if provided.
- Insert swab 3-4cms beyond the anal sphincter, rotating gently and removing.
- The swab should have visible faecal material to enable organism detection in the laboratory.
- Place swab into the tube deep enough that medium covers the cotton tips.
- Ensure labelled CPE screen.

Staff screening for carriage of MR-GNB and CPE is not usually recommended.

6.7 Movement/Transfer/Discharge of Patients

Transfer of patients with MR-GNB to other wards should be minimized to reduce the risk of spread, **but** this should not compromise other aspect of patient's care. All transfer should be discussed with a member of the IPCT prior to transfer.

If a patient with MR-GNB is transferred to another health-care institution the receiving clinical and Infection Control staff must be informed. The ambulance service should be notified as well.

In general, MR-GNB do not present a risk to healthy people in the community or patients in residential or nursing homes who do not have catheters, wounds or other lesions.

For CPE positive patients: Should the patient require diagnostic procedure or test, this should be undertaken in the patient's room if feasible. The procedure/test can be performed

elsewhere if not possible at the patient's room, but should be planned at a time when decontamination of equipment and the environment can be undertaken after the patient has vacated the area. If possible, remove any equipment not required for the procedure from the room to facilitate cleaning. It is important that appropriate cleaning is performed.
A practical solution in many settings is to place the patient at the end of the day's list; this however should not compromise other aspects of patient's care.

6.8 Death of Patient

No special precautions are required. The usual hygienic measures should be adequate.

7. 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. Please refer to the Mandatory and Statutory Training Policy (CORP/EMP 29) for details of the training needs analysis, as staff will require different levels of training.

8. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Monitoring	Who	How often	How Reviewed
The policy will be reviewed in the following circumstances:	IPC team	Every 3 years routinely, unless: - When new national or international guidance is received. - When newly published evidence demonstrates need for charge to current practice.	Policy approved by Infection Prevention and Control Committee
Compliance with policy to negate cross-infection	IPC practitioners	Weekly	"Alert organism" review
Training needs for infection prevention and control	Ward and department managers	Annually	Staff Professional Development Appraisal

9. DEFINITIONS

Best Interest - 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.

CPE – Carbapenemase-producing Enterobacterales are bacteria such as *E coli*, *Klebsiella* spp or *Enterobacter* spp which produce enzymes that destroy carbapenem antibiotics, such as meropenem, conferring resistance.

ESBL – Extended-spectrum beta-lactamases are enzymes produced by bacteria making them resistant to cephalosporin antibiotics such as cefuroxime, cefotaxime and ceftazidime.

MR-GNB - Multi-resistant gram-negative bacteria are organisms exhibiting resistance to multiple classes of antimicrobial agents.

10. 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 5)

11. 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 Act 2014

- Control of Substances Hazardous to Health (COSHH) Guidance - CORP HSFS 7
- 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 Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19
- 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/IC 19
- Waste Management Policy - CORP/HSFS 17 (A)
- Waste Management Manual – CORP/HSFS 17 (B)
- Fair Treatment For All Policy - CORP/EMP 4
- Equality Analysis Policy - CORP/EMP 27.

12 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/

13. REFERENCES

Framework of actions to contain carbapenemase-producing Enterobacterales: September 2022: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107705/Framework_of_actions_to_contain_CPE.pdf

HPA – Advice on carbapenemase producers: Recognition, infection control and treatment. http://www.hpaHPA - Guidance on carbapenem resistance producers.org.uk/webc/HPAwebFile/HPAweb_C/1294740725984

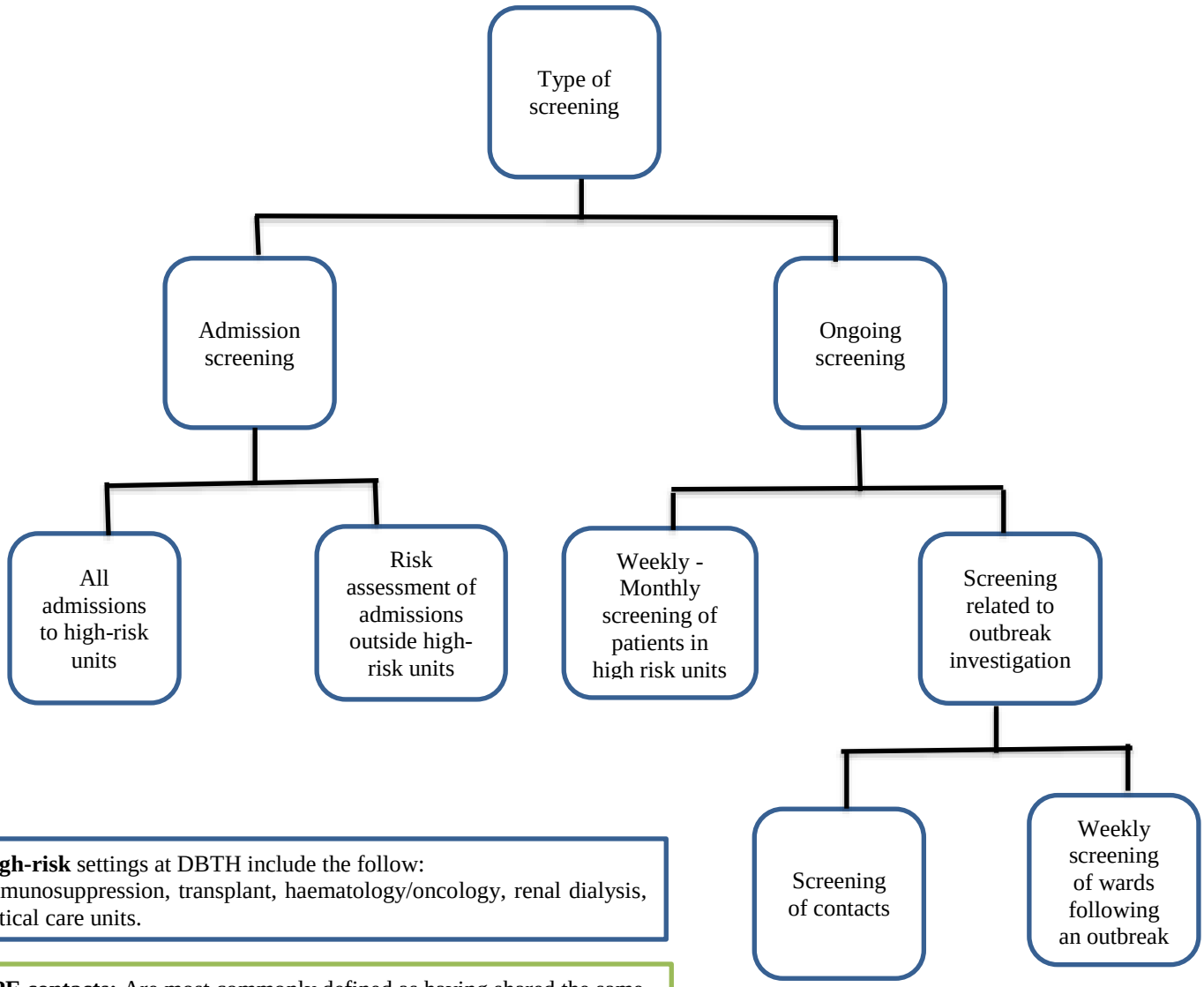
UK Standards for Microbiology Investigations (Detection of bacteria with carbapenem-hydrolysing beta-lactamases (carbapenemases): https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/919216/B_60i3.pdf

Kumarasamy K, Toleman MA, et al. Emergence of a new antibiotic resistance mechanism in India, Pakistan, and the UK: a molecular, biological, and epidemiological study. www.thelancet.com/infection. Published online on August 11, 2010 DOI:10.1016/S1473-3099(10)70143-2

APPENDIX 1 - CARBAPENEMASE –PRODUCING ENTEROBACTERALES SCREENING FOR CPE – THINK RISK IF PATIENT LIKELY FOR OVERNIGHT STAY IN HOSPITAL

R	Recent exposure to antibiotics	Patients that have received the following antibiotics in the previous month are at increased risk of CPE carriage: • Cephalosporins • Piperacillin/Tazobactam • Fluoroquinolones • Carbapenems • Those patients receiving OPAT
I	In the last 12 months	Screen if a patient: • Previously been identified as CPE positive • Was admitted to any hospital, in the UK or abroad • Has had multiple hospital treatment e.g. haemodialysis or receiving cancer chemotherapy
S	Specialty	Patients admitted to the following specialties should be screened: • Augmented care or • High-risk settings – immunosuppression, transplant, haematology/oncology, organ support, extensive care needs e.g. liver, burns unit • Long Term Care facilities where higher levels of interventional care are provided e.g. long term ventilation
K	Knowledge of local CPE transmission	Screen if patient if: • contact with a known case of CPE

APPENDIX 2 – ALGORITHM FOR ADMISSION AND ON-GOING SCREENING STRATEGIES FOR CARBAPENEMASE –PRODUCING ENTEROBACTERALES



High-risk settings at DBTH include the follow: Immunosuppression, transplant, haematology/oncology, renal dialysis, critical care units.

CPE contacts: Are most commonly defined as having shared the same clinical space (for example bay or less commonly ward) as a known CPE carrier, or indirect contact (for example contact with contaminated environment or equipment)

Outbreak screening: An enhanced period of screening is recommended during the outbreak period. As an example, the patients in the affected unit, bay or ward should be screened twice a week for 2 weeks, and weekly for a further 2 weeks, duration of screening to be guided by the IPC team.

NOTE

There is evidence that serial admission screening (repeat screening separated by specified time points) for CPE does not improve the rate of detection. However, repeat screening of long-stay patients may improve the identification of antibiotic-resistant Gram negative bacteria.

Summary of actions required:

- Inform patient of result
- Ensure patient is isolated in a single room with en-suite facilities
- Ensure standard infection control precaution and contact (transmission based) precautions are used
- Communicate to relevant clinical teams, IPC team, and others as per local policies
- Flag patient notes with result (also tag on CAMIS)
- Consider convening incident/outbreak control meeting if there is evidence of transmission in the ward/clinical area
- Identify and screen contacts as indicated
- Review clinical management including use of antimicrobials and devices (whether required)
- Communicate patient's positive status to GP and other health/care providers on discharge/transfer

APPENDIX 3 - RISK PRIORITISATION OF INFECTION PREVENTION AND CONTROL (IP&C) MEASURES, SCREENING AND ISOLATION

	Patient characteristic				
Care environment	Known CPE	Direct transfer from hospital abroad	Direct transfer from UK hospital / hospitalisation last 12 months	Epidemiological link/contact with known CPE	Care dialysis /chemo Oncology
Admission to specialist/augmented unit					
Admission to general acute ward					
Day/ambulatory care	**	**	**	**	**
Outpatient clinic	**	**			
Care/Residential homes					

High risk	Isolate immediately in a single room with en-suite (or dedicated commode or WC) and retain in isolation until screening results available and reported.
Medium risk	Isolate in single room with en-suite facilities (or dedicated commode or WC) if possible until screening available. If not possible (see increased transmission risks) to isolate in single room then nurse with ***strict emphasis*** on maintaining compliance with contact precautions and optimal environmental cleaning following discussion with IPC team **For outpatient and day cases – provide appointment timed for end of clinic or list; consider caring for day case in single room dependent on degree of contact with body fluids e.g. endoscopic procedure would pose greater risk of transmission. Maintain compliance with standard precaution and optimal environmental cleaning. In an outpatient setting, contact precaution should be instigated based on a risk assessment and in discussion with IPC team.
Low risk	No action, other than be alert to change in risk-level in light of any further information relating to patient status. Maintain compliance with standard IPC precautions and optimal environmental cleaning.
The following factors increase the risk of CPE transmission and should be considered when prioritising side rooms. Patient with: Diarrhoea, incontinence (urine or faeces), discharging wounds, medical devices in situ, ventilatory support requirements, high risk of wandering and poor hygiene.	

APPENDIX 4 - EARLY COMMUNICATION ON DISCHARGE OR MEDICAL TRANSFER OF PATIENTS WITH CPE

KEY MESSAGE:	
The patient so that they understand on discharge, their current status (eg infection cleared but may still be a carrier), and the need for good hand hygiene. That, should a close contact be admitted to hospital/healthcare setting for any reason, they need to inform healthcare staff of their exposure	
Alerting neighbouring trusts, commissioners, providers and the local Health Protection Team about CPE outbreaks	
Ensuring discharge letter to GPs and medical (inter-healthcare) transfer documentation to receiving organisations should detail CPE colonisation and infection status, or potential exposure to CPE in a ward environment e.g. if they are a bay contact of a CPE colonised patient, including outstanding screening information	
Communication with primary care providers and GPs is very important, as patients may access multiple local healthcare facilities for their care (including providing advice to GPs on actions that are needed e.g. coding as active problem)	
Communication of information on positive patients prior to patient transfer or discharge to all relevant healthcare professionals along the patient pathway e.g. district nursing teams	
Communicating with family/carers and/or the care facility to which the patient is to be discharged providing an accurate explanation of risk in a non-acute/community setting and IPC advice	

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Policy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Multi-Resistant Gram-Negative Bacteria	Corporate Nursing, IPC	Dr K Agwuh	Existing Policy	November 2023

1. Who is responsible for this policy? Infection Prevention and Control Team Corporate Nursing

2. Describe the purpose of the policy? The aim of this policy is to prevent the emergence and spread of multi-resistant gram-negative bacteria within this Trust through infection control principles.

3. Are there any associated objectives? Timely isolation of patients with or at risk of infection

4. What factors contribute or detract from achieving intended outcomes? None

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**

6. Is there any scope for new measures which would promote equality? N/A

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

Protected Characteristics	Affected	Impact
a. Age	No	
b. Disability	No	
c. Gender	No	
d. Gender Reassignment	No	
e Marriage/Civil Partnership	No	
f. Maternity/Pregnancy	No	
g. Race	No	
h. Religion/Belief	No	
i. Sexual Orientation	No	

8. Provide the Equality Rating of the service/ function/policy /project / strategy

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

9. Date for next review: April 2026

Checked by: Carol Scholey **Date: December 2023**