## Group A Streptococcal Infections - Policy for the Prevention and Control of

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<th>Monitoring Information</th>
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### Group A Streptococcal Infections - Policy for the Prevention and Control of

Ratified by: Infection Control & Decontamination Assurance Group: 2nd May 2018

Review date: November 2022

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**Full History**

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**Associated Trust Policies/procedural documents:**

- Source Isolation Policy and Procedure for Hospital Patients
- Major Outbreak Policy

**Key Words**

- Group A streptococcal Infection, GAS, Scarlet fever

**In consultation with and date:**

Medical Microbiologists, Infection Prevention & Control Team, Governance Managers, Corporate Managers, Department Managers, Service Managers, Senior Operational Managers, Lead Nurses, Senior Nurses, Matrons, Community DD and ADN, Equality Team: 21st February 2018

Infection Control and Decontamination Assurance Group: 2nd May 2018

PEP 30th May 2018

**Contact for Review:**

Lead Nurse/Director of Infection Prevention & Control

**Executive Lead Signature:**

Medical Director
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1. **INTRODUCTION**

1.1 Group A streptococci (GAS) are also known as *Streptococcus pyogenes* and cause a range of infections. Mild non-invasive infections include sore throats and skin infections such as impetigo are common and highly infectious. Invasive Group A Streptococcal (iGAS) infections, including necrotising fasciitis (NF) and toxin mediated conditions such as scarlet fever and streptococcal toxic shock syndrome (STSS) are serious and have a significant mortality.

1.2 The rate of GAS throat carriage in the healthy adult population is probably less than 5%, with most studies reporting a rate of about 1%. Research in 2003/4 showed that the annual rate of iGAS infection in England, Wales and Northern Ireland was 3.33 cases per 100,000. Reported mortality of iGAS infection ranges from 8 to 23%, increasing to >80% for streptococcal toxic shock.

1.3 A significant proportion, between 5 – 12% of iGAS infection is healthcare associated. In addition 2-11% of all severe GAS infections are associated with recent childbirth, a rate of approximately 0.06 per 1000 births. Infection in the mother carries a significant risk of infection in the baby.

1.4 GAS causes outbreaks of infection in healthcare settings, including acute care, maternity, residential and nursing home settings. In acute care surgical and obstetric units are most commonly affected. Outbreaks may occur over prolonged periods, over 6 months, and involve spread from colonised staff to patients, patient to patient spread and infection from fomites.

1.5 **Failure to comply with this policy could lead to disciplinary action.**

2. **PURPOSE**

2.1 The purpose of this policy is to ensure that GAS infections in patients and staff are managed appropriately to minimize the risk of spread of GAS in the healthcare environment.

3. **DEFINITIONS**

3.1 **Group A Streptococcal Infections**

3.1.1 GAS infection is illness associated with GAS, it may be clinically likely from signs and symptoms or microbiologically confirmed.

3.1.2 Invasive GAS (iGAS) is illness associated with isolation of GAS from blood or a normally sterile site. It also includes severe disease including necrotising fasciitis (NF) or Streptococcal Toxic Shock Syndrome (STSS) where the GAS was isolated from a normally non sterile site- e.g. skin

3.1.3 Peripartum GAS infection is defined as isolation of GAS from a mother up to 7 days after delivery in association with clinical signs of infection such as endometritis or STSS, wound infection or other infection of a sterile site

3.1.4 GAS colonisation is when GAS is isolated from a non sterile site without clinical evidence of infection
3.1.5 A fomite (Section 1.4) is an inanimate object or substance, such as clothing, furniture, or soap that is capable of transmitting infectious organisms from one individual to another.

3.2 Healthcare Associated GAS infection

3.2.1 A healthcare-associated GAS infection is defined as a GAS infection that is neither present nor incubating at the time of admission but considered to have been acquired following admission to hospital or as a result of healthcare interventions in other healthcare facilities. Typically, onset of GAS infection is >48 h after admission, or postoperatively at any time after admission and for up to seven days post discharge.

3.3 Outbreak of GAS

3.3.1 An outbreak should be considered if there are two or more cases of suspected GAS infection linked by person or place. These cases will usually be within a month of each other but the interval may extend to six months especially if detected due to typing of isolates over an extended period.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The Board of Directors is responsible for ensuring that adequate resources and processes are in place to implement this policy.

4.2 The Medical Director, as the Executive Lead for health care associated infection, is responsible for signing off this policy.

4.3 The Joint Directors for Infection Prevention and Control are responsible for advising the Board of Directors, through the Executive Lead for health care associated infection, about significant challenges with implementation of the policy.

4.4 Infection Prevention and Control Team (IPCT) is responsible for:
- Maintaining active alert organism surveillance for GAS infections
- Acting as a resource for best practice for clinical staff
- Conducting routine retrospective surveillance of GAS infections from IPCT and Microbiology Laboratory records six monthly to identify possible linked cases.
- Investigating cases of potentially healthcare acquired GAS and undertaking appropriate immediate measures to prevent spread of GAS
- Alert appropriate clinical and operational staff should a potential outbreak of GAS be detected.
- If potential outbreaks of healthcare acquired GAS are detected the IPCT will contribute to the core competencies of the Outbreak Control Team.

4.5 The Medical Microbiologists are responsible for the provision of antimicrobial therapy guidance.

4.6 Assistant Directors of Nursing are responsible, through their Senior Nurses, for:
- Ensuring that all relevant nursing staff are aware of this and related policies
- Contributing to outbreak investigations and control measures as necessary

4.7 Ward Matrons are responsible for:
- Ensuring that the IPCT is informed of patients admitted with GAS or who develop GAS infection in hospital
- Ensuring patients with GAS are appropriately isolated.
- Ensuring that hand hygiene, use of PPE and environmental hygiene standards are maintained to reduce the risk of transmission of infection
- Ensuring staff with potential GAS infections are referred to Occupational Health and do not work while potentially infectious
- Contributing to outbreak investigations, including staff screening and control measures as necessary

4.8 The Occupational Health Service is responsible for:
- Providing advice to staff about exposure to GAS, and providing antimicrobial prophylaxis if appropriate
- Investigating and treating staff with carriage of GAS
- Contributing to outbreak investigations including staff screening when it is determined to be appropriate

4.9 Public Health England (PHE) is responsible for:
- Providing advice to contacts of cases of GAS and iGAS in the community
- Identifying significant contacts of community cases of iGAS. Significant contacts defined as >24 hours continuous exposure as this increases risk of GAS colonisation
- Contributing to outbreak investigations of healthcare acquired GAS

4.10 The Microbiology Laboratory is responsible for:
- Providing a diagnostic and clinical advice service for GAS
- Ensuring the IPCT is informed promptly of hospital inpatients with GAS infection, and also other patients not in hospital who may have healthcare acquired infection. This includes infections occurring within 7 days of delivery.
- Ensuring GAS isolations from hospital patients are reported through the laboratory information system to the ICNet surveillance system.
- Ensuring that all GAS isolates from in-patients, peri-partum patients, neonates, and those from post operative wounds are saved for six months so that typing can be performed should retrospective surveillance indicate the possibility of linked healthcare associated cases.
- Ensuring all microbiologically diagnosed cases of iGAS are notified through the electronic data transfer system (CoSURV) to the PHE. In addition, when appropriate, serious cases of iGAS and those in high risk environments such as nursing homes, should be reported to Public Health England by telephone in order that appropriate contact management can be undertaken.
- Ensuring GAS isolates from invasive disease are routinely referred for typing.

4.11 All clinical staff are responsible for:
- Maintaining standards of hygiene and use of PPE for the prevention of transmission of infection
- Not working when they may have potential GAS infections, such as sore throat or skin infections, and taking appropriate measures to obtain treatment from their GP
- Informing Occupational Health and an appropriate senior manager if aware that they may be infected or colonized with GAS
- Contributing to outbreak investigations including cooperating with staff screening and other control measures as necessary

4.12 Infection Control and Decontamination Assurance Group is responsible for ratifying this policy and ensuring that it is subject to regular review and updating in light of new national guidelines and other evidence.
5. **INFECTION PREVENTION AND CONTROL**

5.1 **Transmission**

5.1.1 The mode of spread of GAS is:
- Droplets expelled from the respiratory tract of carriers and/or infected persons
- Contact:
  - direct contact with mucus from nose or throat of infected person, or skin contact with infected sores/wounds/impetigo
  - Indirect contact with contaminated fomites

5.1.2 Invasion and thus infection occurs 1-3 days after initial colonisation.

5.2 **Management of Cases**

Detailed information on infection control precautions for infections including GAS can be found in the Source Isolation Policy and Procedure for Hospital Patients. Certain points are expanded below.

5.3 **In-Patient isolation**

5.3.1 Hospital in-patients will require information about their infection and why they require isolation. A patient information leaflet is attached in Appendix 1.

5.3.2 National guidance advises that patients with suspected or confirmed GAS infection should be isolated in a side room, preferably with en-suite facilities, for a minimum of 24 hours after the initiation of effective antimicrobial therapy. However, the Microbiologists and IPCT in this Trust advise isolation for 48 hours after the initiation of effective antimicrobial therapy.

5.3.3 Some patients with severe or extensive GAS infection, for example necrotising fasciitis and those with infected eczema where there is a high risk of shedding, may require longer periods of isolation. In these cases isolation should continue until culture negative or on advice from Microbiology.

N.B: Skin decolonisation may also be prescribed on advice from Microbiology for severe or extensive GAS infection.

5.4 **Mothers and Babies**

5.4.1 Pregnant women found to be infected or colonized with GAS during pregnancy should be treated. The greatest risk of infection is >37 weeks pregnancy or up to 28 days post delivery. The GAS status should be clearly documented in obstetric care records to ensure communication between hospital and community midwifery services.

5.4.2 If GAS is detected in either mother or baby in the first 28 days following birth, both should receive appropriate antibiotic treatment.

5.4.3 In hospital mothers and babies should only be separated in exceptional circumstances, e.g. ITU admission.

5.4.4 Breast feeding should normally be continued.
5.5 Personal Protective Equipment

5.5.1 Minimum PPE for healthcare workers when in contact with infectious GAS patients consists of disposable gloves and aprons. A fluid repellent surgical mask and eye shield or visor should be used for operative debridement / change of dressings for necrotising fasciitis and procedures likely to generate droplets until the patient is culture negative.

5.5.2 Health care workers with breaks in their skin must cover lesions with a waterproof dressing.

5.6 Visitors

5.6.1 Visitors, especially household contacts, must be asked about signs of GAS, e.g. sore throat or infected skin lesions. Those with symptoms of infection should be directed to their GP or the appropriate NHS Walk in Centre for treatment. Visitors with untreated infection should only visit if essential on the advice of the IPCT.

5.6.2 Visitors should be advised on hand hygiene and given and shown how to use personal protective equipment, gloves and aprons, if appropriate.

5.6.3 Visitors should be given appropriate information on GAS infection. An information leaflet for contacts of GAS patients is attached in Appendix 2.

5.7 Mortuary & Pathology Departments

5.7.1 Pathology staff should also be informed when unfixed tissue from a case of necrotising fasciitis is sent for examination.

5.7.2 In the event of a patient death
   a. the mortuary staff should be informed of the risk of infection. A cadaver bag should be used.
   b. the body can be viewed, but no embalming or other preparation of the body should take place.
   c. undertakers should be informed of the risk of infection and can be referred to www.hse.gov.uk/pubns/web01.pdf

6. CONTACTS OF GAS INFECTIONS

6.1 Community contacts and visitors
Close personal contacts are defined as household or kissing contacts within 7 days prior to onset of infection and up to 24 hours after initiation of appropriate antibiotics to the index case.

6.1.1 Management of contacts of iGAS is normally the responsibility of the PHE, which must be notified of iGAS cases (HPA 2004).

6.1.2 Close personal contacts of a case of iGAS should be given written information on signs and symptoms of iGAS and advice on actions. If there are 2 related cases of iGAS antibiotic prophylaxis is recommended for all close contacts. Prophylaxis in the community is the responsibility of the PHE and the Acute Response Centre should be contacted (0844 225 3557 or out of hours via the Trust switchboard.) See also Patient Contact Information Leaflet at Appendix 2.
6.2 Health Care Workers (HCW)

6.2.1 HCW are protected by correct use of hand hygiene and PPE.

6.2.2 If breaks in protection from PPE occur, e.g. during resuscitation, HCW should seek advice from Occupational Health or Microbiology. Written information should be given for significant exposure, see Appendix 3.

6.2.3 For severe exposure, e.g. a needle stick injury, antibiotic prophylaxis may be recommended on the advice of Occupational Health or Microbiology

7. ANTIBIOTIC PROPHYLAXIS

7.1 Antibiotic prophylaxis is normally only required in limited circumstances and should only be given when advised by a Consultant in Communicable Disease Control, Consultant Microbiologist or Occupational Health Physician. See Table 1

Table 1. Indications for antimicrobial prophylaxis

<table>
<thead>
<tr>
<th>Individuals requiring antibiotic prophylaxis</th>
<th>Individuals requiring a Patient Information Leaflet and advice</th>
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<tr>
<td>Pregnant women &gt;37 weeks pregnant, or within 28 days of giving birth</td>
<td>Close contacts who are not high risk and do not have symptoms suggesting GAS infection.</td>
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<tr>
<td>Mother and/or baby if either develops GAS colonisation or infection during the first 28 days of life (neonatal period)</td>
<td>Health care workers who have been exposed to droplet particles from a patients respiratory tract i.e. during intubation – d/w microbiologist to ascertain risk and necessity for prophylaxis</td>
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<tr>
<td>Older persons( &gt; 75 years) who are close contacts</td>
<td>Injecting drug users following a case occurring in a local injecting drug user.</td>
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<tr>
<td>Patients with chicken pox with onset within 14 days prior to the onset in the index case</td>
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<tr>
<td>Close contacts who develop symptoms suggestive of GAS infection, i.e. sore throat, fever or skin infection</td>
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<td>As a control measure in clusters or outbreaks</td>
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<tr>
<td>On Microbiology, PHE or Occupational Health advise following risk assessment for severe exposure to infected case, e.g. needle stick injury.</td>
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7.2 Antibiotic choice for adults

For adults oral penicillin V 500mg qds or amoxicillin 500mg tds for 10 days is the first line drug of choice if chemoprophylaxis is indicated. (clarithromycin 500 mg bd or azithromycin 500mg daily for 5 days is a suitable alternative for those with penicillin allergy).
7.3 **Antibiotic choice for children**
For children use penicillin or azithromycin according to doses advised in the BNF for Children. (Azithromycin for > 6 months age, for those < 6 months of age, clarithromycin)

8. **CASES OF GAS IDENTIFIED IN HEALTHCARE SETTINGS**

8.1 **Investigation of a single case of GAS**

8.1.1 On identification of a single case of GAS, the IPCT should establish whether the case is likely to be community or healthcare-associated. See Appendix 4 for Algorithm 1, “Management of a single case of GAS Infection”. Initial investigation should establish whether the patient had any clinical signs consistent with GAS infection at or prior to admission.

8.1.2 Enquiry should include symptoms in household and other close contacts. Any such contacts with symptoms should be referred to their GP and excluded from the healthcare setting until appropriately diagnosed and treated. Those diagnosed with GAS require a minimum of 24 hours antibiotic treatment before considered safe in the healthcare setting.

8.1.3 If the case is likely to be healthcare acquired then the IPCT should consider prospective enhanced surveillance. This could include sampling of infected wounds of patients in the vicinity of the index case or who are being cared for by the same HCWs; enquiry for possible linked cases occurring post discharge or clinically identified without an isolate; other appropriate measures relevant to a particular case.

8.1.4 Review surveillance records for possible linked cases identifiable retrospectively.

8.1.5 Any isolates of GAS identified either retrospectively or prospectively should be typed and compared with patient isolates.

8.1.6 If a case is considered to be hospital acquired, and no likely source is identified then screening of HCWs should be considered – see section 9.

8.2 **Investigation of outbreaks of GAS infection**

8.2.1 An outbreak is defined as two or more linked cases of GAS infection. These may be detected contemporaneously or occur over an extended period of time -up to 6 months - and be detected by prospective or retrospective surveillance activities.

8.2.2 For any outbreak, initial control will involve the same measures as would be taken for an individual healthcare acquired case. This includes identification of cases, treatment and isolation, and management of contacts.

8.2.3 In addition, to control and identify the source of an outbreak the IPCT should follow the steps outlined in Algorithm 2 (Appendix 5) “Management of an outbreak of GAS infection”. This includes an epidemiological review, environmental audit and is likely to include screening of patients and asymptomatic HCWs.

8.2.4 When a potential outbreak is detected, an outbreak control team should be formed. The exact team composition will depend on the nature of the outbreak but is likely to include:
- Infection Prevention & Control Senior Nurse
- Consultant Microbiologist
8.2.5 For some outbreaks it is possible that the Outbreak Control Policy may be invoked.

9. MANAGEMENT AND SCREENING OF HEALTH CARE WORKERS

9.1 Surgeons, nurses, anaesthetists, midwives and wound care teams have been implicated in transmission and outbreaks of healthcare acquired GAS.

9.2 HCW with symptoms suggestive of GAS should inform their line manager and seek advice on whether they should continue clinical duties from their line manager or Occupational Health. Treatment should be undertaken in liaison with the HCW’s GP. If a HCW poses a risk to patients she/he should be excluded from work for a minimum of 24 hours of appropriate antimicrobial treatment and resolution of symptoms of GAS infection has occurred.

9.3 The IPCT may consider it necessary to screen epidemiologically linked HCWs for asymptomatic carriage as part of the investigation of a single case of healthcare acquired, or an outbreak of, GAS infection see Algorithm 2 (Appendix 5). Those who require screening for GAS carriage will be identified by the IPCT. Appendix 7 is a draft letter for staff linked to a case of GAS. Please make the usage consistent.

9.4 Following identification of the potential contact group, screening of HCWs should be conducted by an occupational health practitioner and should follow a stepwise progression.

a. Initial screening swabs of throat and skin lesions. For dry skin lesions a swab moistened with sterile saline should be used
b. HCWs should be examined for skin lesions and dermatitis
c. Additional sites known to be implicated in asymptomatic carriage include anterior nares, anus and vagina. It may be necessary to swab additional sites if the initial investigation fails to identify implicated carriers. If screening of additional, sensitive, sites is deemed necessary, it should only be done after careful consideration and explanation to the HCWs involved

9.5 HCWs may work pending the results of the screen.

9.6 Any HCW found to be culture positive for GAS should be referred to occupational health for treatment and refrain from work or at least work without patient contact until they have received 24 hours of an appropriate antibiotic treatment. Algorithm 3 (Appendix 6) is for the management of colonised and infected healthcare workers and includes antimicrobial treatment and clearance screens.

9.7 For HCW post treatment clearance screens should be taken 24 hours after the end of treatment and again at one, three, six, and twelve weeks post treatment. However if strain typing shows that the HCW was carrying a strain distinct from the outbreak or patient strain then clearance swabs can be discontinued after agreement with Microbiology and Occupational Health.
10. COMMUNICATION

10.1 General principles

10.1.1 Good communication is central to the effective management of GAS infections and prevention of spread in the healthcare environment. It is also important to supply timely information to affected patients and staff if indicated.

10.1.2 The IPCT should be promptly informed of suspected cases by clinical teams.

10.1.3 The microbiology laboratory should inform the IPCT and clinical teams promptly of GAS isolation from hospital patients and other cases that may be healthcare acquired.

10.1.4 GPs in the community should be informed of GAS isolations by phone during working hours from sites other than the throat. Potential iGAS cases in general practice should be communicated to on call services out of hours.

10.1.5 PHE should be notified of cases of iGAS (tel 0344 2253557)

10.2 Patient and Staff Communication

10.2.1 Suitable and accurate information should be provided promptly to the patient (Appendix1) and close personal and staff contacts for iGAS infections (Appendices 2 & 3).

10.2.2 Effective hand over between health care teams should ensure communication with the patient with iGAS infection and their close personal contacts is consistent, accurate and documented.

10.3 Healthcare acquired GAS infections and Outbreaks

10.3.1 Patients, close contacts and HCWs should be provided with clear, concise information about the outbreak. Information should be provided to relevant HCWs to encourage heightened awareness of the symptoms of GAS, to take specimens from symptomatic patients, give early treatment where GAS is suspected, and promptly notify the outbreak control team. Effective communication should be assisted by Communications Department.

10.3.2 All media enquiries must be referred to the Communications Department.

11. AUDIT

11.1 Audit is necessary to evaluate whether outbreaks of GAS infection are detected and appropriately managed.

11.2 The following audits are appropriate:

a. IPCT - six monthly retrospective audit of Hospital GAS infections to determine if there is any evidence of undetected outbreaks. Outbreaks may occur over a protracted period at a low level and review may reveal potential outbreaks which require investigation including strain typing.
b. Microbiology - audits of storage of strains from in-patients, peri-partum patients, neonates, and those from post operative wounds for six months, and submission of strains from iGAS infection for typing. These should be conducted annually.

c. Patients with GAS infections are appropriately isolated if infectious, monitored by annual patient placement audit

12. ARCHIVING ARRANGEMENTS
The original of this policy, will remain with the Infection Prevention & Control Team. An electronic copy will be maintained on the Trust Intranet, P – Policies (Trust-wide) – G – Group A Streptococcal. Archived electronic copies will be stored on the Trust's “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

13. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

13.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

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<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
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<tbody>
<tr>
<td>1.</td>
<td>Patients are appropriately placed on wards so as to minimise the risk of infection to others</td>
<td>Annual audit of patient placement</td>
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<tr>
<td>2.</td>
<td>Hospital Acquired GAS infections – Isolates are stored for a minimum of 6 months</td>
<td>Annual Audit by Microbiology Department</td>
</tr>
<tr>
<td>3.</td>
<td>Isolates of GAS from ALL invasive infections are referred for typing</td>
<td>Annual Audit by Microbiology Department</td>
</tr>
<tr>
<td>4.</td>
<td>Retrospective surveillance of GAS infections from IPCT and Microbiology Laboratory records six monthly to identify possible linked cases</td>
<td>IPCT Surveillance meeting minutes</td>
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13.2 Frequency
In each financial year, the IPCT and Microbiology Department’s quality lead will audit their respective areas of compliance to be monitored annually to ensure that this policy has been adhered to and a formal report will be written and presented at the Infection Control and Decontamination Assurance Group.

13.3 Undertaken by
Infection prevention & control Team and audit & surveillance nurse and clinical Microbiology Department staff

13.4 Dissemination of Results
Results will be disseminated at the Infection Control and Decontamination Assurance Group which is held quarterly.

13.5 Recommendations/ Action Plans
Implementation of the recommendations and action plan will be monitored by the Infection Control and Decontamination Assurance Group which is held quarterly.

13.6 Any barriers to implementation will be risk assessed and added to the risk register.

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Group A Streptococcal Infections - Policy for the Prevention and Control of
Ratified by: Infection Control & Decontamination Assurance Group: 2nd May 2018
Review date: November 2022
13.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

14. REFERENCES

Health Protection Agency (2008) Invasive Group A Streptococcal Infections – Information Leaflet HPA


What is group A streptococcus?
Group A streptococcus (GAS) is a bacterium found in the throat and on the skin and in most people it does not cause any symptoms.

How does it spread?
As the bacterium is found in the throat and on skin it may be passed from one person to another through sneezing, kissing and skin contact. Some people may carry it without any symptoms of illness. This is known as being colonised. In other people the bacterium can cause illness. This is known as being infected.

What kinds of infections are caused by GAS?
Most GAS infections are relatively mild illnesses such as sore throat (otherwise known as ‘strep throat’), impetigo (a crusted skin infection usually around the mouth that often affects children) or cellulitis (an infection causing redness of the skin). Most cases of throat infection will pass without the need for treatment and skin infections may require a short course of antibiotics.
On rare occasions, GAS can cause severe diseases called invasive GAS disease.

Who is at risk of GAS infections?
Anyone can become infected with GAS. However, people with long-term illnesses like cancer, diabetes and kidney disease, and those who use medications such as steroids, are at higher risk for invasive disease. Breaks in the skin, such as surgical wounds, or cuts can also provide an opportunity for the bacteria to enter the body and cause infection.

What is invasive GAS disease?
Invasive GAS disease occurs when the bacterium gets into parts of the body where it is not usually found, such as the blood, muscle, or lungs. Two of the most severe, but rare, forms of invasive GAS disease are necrotising fasciitis (a deep tissue infection with tissue destruction requiring surgery) and Streptococcal Toxic Shock Syndrome (an illness with some of the following: high fever, low blood pressure, muddled thinking, body rash as in scarlet fever, diarrhoea and vomiting, difficulty breathing, kidney or liver damage and blood clotting problems).

Why does invasive GAS disease occur?
Invasive GAS infection occurs when the bacterium gets past the body’s natural defences. This may occur when sores or other breaks in the skin allow the GAS bacteria to get into the bloodstream and deep tissue, or when the person’s ability to fight off infection is decreased because of long-term illness or an illness that affects the immune system. Some types (called ‘strains’) of GAS are more easily able to cause severe disease than others.
I have been told I have GAS disease - what will happen to me now and how will it be treated?

Depending on where the GAS infection has been identified and how severe the symptoms are, you will be given various antibiotics to treat the infection. Very occasionally, immunoglobulin (antibodies that will help you fight the infection, obtained from blood donors) is given as well.

While you have this infection you are likely to be kept in a single room - not in a bay with other patients. This is to help prevent the infection spreading to others and may only be for a few days. However if the infection is quite severe then you may be need to remain in a single room for a longer period of time.

The hospital workers caring for you may sometimes wear disposable gloves, aprons and very occasionally a mask when in contact with you. The protective clothing they wear will depend on which part of your body has the infection, and also what they are actually doing with you during that time.

To help prevent GAS infection spreading to others it is important you wash your hands with soap and water or use the alcohol hand rub often. If you have a throat infection it is important that you cough/sneeze into disposable tissues, throw these away promptly and then wash your hands or use the alcohol hand rub.

Are my relatives, visitors, household contacts at risk of getting GAS disease from me?

Most people in close contact with GAS remain well and symptom free, though some develop a sore throat or mild skin infections. Although healthy people can get invasive GAS disease from a relative or a member of their household with GAS, it is very rare. If your visitors are helping with your care activities then they may also need to wear disposable aprons or gloves, so they should check with the nurses if this is necessary. It is very important that that visitors and carers wash their hands or use the alcohol hand rub often, and especially when leaving your room. Other important times for them to wash their hands or use the hand rub are: before eating, after going to the toilet, and before and after helping you with personal care activities such as washing, dressing, eating or using the toilet.

How would they know if they have developed the infection?

The most important thing to be aware of are the early signs and symptoms of invasive GAS disease, which are:

- High fever
- Severe muscle aches
- Pain in one area of the body
- Redness at the site of a wound
- Vomiting or diarrhoea

What should they do if they develop any of these symptoms?

Contact their GP or seek medical advice immediately. Tell the GP they have been in contact with someone recently diagnosed with invasive GAS disease and now have developed some symptoms that are causing concern. It is likely that the GP will want to see them in the surgery. If they are too unwell to visit the surgery or it is closed they should not delay seeking medical advice.

Remember, most people who come into contact with GAS remain well and symptom free, or may develop mild throat or skin infections.

Contracting invasive GAS disease from a relative or household member is very rare.
If you have any further questions speak to the ward staff or ask them to contact the hospital infection control team.

You can also obtain useful information from the following website:

**NHS Choices**
http://www.nhs.uk/Conditions/Streptococcal-infections/Pages/Introduction.aspx
Invasive Group A Streptococcal Infections
Information Leaflet for those in contact with group A streptococcal infection

You have been given this leaflet because you have been in contact with a case of group A streptococcal (GAS) infection. Although it is very unlikely that you will be affected by GAS infection, the medical team would like you to be able to recognise the signs of a more serious infection.

Questions and answers for close contacts of cases of GAS

What is group A streptococcus (GAS)?
GAS is a bacterium often found in the throat and on the skin. In most people it does not cause any symptoms.

How are GAS infections spread?
The bacteria survive in throats and on hands for long enough to allow easy spread between people through sneezing, kissing and skin contact. People may carry GAS in the throat or on the skin and have no symptoms of illness. This is sometimes known as being colonised.

What kind of illnesses are caused by GAS?
Most GAS infections are relatively mild illnesses such as a sore throat (called 'strep throat') or a skin infection such as impetigo. On rare occasions, these bacteria can cause other more severe diseases.

What is invasive group A streptococcal disease (iGAS)?
Sometimes serious GAS disease may occur when bacteria get into parts of the body where bacteria usually are not found, such as the blood, muscle, lungs or the birth canal after childbirth. These infections are called invasive GAS disease. Two of the most severe, but rare, forms of invasive GAS disease are necrotising fasciitis and Streptococcal Toxic Shock Syndrome.

Why does invasive GAS disease occur?
Invasive GAS infections occur when the bacteria get past the defences of the person who is infected. This may occur when a person has sores or other breaks in the skin that allow the bacteria to get into the tissue, including just after childbirth, or when the person's ability to fight off the infection is reduced because of long-term illness or an illness that affects the immune system. Also, some types of GAS are thought to be more likely to cause severe disease than others.

Am I at risk of getting invasive group A streptococcal disease from close contact with a patient with iGAS?
Most people who come into contact with GAS remain well and symptom-free, or develop mild throat or skin infections. These infections can be easily treated by your GP.

Healthy people can get invasive GAS disease from a relative or a member of their household but it is very rare. Certain groups of people might be more at risk of contracting a more serious infection, for example, people who have recently given birth, or had surgery.

What do I need to be aware of?
The most important thing to be aware of are the early signs and symptoms of invasive disease, which are shown in the box below.

**Early signs and symptoms of invasive GAS disease**

- High fever
- Severe muscle aches
- Pain in one area of the body
- Redness at the site of a wound
- Vomiting or diarrhoea

What should I do if I develop any of these symptoms?
If you develop any of these symptoms contact your GP or seek medical advice immediately. Tell your GP that you have been in contact with someone recently diagnosed with invasive GAS disease and that you have developed some symptoms that you are worried about. It is very likely that your GP will ask you to come into the surgery so you can be examined. If you are too unwell to visit the surgery or it is closed you should not delay in seeking medical advice.

Most people who come into contact with GAS remain well and symptom-free, or develop mild throat or skin infections. Contracting invasive GAS disease from a close contact is very rare.
Invasive Group A Streptococcal Infections

You have been given this leaflet because you have been identified as a member of staff in contact with a patient with group A streptococcal (GAS) infection, who may have acquired their infection through contact with healthcare.

Although it is very unlikely that you will be affected by GAS infection, we would like you to be able to recognise the signs of infection so that you can obtain the best treatment and avoid spreading infection to close contacts and patients.

In addition as part of the investigation of healthcare acquired GAS it is sometimes necessary to screen staff for asymptomatic carriage. The leaflet explains the process of screening and treating healthcare workers who carry outbreak strains of GAS.

ABOUT GAS

What is Group A Streptococcus (GAS)?
GAS is a bacterium, full name *Streptococcus pyogenes*, and it is normally found in the throat or on the skin and usually causes no symptoms.

How are GAS infections spread?
GAS is spread by droplets from the respiratory tract, when sneezing or coughing, or by touch. People may carry GAS in the throat or on the skin and have no symptoms of illness. This is referred to as being colonised or a carrier.

Most people who come into contact with GAS remain well and symptom-free, or develop mild throat or skin infections. Contracting invasive GAS disease from a close contact is very rare. Indeed most staff who develop GAS infections will have contracted them by chance from a contact outside the workplace.

What infections are caused by GAS?
Most GAS infections are relatively mild illnesses such as a sore throat (called ‘strep throat’) or a skin infection such as impetigo. On rare occasions, these bacteria can cause other more severe diseases.

What is invasive group A streptococcal disease (iGAS)?
Serious invasive iGAS disease is rare. It may occur when bacteria invade the blood, muscle, lungs or the birth canal after childbirth. These infections are called invasive GAS disease. Two of the most severe, but rare, forms of invasive GAS disease are necrotising fasciitis (NF) and Streptococcal Toxic Shock Syndrome (TSST).

The most important thing to be aware of are the early signs and symptoms of invasive disease, which are shown below.

**Early signs and symptoms of invasive GAS disease**

- High fever
- Severe muscle aches
- Pain in one area of the body
- Redness at the site of a wound
- Vomiting or diarrhoea
What should I do if I develop any of these symptoms?
If you develop any of these symptoms contact your GP or seek medical advice immediately. Tell your GP that you have been in contact with someone recently diagnosed with invasive GAS disease and that you have developed some symptoms that you are worried about. It is very likely that your GP will ask you to come into the surgery so you can be examined. If you are too unwell to visit the surgery or it is closed you should not delay in seeking medical advice.

HEALTHCARE ASSOCIATED GAS AND STAFF SCREENING

The Trust Infection Prevention and Control Team conducts surveillance of GAS infections identified in the Trust because occasionally outbreaks of healthcare acquired GAS have been reported. Infection may be spread from patient to patient, or from a staff carrier to patients.

If a potential outbreak is detected it is necessary to conduct investigations to find the source of infection. On occasion this will mean screening staff who have been in contact with cases to see if they are unwittingly carrying an outbreak strain.

If staff screening is necessary it will be undertaken in confidence by the Occupational Health Team. Screening usually involves swabbing the throat and any skin lesions, e.g. eczema. Occasionally other sites may need to be screened also.

Any staff carriers identified are decolonised with antibiotic treatment. Follow up screening to check that decolonisation is successful is undertaken.

If staff screening is ever required it will only be undertaken if absolutely necessary. A full explanation and opportunity to ask questions will be given before any investigations are undertaken.
1. Includes hospital inpatients, patients recently discharged (≤7 days) and women who gave birth in any setting including at home.
2. Invasive GAS infection (iGAS) is defined through isolation of GAS from a normally sterile body site. Infections where GAS is isolated from a non-sterile site in combination with a severe clinical presentation should be managed as per iGAS infection.
3. Consider healthcare-associated if symptoms/signs of infection not present on admission or if discharged from hospital or gave birth within the previous 7 days and where there is no other obvious source of transmission e.g. from close household contacts.
4. Consider HCWs, visitors, other patients/household members in direct contact/ close proximity to case (same bed space, theatre delivery room) within 7 days prior to diagnosis.
5. IPCT to consider whether asymptomatic HCWs should be invited for screening by Occupational health. Indications for this may include strong epidemiological link, absence of alternative potential source for the infection and/or where patient developed invasive GAS infection.
1. An outbreak should be considered if there are two or more cases of suspected GAS infection related by person or place. These cases will usually be within a month of each other but the interval may extend to several months.
2. Includes hospital inpatients, patients recently discharged (≤7 days) and women who gave birth in any setting including at home.
3. Clearly label isolates sent to the reference laboratory as being part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventive measures should not await results of typing.
4. Outbreak control team may include infection control doctor and nurses, consultant microbiologist, consultant from the specialty involved, occupational health adviser, local health protection specialist, cleaning manager, bed manager, appropriate healthcare manager, local commissioning lead and communications adviser.
5. Other patients, HCWs, equipment and the environment are possible sources of outbreaks. Develop time lines and inpatient journeys to identify overlaps of hospital stays and common exposures.

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**APPENDIX 5 - ALGORITHM 2 - MANAGEMENT OF AN OUTBREAK OF GAS INFECTION**

**Identification of suspected or confirmed GAS outbreak in acute healthcare or maternity setting**

- Inform the IPCT, patients clinical team and local health protection unit
- Report as SUI if appropriate
- Inform and send isolates to reference laboratory

**IPCT to convene outbreak control team**

**Undertake epidemiological investigation including review of microbiology and surveillance records of possible healthcare-associated GAS cases over 6 months**

- Review methods of decontamination, cleaning and other infection control policies and adherence to policies
- Take immediate action to rectify any deficiencies

**Consider screening (throat and skin lesions) of HCWs epidemiologically linked to cases**

**Source of outbreak established?**

- **NO**
  - Consider repeat screening of showers HCWs epidemiologically linked to outbreak and screen at other sites (nose, anus & vagina)

- **YES**
  - Take remedial action

**Identify any common source equipment including fixed facilities such as baths and showers**

**Consider environmental sampling of epidemiologically linked equipment or facilities**

---

1. An outbreak should be considered if there are two or more cases of suspected GAS infection related by person or place. These cases will usually be within a month of each other but the interval may extend to several months.
2. Includes hospital inpatients, patients recently discharged (≤7 days) and women who gave birth in any setting including at home.
3. Clearly label isolates sent to the reference laboratory as being part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventive measures should not await results of typing.
4. Outbreak control team may include infection control doctor and nurses, consultant microbiologist, consultant from the specialty involved, occupational health adviser, local health protection specialist, cleaning manager, bed manager, appropriate healthcare manager, local commissioning lead and communications adviser.
5. Other patients, HCWs, equipment and the environment are possible sources of outbreaks. Develop time lines and inpatient journeys to identify overlaps of hospital stays and common exposures.
1. Pharyngeal carriage treatment options (adults) include oral penicillin V (500mg four times a day for 10 days), amoxicillin (500mg three times a day for 10 days), or azithromycin 500mg once a day for 5 days. Non-pharyngeal carriage – penicillin treatment alone may not be sufficient. Treatment options include clindamycin 300 mg four times a day for 10 days, or azithromycin 500mg once a day for 5 days with some limited reports in literature of combining with oral rifampicin or oral vancomycin

2. Clearly label isolates sent to the reference laboratory as being part of a suspected outbreak to prioritise processing. Epidemiological investigations and preventative measures should not await results of typing

3. Clindamycin 300mg (four times a day for 10 days) should be used for eradication of throat carriage in cases where first-line therapy penicillin has been unsuccessful
APPENDIX 7 - HCW SCREENING LETTER FOR MANAGEMENT OF A SINGLE CASE OF GAS ACQUIRED IN THE ACUTE CARE SETTING

Letter for HCWs in contact with case of GAS (can be adapted for screening in outbreaks)

Occupational Health Department

Date:

Dear member of staff,

Patient on XXX ward with group A streptococcus (GAS) infection

This letter is being distributed to all staff members who have been in contact with a patient who has developed an infection with GAS while in hospital.

By contact we mean direct contact during normal care activities, or present in the delivery suite or theatre, or working within the patient's room or bed space.

Occasionally, staff can transmit GAS to patients while working with a sore throat, an infected skin lesion, eczema or dermatitis, or very occasionally from vaginal or rectal colonisation.

If, in the last seven days, you have had a sore throat, an infected skin lesion, eczema or dermatitis or itching or soreness in the perineal area, please attend the occupational health department to be screened for GAS today.

Results will be available the following day or within 48 hours.

Our aim is to reduce the risk of further cases of GAS arising. Any healthcare worker found to be carrying GAS will receive treatment to eradicate the infection or carriage of this organism.

Most infections with GAS are mild and you are very unlikely to pick up GAS from a patient. However, if you become concerned about any symptoms that could be attributable to GAS in the next 30 days, such as those mentioned above, or more serious problems such as severe pain or muscle tenderness, high fever with diarrhoea or vomiting, or redness at the site of a wound, please seek medical attention.

Infection Control Doctor

Occupational Health Doctor
## COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th><strong>Staff groups that need to have knowledge of the strategy/policy</strong></th>
<th>Clinical staff, Occupational Health Staff, Microbiology Lab staff, Infection Prevention and Control Team</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The key changes if a revised policy/strategy</strong></td>
<td>Routine revision taking into consideration community services, the result of which is that no significant changes were found to necessary to content. Antibiotic prophylaxis section updated regarding antibiotics to be prescribed for adults and children. Job titles in relation to duties and responsibilities section updated. References checked and updated. Communication Plan reviewed and updated. Equality Impact Assessment reviewed and new format used but no changes to content. Hyperlinks to other Trust policies checked and updated.</td>
</tr>
<tr>
<td><strong>The key objectives</strong></td>
<td>To ensure that GAS infections in patients and staff are managed appropriately to minimize the risk of spread of GAS in the healthcare environment.</td>
</tr>
<tr>
<td><strong>How new staff will be made aware of the policy and manager action</strong></td>
<td>Advice from Infection Prevention and Control Team in the event of a case of GAS in the area that they work.</td>
</tr>
<tr>
<td><strong>Specific Issues to be raised with staff</strong></td>
<td>Seeking advice from Occupational health about exclusion from work and seeking treatment from own GP if a member of clinical staff has potential or confirmed GAS infection e.g. sore throat or infected skin lesions</td>
</tr>
<tr>
<td><strong>Training available to staff</strong></td>
<td>Support is available from the Medical Microbiologists, Infection Prevention and Control Nurses and Occupational Health Service.</td>
</tr>
<tr>
<td><strong>Any other requirements</strong></td>
<td>No negative impacts</td>
</tr>
<tr>
<td><strong>Issues following Equality Impact Assessment (if any)</strong></td>
<td>The original of this policy, will remain with the Infection Prevention &amp; Control Team. An electronic copy will be maintained on the Trust Intranet, P – Policies (Trust-wide) – G – Group A Streptococcal. Archived electronic copies will be stored on the Trust's &quot;archived policies&quot; shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.</td>
</tr>
<tr>
<td><strong>Location of hard / electronic copy of the document etc.</strong></td>
<td>No negative impacts</td>
</tr>
</tbody>
</table>
APPENDIX 9: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Policy for the Prevention and Control of Group A Streptococcal Infections</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Trust-wide</td>
</tr>
<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Judy Potter, Lead Nurse/Director of Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Date completed:</td>
<td>1st February 2018</td>
</tr>
</tbody>
</table>

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**
   - reduce transmission of *Group A Streptococcus* in hospital
   - ensure that patients with GAS are managed appropriately
   - patients are provided with accurate information about GAS infection,

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*
   - Carers  □
   - Staff  X
   - Patients  X
   - Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** (By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)
   *Please insert an “x” in the appropriate box (x)*

<table>
<thead>
<tr>
<th>Protected characteristic</th>
<th>Relevant</th>
<th>Not relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>□</td>
<td>X</td>
</tr>
<tr>
<td>Disability</td>
<td>□</td>
<td>X</td>
</tr>
<tr>
<td>Sex - including: Transgender, and Pregnancy / Maternity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>□</td>
<td>X</td>
</tr>
<tr>
<td>Religion / belief</td>
<td>□</td>
<td>X</td>
</tr>
<tr>
<td>Sexual orientation – including: Marriage / Civil Partnership</td>
<td>□</td>
<td>X</td>
</tr>
</tbody>
</table>
4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

N/A

5. Do you think the document meets our human rights obligations? Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- **Fairness** – how have you made sure it treat everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?


7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Issue:</strong></td>
<td></td>
</tr>
<tr>
<td>How is this going to be monitored/ addressed in the future:</td>
<td></td>
</tr>
<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
<td></td>
</tr>
</tbody>
</table>