### Policy for the Management of Panton-Valentine Leukocidin (PVL) and other High Risk *Staphylococcus aureus* Infections in the Hospital Environment

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Lead Nurse for Infection Prevention &amp; Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author of Policy/Strategy</td>
<td>Judy Potter, Lead Nurse for Infection Prevention and Control</td>
</tr>
<tr>
<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
</tr>
<tr>
<td>Contact details</td>
<td>x2690</td>
</tr>
<tr>
<td>Date of original document</td>
<td>October 2008</td>
</tr>
<tr>
<td>Impact Assessment performed</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Ratifying body and date ratified</td>
<td>Infection Control and Decontamination Assurance Group: 23rd July 2018</td>
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<tr>
<td>Review date (and frequency of further reviews)</td>
<td>November 2022 (every 4.5 years)</td>
</tr>
<tr>
<td>Expiry date</td>
<td>May 2023</td>
</tr>
<tr>
<td>Date document becomes live</td>
<td>01 August 2018</td>
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Please specify standard/criterion numbers and tick ✓ other boxes as appropriate

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<thead>
<tr>
<th>Monitoring Information</th>
<th>Strategic Directions – Key Milestones</th>
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<tr>
<td>Patient Experience</td>
<td>Waiting</td>
</tr>
<tr>
<td>Assurance Framework</td>
<td>Privacy and Dignity</td>
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<td>Monitor/Finance/Performance</td>
<td>Efficiency and Effectiveness</td>
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<td>CQC Regulations/Outcomes:</td>
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<td>Delivery of Care Closer to Home</td>
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<td>Infection Control ✓</td>
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</table>

Other (please specify):

**Note:** This policy has been assessed for any equality, diversity or human rights implications

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**Controlled document**

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Policy for the Management of Panton-Valentine Leukocidin (PVL) and other High Risk Staphylococcus aureus Infections in the Hospital Environment

Ratified by: Infection Control & Decontamination Assurance Group: 23rd July 2018
Review date: January 2023

Full History

<table>
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<th>Date</th>
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<td>Lead Nurse</td>
<td>New guideline</td>
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<td>5.0</td>
<td>2018</td>
<td>Lead Nurse</td>
<td>Change of format to reflect revised Trust policy template. Inclusion of section to reflect precautions required when caring for patients with PVL-SA in their own homes.</td>
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Associated Policies:
- MRSA Policy
- Patient Placement and Movement Policy

Key Words
- PVL
- Boils
- Staphylococcus aureus

In consultation with and date:
Infection Control Nursing Team, Occupational Health Consultant, Consultant Microbiologists, Divisional Director Specialist Services: 6th July 2018
Infection Control & Decontamination Assurance Group: 23rd July 2018

Contact for Review:
Lead Nurse, Infection Prevention & Control

Executive Lead Signature:
(Only applicable for Strategies & Policies)
Medical Director
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KEY POINTS OF THIS POLICY:

- Panton-Valentine Leukocidin (PVL) is a toxin that destroys white blood cells and is excreted by some strains of *Staphylococcus aureus* (SA).

- PVL-SA predominantly causes skin and soft tissue infections, usually recurrent due to the overproduction of white cells to compensate for the destruction by the leukocidin.

- PVL-SA can also cause severe invasive infections such as septicaemia, osteomyelitis and pneumonia. Necrotising haemorrhagic pneumonia is the most serious clinical feature with a high mortality rate (> 62%). This often follows a “flu-like” illness which may be a genuine viral infection or reflect the bacteraemia, and tends to affect otherwise healthy young people in the community.

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

- The main route of transmission in healthcare settings is by contact via the unwashed hands of healthcare workers. Inadequately decontaminated shared equipment is also a vehicle for transmission.

- Source isolation precautions must apply to all known or suspected cases of PVL-SA in hospital.

- Community healthcare workers must apply good hygiene and standard infection control precautions when delivering care in patients own homes.

- Clinical healthcare workers may need to be excluded from work depending on level of risk. Staff found to be colonised or infected with PVL-SA will be treated in collaboration with Occupational Health and Infection Control.
1. INTRODUCTION

1.1 The following policy is based on the advice given in the Guidance on the diagnosis and management of PVL-associated Staphylococcus aureus infections (PVL-SA) England (2008), a report prepared by the PVL sub-group of the Steering Group on Healthcare Associated Infection.

1.2 Panton-Valentine Leukocidin (PVL) is a toxin that destroys white blood cells and is excreted by some strains of Staphylococcus aureus (SA). Strains of PVL-SA producing a new pattern of infection have emerged in the UK and worldwide. In the UK, PVL-SA accounted for less than 2% of clinical SA isolates submitted to the national Reference Laboratory in 2008 whether meticillin sensitive (MSSA) or meticillin resistant (MRSA). However PVL has been strongly associated epidemiologically with virulent transmissible strains of S. aureus, including Community Associated (CA) MRSA and is a valuable marker and target for screening for virulence in some strains of S. aureus.

1.3 Panton and Valentine first identified the exotoxin, which they classified as leukocidin back in 1932 (Panton and Valentine, 1932). In the 1950s and 60s, the phage type 80/81 strain of PVL-MSSA successfully spread in the UK and abroad resulting in widespread disease. This presented most commonly as boils and abscesses in previously healthy individuals, either in the community, hospitalised patients or healthcare workers. The increase in morbidity and mortality associated with PVL-MRSA has caused public health concerns worldwide. At present most PVL-SA strains in the UK have been MSSA. However in North America a major problem has emerged with most community acquired (CA) MRSAs producing PVL. One particular community strain is now spreading in hospitals.

1.4 In recent years there has been an increase in the number of PVL-SA isolates referred to the Reference Laboratory from invasive infections. It is unclear whether this was a reflection of increased prevalence or improved case ascertainment, but there is now a programme whereby any suspicious isolate should be submitted for testing for PVL production, hence PVL-SA are increasingly recognised. Data suggests that infections caused by PVL-SA are still currently uncommon in England.

1.5 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

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

3. DEFINITIONS

3.1 Panton-Valentine Leukocidin (PVL) is a toxin that destroys white blood cells and is excreted by some strains of Staphylococcus aureus (SA).

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 PVL-SA infections
- Acting as a resource for best practice for clinical staff
- Investigating cases of potentially healthcare acquired PVL-SA and undertaking appropriate immediate measures to prevent spread
- Alert appropriate clinical and operational staff should a potential outbreak of PVL-SA be detected.
- If potential outbreaks of healthcare acquired PVL-SA 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 PVL-SA or who develop PVL-SA infection in hospital
- Ensuring patients with PVL-SA 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 PVL-SA 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 PVL-SA, and providing antimicrobial prophylaxis if appropriate
- Investigating and treating staff with carriage of PVL-SA
- 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 PVL-SA in the community
- Identifying significant contacts of community cases of PVL-SA
- Contributing to outbreak investigations of healthcare acquired PVL-SA

4.10 **The Microbiology Laboratory** is responsible for:
- Providing a diagnostic and clinical advice service for PVL-SA
- Ensuring the IPCT is informed promptly of hospital inpatients with PVL-SA infection, and also other patients not in hospital who may have healthcare acquired infection.
4.11 All clinical staff are responsible for:
   o Maintaining standards of hygiene and use of PPE for the prevention of
     transmission of infection
   o Not working when they may have potential PVL-SA infections, such as
     recurrent boils and other skin infections, and taking appropriate measures to
     obtain treatment from their GP
   o Informing Occupational Health and an appropriate senior manager if aware
     that they may be infected or colonized with PVL-SA
   o 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. CLINICAL FEATURES

5.1 As with other strains of S. aureus, PVL-SA predominantly cause Skin and Soft
   Tissue Infections (SSTI), usually recurrent due to the overproduction of white cells
   to compensate for the destruction by the leukocidin. PVL-SA can also cause
   severe invasive infections such as septicemia, osteomyelitis and pneumonia.
   Necrotising haemorrhagic pneumonia is the most serious clinical feature with a high
   mortality rate (> 62%). This often follows a “flu-like” illness which may be a genuine
   viral infection or reflect the bacteraemia, and tends to affect otherwise healthy
   young people in the community.

5.2 Skin and soft tissue infections are often recurrent and include:
   - Boils (furunculosis), carbuncles, folliculitis, purulent eyelid infections
   - Cutaneous lesions
   - Pain and erythema out of proportion to severity of cutaneous findings
   - Necrosis

5.3 Invasive infections:
   - Necrotising pneumonia
   - Necrotising fasciitis
   - Osteomyelitis, septic arthritis, and pyomyositis
   - Purpura fulminans (clinical picture reminiscent of meningococcal septicaemia)

6. TRANSMISSION

6.1 Contact:
The main route of transmission in healthcare settings is by contact via the
   unwashed hands of healthcare workers. Inadequately decontaminated shared
   equipment is also a vehicle for transmission.

6.2 Airborne:
As with MRSA this is a much less important mode of transmission. PVL-SA may be
   transmitted via the airborne route on skin scales but this is only a significant risk if
   the patient has an excessive exfoliating skin condition such as eczema or psoriasis.
   However, the organism may remain viable in the environment for a long period of
   time (i.e. months) – thus keeping dust to a minimum is crucial. The risk of spread
   also exists in patients with PVL pneumonia who are ventilated or requiring airway
   succioning. Transmission of PVL–SA to staff has been documented following
contact with respiratory secretions during intubation of a patient with necrotising pneumonia, where Personal Protective Equipment (PPE) was not worn (Chalumeau et al, 2005). Therefore the need for appropriate PPE is paramount. Staff who fail to wear PPE when dealing with respiratory secretions in a suspected case, should be screened 3-7 days post exposure for PVL.

7. **RISK FACTORS**

7.1 The risk factors for PVL-SA seen in the UK are similar to those for CA-MRSA in North America. These include compromised skin integrity, skin to skin contact and the sharing of contaminated items such as towels. The worldwide picture suggests that closed communities with people in close contact result in higher transmission risks of staphylococcal infection.

7.2 The following settings can be assumed to increase the risk of PVL-SA based on their increased risk of CA-MRSA spread in North America:

- Households
- Close contact sports
- Military training camps
- Gyms
- Prisons

8. **WHEN TO SUSPECT A PVL-SA INFECTION**

8.1 PVL associated SA infection should be suspected if the patient has a necrotising SSTI, recurrent furunculosis or abscesses, or there is a clustering of SSTIs within a household or social group; also in invasive infections in immunocompetent people, particularly community acquired necrotising /haemorrhagic pneumonia in young, previously fit people.

9. **DECOLONISATION**

9.1 Topical decolonisation is often used to interrupt transmission and should commence after the acute infection has resolved. In the hospital environment, decolonisation can be used to promote clearance of the organism from a specific individual and also minimise the infection risks to other patients by reducing bacterial loading. Preoperative patients should commence decolonisation prior to surgery. Topical decolonisation without prior screening should be offered to primary cases. The five day decolonisation regimen is similar to that undertaken for MRSA decolonisation but with hair washing occurring on the 1st, 3rd and 5th day of treatment (See MRSA Policy, Appendix 2). Advice should be sought from a dermatologist where any pre-existing skin conditions are present.

9.2 Decolonisation of neonates, especially premature neonates is difficult. Where decolonisation is required, nasal mupirocin may be used. Antiseptic skin wash preparations must be aqueous and not alcohol based to avoid the risk of burn injuries.
10. SCREENING

10.1 Patients

10.1.1 If screening is required the method is the same as that for MRSA and involves swabbing:

- Both anterior nares (one swab will do for both – first moisten the swab with sterile saline)
- Throat
- Perineum (first moisten swab with sterile saline)
- Any wound, ulcer or other area of broken skin/skin lesion
- Manipulated sites (e.g. intravascular catheters, tracheostomies)

10.1.2 In addition, obtain:

- Catheter Specimen of Urine (CSU) - if catheterised
- Sputum - if expectorating

10.1.3 Make sure the swabs are labelled with the patient’s details and sent to the laboratory with a completed microbiology request form - the investigation required is ‘PVL screen’. It is important to remember that in the case of a potentially infected wound, a swab for culture and sensitivity should be sent to determine the identity of any causative organism.

10.2 Contacts

10.2.1 A decision will be made as to the appropriateness of contact screening. Close contacts that are infected or likely to be colonised because of a history of past infection should undergo decolonisation without prior screening. Repeat screening of positive contacts is not recommended unless they are particularly vulnerable to infection, pose a special risk to others (e.g. healthcare workers) or have evidence of ongoing suspected PVL infection. If required, repeat screens should be performed at least 7 days post decolonisation.

11. SOURCE ISOLATION PRECAUTIONS FOR IN-PATIENTS

Source isolation precautions must apply to all in-patients with known or suspected PVL-SA. Patients must be isolated and personal protective equipment (gloves and aprons) must be worn for direct patient contact and environmental cleaning. If isolation in a single room is not possible, spatial isolation in a bay should be implemented but only with the agreement of the Infection Prevention and Control Team as this will not be an option in some clinical settings. A risk assessment will need to be performed before this can take place. PVL-SA positive patients must not be situated in a bay with other patients who are immunosuppressed, have urinary catheters in situ, intravascular devices or open wounds.

12. MAINTAINING STANDARDS OF CARE

It is important to remember that control measures should not compromise standards of care or the need for urgent specialist care. The patient’s overall needs must take precedence.
12.1 Clinical investigations
Patients can undergo investigations in all departments, provided the department has been informed in advance. It is recommended that patients are dealt with promptly to minimise delay in returning to the ward. Standard infection control precautions should be practised by staff within the department. Equipment should be decontaminated, in accordance with the decontamination policy, before use on the next patient.

12.2 Transfers to other wards and community hospitals
Patients can be transferred from one ward to another ward or unit, if clinical need dictates. The receiving area must be informed in advance of the PVL-SA status to ensure that the appropriate facilities are available and the required precautions are applied. Movement for non-clinical reasons, e.g. outlying PVL-SA positive medical patients to surgical wards to increase bed availability in medicine, must be avoided (See Patient Placement and Movement Policy).

12.3 Mobilisation
If mobilisation is required when a patient is isolated in a single room, the patient can leave the room to allow mobilisation in an area away from the ward, e.g. main corridor. This does not mean that the patient can wander freely around the ward where close contact with other patients is inevitable. The distinction must be explained carefully to patients who may find it confusing.

12.4 Personal Hygiene
If en suite facilities are not available, patients may use communal facilities but these must be cleaned thoroughly after use. If patients are leaving an isolation room for this purpose, they must be advised this does not mean they can move freely around the ward.

12.5 Physiotherapy/Occupational Therapy
Please refer to the MRSA Policy (Appendix 9) as this is also applicable for PVL-SA.

12.6 Infection prevention and control for affected people in their own homes
The key principles of preventing and controlling the spread of infection in the community setting centre on:
- early suspicion of infection, with rapid diagnosis and appropriate treatment
- ensuring lesions are covered with clean, dry dressings, which are changed as soon as discharge seeps to the surface
- personal hygiene and good skin care (particularly those with eczema)

Standard precautions must be applied by health care workers providing direct care to patients with PVL-SA.

13. MANAGEMENT OF CLINICAL HEALTHCARE STAFF COLONISED/INFECTED WITH PVL-SA

13.1 A strong suspicion of PVL-SA should be applied to staff who have recurrent boils or other skin infections and Microbiology advice should be sought in response when this clinical picture is apparent. Staff found to be colonised or infected with PVL-SA will be treated in collaboration with Occupational Health and Infection Control.

13.2 Exclusion from work may be necessary, depending on the level of risk.
14. **ARCHIVING ARRANGEMENTS**  
The original of this policy, will remain with the author Lead Nurse, Infection Prevention & Control. An electronic copy will be maintained on the Trust Intranet, (A-Z,) P – Policies (Trust-wide) – P – PVL - Policy for the Management of Panton-Valentine Leukocidin (PVL) and other High Risk *Staphylococcus aureus* Infections in the Hospital Environment. 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.

15. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY/ STRATEGY**

15.1 To evidence compliance with this policy, the following elements will be monitored:

<table>
<thead>
<tr>
<th>What areas need to be monitored?</th>
<th>How will this be evidenced?</th>
<th>Where will this be reported and by whom?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Source isolation precautions must apply to all in-patients with known or suspected PVL-SA</td>
<td>Infection Control Nurse Specialists will check on routine ward visits.</td>
<td>Infection Control and Decontamination Assurance Group</td>
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</table>

16. **REFERENCES**


http://cid.oxfordjournals.org/content/41/3/e29.full.pdf+html

APPENDIX 1: COMMUNICATION PLAN

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

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<th>Staff groups that need to have knowledge of the policy</th>
<th>All clinical staff</th>
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<tr>
<td>The key changes if a revised policy</td>
<td>Change of format to reflect revised Trust policy template. Inclusion of section to reflect precautions required when caring for patients with PVL-SA in their own homes</td>
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<tr>
<td>The key objectives</td>
<td>The purpose of this policy is to ensure that PVL-SA infections in patients and staff are managed appropriately to minimize the risk of spread in the healthcare environment.</td>
</tr>
<tr>
<td>How new staff will be made aware of the policy and manager action</td>
<td>Local induction</td>
</tr>
<tr>
<td>Specific Issues to be raised with staff</td>
<td>Reporting skin sepsis e.g. boils, abscesses to Occupational Health promptly for advice</td>
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<tr>
<td>Training available to staff</td>
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</tr>
<tr>
<td>Any other requirements</td>
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<td>Location of hard / electronic copy of the document etc.</td>
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APPENDIX 2 - RAPID IMPACT ASSESSMENT SCREENING FORM

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<tr>
<td>Name, job title and contact details of person completing the assessment</td>
<td>Judy Potter, Lead Nurse/Director Infection Prevention and Control</td>
</tr>
<tr>
<td>Date:</td>
<td>20(^{th}) May 2015</td>
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**EXECUTIVE SUMMARY**
This section summarises:
- the impacts identified for action
- mitigating action
- the likely severity of the impact as a result of that action ("result").

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<tr>
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<th>Action</th>
<th>Result</th>
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<tbody>
<tr>
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<td>N/A</td>
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</table>

(If you need to progress to a full impact assessment, please include this as an action, above.)

1. **What is the main purpose of this policy / plan / service?** To ensure that PVL-SA infections in patients and staff are managed appropriately to minimize the risk of spread in the healthcare environment.

2. **Who does it affect?** Please tick as appropriate.
   - Carers ☐
   - Staff ☑
   - Patients ☑
   - Other (please specify)

3. **What impact is it likely to have on different sections of the community / workforce, considering the “protected characteristics” below?**
Please insert a tick in the appropriate box  √

<table>
<thead>
<tr>
<th>Protected Characteristics</th>
<th>Positive impact -- it could benefit</th>
<th>Negative impact -- it treats them less favourably or could do</th>
<th>Negative impact -- they could find it harder than others to benefit from it or they could be disadvantaged by it</th>
<th>Non-impact – missed opportunities to promote equality</th>
<th>Neutral -- unlikely to have a specific effect</th>
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<tbody>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

In identifying the impact of your policy across these characteristics, please consider the following issues:

- **Fairness** - Does it treat everyone justly?
- **Respect** - Does it respect everyone as a person?
- **Equality** - Does it give everyone an equal chance to get whatever it is offering?
- **Dignity** - Does it treat everyone with dignity?
- **Autonomy** - Does it recognise everyone’s freedom to make decisions for themselves?

If you have any negative impacts, you will need to progress to a full impact assessment.
In sections 4 and 5, please copy and repeat the tables below, for each “protected characteristic” considered. Alternatively, you can use one table for more than one “protected characteristic”, if the outcomes are similar.

4. If you have identified any positive impacts (see above), what will you do to make the most of them?

<table>
<thead>
<tr>
<th>“Protected characteristic” affected:</th>
<th>Issue</th>
<th>What did you find out about?</th>
<th>What did you learn or confirm?</th>
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<tbody>
<tr>
<td>Who did you ask to understand the issues or whose work did you look at?</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>By who?</td>
<td>When?</td>
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</tbody>
</table>

5. If you have identified any missed opportunities (“non-impacts”), what will you do to take up any opportunities to promote equality?

<table>
<thead>
<tr>
<th>“Protected characteristic” affected:</th>
<th>Issue</th>
<th>What did you find out about?</th>
<th>What did you learn or confirm?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who did you ask to understand the issues or whose work did you look at?</td>
<td>As above</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td>By who?</td>
<td>When?</td>
<td></td>
</tr>
</tbody>
</table>

6. If you have identified a neutral impact, show who you have consulted or asked to confirm that this is the case, in the table below:

<table>
<thead>
<tr>
<th>Who did you ask or consult to confirm your neutral impacts?</th>
<th>Infection Control &amp; Decontamination Assurance Group</th>
<th>Policy Expert Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Please list groups or individuals below. These may be internal or external and should include the groups approving the policy.)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>