1 Introduction

1.1 This policy intends to eliminate the risk of transmission of infection from an index patient with Tuberculosis (TB) to patients and staff. Prevention of Tuberculosis is referenced in several infection prevention and control policies in the Trust; however, this policy aims to bring the various aspects of prevention of TB together.

1.2 This policy is for Trust use only. It applies to infection with *Mycobacterium tuberculosis*, *Mycobacterium africanum*, *Mycobacterium bovis*, *Mycobacterium microti* and *Mycobacterium caprae*. The prevention of TB outside the Trust is a separate issue addressed by the Public Health England working together with the North of Tyne TB service and therefore individual patient management and chemotherapy in these instances are outside the scope of this policy. TB is a notifiable disease under Public Health Act and all suspected cases must be notified to the Health Protection Team at PHE. This is the responsibility of the diagnosing physician.

1.3 Immunisation of Staff

- This is dealt with in the Immunisation for Trust Staff and Protection against Infectious Disease Policy. Immunisation with BCG remains an important means of preventing TB in health care staff in the UK. For this reason, every effort should be made to ensure that staff who are in contact with patients or clinical specimens have been immunised with BCG.

It may be advisable to exclude staff who are particularly vulnerable to TB (e.g. those who are themselves immunocompromised in some way) from working on such wards; this decision should be made by Occupational Health Physician.

2 Scope

This policy applies to all healthcare professionals working across acute and community services within NuTH. This includes medical staff, nurses, allied health professionals, students and temporary clinical staff employed by the Trust or volunteers working in the Trust.
3 Aims

The aim of this policy is to prevent the spread of TB to patients and staff and to effectively manage patients with TB within Trust operated premises.

4 Duties (Roles and Responsibilities)

4.1 The Chief Executive has overall responsibility for implementation, monitoring and review of this policy. This responsibility is delegated to the Director of Infection Prevention and Control (DIPC).

4.2 The Infection Prevention and Control Committee (IPCC) will review the policy and any new evidence base within the time frame set out in the policy.

4.3 Ward Sisters/Charge Nurses, community staff are responsible for ensuring implementation within their area, and for ensuring all staff working within the area, adhere to the principles at all times.

4.4 It is the responsibility of all staff to ensure that they understand and implement this policy and attend training sessions as specified in their role.

4.5 It is the responsibility of the Trust to ensure that policies, education, training and procedures are in place to minimise the risk of infection.

4.6 Occupational Health and Well Being is responsible for assessing staff to exclude TB

5 Definitions

TB Tuberculosis
BCG Bacillus Calmette-Guerin
IPCT Infection Prevention Control Team
MDR Multi Drug Resistant
MTB Mycobacterium Tuberculosis
PTB Pulmonary Tuberculosis
CHP Consultant in Health Protection
PHE Public Health England

6 Tuberculosis

Tuberculosis is caused by the bacterium Mycobacterium tuberculosis (MTB). It can affect many parts of the body and is spread by inhaling MTB in droplets coughed or sneezed out by someone with Infectious TB.

Not all forms of TB are infectious. Individuals with TB in organs other than lungs are rarely infectious. Individuals with respiratory or pulmonary TB (that is when disease is
present in the lungs or airways) are infectious particularly when MTB is visible in their sputum under a microscope (smear positive). The risk of becoming infected depends on the duration and proximity of contact with the infectious patient and the vulnerability of the contact. The risk is greatest in those with close prolonged close contact.

Most patients cease to be infectious following two weeks of effective treatment.

**Signs and symptoms**

TB can affect many sites of the body, causing a wide range of symptoms, some of which may be non-specific.

Signs and symptoms of non-pulmonary TB vary depending on the part of the body involved. Weight loss and night sweats are commonly associated with most forms of non-pulmonary TB. TB should also be considered in patients from high risk groups with unexplained fever.

Pulmonary TB should be considered as a possible diagnosis in patients with a persistent cough (of 3 or more week’s duration) associated with any of the following symptoms.

- Weight loss
- Night sweats
- Intermittent fever
- Chest pain

Risk of cross infection is highest from smear positive pulmonary TB cases and there may be risk from non-pulmonary TB cases in some instance, eg abdominal drains in gut, TB not on appropriate treatment.

The recommendations below deal with three levels of isolation for infection prevention and control in acute and community settings:

- Negative-pressure rooms, which have air pressure continuously or automatically measured and vented to the outside of the building,
- Single rooms that do not have any special ventilation systems but have windows that access the outside of the building
- Beds on a ward e.g. in a bay, for which no particular engineering standards are required

6.1 All patients with TB should have risk assessments for drug resistance (see section 7.1) and for HIV. If risk factors for Multi Drug Resistant (MDR) TB are present, see section 7.2 for recommendations on infection prevention and control. Cephid Xpert-test to look for MDR TB can be requested at TB Lab, PHE, Newcastle.

6.2 Unless there is a clear clinical or socioeconomic need, individuals with TB at any body site of disease should not be admitted to hospital for diagnostic tests or for care.
6.3 If admitted, a patient with suspected respiratory TB should be given single room accommodation, preferably with en suite sanitary facilities or dedicated sanitary facility, urgent referral from Respiratory/ID Physician should be sought and IPC Team and Community TB nurses should be made aware.

6.4 Patients with Respiratory TB must be separated from immunocompromised patients, either by admission to single room accommodation or a negative-pressure single room.

6.5 Smear-positive TB patients without risk factors for MDR TB should be cared for in a single room, until:
   - they have completed 2 weeks of the standard recommended TB treatment, or
   - they are discharged from hospital.

6.6 Aerosol-generating procedures such as bronchoscopy, sputum induction or nebuliser treatment should ideally be carried out in an appropriately engineered and ventilated area for:
   - All patients on an HIV ward, regardless of whether a diagnosis of TB has been considered
   - All patients in whom TB is considered a possible diagnosis, in any setting

6.7 Healthcare workers caring for people with TB should comply with Standard Infection Control Precautions. Wearing of masks is indicated when:
   - MDR TB is suspected (FFP3 masks must be used while the patient is considered infectious)
   - Aerosol-generating procedures are being performed (FFP3 masks must be used)
   - The patient has a very productive cough and the HCW is directly exposed to respiratory secretions; following a risk assessment and direction from the patients physician or an Infection Prevention and Control Nurse (IPCN) (FFP3/surgical mask as directed)

When such personal respiratory protective equipment is required the reason must be explained to the patient, their relatives/carers and visitors. All single use respiratory equipment used on patients must be disposed of as clinical waste.

Label all specimens as Infection Hazard to alert laboratory staff.

Staff working on respiratory/ID wards and areas where TB patients are likely to be admitted should ensure they are FIT tested to enable them to wear the correct fitting FFP3 mask.

6.8 TB patients who are HIV-positive or immunocompromised patients should be considered infectious and should remain in a negative-pressure room until:

6.8.1 For individuals who are sputum smear positive at admission:
- The patient has had at least 2 weeks of **appropriate** multiple drug therapy
- If moving to accommodation (inpatient or home) with HIV-positive or immunocompromised patients, the patient has had at least three negative microscopic smears on separate occasions over a 14-day period, and the patient
  - is demonstrating tolerance to the prescribed treatment
  - is demonstrating an ability and agreement to adhere to treatment, and
  - either
    - any cough has resolved completely,
    - or
    - there is definite clinical improvement on treatment, e.g. remaining afebrile for a week

6.8.2 For individuals who are sputum smear negative at admission, that is, three negative samples were taken on separate days; samples were spontaneously produced sputum if possible, or obtained by bronchoscopy or lavage if sputum samples were not possible,
- Risk assessments for infection prevention and control purposes should be made in conjunction with IPC Team and/or Respiratory/ID Physician
- Risk assessments for Paediatrics for Infection Control purposes should be made in conjunction with IPCT and Paediatric ID Consultants

6.9 Inpatients with smear-positive respiratory TB should be asked (with explanation) to wear a surgical mask whenever they leave their room until they have had 2 weeks’ drug treatment. The mask should be changed hourly when used.

7 Risk Assessment and Infection Prevention and Control in MDR drug-resistant TB

7.1 Risk Factors
A risk assessment for drug resistance should be made for each patient with TB, based on the risk factors listed below; this should be done by an ID/respiratory physician
- History of prior TB drug treatment; prior TB treatment failure
- Contact with a known case of drug-resistant TB
- Birth in a foreign country, particularly in countries with high incidence of TB – eg African or Indian subcontinent (full list available from Ref 4 – NICE guidance)
- HIV infection
7.2 Infection Prevention and Control

7.21 Patients with suspected or known infectious MDR TB who are admitted to hospital should be referred urgently to Infectious Disease (ID) physician or ID paediatrician for admission to a negative-pressure room (R19). Care should be carried out in the negative-pressure room until the patient is deemed to be non-infectious or not infected with MDR TB, and ideally until sputum cultures are negative. A multi-disciplinary meeting will be arranged to involve IPCT and PHE to ensure all aspects of care are covered.

It is particularly important, where required, to work with interpreters, other communication support and provide information in a format that patients can understand.

7.2.2 Staff and visitors should wear FFP3 masks during contact with a patient with suspected or known MDR TB while the patient is considered infectious.

7.2.3 Before the decision is made to discharge a patient with suspected or known MDR TB from hospital, secure arrangements for the supervision and administration of all anti-TB therapy should have been agreed with the patient and their carers.

7.2.4 The decision to discharge a patient with suspected or known MDR TB should be discussed with the patient’s consultant, the IPC team, the local microbiologist, the local TB service, the consultant in health protection and the community TB nursing team.

7.2.5 Negative-pressure rooms used for infection prevention and control in MDR TB should meet the standards of the Interdepartmental Working Group on Tuberculosis and should be clearly identified for staff, for example by a standard sign. Such labelling should be kept up to date.

7.2.6 For a summary of recommendations on Infection Prevention and Control, see the algorithm on isolation decisions for patients with suspected respiratory TB (Appendix A)

7.3 Community Settings

7.3.1 Community staff must comply with Standard Infection Prevention and Control Precautions

7.3.2 Wearing of masks please refer to point 6.7

7.3.3 Clinical waste in patients' homes should be managed in accordance with District Nursing Service Process for Collection of Clinical Waste from Patients’ Home (Appendix C). This is arranged using the 'Request for Collection of Clinical Waste from a Patients Home’ form (Appendix D)
8 Endoscope Disinfection

Tuberculosis may be transmitted via inadequately disinfected endoscopes. The correct decontamination processes of these instruments are identified in the Trust Endoscope Disinfection Policy.

9 Action to be taken on the Diagnosis of Smear-Positive Pulmonary Tuberculosis in a patient

9.1 If the patient has been isolated since admission, no further action need be taken.

9.2 If the patient has been on the open ward for some time (which may be up to several weeks) before the diagnosis is confirmed, the following action should be taken:

9.2.1 Contact IPC Team who will request initiation of a meeting by Respiratory Physician, involving PHE and staff who have been involved in care of the patient, respiratory ward staff and Occupational Health for staff contact tracing.

9.2.2 Staff Contacts
The risk of transmission of TB to a member of staff is low; there is probably no greater incidence of TB in health care staff than in the general population (with the possible exception of laboratory staff and those who work regularly with specimens and culture isolates from patients with TB).

9.2.3 A “close contact” is defined as
- A staff member who has had clinical contact with a patient exceeding 8 hours cumulatively
- A staff member who has performed a bronchoscopy on the patient
- A staff member who has performed any of the following procedures, even if this is limited to a single contact:
  - induction of sputum
  - suctioning airways
  - fine-needle aspiration
  - swallowing assessments
  - chest physiotherapy

A close contact is not defined as those who:
- have no face-to-face contact with the patient
- do not have clinical contact (e.g. domestic staff, ward clerks, and porters)
- have only single or infrequent contact with the patient (with the exception of
- the staff listed above)
Using the above criteria, the IPC Team will inform Occupational Health who will draw up a list of close contacts in conjunction with the ward sister/Charge Nurse. The Occupational Health team will check the list for anyone that may be regarded as particularly vulnerable to TB. This would include:

- Staff who have not received BCG immunisation
- Staff who have been immunised but do not have a visible BCG scar
- Staff who are themselves immunocompromised/immunosuppressed

Occupational Health would take the guidance of ID Physician or Chest Physician to decode relevant action,

9.3 **Occupational Health and Well Being**

9.3.1 The Trust accepts its responsibility for adopting appropriate control measures to reduce the risk of infection to their employees and ensure these control measures are properly used.

9.3.2 The Trust conforms to ‘The prevention, management and control of Tuberculosis in North of Tyne guidelines (2011)’ and this is incorporated in the [Immunisation for Trust Staff and Protection against Infectious Disease Policy](#).

9.4 **Patient Contacts**

9.4.1 Following diagnosis of TB in a patient, a risk assessment should be undertaken. This should take into account:

- The degree of infectivity of the index case
- The length of time before the infectious patient was isolated
- Whether other patients are unusually susceptible to infection (e.g. immunocompromised)
- The proximity of contact.

Contact tracing and testing should be carried out only for patients for whom the risk is regarded as significant.

9.4.2 Patients should be regarded as at risk of infection if they spent more than 8 hours in the same bay as an inpatient with sputum smear-positive TB and who had a cough/sputum inducing procedures eg chest physio. The risk should be documented in the contact’s clinical notes, for the attention of the contact’s consultant. A list of such patients will be drawn up by the ward staff with help from IPCT as required. This will also form part of the discussion of the contact tracing meeting (see section 6) The contact should be given ‘Inform and advise’ information by their admitting
Consultant and their GP should be informed with a standard letter. 
(Appendix B)

10 **Other Infection Prevention and Control Issues**

10.1 **Diagnosis of TB in a staff member**

Occasionally, TB may be diagnosed in a member of staff, other than as part of the contact tracing process. It is extremely important that Occupational Health be informed of the diagnosis. Contacts of the affected staff would normally be dealt with by a respiratory physician, who may wish to involve the IPCT if patients have been exposed to infection. In addition, Occupational Health will inform the IPC Team if the infection is thought to have been occupationally acquired, since other patients and/or staff members may have been exposed to the same source of infection.

10.2 **Bronchoscopy**

Some smear-negative patients may become smear-positive after bronchoscopy. This may be a temporary phenomenon, but such patients should be treated as smear-positive (i.e. isolated) until they become smear-negative again. However, it is not recommended that the sputum of each patient with TB who undergoes a bronchoscopy should be checked after the procedure; therefore patients should normally remain in isolation after bronchoscopy until coughing has returned to normal, which would usually take 24-48 hours. Staff performing the bronchoscopy should wear a FFP3 mask during the procedure.

10.3 **Fine-needle Aspiration**

This procedure poses a negligible risk to staff, but it is recommended that staff performing the procedure on a patient with confirmed or suspected TB should wear a FFP3 mask.

10.4 **Waiting areas in Chest Clinics/TB Clinics**

Patients with infectious or potentially infectious forms of tuberculosis should

- Be kept separate from other patients as far as possible (moved straight to a clinic room).
- Wear a surgical mask. Patients with known infectious MDR-TB should wear FFP3 masks.
- Patient focused hygiene measures (cough hygiene) can help reduce aerolisation of potentially infected droplet nuclei.
- Confirmation that the patient is no longer infectious should be sought from the TB physician (this will normally mean that three consecutive sputum smears on separate days have been negative on microscopic examination, provided patient has not stopped coughing altogether).
10.5 Visits to other departments
This is covered in the Trust’s Isolation Policy. However, it should be noted that some departments have small rooms with poor ventilation. To avoid a risk of infection to other patients TB smear positive patients should be seen, wherever possible, on the ward in the first instance or at the end of an afternoon session in clinic if clinically indicated. All smear-positive patients should wear a mask if being transported through patient or public areas of the hospital. A routine surgical mask is satisfactory for this purpose and should be changed at hourly intervals. If the patient is known or suspected to be infected with MDR-TB, then advice on any additional procedures, including the use of FFP3 masks, should be sought from the IPCT.

10.6 Terminal Cleaning
Terminal cleaning of rooms in the acute and community settings and areas used by patients with TB/MDR TB should be carried out using chlorine releasing detergents at 1000 parts per million.

10.7 Ambulance Transport
Ambulance staff need sufficient information for organizing appropriate vehicle in addition to their own protection. As with visits to other departments, patients with smear-positive pulmonary TB should wear a surgical mask (changed at hourly intervals if necessary) during ambulance transport – if the patient has not completed 2 weeks of appropriate anti tuberculous treatment. If the patient is known or suspected to be infected with MDR-TB, then advice on transport should be sought on an individual basis from the IPCT, Respiratory Physician, or an ID physician. Standard procedures and close liaison with ambulance trust is necessary for contact tracing for ambulance staff who have been inadvertently in contact with a patient with confirmed infectious or potentially infectious pulmonary tuberculosis and will be covered by ambulance trust policies.

10.8 Death
In the event of a death in a patient with TB reference should be made to the Care of the Cadaver policy.

11 Training
All staff are responsible for accessing IPC policies in order to assist in the management of their patients.

12 Equality and Diversity
The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.
13 Monitoring and Compliance

Compliance with this policy will be monitored by ID Physicians, Respiratory Physicians and the IPC team on an individual case to case basis and will address any issues not currently complied with and monitor until patients discharge. As a Notifiable Disease, statutory documentation would also be completed by Consultant or Clinician in Charge.

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
<th>By</th>
<th>Committee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>All aspects of this policy</td>
<td>Individual review of patient management case by case</td>
<td>Infection Prevention and Control Team</td>
<td>Infection Prevention and Control Committee</td>
<td>Every three years or as needed.</td>
</tr>
</tbody>
</table>

14 Consultation and Review

Consultation on this policy was carried out in association with ID Physicians (Adult and paediatric), Respiratory Physicians and the IPC team. This policy will be formally reviewed every three years, or as and when significant changes make earlier review necessary.

15 Implementation (including raising awareness)

Matrons/Sisters/Charge Nurses and Clinical Leads should ensure that staff are aware of this policy. The policy is available for staff to access via the NuTH Intranet.

16 References


4 National Institute for Health and Clinical Excellence (March 2011)). Clinical Guideline 33
Tuberculosis: clinical diagnosis and management of tuberculosis, and measures for its prevention and control.

5 The prevention, management and control of Tuberculosis in North of Tyne (NoT).
NoT Tuberculosis Network Group. Jan 2011

17 Associated Documentation

- Care of the Cadaver policy
- Cleaning and Disinfection Procedure
- Decontamination of Healthcare Equipment following Patient Use and Prior to Service and/or Repair
- Decontamination of the Patient Environment including Terminal and Deep Cleaning
- Guidelines for Skin Care
- Hand Hygiene Policy
- Endoscope Disinfection Policy
- Hospital Discharge and Homeless Prevention Policy
- Immunisation for Trust Staff and Protection against Infectious Disease Policy
- Isolation Policy
- Laundry Management Policy
- Personal Protective Equipment
- Standard Infection Control Precautions
- Transport of Clinical Specimens
- Waste Management Policy and Procedures

Link to ‘Putting Patients at the Heart of All We Do’- provides information about support in the community for people with protected characteristics
Appendix A: Isolation decisions for patients with suspected respiratory TB

Wear PPE as directed in policy above

- Known or suspected MDR TB, based on risk assessment?
  - Yes: Admit to negative-pressure room
  - No: Admit to single room

- Sputum smear positive (1 or more from 3 samples)?
  - Yes: Risk for MDR TB?
    - Yes: Negative-pressure room (irrespective of HIV status), Molecular probe for rifampicin resistance
    - No: Single room on ward
  - No: Risk for MDR TB?
    - Yes: Does ward have immuno-compromised patients?
      - Yes: Standard ward
      - No: Negative-pressure room
    - No: Does ward have immuno-compromised patients?
      - Yes: Standard ward
      - No: Negative-pressure room
Appendix B

Letter Template

Template of a letter to be sent to the GPs of patients who are contacts of a patient with TB in Newcastle hospital, but who are not thought to be particularly vulnerable to TB
Copy to the Consultant under whose care they were

Dear <GP>,

Re: <Name of patient, etc.>

I am writing to inform you that while <patient's name> was in <ward no.>, <hospital name>, between <dates of admission/discharge>, he/she was nursed in bed adjacent to a patient who was subsequently found to have active pulmonary tuberculosis.

The risk of infection is low, and in accordance with the British Thoracic Society Guidelines for the Control and Prevention of Tuberculosis, we would not normally advise any special action unless the patient was unusually prone to infection, e.g. with Immunosuppression due to disease or treatment. As I understand it, this does not apply to <patient's name>. Clearly, the potential exposure should be borne in mind if he/she were to develop otherwise unexplained symptoms. I would be happy to advise you further if required.
Clinical waste in Patients Homes – Model Flow chart

Waste arising in patients home – carry out a risk assessment

Is the waste likely to cause a risk of infection?

YES

Hazardous Infectious waste (CAT B)
Examples include:
- Waste containing a significant quantity of blood (e.g. haemodialysis)
- Dressings from infected blood stained wounds (e.g. HIV, Hepatitis B)
- Wound vacuum drains (excluding topical negative pressure)
- Acute gastro intestinal infections (e.g. Clostridium Difficile)
- Heavily exuding infected wounds (e.g. MRSA)

Dispose of as hazardous infected clinical waste (Orange bag) ready for collection

NO

If possible double bag and place into domestic waste (black bag)

Additional considerations
- Gain prior consent from patient for storage and collection of hazardous infectious waste.
- Ensure safe storage away from children/animals (waste cannot be left on the street awaiting collection).
- Bags should be appropriately labelled (date, service and locality) and secured with plastic tag.
- Medicinal waste should be returned to patients pharmacy
- Sharps waste generated by patient and not healthcare worker must go back to patients GP in appropriate sharps box

The health care worker responsible for generating the waste must seek approval from their Cluster Co-ordinator for collection to be undertaken by the contracted waste supplier.

Cluster Co-ordinator to send details to contactor who will arrange collection

NB Staff will need to inform their Cluster Co-ordinator once waste collection service no longer required.
### District Nursing Service

#### Process for Collection of Clinical Waste from Patient Home

<table>
<thead>
<tr>
<th>Process</th>
<th>Responsibility</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify need for collection of clinical waste according to flow chart Appendix 1</td>
<td>District Nurse</td>
<td></td>
</tr>
<tr>
<td>Forward Request Form to Cluster Co-ordinator for authorisation</td>
<td>District Nurse</td>
<td></td>
</tr>
<tr>
<td>Check Request Form + authorise Forward via email to SRCL (<a href="mailto:sallan@srcl.com">sallan@srcl.com</a>, <a href="mailto:myates@srcl.com">myates@srcl.com</a>, <a href="mailto:adevlin@srcl.com">adevlin@srcl.com</a>) Copy to <a href="mailto:Angie.Drinkald@newcastle-pct.nhs.uk">Angie.Drinkald@newcastle-pct.nhs.uk</a> <a href="mailto:James.Dixon@nuth.nhs.uk">James.Dixon@nuth.nhs.uk</a></td>
<td>Cluster Co-ordinator</td>
<td></td>
</tr>
<tr>
<td>Input details onto spreadsheet</td>
<td>Admin Team Lead</td>
<td></td>
</tr>
<tr>
<td>Confirmation received SRCL to ‘Reply to All’ with confirmation</td>
<td>SRCL</td>
<td></td>
</tr>
<tr>
<td>Email District Nurse to confirm service set up</td>
<td>Admin Team Lead</td>
<td></td>
</tr>
<tr>
<td>Forward Spreadsheet to clinical Nurse Lead monthly for audit Copy to <a href="mailto:James.Dixon@nuth.nhs.uk">James.Dixon@nuth.nhs.uk</a></td>
<td>Admin Team Lead</td>
<td></td>
</tr>
<tr>
<td>Inform Central Admin when service to cease</td>
<td>District Nurse</td>
<td>As soon as possible when identified</td>
</tr>
<tr>
<td>Email SRCL (<a href="mailto:sallan@srcl.com">sallan@srcl.com</a>, <a href="mailto:myates@srcl.com">myates@srcl.com</a>, <a href="mailto:adevlin@srcl.com">adevlin@srcl.com</a>) to cancel service Using standard email memo Copy to <a href="mailto:James.Dixon@nuth.nhs.uk">James.Dixon@nuth.nhs.uk</a> Copy to cluster co-ordinator for information</td>
<td>Admin Team Lead</td>
<td>As soon as possible when identified</td>
</tr>
</tbody>
</table>
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. Assessment Date: 12/11/2014

2. Name of policy / strategy / service:
   Prevention and Control of Tuberculosis

3. Name and designation of Author:
   Dr Manjusha Narayanan, Consultant Microbiologist

4. Names & designations of those involved in the impact analysis screening process:
   Dr Manjusha Narayanan, Consultant Microbiologist

5. Is this a: Policy √ Strategy Service
   Is this: New Revised √
   Who is affected Employees √ Service Users Wider Community

6. What are the main aims, objectives of the policy, strategy, or service and the intended outcomes? (These can be cut and pasted from your policy)
   The aim of this policy is to prevent the spread of TB to patients and staff and to effectively manage patients with TB within the Trust.

7. Does this policy, strategy, or service have any equality implications? Yes ☐ No √
   If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
   The policy is applicable to all
8. Summary of evidence related to protected characteristics

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address (by whom, completion date and review date)</th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? (by whom, completion date and review date)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Age</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Maternity / Pregnancy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes □ No □

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No
PART 2

Name: 
Dr Manjusha Narayanan

Date of completion: 
12 November 2014

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)