

Title: **ASPERGILLUS AND OTHER INVASIVE FUNGI
DURING BUILDING WORK**

Ref: 0960 Version 4
Classification: Protocol

Directorate: Infection Control

Due for Review: 25/05/21
[Document Control](#)

Responsible
for review: Director for Infection Prevention & Control

Ratified by: Infection Prevention and Control Committee

Applicability: All staff

Policy statement:

It is a policy of TSDFT that the following recommendations are implemented and strictly adhered to when any form of building work is to be undertaken. Such work includes the following; demolition, construction, renovation work or any other activity where there is an increased risk of creating airborne particles originating from soil, dust or the fracture of building materials.

1.0 Background

When building work takes place within the hospital environment, certain categories of patients (e.g. immunosuppressed, chronic lung disease) are at increased risk of developing invasive fungal infections. During demolition, construction and renovation work, dust is generated that may contain fungal spores that can be inhaled by susceptible patients. There have been documented outbreaks of invasive fungal infections whilst such work was ongoing, nearly all of which were preventable.

Building work should be regarded as any renovation, redecoration and maintenance work that involves disturbance to any fabric of the building, including ceiling tiles.

To ensure a safe environment to prevent infection in high risk patients, there needs to be a co-ordinated strategy with procedures in place prior to, during and following completion of building work.

This policy advises on general measures that must be taken to ensure that patients are not put at unnecessary risk.

What is Aspergillus?

Aspergillus belongs to a group of moulds that are found world wide. They are particularly prevalent where warmth and moist conditions encourage growth.

The spores are found in soil, decomposing plant matter, household dust especially when vacuuming, building materials, ornamental plants, specific food stuffs and water.

For more information on Aspergillois and associated risk factors see appendix 3.

2. Responsibilities

Generally joint responsibility for the control of Aspergillus falls with the named Project Manager and the Infection Prevention and Control Team (IPCT). Close liaison with some or all the following departments/ individuals is likely to be required.

- Capital planning

- Estates/ Property Management
- Hotel Services
- Health and Safety Advisor
- Microbiology
- Heads of relevant Departments for Medical and Nursing Staff including Cancer Services, ITU, Respiratory Medicine
- Divisional Managers and Assistant Directors of Nursing
- Theatre Leads
- Design Team representatives
- Contractors

The IPCT will have an overview of areas requiring additional special environmental requirements and these will include.

- All Theatre complexes
- All areas fitted with HEPA filtration
- Critical Care Unit
- Oncology/ Haematology Unit
- Cytotoxic Suite
- Special Care Baby Unit
- Areas housing immunocompromised patients (e.g. on high dose steroids)
- Areas housing patients with chronic lung disease
- Patients undergoing major surgery
- Areas facing the windows where immunosuppressed patients are housed.

2.1 Aspergillus within the Estate

The Estates Department/ Project Manager Representative has a major role to play in ensuring the control of spore propagation during renovation work or new build work, particularly when it is close to air intakes. It is important that they discuss proposals with the IPCT as early as possible during the planning process.

During the project definition stage a risk evaluation will take place to determine the severity of risk particularly with regard to air intakes and the proximity of vulnerable patient groups to potential dust and this will be submitted to the IPCT.

3.0 Control and containment

- a) The Contractor is responsible for the suppression of any dust arising from the work site and a written protocol must be supplied to the IPCT.
- b) The Contractor will provide a physical barrier between the site and all other patient areas.
- c) The Contractor in conjunction with the Estates Department will provide alternative routes for patients and visitors so as to minimise the risk of the spread of dust through the opening and closing of doors.
- d) The Contractor is responsible for controlling/limiting access to the Site. Susceptible persons will not be allowed to visit the site and should keep away from the vicinity. In the event of Health Care Workers having cause to visit the site, they will need to be aware of the risk of dust contaminating their clothing and as such should wear protective, disposable clothing if they are returning to their work place.

- e) There should be a formal review process for monitoring environment control/containment, which is undertaken at regular periods throughout the work and on completion. This will be led by the Director of Infection Prevention & Control (DIPC).

4.0 Environmental measures to be considered/undertaken during building work

A formal risk assessment must be carried out by the IPCT along with a representative from Project Services/ Estates and, where applicable, the Contractors prior to commencement of any work. (See appendix I for assessment proformas)

All building work must be undertaken in compliance with this policy, relevant HTMs, Building Notes, national guidelines and legal requirements (e.g. Health and Safety and Work Act). Any discrepancies should be identified and discussed with the Project Manager and ICSD prior to commencement of the work.

If the building work is located close to patients at high risk of acquiring Aspergillosis, serious consideration should be given to moving them to an alternative area. If this is not possible, it may be necessary to consider postponement of immunosuppressive treatment or the use of anti-fungal prophylaxis.

Robust, dust-proof barriers that are at least double polythene sheeting should be constructed between patient care areas and any building work. They should have airtight seals that prevent the passage of any dust that may contain fungal spores.

These barriers must be inspected by the IPCT **prior** to commencement of any work and then daily by a designated individual who will maintain a record of the inspections.

In certain situations, additional dust containment measures may be necessary, such as the use of water sprays. It should be noted that the use of water as a means of suppressing dust can encourage the growth of Aspergillus.

If there is a water leak during any building work, it must be repaired and cleaned as soon as possible as damp materials encourage fungal growth. If it cannot be rectified within 72 hours of the incident, affected fabric and materials will need to be disposed of safely.

Ventilation ducts within the construction/building work area should be sealed whenever possible.

Where possible, air from the construction site should be exhausted to the outside of the building away from the hospital. If this is not possible, consideration should be given to HEPA filtration in the unit air supply to patients in high risk areas.

During the construction phase, particularly where the site is within the Hospital building then the Contractor is to be responsible for the creation of a **negative** pressure within the site relative to the adjacent areas. Rooms in use by patients should have air pressures maintained continuously above that of corridors/ stair wells, whenever possible, unless there are infection control requirements for not doing so.

All Air Handling Units (AHU) serving the areas being worked upon or AHU with air intakes that are down wind of the site will be kept clean. Particular attention will be given to the cleanliness within the air intakes and other sections to ensure that any organic matter is kept to the very minimum. It will also be necessary to confirm that all insulation is non organic. All drain traps will be kept full but also Chlorinated to ensure there is no possible source of contamination.

Cleaning of the Air Handling Plant must be in accordance with HTM 03-01. This work is already undertaken as part of the normal Planned Preventative Maintenance but will need to be recorded in the Site Construction Log book.

Where the site is adjacent to high risk areas all duct connections (including service ducts) are to be fully sealed. Such ducts include conduits that pass through the wall as well as ventilation ducts. All windows are to be kept sealed shut.

Where possible, the building site workers should have designated access to the work area as far away as possible from patient care areas.

If building work takes place on upper floors, consideration should be given to designating a lift for the sole use of the construction workers and their equipment or an external hoist system considered for removal of debris.

If the contractors are not given sole use of lifts, then all internal surfaces of the lift car should be visibly clean and dust-free before being used by patients and catering staff.

Construction workers whose clothes have become contaminated with possible fungal spores should avoid contact with non-construction areas and they must **not** enter patient areas. They should also wear an overall to be removed on leaving the work site.

All waste material must be removed with minimal creation of dust e.g. bagging of waste, use of sealed containers, covering of skips. The use of material chutes is not prohibited but will need to be risk assessed with regards to the spread of dusts at the point of impact. Likewise the emptying of sealed containers will need to be considered with regards to the spread of dust.

Dustsheets must be single-use only.

Place adhesive floor strips outside the door to the construction area to trap dust.

Any Vacuuming work deemed necessary will be undertaken with a Vacuum cleaner fitted with a HEPA filter capable of removing particles of more than 1.5 microns diameter. Once contaminated the filter cartridge is to be considered as contaminated waste and disposed of in accordance with the Trust Waste policy.

Consideration should be given to the isolation and disabling of ventilation in areas where building work is ongoing.

If building work is occurring in the vicinity of high-risk areas, it will be necessary to seal windows for the duration of the work and for at least a week following completion of the work (see section 9.0 for Health and Safety considerations).

Information leaflets should be made available for patients and their relatives to explain the need for the windows to be sealed.

Staff and visitors should **not** enter construction areas without the express consent of the Project Manager.

There should be an increase in the frequency of cleaning in areas adjacent to the work being undertaken.

Newly constructed/refurbished areas should be cleaned thoroughly before high-risk patients are allowed to enter. This should include vacuuming of areas above false ceilings where necessary. The Infection Control Team will inspect areas to ensure that they have been cleaned appropriately.

When building work is finished, the ventilation system, direction of airflow and room pressurisation should be tested and adjusted if necessary **before** patients are allowed to enter.

Where all the above methods can not reduce the risk to acceptable levels then consideration will need to be given to re-locating at risk patients to safe areas

If it is necessary for a severely immunocompromised patient to be transported close to a construction area they should wear a fit-tested FFP3 mask.

6.0 Environmental monitoring

The robustness of environmental measures should be monitored on a daily basis.

Dust-proof barriers should be inspected daily to ensure that the seals are intact.

The value of air and environmental sampling during building work is unclear. However, in certain circumstances it may be necessary and the DIPC or consultant microbiologist will advise on this.

If a case of Aspergillosis occurs (or is suspected) then work will be stopped and an Outbreak Meeting convened.

7.0 Risk assessment prior to commencement of building work

Once the project management team becomes aware of any proposed building work within the Trust, they must complete Section A (see appendix I) and send it to the IPCT.

The IPCT will complete Section B (see appendix I) and forward a copy to a **named** Project Manager.

It is the responsibility of the representative to ensure that contractors and subcontractors have read this policy and completed a risk assessment.

8.0 Post completion of building work

Upon completion the contractor is to be responsible for the first level of cleaning. Thereafter the Hotel Services are to under take a deep clean of the area. The area will only be declared fit for use once the IPCT are satisfied with the level of cleanliness.

9.0 Additional Health and Safety considerations

Generally, Aspergillus is not normally considered a risk to otherwise healthy individuals. However, if a member of staff does has a disability that could result in a increased susceptibility to infection (see section 3 in Appendix 3) then a risk assessment must be made by the Occupational Health department for that individual.

As some work is likely to be undertaken in the Summer months and windows may have to be sealed, there may be an increased risk of dehydration and other heat related stress. This will need to be considered in advance to that appropriate measures can be undertaken to minimise such risks e.g. relocation of patients, safe provision of cool air, increased frequency of breaks, availability of refreshments.

10.0 Appendices

Appendix 1: Risk assessment for Aspergillus during renovation or construction.

Appendix 2: Audit trail document

Appendix 3: Clinical aspects of aspergillosis and risk factors

Appendix 4: Daily check so all contractors are aware of the need to reduce the risk of building dust spreading that could contain Aspergillus

Risk Assessment for Aspergillus During Renovation / Construction

1. Instruction for completion
 - 1.1 Once Facilities Department are aware of any proposed renovation/construction and work in the Trust they must complete Section A prior to sending it to the Infection Control Nurse or other member of the Infection Control Team. This included proposed work on ducting, ventilation systems and false ceiling work.
 - 1.2 The Infection Control Nurse will complete Section B and forward completed copy to named Project Management representative.
 - 1.3 It is the responsibility of the named Project Management representative to ensure contractors see a copy of both the Aspergillus Policy and completed risk assessment.

Section A (for completion by facilities project management representative)

1. Date proposed renovation/ construction due to commence:
2. Name of facilities project representative completing form:
3. Contact number:
4. Description of proposed building work:
5. Description of proposed site area:
6. Any additional comments:

Section B (for completion by Infection Prevention & Control Team)

1. Date form A received from facilities project representative: Date
2. Section B completed by: Date
3. High risk areas identified by Infection Control Support Team:

Other at risk areas identified:

Comments:

4. Relevant Manager(s) informed:
5. Has above Manager(s) been sent policy on Aspergillus: Yes () No ()
6. Other hospital services informed:
7. Date of visit to site with Project Management Representative to inspect suitability and robustness of control measures (prior to work commencing) Date
8. Additional comments: (provide on separate sheet if necessary)

9. Contact details of Project Management Representative (and deputy)

Name:

Telephone:

E-mail:

Audit

TOPIC : Cleaning During Building, Upgrading and Demolition Work in Health Care Premises

OUTCOME: Dust and building debris is kept to a minimum to reduce the risk of hospital acquired infection.

STATEMENT AUDIT CRITERIA (YES/ NO/ N/A)

The additional cleaning requirements are clearly defined prior to the commencement of any building, upgrading or demolition work.

TARGET

ACTUAL

VARIANCE

1. A risk assessment is carried out prior to work commencement, involving the Infection Control Support Team, Domestic Services Manager and Estates Department.
2. There is written communication of the requirement for additional cleaning during building or demolition work.
3. The Domestic Services Manager monitors the provision and standard of the additional cleaning.
4. Responsibility for clear communication is defined prior to the commencement of work.
5. The standard of cleanliness, agreed following the risk assessment, is maintained during the building, upgrading or demolition work.
6. The Domestic Services Manager documents deficiencies in the standard of cleanliness.
7. There is evidence to show that action to remedy deficiencies in the standard of cleanliness has been taken.

Action plan (including timescales)

Signature of Auditor:

Date of Audit:

Job Title:

Review Date:

Location of Audit:

Clinical aspects of aspergillus and associated risk factors

1. What are the main pathogens causing invasive fungal infections?

The most important fungi associated with invasive infections is *Aspergillus*, with the majority of infections being caused by *A. fumigatus* or *A. flavus*.

Aspergillus species and other fungi associated with invasive disease are capable of producing spores, which can persist in the environment and remain suspended in the air for significant periods of time.

These fungal spores are resistant to many disinfectants, extremes of temperature and light, allowing them to survive for long periods in the environment.

This policy concentrates on *Aspergillus* species, but the recommendations are applicable to other fungi capable of causing invasive infections

2. Where do fungi such as Aspergillus come from?

These fungi occur naturally in the environment in reservoirs such as soil and water. They are found inside buildings.

In the hospital setting, fungi have been isolated from unfiltered air, ventilation ducts, dust (especially dust generated during building work), flowers and damp/decaying wooden fittings.

3. Who is 'at risk' of developing Aspergillosis?

- Patients with profound neutropenia (defined as a neutrophil count of $< 1 \times 10^9/L$)
- Acquired or Congenital immunodeficiency such as severe combined immunodeficiency, chronic granulomatous disease or AIDS
- Patients receiving high-dose systemic corticosteroid therapy
- Solid organ transplant recipients
- Those who have undergone major surgery
- Patients with chronic lung disease

The Infection Prevention & Control Team should be involved in the risk assessment process to identify any at-risk patients.

4. How do patients acquire invasive fungal infections?

Usually by the inhalation of fungal spores which can then lead to severe pneumonia or sinusitis.

The fungi can also spread via the bloodstream to other organs including the brain, liver and kidneys.

5. How serious are invasive fungal infections?

For certain groups of patients invasive fungal infections can be fatal e.g. for some bone marrow transplant patients, mortality rates of 80-100% are typical. Even in non fatal infections, morbidity is significant and in certain cases surgical debridement of infected tissue may be extensive and result in severe facial disfigurement.

Aspergillosis is difficult to diagnose and techniques may only produce positive results in the later stages of infection.

Invasive techniques may be required for diagnosis (e.g. lung biopsy) which may not be appropriate for thrombocytopenic patients. Many cases of aspergillosis are diagnosed only at post mortem.

Invasive fungal infections are also difficult to treat due to the limited range of anti-fungal drugs available.

6. How can invasive fungal infections be prevented?

- Environmental measures
- Identification of 'at-risk' groups
- High index of suspicion in at-risk patients (particularly when there may be high level of spores in the environment)
- Provision of HEPA-filtered air
- Antifungal prophylaxis.

Daily check so all contractors are aware of the need to reduce the risk of building dust spreading that could contain Aspergillus

Project:		Main contractor:	Time:	Date:	
Check list:			Required	In place	PM
Robust, dust-proof sealed hoarding that has double polythene sheeting - (adjacent to high risk areas)					
Zipper curtain across doorway or where the door has been removed – (seals intact & sealed at the bottom)					
Ducted ventilation grills within the construction site should be covered and sealed whenever possible					
Sticky mat in place on public side of works, within building site compound on large sites, changed as needed					
Additional cleaning & mopping in place to reduce dust carried out by contractor or cleaning team					
Use of HEPA filtered vacuum cleaner (capable of removing particles of more than 1.5 microns diameter)					
Vacuuming of concealed areas – boxings & false ceilings where works to these are outside a room/ hoarding					
Cutting carried out in an agreed area outside of the building, within the hoarding or behind a closed door					
Air from the construction site to be exhausted to the outside of the building away from occupied areas					
Overshoes to be worn inside the hoarding for very dusty work & removed on exit					
Dust sheets must be single use only					
All waste material to be removed with minimal creation of dust, such as:-		<ul style="list-style-type: none"> • Bagging of waste • Use of sealed container (wheeled bin, etc.) • Removal of waste out of hours 			
Contractors/sub-contr's to avoid contact with non-construction areas & patient areas as far as practicable					
Operatives to wear overalls to be removed on leaving the work site when practicable or as instructed					
Designated site access and transit routes to be agreed with the contractor, sub/contractor, PM, Department Managers and Infection Control					
Close & seal/ lock windows adjacent to the work site that have potential to admit dust from the building site					
Water leaks to be repaired and cleaned as soon as possible. (Note: damp materials encourage fungal growth)					

Adapted from the 0960 - Aspergillus and other Invasive Fungal Infections During Building Work Policy Sept '17/IP&CT – MAKE COMMENTS TO BACK OF SHEET

Protocols & Guidelines – Document Control

This is a controlled document. It should not be altered in any way without the express permission of the author or their representative. On receipt of a new version, please destroy all previous versions.

Ref: 0960	Title: Aspergillus and other Invasive Fungal Infections During Building Work, Control and Development of		
Date of Issue:	25 May 2018	Next Review Date:	25 May 2021
Version:	4		
Author:	Director of Infection Prevention and Control		
Division Responsible:	Infection Control		
Classification:	Protocol		
Applicability:	All staff		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief.		
Evidence based:	Yes		
References:	<p>Centres for Disease Control 1994. Issues on Prevention of Nosocomial Pneumonia. American Journal of Infection Control Volume 22, Page 247 - 292.</p> <p>Fitzpatrick F Prowt S, Gilleec, E.A. Fenlan LE, and Murphy OM, 1999, Nosocomial Aspergillus During Building Work - Multi-disciplinary approach (letter). Journal of Hospital Infection Volume 42 No. 2 Page 170 - 171.</p> <p>Wensell RP, Hospital Environment for Higher Risk Patients, Prevention and Control of Nosocomial Infection. Williams and Wilkins 3rd Edition 1997, Pg 463 – 489.</p> <p>Leeds Teaching Hospitals. Infection Control Guidelines; Control and Prevention of Aspergillosis and other Invasive Fungal Infections during Building Work.</p> <p>HSG (95) 10 Hospital Infection Control: Guidance on the control of infection in hospitals prepared by the joint DH/PHLS Hospital Infection Working Group</p> <p>Infection Control in the Built Environment. Design & Planning. NHS Estates 2001.</p>		
Produced following audit:	No		
Audited:	No		
Approval Route:	See ratification sheet	Date Approved:	26 April 2018
Approved By:	Infection Prevention and Control Committee		
Links or overlaps with other policies:			
All TSDFT Trust strategies, policies and procedure documents.			

PUBLICATION HISTORY:

Issue	Date	Status	Authorised
1	26 November 2006	New	Director of Nursing & Quality. Medical Director
1	2 April 2009	Date change	Director of Nursing & Quality. Director for Infection Prevention & Control
1	25 June 2009	Document Information	
1	10 March 2011	Date Change	Director of Nursing & Quality. Director for Infection Prevention & Control
2	20 March 2013	Revised	Director of Infection Prevention & Control Director of Quality and Patient Experience Director of Nursing and Professional Practice
2	9 January 2015	Date change	Infection Control Department
3	20 January 2017	Revised	Infection Control Department
4	25 May 2018	Revised	Infection Prevention and Control Committee

The Mental Capacity Act 2005

The Mental Capacity Act provides a statutory framework for people who lack capacity to make decisions for themselves, or who have capacity and want to make preparations for a time when they lack capacity in the future. It sets out who can take decisions, in which situations, and how they should go about this. It covers a wide range of decision making from health and welfare decisions to finance and property decisions

Enshrined in the Mental Capacity Act is the principle that people must be assumed to have capacity unless it is established that they do not. This is an important aspect of law that all health and social care practitioners must implement when proposing to undertake any act in connection with care and treatment that requires consent. In circumstances where there is an element of doubt about a person's ability to make a decision due to 'an impairment of or disturbance in the functioning of the mind or brain' the practitioner must implement the Mental Capacity Act.

The legal framework provided by the Mental Capacity Act 2005 is supported by a Code of Practice, which provides guidance and information about how the Act works in practice. The Code of Practice has statutory force which means that health and social care practitioners have a legal duty to have regard to it when working with or caring for adults who may lack capacity to make decisions for themselves.

“The Act is intended to assist and support people who may lack capacity and to discourage anyone who is involved in caring for someone who lacks capacity from being overly restrictive or controlling. It aims to balance an individual's right to make decisions for themselves with their right to be protected from harm if they lack the capacity to make decisions to protect themselves”. (3)

All Trust workers can access the Code of Practice, Mental Capacity Act 2005 Policy, Mental Capacity Act 2005 Practice Guidance, information booklets and all assessment, checklists and Independent Mental Capacity Advocate referral forms on iCare

http://icare/Operations/mental_capacity_act/Pages/default.aspx

Infection Control

All staff will have access to Infection Control Policies and comply with the standards within them in the work place. All staff will attend Infection Control Training annually as part of their mandatory training programme.

Rapid (E)quality Impact Assessment (EqIA) (for use when writing policies)

Policy Title (and number)		Version and Date	
Policy Author			
An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.			
Who may be affected by this document?			
Patients/ Service Users <input type="checkbox"/> Staff <input type="checkbox"/> Other, please state... <input type="checkbox"/>			
Could the policy treat people from protected groups less favorably than the general population? <i>PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below</i>			
Age	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gender Reassignment	Yes <input type="checkbox"/> No <input type="checkbox"/>
Race	Yes <input type="checkbox"/> No <input type="checkbox"/>	Disability	Yes <input type="checkbox"/> No <input type="checkbox"/>
Gender	Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy/Maternity	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual Orientation			Yes <input type="checkbox"/> No <input type="checkbox"/>
Religion/Belief (non)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Marriage/ Civil Partnership			Yes <input type="checkbox"/> No <input type="checkbox"/>
Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers ¹ ; travellers ² ; homeless ³ ; convictions; social isolation ⁴ ; refugees)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Please provide details for each protected group where you have indicated 'Yes'.			
VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion			
Is inclusive language ⁵ used throughout?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Are the services outlined in the policy fully accessible ⁶ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Does the policy encourage individualised and person-centred care?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
Could there be an adverse impact on an individual's independence or autonomy ⁷ ?			Yes <input type="checkbox"/> No <input type="checkbox"/> NA <input type="checkbox"/>
EXTERNAL FACTORS			
Is the policy a result of national legislation which cannot be modified in any way?			Yes <input type="checkbox"/> No <input type="checkbox"/>
What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)			
Who was consulted when drafting this policy?			
Patients/ Service Users <input type="checkbox"/>		Trade Unions <input type="checkbox"/>	
Staff <input type="checkbox"/>		Protected Groups (including Trust Equality Groups) <input type="checkbox"/>	
General Public <input type="checkbox"/>		Other, please state... <input type="checkbox"/>	
What were the recommendations/suggestions?			
Does this document require a service redesign or substantial amendments to an existing process? <i>PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below</i>			Yes <input type="checkbox"/> No <input type="checkbox"/>
ACTION PLAN: Please list all actions identified to address any impacts			
Action	Person responsible	Completion date	
AUTHORISATION:			
By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form		Signature	
Validated by (line manager)		Signature	

Please contact the Equalities team for guidance:

For South Devon & Torbay CCG, please call 01803 652476 or email marisa.cockfield@nhs.net

For Torbay and South Devon NHS Trusts, please call 01803 656676 or email pfd.sdhct@nhs.net

This form should be published with the policy and a signed copy sent to your relevant organisation.

- ¹ Consider any additional needs of carers/ parents/ advocates etc, in addition to the service user
- ² Travelers may not be registered with a GP - consider how they may access/ be aware of services available to them
- ³ Consider any provisions for those with no fixed abode, particularly relating to impact on discharge
- ⁴ Consider how someone will be aware of (or access) a service if socially or geographically isolated
- ⁵ Language must be relevant and appropriate, for example referring to partners, not husbands or wives
- ⁶ Consider both physical access to services and how information/ communication is available in an accessible format
- ⁷ Example: a telephone-based service may discriminate against people who are d/Deaf. Whilst someone may be able to act on their behalf, this does not promote independence or autonomy

Clinical and Non-Clinical Policies – New Data Protection Regulation (NDPR)

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU New Data Protection Regulation (NDPR) in mind and therefore provides the reader with assurance of effective information governance practice.

NDPR intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy.

Furthermore, NDPR requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data. The most effective way of being open is through data mapping. Data mapping for NDPR was initially undertaken in November 2017 and must be completed on a triannual (every 3 years) basis to maintain compliance. This policy supports the data mapping requirement of the NDPR.

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's [Data Protection & Access Policy](#),
- Visit our [GDPR](#) page on ICON