

## MEASLES MANAGEMENT & CONTACT TRACING POLICY

		POLICY	
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Lead Division/ Directorate	Clinical Support, Therapies and Outpatients		
Lead Specialty/ Service/ Department	Infection Prevention and Control Team		
Position of Person able to provide Further Guidance/Information	Infection Prevention and Control Team		
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Not Applicable		Not Applicable	
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## 1.0 INTRODUCTION

Measles is caused by a paramyxovirus. The primary site of infection is the respiratory epithelium of the nasopharynx. Viraemia with subsequent infection of the reticuloendothelial system occurs 2-3 days after invasion. A second viraemia occurs 4-7 days after the initial phase, which may result in infection of the lower respiratory tract and other organs. Measles virus is shed from the nasopharynx.

### Case Definition

- Generalised rash lasting for more than 3 days; and
- Temperature in excess of 38°C; and
- Coryza or conjunctivitis.

Further defined in Table.

## 2.0 POLICY STATEMENT

The purpose of the document is to provide clinical staff with guidelines for management of Measles infected/contact patients and to identify strategies for the prevention and of infection to other patients, staff and visitors.

The policy applies to all staff working within Sherwood Forest Hospitals

## 3.0 DEFINITIONS/ ABBREVIATIONS

<b>OH</b>	Occupational Health
<b>IPCT</b>	Infection, Prevention & Control
<b>MMR</b>	Measle, Mumps and Rubella Vaccine
<b>PEP</b>	Post Exposure Prophylaxis
<b>UKHSA</b>	United Kingdom Health Security Agency
<b>VRD</b>	Viral Reference Department

**Measles** – an acute, contagious viral disease, usually occurring in childhood and characterised by eruption of red spots on the skin, fever, and catarrhal symptoms. Also called rubeola.

**Measles Contacts** – person(s) who have come in close proximity for 15 minutes or longer to someone suffering from measles.

**Isolation** – social separation of a person who has or is suspected of having a contagious disease.

**Rash** – a skin eruption.

**Immunisation** – the process of inducing immunity to an infectious organism or agent in an individual through vaccination.

## **4.0 ROLES AND RESPONSIBILITIES**

### **4.1. Roles of the Managers**

Divisional Directors of Nursing and Matrons must ensure that resources are available for health care workers to undertake effective standard and isolation precautions pertinent to Measles.

### **4.2. Health care personnel**

Have a clinical and ethical responsibility to carry out effective infection prevention and control procedures applicable to the control of Measles and to act in a way which minimises risk to the patient.

### **4.3. The Infection Prevention and Control Team**

Is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required. The team is responsible for ensuring this policy remains consistent with the evidence-base for safe practice, and for reviewing the policy on a regular basis.

The Infection Prevention and Control team are responsible for contact tracing patients in the event of a case being identified in the hospital.

### **4.4. The Occupational Health Department**

Is responsible for managing appropriate pre-placement health screening for all staff and for managing appropriate contact tracing for staff who are contacts of a confirmed/suspected positive Measles. The aim is to reduce the risk of patients acquiring Measles from healthcare workers who are or may become infectious; and to reduce the risk of health care workers acquiring Measles through the course of their work.

### **4.5. Consultant Medical Staff**

Are responsible for ensuring their junior staff understand this policy, and adhere to the principles contained in it at all times.

## **5.0 APPROVAL**

Following appropriate consultation this policy (v1.0) has been approved by the Trust's Infection Prevention and Control Committee.

## 6.0 DOCUMENT REQUIREMENTS (POLICY NARRATIVE)

### 6.1 Clinical Management

Incubation period: 10-12 days from exposure until prodrome. Period from exposure to onset of rash onset averages 14 days (range 7-21 days).

Prodrome: lasts 2-4 days (range 1-7 days). Characterised by fever followed by the onset of cough, coryza and or conjunctivitis.

Koplik's spots: lesions present on the mucous membranes, which is considered to be pathognomonic for measles. It occurs 1-2 days before the skin rash and lasts for 1-2 days after the rash has faded. Koplik's spots appear as punctuate blue-whitish spots on the bright red background of the buccal mucosa.

Measles rash: maculopapular eruption, which lasts 5-6 days. It begins at the hairline, and then involves the face and upper neck. Over the next 3 days the rash gradually proceeds downwards and outwards until it reaches the hands and feet. The maculopapular rash is usually discrete but may become confluent particularly on the upper body. Initially lesions blanch under pressure, but after 3-4 days they do not blanch with pressure. Fine desquamation occurs over more severely involved areas. The rash fades in the same order that it appears, from head to extremities. The rash may be difficult to recognise in non- Caucasians.

**Table 1. Case definitions for measles**

Case definition categories	Definition
Laboratory confirmed	A suspected case with laboratory confirmation of acute infection.
Epidemiologically confirmed (a term used for surveillance purposes to define confirmed cases in the absence of a laboratory test to confirm measles)	A clinically classical case of measles with a direct epidemiological link to a confirmed case (where onset of symptoms occurred within 7 to 21 days of exposure), or related to another epidemiologically confirmed case (for example in an outbreak setting).
Likely (probable)	A clinically classical case of measles with epidemiological features that either increase the likelihood of the patient having been exposed and/or favour the diagnosis of measles relative to other causes of rash illness. Clinical features are outlined in Table 2 and epidemiological risk factors are summarised in 'Factors to consider...' below.
Likely breakthrough	A suspected case of measles in a patient who has had 2 doses of measles containing vaccine (usually at least 6 years after vaccination) or has confirmation of previous measles infection (IgG positive). The case will usually

	have mild symptoms (Table 2) and epidemiological information that suggest exposure to measles (see 'Factors to consider...' below). Please note these cases are rare.
Unlikely (possible)	A suspected case of measles which does not meet the definition of a likely case, either because it is not clinically classical (Table 2) or because the epidemiological context is not suggestive of measles.

**Table 2. Clinical features of measles**

Clinical features	Symptoms
Classical primary measles: generally very unwell and considered measles until proven otherwise	<ul style="list-style-type: none"> <li>fever equal to or over 38°C in the absence of antipyretics, and</li> <li>generalised maculopapular rash, and</li> <li>one or more of: <ul style="list-style-type: none"> <li>conjunctivitis</li> <li>cough</li> <li>coryza</li> </ul> </li> </ul>
Mild: generally a milder illness	<ul style="list-style-type: none"> <li>fever typically 37.5°C to 39°C</li> <li>rash may be more localised</li> <li>may not have conjunctivitis, coryza or cough</li> </ul>
Rash or fever following vaccination	Rash and mild fever on day 10 or 11 post-MMR vaccination is likely to be vaccine related

**Box 1: Factors to consider in the risk assessment**

*Factors increasing the risk of exposure*

- membership of a community known to be more susceptible, for example, traveller community, Charedi Orthodox Jewish community, anthroposophical (Steiner) communities, local community with low MMR vaccination coverage
- visited an area (local or international) where measles is known to be circulating, during the incubation period
- attendance at large international mass gathering events, where substantial mixing occurs between individuals potentially travelling from areas where measles is circulating; this would include, for example, events such as music festivals

*Factors favouring the diagnosis of primary measles infection*

- age: the likelihood of a suspected case being confirmed as measles is higher among adolescent and young adults. In infants and toddlers, measles-like clinical presentations due to other illnesses, such as roseola or scarlet fever, are common
- a lack of immunity or incomplete vaccination: the diagnosis is more likely if cases are unvaccinated or partially vaccinated, and have no prior history of measles infection

**Table 3: Risk assessment of cases**

Laboratory/ epidemiological features		Clinical features		
		Typical	Mild	Atypical
	Laboratory confirmed	Red	Red	Red
	Epidemiologically confirmed	Red	Red	Amber
	Factors that favour measles (Box 2)	Red	Amber	Amber
	None of the above	Amber	Green	Green

**Table 4: Management of cases and vulnerable contacts**

Risk assessment	Management
Green	<ul style="list-style-type: none"> <li>Post oral fluid kit – sample returned to Viral Reference Department (VRD) UKHSA</li> </ul>
Amber	<ul style="list-style-type: none"> <li>Urgent testing of case.</li> <li>Assess susceptibility of vulnerable contacts* and arrange PEP if appropriate.</li> <li>Post oral fluid kit – sample returned to VRD</li> </ul>
Red	<ul style="list-style-type: none"> <li>Do not await further testing of case.</li> <li>Assess susceptibility of vulnerable contacts* and arrange PEP if appropriate.</li> <li>Post oral fluid kit – sample returned to VRD</li> </ul>

\* Vulnerable contacts include immunocompromised contacts, infants and pregnant women for cases where primary measles is suspected and immunocompromised contacts where breakthrough measles (reinfection) is suspected.

## Measles Immunity

People who have been vaccinated with 2 doses of measles vaccine or have had confirmed measles previously.

## 6.2 Complications

The most frequent complications include viral pneumonitis and otitis media, as well as diarrhoea. Measles infection often leads to a temporary reduction in immune responses in the few weeks following infection, which may increase the risk of severe secondary bacterial and viral infections. Tracheobronchitis ('measles croup') and pneumonia due to secondary bacterial infection are frequent complications of measles. (UKHSA, 2023)

## 6.3 Epidemiology of Measles

Occurrence: Worldwide

Reservoir: Human disease

Temporal pattern: Peaks in late winter and spring

Transmission: Primarily person-person spread via large respiratory droplets.

Airborne transmission: Via aerosolized droplet nuclei contributes to spread in confined spaces for up to 2 hours after a person with measles occupied the area.

Communicability: highly communicable >90% secondary attack rates in susceptible persons. Measles may be transmitted 4 days prior to 4 days after rash onset.

## 6.4 Testing of cases

Oral fluid testing: this should be undertaken for all suspect cases (provided by UKHSA). See [appendix 1](#).

Viral throat swab: this should be undertaken for all suspected cases and sent to the Microbiology Laboratory. See [appendix 2](#).

All testing is carried out in external labs and can take several days to receive the results.

## 6.5 Principles of risk assessment and public health management

### 1. Unlikely measles case

Step 1. Identify any recent local transmission, if none continue to step 5.

Step 2. Identify if the symptoms are clinically typical of measles, if not continue to step 5.

Step 3. Identify if any close contacts are in the high-risk group (see below), if not continue to step 5.

Step 4. Assess susceptibility of the high-risk group (see below) contacts (including urgent testing as appropriate), arrange urgent testing of case, and then PEP for contacts if necessary (after discussion with Consultant Microbiologist and UKHSA).

Step 5. Request oral fluid kit for the patient, from the UKHSA/obtain a viral throat swab and send to Trust Laboratory.

Step 6. If positive manage as a laboratory confirmed case, if negative discard case.

### 2. Likely measles

Step 1. Identify if there are any contacts in the high-risk group (see below), if not continue to step 3.

Step 2. Assess the susceptibility of the high-risk group (see below) contacts (including urgent testing as appropriate), and then arrange for PEP if necessary.

Step 3. Identify if there are any immunocompetent vulnerable contacts, if not continue to step 5.

Step 4. Assess susceptibility of immunocompetent vulnerable contacts (including urgent testing as appropriate), arrange urgent testing of the case, and then PEP for contacts if necessary (after discussion with Consultant Microbiologist and UKHSA).

Step 5. Request the oral fluid kit to be sent to the case/obtain a viral throat swab and send to Trust Laboratory.

Step 6. If positive manage as a laboratory confirmed case, if negative discard case.

### 3. Epi or lab confirmed cases

Step 1. Identify if there are any contacts in the high-risk group (see below), if not continue to step 3.

Step 2. Assess the susceptibility of any contacts in the high-risk group (see below); arrange for PEP if necessary (after discussion with Consultant Microbiologist and UKHSA).

Step 3. Request the oral fluid kit to be sent to the case if not undertaken already/obtain a viral throat swab and send to Trust Laboratory.

Step 4. Manage as a laboratory confirmed case. If negative in reference laboratory discard case.

### High Risk Groups

- immunocompromised
- pregnant women
- children under 12 months
- Healthcare worker

## 6.6 Management of Index Case and Contacts

### STEP 1 Establish clinical classification and isolate index case

- In Emergency Department: admit to isolation room or triage room
- On ward: admit to side room (preferably side room 1(lobby ventilated pressure room)) with door closed.
- FFP3 mask must be worn at all times when in contact with these patients.
- Patients with known or suspected measles should be cared for by those staff known to be immune to measles
- Alert Infection Prevention and Control Team (x 3525) or out of hours Consultant Microbiologist.
- Inform the UKHSA
- The UKHSA will require contact details for the case (or parent, guardian, next of kin as appropriate).
- For the case the UKHSA will also require information on date of onset of rash, MMR history, travel history, contact with other case(s) if known.

### STEP 2 Contact Information (if the case was NOT isolated within 15 minutes of arrival into the department)

- Record names of all parent/guardians, siblings/children and record names of staff who were primary contacts.
- Record name, current location, contact number, date of birth, measles history/MMR status of all patients exposed to the case for > 15 minutes.
- Check if contacts are pregnant or immunocompromised.
- Send staff contacts details to Occupational Health

### Children aged > 13 months

- Check the MMR status of exposed children >13 months
- Children with no history of MMR should be offered vaccination <72 hours post exposure.
- Children aged >18 months with record of one MMR should be offered MMR 2 if more than 4 months since MMR 1 (contact in the community via their GP, in-patients via responsible clinician unless 'live' vaccination is contra-indicated).

## **Vulnerable Contacts**

- Collect name, current location (i.e. hospital ward or in the community), contact number, date of birth, measles history/MMR status of patients exposed to the case for >15 minutes and discuss with the Infection Prevention and Control/UKHSA.

## **6.7 PPE for assessment and management of confirmed and suspected cases of measles**

Staff should wear the following PPE when assessing or managing patients with confirmed or suspected measles:

- single-use, disposable gloves
- single-use, disposable apron (or gown if extensive splashing or spraying, or performing an aerosol generating procedure (AGP))
- respiratory protective equipment (RPE) – FFP3 mask (must be fit tested)
- eye/face protection (goggles or visor)

If the patient has confirmed or suspected measles, then if possible/tolerated the patient should wear a surgical face mask (type I/II/IIR) in communal areas (for example, during transfer).

## **6.8 Visitors**

Parents and carers should be supported to attend the care area while minimising the risk of exposure to other patients and themselves. Non-essential visitors should be minimised. Parents, carers, or visitors with symptoms (or who are a known, non-immune contact – for example, siblings) should not visit. However, if their presence is considered essential for compassionate (end of life) or other care reasons (for example, they are a parent or child) a risk assessment should be undertaken and mitigations (including source control) put in place to support attendance wherever possible.

Parents, carers, and visitors should be instructed on effective hand hygiene, be made aware of any infection risks, and offered appropriate PPE. Appropriate PPE, surgical face masks should be considered for parents, carers, or visitors who are considered a non-immune contact. Parents, carers, or visitors who are considered a household contact of the infected patient do not require PPE.

Parents, carers, or visitors should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment.

It may be considered appropriate to restrict visiting in the event of an outbreak of measles within the healthcare setting. This is a local outbreak management team decision.

## **6.9 Duration of precautions**

In general, patients should remain in isolation or cohorted, and transmission-based precautions (TBP) should be applied until resolution of symptoms and/or in accordance with the exclusion period (4 full days after rash onset, where day 0 is the date of onset of rash).

The duration of TBPs may require modification as some patients with more severe illness or underlying immune problems may remain infectious for a longer period. TBPs should only be discontinued in consultation with clinicians (including microbiology/IPC team).

### **6.10 Cleaning**

In line with Trust cleaning procedures the clean required for measles would be and Amber clean.

### **6.11 Agency/Team contact details**

UKHSA – 03442254524 – must be contact as soon as Measles is suspected (they will support with determination of likelihood)

Consultant Microbiologist – via Switchboard

IPC Team – 3525 – between 8am-4pm 7 days a week.

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

<b>Minimum Requirement to be Monitored</b>  (WHAT – element of compliance or effectiveness within the document will be monitored)	<b>Responsible Individual</b>  (WHO – is going to monitor this element)	<b>Process for Monitoring e.g. Audit</b>  (HOW – will this element be monitored (method used))	<b>Frequency of Monitoring</b>  (WHEN – will this element be monitored (frequency/ how often))	<b>Responsible Individual or Committee/ Group for Review of Results</b>  (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Use of personal protective equipment	IPCT	Audit	Monthly	IPCC
Hand hygiene	IPCT	Audit	Monthly	IPCC

## 8.0 TRAINING AND IMPLEMENTATION

There is no specific training requirement in relation to this policy. When treating patients with suspected/confirmed infection related to measles, healthcare staff should follow this policy. If required, further assistance can be sought from senior colleagues and/or the Infection Prevention and Control Team.

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix 3](#)
- This document has been subject to an Environmental Impact Assessment, see completed form at [Appendix 4](#)

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

### Evidence Base:

- National Measles guidelines, UKHSA, February 2024
- Guidance for risk assessment and infection prevention and control measures for measles in healthcare settings, NHS England, January 2024

### Related SFHFT Documents:

- Isolation Policy
- Personal Protective Equipment (PPE) Policy

## 11.0 KEYWORDS

PPE, MMR

## 12.0 APPENDICES

[Appendix 1](#) – How to take an oral fluid swab  
[Appendix 2](#) – Viral throat swab  
[Appendix 3](#) – Equality Impact Assessment  
[Appendix 4](#) – Environment Impact Assessment

## Appendix 1: How to take an oral fluid swab

### How to take oral fluid swabs

**1**

2 x blue swab in plastic clear tube

2 x clear plastic bags, labelled "VRD" and "PHL"

Cardboard Box labelled UKHSA URGENT MEASLES TESTING

Contents

Request form

White plastic envelope

**2**

**X2**

Remove blue swab from packet. Rub the blue swab along the gum line for 2 minutes.

2 mins

**3**

**X2**

Place wet swab back inside the clear tube and replace the cap. Write patient's name, date of birth (DOB), today's date on each tube.

**4**

Repeat steps 2 and 3

**5**

Place the first tube inside the clear bag labelled VRD. Push out air, remove red strip from top and seal.

**6**

Place second tube into the clear bag labelled PHL. Push out air, remove red strip from top and seal.

**7**

Check and complete request form and place with both clear bags containing the samples into cardboard box and close.

**8**

Place cardboard box into white polythene envelope, seal and return to courier or healthcare professional.

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## Appendix 2: Viral throat swab



### **APPENDIX 3 - EQUALITY IMPACT ASSESSMENT FORM (EQIA)**

<b>Name of service/policy/procedure being reviewed: MEASLES MANAGEMENT &amp; CONTACT TRACING POLICY</b>			
<b>New or existing service/policy/procedure: New</b>			
<b>Date of Assessment: 08/02/2024</b>			
<b>For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)</b>			
<b>Protected Characteristic</b>	<b>a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?</b>	<b>b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?</b>	<b>c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality</b>
<b>The area of policy or its implementation being assessed:</b>			
<b>Race and Ethnicity</b>	None	None	None
<b>Gender</b>	None	None	None
<b>Age</b>	None	None	None
<b>Religion</b>	None	None	None
<b>Disability</b>	None	None	None
<b>Sexuality</b>	None	None	None
<b>Pregnancy and Maternity</b>	None	None	None
<b>Gender Reassignment</b>	None	None	None
<b>Marriage and Civil Partnership</b>	None	None	None

<b>Socio-Economic Factors</b> (i.e. living in a poorer neighbourhood / social deprivation)	None	None	None
<b>What consultation with protected characteristic groups including patient groups have you carried out?</b> <ul style="list-style-type: none"> <li></li> </ul>			
<b>What data or information did you use in support of this EqIA?</b> <ul style="list-style-type: none"> <li></li> </ul>			
<b>As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?</b> <ul style="list-style-type: none"> <li>No</li> </ul>			
<b>Level of impact</b>  From the information provided above and following EQIA guidance document Guidance on how to complete an EIA ( <a href="#">click here</a> ), please indicate the perceived level of impact:  Low Level of Impact  For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.			
<b>Name of Responsible Person undertaking this assessment:</b> Sally Palmer			
<b>Signature:</b>			
<b>Date:</b> 08/02/2024			

## **APPENDIX 4 – ENVIRONMENTAL IMPACT ASSESSMENT**

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

<b>Area of impact</b>	<b>Environmental Risk/Impacts to consider</b>	<b>Yes/No</b>	<b>Action Taken (where necessary)</b>
<b>Waste and materials</b>	<ul style="list-style-type: none"> <li>Is the policy encouraging using more materials/supplies?</li> <li>Is the policy likely to increase the waste produced?</li> <li>Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?</li> </ul>	Yes Yes Yes	Additional PPE will be required
<b>Soil/Land</b>	<ul style="list-style-type: none"> <li>Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals)</li> <li>Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)</li> </ul>	No	
<b>Water</b>	<ul style="list-style-type: none"> <li>Is the policy likely to result in an increase of water usage? (estimate quantities)</li> <li>Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water)</li> <li>Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)</li> </ul>	No	
<b>Air</b>	<ul style="list-style-type: none"> <li>Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.)</li> <li>Does the policy fail to include a procedure to mitigate the effects?</li> <li>Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?</li> </ul>	No	
<b>Energy</b>	<ul style="list-style-type: none"> <li>Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)</li> </ul>	No	
<b>Nuisances</b>	<ul style="list-style-type: none"> <li>Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?</li> </ul>	No	