| Policy | Worcestershire NHS Acute Hospitals NHS Trust |
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# Management of Patients with Proven or Suspected Transmissible Spongiform Encephalopathies (TSEs) Policy

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| **Department / Service:** | Infection Prevention and Control |
| **Originator:** | Liz Watkins |
| **Accountable Director:** | Liz Watkins Director for Infection Prevention and Control |
| **Approved by:** | Trust Infection Prevention & Control Committee |
| **Date of approval:** | 5th May 2026 |
| **Review Date:**<br>**This is the most current document and is to be used until a revised version is available** | 5th May 2029 |
| **Target Organisation(s)** | Worcestershire Acute Hospitals NHS Trust |
| **Target Departments** | All Clinical Departments |
| **Target staff categories** | All Clinical Staff |

| **Policy Overview:** |
|---|
| This is an over-arching policy which provides guidance and advice around CJD and other transmissible spongiform encephalopathies (TSEs). |

**Key amendments to this guideline:**

| Date | Amendment | By: |
|---|---|---|
| May 2023 | New Policy approved - replaces WAHT-INF-012 Creutzfeldt-Jakob Disease (CJD) and variant CJD (vCJD) – Minimising the risk of Transmission | TIPCC, Chaired by Jackie Edwards, interim CNO |
| May 2026 | Change of Title<br>Review and update of national guidance<br>Inclusion of advice for Community Care | DIPC |

## Contents

## 1. Introduction and Further Information

Transmissible spongiform encephalopathies (TSEs) otherwise known as prion diseases, are rare, fatal, degenerative diseases affecting the central nervous system (CNS) that occur in humans and certain other mammals.

There are several recognised TSEs, including Creutzfeldt-Jakob Disease (CJD) in humans, bovine spongiform encephalopathy (BSE) in cattle and scrapie in sheep (Department of Health (DH), 2017 a.).

TSEs are caused by unconventional infectious agents currently thought to be infectious proteins known as prions. These abnormal proteins are resistant to normal methods of decontamination. There are different forms of CJD, the commonest form occurring as a sporadic disease, the cause of which is unknown. There are also familial forms of human TSEs, which appear to have a solely genetic origin. Transmission of TSEs to humans has also occurred from both human and bovine sources resulting in iatrogenic CJD and variant CJD (vCJD) respectively.

The groups of human TSEs are as below:

- Idiopathic diseases: Sporadic CJD and sporadic fatal insomnia
- Familial diseases: Familial CJD, Gerstmann-Sträussler-Scheinker disease
- (GSS) and fatal familial insomnia

- Acquired diseases: Human agents: Kuru and iatrogenic CJD Bovine agent: Variant CJD

The Health and Social Care Act (2008) (Updated 2022) Code of Practice on the prevention and control of infections and related guidance requires all Trusts to have clear arrangements for the effective prevention, detection and control of Healthcare Associated Infection (HCAI), including TSE.

National guidance on safe working and the prevention of infection by TSE is regularly updated on the Department of Health (DH) website. This policy is based upon this guidance which can be found at

Minimise transmission risk of CJD and vCJD in healthcare settings - GOV.UK

This policy provides advice on safe working practices with the aim of preventing the transmission of CJD and variant CJD (vCJD).

## 2. Definitions

The use of the term “CJD” in this policy encompasses sporadic CJD, sporadic fatal insomnia, variable protease-sensitive prionopathy (VPSPr), vCJD, iatrogenic CJD, genetic CJD, Fatal Familial Insomnia (FFI) and Gerstmann-Straussler-Scheinker Disease (GSS), in order to assist readability.

## DEFINITIONS

| Term / Abbreviation | Explanation / Definition |
|---|---|
| BSE | Bovine Spongiform Encephalopathy. BSE, commonly known as mad cow disease, is a fatal eurodegenerative disease (encephalopathy) in cattle that causes a spongy degeneration of the brain and spinal cord. |
| CCR | Clinical Case Review |
| CJD | Creutzfeldt-Jakob Disease. CJD is one of the causes of spongiform encephalopathy, which is a neurodegenerative disease that results in dementia, incapacitation, and death.<br>The use of the term "CJD" in this policy encompasses sporadic CJD, sporadic fatal insomnia, variable protease-sensitive prionopathy (VPSPr), vCJD, iatrogenic CJD, genetic CJD, Fatal Familial Insomnia (FFI) and Gerstmann-Straussler-Scheinker Disease (GSS), in order to assist readability. |
| CSF | Cerebrospinal fluid |
| DH | Department of Health |
| DIPC | Director of Infection Prevention and Control |
| GSS | Gerstmann-Straussler-Scheinker syndrome |
| HCAI | Healthcare Associated Infection |
| HTM | Health Technical Memorandum |
| Iatrogenic | Resulting from the activity of a health care provider or institution; any adverse condition in a patient resulting from treatment by a physician, nurse, or allied health professional |
| IPC | Infection Prevention and Control |
| OH | Occupational Health Department |
| PIR | Post Infection Review |
| RCA | Root Cause Analysis |
| TSE | Transmissible Spongiform Encephalopathy |
| UK HSA | UK Health Security Agency |
| vCJD | Variant Creutzfeldt-Jakob Disease. Variant CJD (vCJD) occurs in younger people and has been linked to consumption of beef products contaminated with bovine spongiform encephalopathy (BSE). |
| WHO | World Health Organisation |

## 3. Responsibilities and Duties

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

### The Chief Executive (CEO) –

As accountable officer is responsible for the overall leadership and management of the Trust and its performance in terms of service provision, financial and corporate viability, ensuring that the Trust meets all its quality and safety, statutory and service obligations and for working closely with other partner organisations. The CEO delegates aspects of this responsibility to relevant Executive Directors.

### Executive Director of Infection Prevention and Control (EDIPC) / Director of Infection Prevention and control (DIPC) –

Is responsible for the management and control of healthcare associated infection (HAI), including implementation of this policy.

### Divisional Management Teams –

Are responsible for monitoring implementation of this policy and for ensuring action is taken when staff fail to comply with the policy.

### Ward and Department Managers –

Are responsible for ensuring that all possible measures are taken to reduce the spread of infection to patients, visitors and staff. All managers are responsible for ensuring this policy is implemented in their areas and for ensuring all staff who work within the area adhere to the principles and standards at all times. All managers are responsible for ensuring that staff have access to up-to-date training to enable them to adopt safe working practices at all times and are appropriately trained to minimise risks to themselves and others.

### Consultant Medical and Surgical staff –

Are responsible for ensuring that all possible measures are taken to reduce the spread of infection to patients, visitors and staff. They are responsible for ensuring this policy is implemented in their areas and for ensuring all staff who work within the area adhere to the principles and standards at all times. They are responsible for ensuring their junior staff read and understand this policy and adhere to the principles contained in it at all times.

**Site Management Team and Bed Managers -**

Are responsible for ensuring patients are placed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.

**On-Call Managers and the On-Call Executive –**

Are responsible for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

**The Infection Prevention and Control Team (IPCT) –**

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. They are also responsible for the development and dissemination of the policy and for ensuring the policy remains consistent with the evidence-base for safe practice, and for reviewing the policy on a three-yearly basis unless new guidance is published before this time.

**Occupational Health –**

Is responsible for ensuring that appropriate individual advice is available for staff who are advised they are MRSA positive.

**All staff working on Trust premises, including agency and locum staff and contractors –**

Are responsible for adhering to this policy and for reporting breaches of this policy to the person in charge and to their line manager.

**Statement of Intent**

The purpose of this policy is to ensure effective arrangements are in place for the management of patients in risk groups for TSE and care of patients with known or suspected TSE to reduce the risk of transmission of the infection.

## 4. Key Points

All staff caring for patients with potentially transmissible infections must receive training in the prevention and control of infection. Evidence to date does not suggest that in the majority of situations that management of TSE patients in the healthcare setting should be different to that used for other patients.

Only in certain situations are additional measures to prevent transmission to patients and staff in the healthcare setting instituted and these are based on risk grouping of patients.

Advice may be obtained from the CJD surveillance unit in Edinburgh, but local UK Health Security Agency (UKHSA) teams are tasked to work with the Trust to identify risks that may have arisen to other patients when a patient diagnosed with CJD or vCJD had undergone surgery or donated blood, organs, or tissues. The trust will identify contacts who are potentially at risk, based on advice and discussion with the above agencies.

## 5. Overview of TSEs

- TSEs are caused by prions and are sometimes called prion diseases. Abnormal prion proteins are found in Creutzfeldt-Jakob disease (CJD), and in other related diseases such as kuru and bovine spongiform encephalopathy (BSE). Prions are resistant to heat and resistant to many disinfectants and many conventional decontamination processes.

- TSEs are not contagious they are experimentally transmissible by inoculation and in some cases by oral challenge.

### 5.1 Classical CJD

- CJD is one of the causes of spongiform encephalopathy, which is a neurodegenerative disease that results in dementia, incapacitation, and death. In certain families it is an inherited disease, but the majority of cases occur sporadically. CJD can also arise due to transmission from an infected individual to a previously healthy person. Transmission can be through inoculation of infected tissue e.g., from central nervous system. The disease can take years to develop after the initial exposure. Gerstmann-Straussler-Scheinker syndrome (GSS) is another degenerative disease similar to CJD.

- CJD is diagnosed clinically, and all suspected cases should be referred to a specialist, usually a consultant neurologist. Other conditions may resemble CJD, for example Alzheimer's, Parkinson's, and motor neurone disease. It is important for clinical staff to consider the possibility of CJD in these patients.

### 5.2 Variant CJD

- Variant CJD (vCJD) occurs in younger people and has been linked to consumption of beef products contaminated with BSE. BSE is not confined to United Kingdom (UK) cattle. Cases have been described in Germany, France, and other parts of Europe as well as in Canada and USA.

### 5.3 Latrogenic CJD

- Most of the cross-infection incidents of iatrogenic CJD reported have been associated with neurosurgery. Experimentally, the agent can be transmitted to primates by inoculation of tissues from an affected patient. Brain and other neurological tissues are most likely to transmit the disease, though CJD has also been transmitted via corneal transplants, cadaveric pituitary hormones, and dura mater (see below).

## 6. Risk Factors

### 6.1 CJD Risk factors in asymptomatic patients

- Patients at risk from familial forms of CJD linked to genetic mutations are those who have:
  - 2 or more blood relatives affected by CJD
  - A relative known to have a genetic mutation indicative of familial CJD
  - Had a specific genetic test showing them to be at significant risk of developing CJD or other prion disease

- Latrogenic CJD has arisen from transplantation or injection of tissues of neural origin. In three cases, the agent was transmitted via a corneal transplant. In addition, cadaver pituitary extracts of hormones (Growth Hormone, Follicle Stimulating Hormone, and Thyroid Stimulating Hormone) contaminated with CJD agent and cadaver dura mater are thought to have infected several recipients.

- Questioning to extract a history of the above exposure is important but particularly difficult. Individuals who underwent neurosurgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of dura mater and should be treated as at risk unless evidence can be produced that dura mater was not used. Fertility treatment many years ago, thyroid function tests and operations for cerebrospinal fluid (CSF) leaks need particular enquiry.

- The last group of asymptomatic patients potentially at risk from iatrogenic exposure are those patients who have been contacted as potentially at risk because of exposure to a patient who went on to develop CJD or vCJD through instruments previously used on the CJD patient, or receipt of blood, plasma derivatives, organs or tissues donated by the CJD patient.

### 6.2 Risk groups in symptomatic patients

- Symptomatic patients are classified as definite, probable, or possible CJD or vCJD. (See link to Department of Health guidelines Annex B for detailed diagnostic criteria)
  Click here for link to Annex B

- Patients with a neurological disease of unknown aetiology who do not fit the diagnostic criteria for possible CJD or vCJD, but where the diagnosis of CJD is being considered are also considered to be a risk group for surgical procedures.

### 6.3 Wider risks of vCJD compared to classical CJD

- In vCJD the abnormal prion protein is more widespread in the body. In addition to neural origin tissue, it has been found in tonsils, spleen, appendix and rectal lymphoid tissue, lymph nodes, thymus, and adrenal glands. It has not been found in peripheral nerves but is present in spinal dorsal root ganglia and the trigeminal ganglion. Prions have been found in the appendixes of 2 patients, 8 and 24 months

before the patient developed clinical neurological disease and infectivity has been experimentally demonstrated in tonsils, spleen, and blood.

- The emergence of vCJD and its presence in peripheral tissues before clinical disease has increased the importance of instrument decontamination and traceability of instruments and stringent quality policies that are fully acceptable and accredited are now essential. To date there have been no known transmissions of vCJD via surgery or these uses of tissues or organs.

- There is now evidence that blood can be infectious in vCJD: four human cases of transmission via blood transfusion of non-leucodepleted red blood cells have been reported in the UK. A case of probable asymptomatic vCJD infection via plasma products was reported in a haemophiliac patient in 2009.

- Since 1997, when the theoretical risk of vCJD transmission through blood was first considered, the UK blood services have taken a number of precautionary measures to protect the blood supply and associated plasma products. These include the use of a comprehensive checklist prior to a person donating blood.

**6.4 Blood components, plasma products or tissues**

- Plasma for the manufacture of plasma products, such as clotting factors, has been obtained from non-UK sources since 1998.

- Synthetic (recombinant) clotting factor for treatment of haemophilia has been provided to the under-16s since 1998, and for all patients in whom it is suitable since 2005.

- Since 1999 white blood cells (which may carry a significant risk of transmitting vCJD) have been reduced in all blood used for transfusion, a process known as leucodepletion.

- Since 2002, fresh frozen plasma for treating babies and young children born on or after 1 January 1996 has been obtained from the USA. In 2005 its use was extended to all children up to the age of 16.
- Since 2004, individuals who have received a transfusion of blood components since January 1980 or are unsure if they have had a blood transfusion, are excluded from donating blood or platelets.

- Since 2009, cryoprecipitate, a special cold-treated plasma preparation, has been imported from the USA for children up to the age of 16.

- Asymptomatic patients who have had a blood transfusion in the UK are advised not to give blood donations, but they are not otherwise considered to be a risk group for vCJD.

**Annex J - Risk Assessment to identify patients with, or at risk of, CJD and vCJD**

- This provides a clear and pragmatic way of assessing CJD and vCJD risk prior to surgery or endoscopy. Growing numbers of patients have been informed that they are at increased risk of CJD or vCJD. It includes a question to be asked of all patients about to undergo surgery or neuro-endoscopy on high-risk tissues. Click here for link to Annex J

  **Evidence of risk assessment must be documented within the clinical notes for all scopes including Nasendoscopes. The patient will be asked if they have ever been notified that they are at a risk of CJD/vCJD.**

## 6.5 Risk categories table

**Table 1: Patients should be categorised as follows, in descending order of risk:**

| | |
|---|---|
| 1. Symptomatic patients | 1.1 Patients who fulfil the diagnostic criteria for definite, probable, or possible CJD or vCJD (see Annex B for diagnostic criteria).<br><br>1.2 Patients with neurological disease of unknown aetiology who do not fit the criteria for possible CJD or vCJD, but where the diagnosis of CJD is being actively considered. |
| 2. Patients "at increased risk" from genetic forms of CJD | 2.1 Individuals who have been shown by specific genetic testing to be at significant risk of developing CJD or other prion disease.<br><br>2.2 Individuals who have a blood relative known to have a genetic mutation indicative of familial CJD.<br><br>2.3 Individuals who have or have had two or more blood relatives affected by CJD or other prion disease. |
| 3. Patients identified as "at increased risk" of v CJD through receipt of blood from a donor who later developed vCJD | Individuals who have received labile blood components (whole blood, red cells, white cells, or platelets) from a donor who later went on to develop vCJD. |
| 4. Patients identified as "at increased risk" of CJD/vCJD due to iatrogenic exposures | 4.1 Recipients of hormone derived from human pituitary glands e.g., growth hormone, gonadotropin, are at "increased risk" of transmission of sporadic CJD. In the UK the use of human-derived gonadotropin was discontinued in 1973 and use of cadaver-derived human growth hormone was banned in 1985. However, the use of human-derived products may have continued in other countries after these dates.<br><br>4.2 Individuals who underwent intradural brain or intradural spinal surgery before August 1992 who received (or may have |

| | |
|---|---|
| | received) a graft of human-derived dura mater are "at increased risk" of transmission of sporadic CJD. (People who underwent neurosurgical procedures or operations for a tumour or cyst of the spine before August 1992 may have received a graft of dura mater and should be treated as "at increased risk", unless evidence can be provided that dura mater was not used).<br><br>4.3 Individuals who have surgery using instruments that had been used on someone who went on to develop CJD/vCJD, or was "at increased risk" of CJD /vCJD<br><br>4.4 Individuals who have received an organ or tissue from a donor infected with CJD/vCJD or "at increased risk" of CJD/vCJD<br><br>4.5 Individuals who have been identified prior to high-risk surgery as having received blood or blood components from 300 or more donors since January 1990<br><br>4.6 Individuals who have received blood from someone who went on to develop vCJD<br><br>4.7 Individuals who have given blood to someone who went on to develop vCJD<br><br>4.8 Individuals who have received blood from someone who has also given blood to a patient who went on to develop vCJD<br><br>4.9 Individuals who have been treated with certain implicated UK sourced plasma products between 1990 and 2001 |

- Recipients of ocular transplants, including corneal transplants, are not considered to be "at increased risk" of CJD/vCJD.

## 7. Infection Prevention and Control Precautions

- In most routine clinical contact, no additional precautions are needed for the care of patients in the "increased risk" patient groups. However, when certain invasive interventions are performed, there is the potential for exposure to the agents of TSEs. In these situations, it is essential that control measures are in place to prevent iatrogenic CJD/vCJD transmission.

- All people who are "at increased risk" of CJD/vCJD are asked to help prevent any further possible transmission to other patients by following this advice:

- Do not donate blood. No-one who is "at increased risk" of CJD/vCJD, or who has received blood donated in the United Kingdom since 1980, should donate blood.
- Do not donate organs or tissues, including bone marrow, sperm, eggs, or breast milk.
- If you are going to have any medical, dental, or surgical procedures, tell whoever is treating you beforehand so they can make special arrangements for the instruments used to treat you if you need certain types of surgery or investigation.
- You are advised to tell your family about your increased risk. Your family can tell the people who are treating you about your increased risk of CJD/vCJD if you need medical or surgical procedures in the future and you are unable to tell them yourself.

**Annex B – Diagnostic Criteria**

- This guidance categorises CJD patients in descending order of risk, distinguishing between symptomatic and asymptomatic patients. Symptomatic patients are those who fulfil the internationally accepted diagnostic criteria, set out below, for definite, probable, and possible CJD or vCJD
  Click here for link to Annex B

**Annex L – Managing CJD/vCJD in Ophthalmology**

- This link contains advice on the precautions to be taken for ophthalmic procedures on patients with, or "at increased risk" of, CJD.
  Click here for link to Annex L

## 8. Hospital care of CJD/vCJD patients (Defined in Table 3)

### 8.1 Invasive Medical Procedures and Sample Labelling

- Single use disposal equipment should be used wherever practicable, and all other small items of equipment contaminated whilst obtaining specimens should be destroyed by incineration.

- Blood, biopsy, and lumbar puncture samples from patients identified in table 1 should only be taken by trained personnel who are aware of the hazards involved.

- Eye protection (googles/fluid repellent mask with eye shield) should be worn in addition to the standard personal protective equipment where splashing may occur. Particular care should be taken with lymphoid tissue specimens from such patients.

- Standard practice should be to use disposable gloves, aprons and single-use, disposable instruments when performing a lumbar puncture for the collection of CSF.

- Samples from patients who fall within the “at increased risk” category or were confirmed as having CJD should be marked with a biohazard label. It is advisable to inform the receiving laboratories in advance of the sample before this is sent to them.

- There are no special requirements for the care of CJD/vCJD patients on the ward. There is no evidence to suggest that normal or routine clinical contact of a CJD/vCJD patient presents a risk to healthcare workers, relatives, and others.

- Isolation of patients with CJD/vCJD is not necessary, and they can be nursed in an open ward using standard infection prevention and control precautions.

- Care must be taken when performing procedures that carry a risk of transmission of infection from items contaminated with body fluids. These procedures include:
  - Venepuncture
  - Insertion of intravascular catheters
  - Intramuscular or intravenous injections
  - Drug administration
  - Dressing of wounds and pressure ulcers

- For these procedures the staff must adhere to standard precautions and wear disposable gloves and a disposable plastic apron. Eye protection should also be worn if there is a risk of splashing.

- Most infectivity is likely to be concentrated in the Central Nervous System (CNS) and also possibly in lymphoid tissue. Therefore, it is important to ensure that only trained staffs aware of the hazards carry out invasive procedures involving body fluids that may lead to contact with infective tissue.

- Careful attention to standard infection control precautions will minimise any risks from blood (e.g., risk of being exposed to blood born viruses).

- These procedures should be carried out by trained personnel aware of the hazards involved. All associated waste should be incinerated.

### 8.1.2 Diagnostic samples

- Body secretions, body fluids (including saliva, blood, CSF, and excreta) are all low risk for CJD/vCJD. It is therefore likely that the majority of samples taken, or procedures performed will be low risk. Contact with small volumes of blood (including inoculation injury) is considered low risk, though it is known that transfusion of large volumes of blood and blood components may lead to vCJD transmission.

- Blood and body fluid samples from patients with, or "at increased risk" of, CJD/vCJD, should be treated as potentially infectious for blood-borne viruses and handled with standard infection prevention and control precautions as for any other patient, i.e.:
    - Use of disposable apron, disposable gloves, and eye protection where splashing may occur
    - Avoidance of sharps injuries and other forms of parenteral exposure
    - Safe disposal of sharps by incineration in a yellow lidded sharps container. It is best if a separate container is kept for the patient
    - Contaminated waste disposed of in line with Waste Management Policy (see section 11)
    - Single-use disposable equipment should be used wherever practicable
- **Specimens must be placed in leak-proof containers and securely capped. The container must be placed in the sealed compartment of a double-compartment plastic bag, with the form in a separate pocket. The form must be labelled 'Danger of Infection' and the diagnosis of CJD or "at increased risk of CJD/vCJD" must be clearly indicated.**
- **The laboratory MUST be informed in advance before a sample is sent.**

Click here for link to Annex J

### 8.3 Spillages

- When a spillage of any fluid (including blood and CSF) from a patient with, or "at increased risk" of, CJD/vCJD occurs in a healthcare setting, the main defence is efficient removal of the contaminating material and thorough cleaning of the surface.
- All body fluid spillages originating from a confirmed or "at increased risk" of CJD positive patient should be cleaned up without any delay, maintaining contamination of the environment at a minimum.
- Standard infection prevention control precautions should be used to clear up spillages of any fluid (including spillages of blood and CSF) from a patient with, or "at increased risk" of, CJD/vCJD. Disposable gloves and an apron should be worn when removing such spillages and eye protection if there is a risk of splashes.
- The infectious agent associated with TSEs is unusually resistant to inactivation. Dilution is the most important element in cleaning up spillages on a hospital ward. Therefore, spillages of blood and CSF should be firstly removed using absorbent material and disposed of as clinical waste. High concentration 10,000 ppm (DH, 2017

c.) available chlorine for 1 hour is known to be an effective decontaminant. Only in exceptional circumstances should alternatives be used to clean up spillages of high-risk material. Standard spillage procedures should then be followed (Standard (Universal) Infection Control Precautions Policy, page 11). Please telephone Infection Control for specialist advice.

- Potentially infectious materials should be removed using absorbent material and any waste (including used cleaning equipment e.g., mop heads, gloves, and aprons) disposed of as clinical waste.

### 8.4 Clinical Waste

- General guidance on the safe management of clinical waste is given in the Department of Health's guidance document 'Health Technical Memorandum (HTM) 07-01: Safe Management of Healthcare waste": This Guidance can be found at

  Department of Health HTM 07-01 – Safe Management of Healthcare Waste

- According to this guidance, "Waste known or suspected to be contaminated with transmissible spongiform encephalopathy (TSE) agents, including CJD, must be disposed of by high temperature incineration in suitable authorised facilities." Additional guidance on the management of TSE-infected waste is given in the Department of Health's 'Transmissible spongiform encephalopathy: Safe working and the prevention of infection.'

- The Advisory Committee on Dangerous Pathogens (ACDP) TSE Working Group have considered the disposal of clinical waste, and have agreed that tissues and contaminated materials such as dressings and sharps, from patients with, or "at increased risk" of, CJD/vCJD, should be disposed of as in the following table:

  **Table 2: Disposal of clinical waste from patients with, or "at increased risk" of, CJD or vCJD**

| Diagnosis of CJD | High or medium risk tissue* | Low risk tissue and body fluids** |
|---|---|---|
| Definite | Incinerate | Normal clinical waste disposal |
| Probable | Incinerate | Normal clinical waste disposal |
| "At increased risk" | Incinerate | Normal clinical waste disposal |

- ** Tissues and materials deemed to be low risk include body fluids such as

urine, saliva, sputum, blood, and faeces. Blood from vCJD patients is considered to be low risk except when transfused in large volumes.

- Annex C contains advice on the general principles of decontamination and waste disposal for transmissible spongiform encephalopathies.

Click here for link to Annex C

### 8.5 Childbirth

- Childbirth should be managed using standard infection control procedures.
- The placenta and other associated material and fluids although are designated as low-risk tissues, should be treated as potentially infected and disposed of unless they are needed for investigation, in which case the precautions for dealing with infected tissue should be followed.
- Current guidance recommends that this type of waste be incinerated.

### 8.6 Surgical procedures

- Assessment to be carried out before surgery and/or endoscopy to identify patients with, or at increased risk of, CJD or vCJD (DH, 2017 d., Annex J). The Department of Health (2017 d.) within Annex J. provides a method of assessing CJD and VCJD risk prior to surgery or endoscopy.
- Certain groups of patients have been informed that they are at risk of CJD or vCJD. The Department of Health therefore recommends that:
  **All patients about to undergo any surgery or endoscopy should be asked if they have ever been notified as being at increased risk of CJD or vCJD.** (Please refer to the outlined recommendations in Paragraph 1 and 2 of
  DH (2017 d.) Annex J.)

  **All patients undergoing surgery or neuro-endoscopy which may involve contact with tissues of potentially high-level TSE infectivity ("high risk tissue") should, through a set of detailed questions, be assessed for their possible, unrecognised, CJD/vCJD risk.**

  (Please refer to the outlined recommendations in Paragraph 3 and 4 of DH (2017 d.) Annex J.)
- Measures depend on how likely the patient is to be carrying the infectious agent

and how likely it is that infection could be transmitted by those procedures being carried out. Patients should be classified by risk status set out in table 3.

Click here for link to Annex J

### 8.7 Theatre management

For symptomatic patients i.e., those who fulfil the criteria for definite, probable, or possible CJD or vCJD i.e., line 1 in table 3.

1) The intervention should be performed in an operating theatre
2) If procedures have to be performed at the bed side e.g., a lumbar puncture, care should be taken to ensure that the environment may be readily cleaned should a spillage occur. Protective clothing (see below) should be worn by healthcare personnel providing diagnostic procedures. Procedures should be performed at the end of a list to allow normal cleaning of theatre services before the next session
3) Only the minimum number of healthcare personnel required should be involved
4) The following single-use protective clothing should be worn and disposed of in line with local policies:
   a. liquid repellent operating gown, worn over a plastic apron
   b. gloves
   c. mask and goggles or full-face visor
5) Use single-use disposable surgical instruments and equipment where possible
6) Destroy all single-use items by incineration
7) For asymptomatic patients at risk from familial or iatrogenic CJD i.e., lines 2 and 3 in table 3, the same precautions apply but the protective clothing may be reprocessed if not designated single use

#### 8.7.1 Handling of instruments that are not designated as single use

Where single-use instruments are not available the handling of reusable instruments depends on a combination of the risk status of the patient, the tissue involved in the procedure and the type of CJD.

The following matrices set out separately the actions to be taken:

**Table 3: Handling of Instruments – patients with, or "at increased risk" of CJD (Other than v CJD**

| TISSUE INFECTIVITY | Status of Patient | | |
|---|---|---|---|
| | Definite or Probable | Possible | At increased risk |
| **HIGH**<br>• Brain<br>• Spinal cord<br>• Cranial nerves, specifically the entire optic nerve and the intracranial components of the other cranial nerves<br>• Cranial Ganglia<br>• Posterior eye, specifically the posterior hyaloids face, retina, retinal pigment epithelium, choroid, sub retinal fluid and optic nerve<br>• Pituitary gland | Single use or Destroy or Quarantine for reuse exclusively on the same patient | Single use or Quarantine for reuse exclusively on the same patient pending diagnosis. | Single use or Destroy or Quarantine for reuse exclusively on the same patient |
| **MEDIUM**<br>• Spinal ganglia<br>• Olfactory epithelium | Single use or Destroy or Quarantine for reuse exclusively on the same patient | Single use or Quarantine for reuse exclusively on the same patient pending diagnosis | Single use or Destroy or Quarantine for reuse exclusively on the same patient |
| **LOW** | No special precautions | No special precautions | No special precautions |

**Table 4: Handling of instruments- patients with, or "at increased risk" of vCJD**

| TISSUE INFECTIVITY | Status of patient | | |
|---|---|---|---|
| | Definite or Probable | Possible | At increased risk |
| **HIGH**<br>• Brain<br>• Spinal cord<br>• Cranial nerves, specifically the entire optic nerve and the intracranial components of the other cranial nerves<br>• Cranial Ganglia<br>• Posterior eye, specifically the posterior hyaloids face, retina,<br>• retinal pigment epithelium,<br>• choroid, subretinal fluid and<br>optic nerve<br>• Pituitary gland | Single use<br>or<br>Destroy<br>or<br>Quarantine for reuse exclusively on the same patient | Single use<br>or<br>Quarantine for reuse exclusively on the same patient pending diagnosis | Single use<br>or<br>Destroy<br>or<br>Quarantine for reuse exclusively on the same patient |
| **MEDIUM**<br>• Spinal ganglia<br>• Olfactory epithelium<br>• Tonsil<br>• Appendix<br>• Spleen<br>• Thymus<br>• Adrenal gland<br>• Lymph nodes and gut-associated lymphoid tissues | Single use<br>or<br>Destroy<br>or<br>Quarantine for reuse exclusively on the same patient | Single use<br>or<br>Quarantine for reuse exclusively on the same patient pending diagnosis | Single use<br>or<br>Destroy<br>or<br>Quarantine for reuse exclusively on the same patient |
| **LOW** | No special precautions | No special precautions | No special precautions |

Although dura mater is designated low infectivity tissue, procedures conducted on intradural tissues (i.e., brain , spinal cord, and intracranial sections of cranial nerves) or procedures in which human dura mater has been implanted in a patient prior to 1992, are high risk and instruments should
be handled as such.

In general, it is not possible to identify specific risk groups for the iatrogenic transmission of vCJD. However, the CJD Incidents Panel may identify individual patients who have been potentially exposed to vCJD (for example via surgical instruments used on a patient who went on to develop vCJD, or blood products derived from a donor who when on to develop vCJD). In these circumstances the individuals will have been informed of the risk by the Panel and advised to inform clinicians in the event of them needing surgery.

Click here for link to Part 3 Laboratory containment and control measures

Click here for link to Annex K

### 8.7.2 Complex instruments

- Some expensive items of equipment, e.g., drills may be prevented from becoming contaminated by using shields, guards, or other coverings so that the entire items do not need to be destroyed. The drill bit, other parts in contact with high-risk tissue(s) and the protective coverings would then need
- to be incinerated.

- Advice should be sought from Infection Prevention and Control and the manufacturer to determine practicality.

### 8.7.3 Quarantining of surgical instruments including surgical trays

- Quarantining of instruments is described in procedures involving tissues designated as high or medium infectivity on a possible CJD or vCJD patient pending a confirmed diagnosis. After completion of the surgical procedure single-use instruments should be disposed of by incineration. Reusable instruments should be washed, removing gross soil.

- After washing, the instruments should be placed on disposable instrument tray and allowed to air dry. They should then be placed in an impervious, rigid, plastic container with a close-fitting lid.

- The container should be sealed with heavy duty tape and labelled with the patient's identification details. The instrument tray can be disposed of by incineration.

- The sealed box can be stored indefinitely in a suitably designated place, to be decided by the Trust, until the outcome of any further investigations are known.

- Only if a definitive, alternative diagnosis is confirmed may the instruments be decontaminated following the usual routine procedures and returned to use.

### 8.8 CJD Infection prevention and control precautions in theatres and day surgery Pre-operative Assessment: Summary of advice

- Growing numbers of patients have been informed that they are at increased risk of CJD or vCJD. Therefore, it is recommended that all patients about to undergo any surgery or endoscopy should be asked if they have ever been notified as at increased risk of CJD or vCJD.

- In addition, patients undergoing surgery or neuro-endoscopy which may involve contact with tissues of potentially high-level TSE infectivity ("high risk tissues") should, through a set of detailed questions, be assessed for their possible CJD/vCJD risk exposure.

#### 8.8.1 TSE and Endoscopy

All patients attending for endoscopy will be risk assessed for TSE using the endoscopy documentation. Patients will be asked if they have ever been notified that they are at risk of CJD/vCJD for public health reasons. (This is the official terminology for someone who is potentially at risk e.g., a dura mater graft recipient, or recipient of factor V111 who is potentially at risk of developing CJD. These patients will have had an official letter from the CJD incident panel informing them that they are ''at risk for public health purposes'').

The general procedures set out in the Health Technical Memorandum 01-06: Decontamination of Flexible Endoscopes equivalent national guidance and the BSG Guidance on Decontamination of Equipment for Gastrointestinal Endoscopy (2020) should be followed. In order to decrease the risk of transmission of TSEs through endoscopic procedures, additional precautions for the decontamination of flexible endoscopes used in all patients with definite, probable, or possible CJD/vCJD, and in those identified as "at increased risk" of developing CJD/vCJD, are recommended, and general precautions are reinforced.

Click here for link to Annex F

Any patients requiring endoscopy or surgery and have ever been notified that they are at risk of CJD/vCJD for public health reasons or who have been assessed as "at risk" must be referred to an Acute NHS Trust

#### 8.8.2 Dentistry

The risks of transmission of infection from dental instruments are thought to be very low provided satisfactory standards of infection prevention and control and decontamination are maintained. There is no reason why any patient with, or "at increased risk" of CJD or vCJD, should be refused routine dental treatment.

Information for dentists about the management of patients with, or "at increased risk" of, CJD can be found in Decontamination Health Technical Memorandum 01-05: Decontamination in primary care dental practices (March 2013) at: Decontamination in Primary Care Dental Practices. This also includes advice for dentists on the re-use of endodontic instruments and vCJD.

Dental instruments used on patients with, or "at increased risk" of CJD or vCJD can be handled in the same way as those used in any other low risk surgery i.e., these instruments can be reprocessed following the Trusts Decontamination and Decontamination of Medical Devices Policy and returned to use.

### 8.9 Sharps and inoculation injuries

- Although cases of CJD/vCJD have been reported in healthcare workers, there have been no confirmed cases linked to occupational exposure. However, it is prudent to take a precautionary approach.

- The highest potential risk in the context of occupational exposure is from exposure to high infectivity tissues through direct inoculation, for example as a result of sharps injuries, puncture wounds or contamination of broken skin, and exposure of the mucous membranes.

- Healthcare personnel, who work with patients with definite, probable, or possible CJD/vCJD, or with potentially infected tissues, should be appropriately informed about the nature of the risk and relevant safety procedures.

- For any accident involving sharps or contamination of abrasions with blood or body fluids, wounds should be gently encouraged to bleed, gently washed (avoid scrubbing) with warm soapy water, rinsed, dried, and covered with a waterproof dressing, or further treatment given appropriate to the type of injury. Splashes into the eyes or mouth should be dealt with by thorough irrigation. Such accidents must be reported immediately, and the Sharps and splashes incidents Policy followed. This can be found here Sharps or Splash Incidents (Innoculation).pdf

- Consultant Occupational Health physicians and microbiologists should be informed and will assist in counselling the staff member.

### 8.10 Linen, laundry, and Patients' personal laundry

Linen and laundry should be handled and segregated. Any soiled items **MUST NOT** be manually sluiced. Patients/ relatives/ carers should be encouraged to wash personal laundry at home. The laundering of patients' own clothes in community hospitals should be done by exception only.

## 9. Infection Prevention and Control Precautions in Patient's Own Home

### 9.1 Standard Precautions

People should not be dissuaded from routine contact with CJD patients as both CJD and vCJD are not thought to present a risk through normal social or routine clinical contact. No special measures over and above standard infection prevention and control precautions are generally required for caring for CJD patients in the community, as it is unlikely that procedures will be adopted that will lead to contact with high or medium risk tissues. Normal standard infection prevention and control procedures should be used as for any other patient. Any exposure to bodily fluids must be treated as potentially infectious in line with standard infection prevention and control precautions including hand hygiene and the wearing of personal protective equipment.

### 9.2 Spillages

It is assumed that all spillages in patients' own homes will be of low-risk material e.g., blood and urine. Standard infection prevention and control precautions should be followed to clear up spillages of material from patients with, or "at increased risk" of, CJD/vCJD in the community. Spillages of body fluids should be removed using disposable paper towel and the surface washed thoroughly with detergent and warm water using disposable apron, disposable gloves, and eye protection where splashing may occur

### 9.3 Clinical waste

Any clinical waste generated in a patient's own home is unlikely to contain high risk material. Continence products and wound dressings should be double bagged and disposed of in the patient's wheelie bin or clinical waste stream if available. Where appropriate, arrangements should be made with the local authority for removal of clinical waste.

### 9.4 Linen and Patients' personal laundry

A patient's personal laundry, own bed linen and bed clothes can be washed in a domestic washing machine. It may be preferable to wash them separately to other household items. Any soiled items should not be manually sluiced.

## 10. CJD – After Death

### 10.1 Last Offices

Standard precautions adopted when the patient was alive should be continued to protect all who handle cadavers against infectious hazards. The body must not be handled unnecessarily; therefore, all procedures should be performed at one time.

### 10.2 After Death

After death of a patient defined in Table 1, the removal of the body from the ward to the mortuary should be carried out using normal infection control measures for bodies

where there is a known infection i.e., the bodies should be placed in a body bag prior to transportation.

### 10.3 Viewing the deceased

Viewing and possible superficial contact such as touching, or kissing need not be discouraged even if a post-mortem examination has taken place.

### 10.4 Undertakers and embalmers

The undertaker should receive infection prevention and control notification sheet, appropriately completed, prior to handling the body of the deceased.

An infection control notification sheet should be completed and given to the undertakers concerned with the deceased (see Appendix 1).

### 10.5 Post-Mortem Examinations

Post-mortem examinations are required to confirm suspected or possible cases of CJD but are not required for definite cases. Specialist post-mortem must be arranged in a regional neuropathology unit or in a high-risk autopsy unit such as at the CJD Unit, Edinburgh if required.

**Any deviation to this policy should be reported on Datix. Refer to the** Incident Reporting Policy

Please clink here for link to Annex H

## 11. Implementation

### 11.1 Plan for Implementation

The policy will be shared and uploaded on to The source.

### 11.2 Dissemination, Training and Awareness

Staff will receive training as identified in the Trust's Training Needs Analysis Appendix A of the Trust's Mandatory Training Policy]

## 12. Monitoring and Compliance

The NHS Resolution requirements are:

Organisations should measure, monitor and evaluate compliance with the minimum requirements within the NHS Resolution Risk Management Standards. This should include the use of audits and data related to the minimum requirements. The organisation should define the frequency and detail of the measurement, monitoring and evaluation processes.

Monitoring demonstrates whether the process for managing risk, as described in the approved documentation, is working across the entire organisation. Where failings have been identified, action plans must have been drawn up and changes made to reduce the risks. Monitoring is normally proactive - designed to highlight issues before an incident occurs - and should consider both positive and negative aspects of a process.

| Section / page no: | Key control: | Checks to be carried out to confirm compliance with the policy: | How often the check will be carried out? | Responsible for carrying out the check: | Results of the check reported to: *(Responsible for also ensuring actions are developed to address areas of non-compliance)* | Frequency of reporting: |
|---|---|---|---|---|---|---|
| **No.** | **WHAT?** | **HOW?** | **WHEN?** | **WHO?** | **WHERE?** | **WHEN?** |
| | Compliance with admission guidance | Screening audits for wards and departmental audits | Monthly | Ward Managers IPC Link Practitioners | Trust Infection Prevention and control Committee | Monthly |
| | Evidence of infection | Root cause analysis | As arises | Multi-Disciplinary Team | Divisional Reports, TIPCC, DATIX | As arises |

## 13. Policy Review

This policy will be reviewed every three years or earlier if regulations change by the named individual on the front of the policy and circulated for comment prior to approval by the Trust Infection Prevention and Control Committee (TIPCC).

Dissemination of the document will be as per the Trust Policy for Policies (WAHT-CG-827). Reference to the relevant Infection Prevention policies will also be made during induction, annual and other update sessions for staff. The policies will be available to view on the Trust Key Documents page on the intranet.

## 14. References

Advisory Committee on Dangerous Pathogens: Spongiform Encephalopathy Advisory Committee (1998). Transmissible spongiform encephalopathy agents: safe working and the prevention of infection. The Stationery Office Bookshops, London. ISBN 0-11-322166-5.

British Society of Gastroenterologists (2020) Guidance on decontamination of equipment for gastrointestinal endoscopy. The Report of a Working Party of the British Society of Gastroenterology Endoscopy Committee

Department of Health (2000) Creutzfeldt-Jacob Disease: Guidance for Healthcare workers.

Department of Health (2003) Revised TSE Guidance. Transmissible Spongiform Encephalopathy Agents: Safe working and the prevention of infection. Infection Control of CJD and variant CJD in healthcare and community settings. Part 4. (Revised and updated 2015)

Department of Health (2003) Winning Ways: Working together to reduce Healthcare Associated Infection in England. DH London 2365

Department of Health and Social Care (2012) Minimise transmission risk of CJD and vCJD in healthcare settings. London (Updated 2021)

Department of Health (2013) Decontamination Health Technical Memorandum (HTM) 01-05: Decontamination in primary care dental practices. DH London 18872 Available at: Health Technical Memorandum 05-01: Decontamination in primary care dental practices

Department of Health (2013) Health Technical Memorandum (HTM) 07-01: Safe Management of Healthcare waste. London

Department of Health (2016) Management and decontamination of flexible endoscopes Health Technical Memorandum (HTM) 01-06), London.

Department of Health (2016) Health Technical Memorandum 01-06: Decontamination of flexible endoscopes: Part C – Operational management. Available at: Decontamination of flexible endoscopes.

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.*(updated 2022). Available at: The-health-andsocial-care-act-2008-code-of-practice-on-the-prevention-and-control-of infections-and-related-guidance

Department of Health (DH) (2017 a.) *Minimise transmission risk of CJD and vCJD in healthcare settings Guidance*. Available at: https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

Department of Health (2017 b.) *Annex B: Diagnostic criteria*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/

attachment data/file/209761/Annex_B_-_Diagnostic_criteria.pdf

Department of Health (2017 c.) *Infection control of CJD, vCJD and other human prion diseases in healthcare and community settings*. Available at: https://www.gov.uk/government/publications/guidance-from-the-acdp-tse-risk-management-subgroup-formerly-tse-working-group

Department of Health (2017 d.) *Annex J: assessment to be carried out before surgery and or endoscopy to identify patients with, or at increased risk of, CJD or vCJD.* Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/636811/Annex_J_presurgical_assessment_vCJD.pdf

Department of Health (2015) *Annex F: Endoscopy*. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment data/file/470292/ACDP_TSE_Annex_F_Oct_2015.pdf

Department of Health (2009) Guidelines for pathologists and pathology laboratories for the handling of tissues from patients with, or at risk of, CJD or vCJD. Available at: Annex K (publishing.service.gov.uk).

NHS England and NHS Improvement (2021) National Standards of Healthcare Cleanliness

Wight, A (1993) PL(92)CO/4-neuro and ophthalmic surgery procedures on patients with or suspected to have, or at risk of developing, Creutzfeldt-Jakob disease (CJD), or Gerstmann-Straussler-Scheinker syndrome (GSS) Journal of Public Health Medicine, 15(2) 209-10

## 15. Background

**15.1 Equality requirements –** Please refer to supporting document 1

**15.2 Financial risk assessment –** Please refer to supporting document 2

## 16. Consultation

Members of TIPCC will be consulted, representing all divisions.

### 16.1 Contribution List

This key document has been circulated to the following individuals for consultation.

| Designation |
|---|
| Liz Watkins DIPC |
| Emma Fulloway IPC Nurse Manager |
| Kerrie Howells |
| Stuart Coleman |
| Emma Tandy |
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This key document has been circulated to the chair(s) of the following committee's/ groups for comments.

| Committee |
|---|
| TIPCC |

### 16.2 Approval Process

The draft document will be submitted to TIPCC for awareness prior to the receipt of comment, and again for approval once comments received before document code and version number are confirmed and the policy is released for placement on the Trust intranet. The final draft will be checked to ensure it complies with the correct format and that all supporting documentation has been completed.

## 17. Version Control

This section should contain a list of key amendments made to this document each time it is reviewed.

| Date | Amendment | By: |
|---|---|---|
| | | |
| | | |
| | | |

## 18. Annexes

Annex A1 – Distribution of TSE Infectivity in Human Tissues and Body Fluids

Annex A (publishing.service.gov.uk)

Annex A2 – Distribution of Infectivity in Animal Tissue and Body Fluids

Dura mater recipients and risk of vCJD (publishing.service.gov.uk)

Annex B – Diagnostic criteria

Click here for link to Annex B

Annex C – Decontamination and Waste Disposal

Click here for link to Annex C

Annex D – Transport of TSE Infected Material

Click here for link to Annex D

Annex E – Quarantining of surgical instruments

Click here for link to Annex E

Annex F – Endoscopy

Click here for link to Annex F

Annex H – Funeral arrangements after a CJD death

Please clink here for link to Annex H

Information sheet for funeral directors, relatives and others following a CJD death

Click here for link to Funeral Arrangements following a CJD Death

Annex I – Outline Protocol for Management of Instruments and Tissues from Brain Biopsy Procedures on Patients with Progressive Neurological Disorders

Click here for link to Annex I

Annex J – Assessment to be carried out before surgery and endoscopy to identify patients with, or at risk of, CJD and vCJD

Click here for link to Annex J

Annex K - Guidelines for pathologists and pathology laboratories for the handling of tissues from patients with, or at risk of, CJD or vCJD

Click here for link to Annex K

Annex L – Managing CJD/vCJD in Ophthalmology
This link contains advice on the precautions to be taken for ophthalmic procedures on patients with, or “at increased risk” of, CJD.
Click here for link to Annex L

Annex M – Managing vCJD Risk in General Surgery and Liver Transplantation
Click here for link to Annex M

## 19. Appendices

### Appendix 1

**Specimen Infection Control Notification Sheet**

Name of deceased: …….....…… Date and time of death: ……..... Source hospital and ward: ……..... The deceased's remains are a potential source of infection: **YES / UNKNOWN** (see note 1 below) (ring as appropriate) If **YES** (see note 2 below), the remains present an infectious hazard of transmission by: (circle as appropriate):

**Inoculation Aerosol Ingestion** ☐ Instructions for handling remains (If **YES** above, tick as ☐ appropriate):

Body bagging Embalming presents high risk

**Signed**: (Note 3) …….. **Print name** …….. On behalf of: …… (hospital / mortuary / General Practitioner)

**Notes**

Note 1: Not all infected patients display typical symptoms, therefore some infections may not have been identified at the time of death.

Note 2: In accordance with health and safety law and the information provided in the Health Services Advisory Committee Guidance *Safe working and the prevention of infection in the mortuary and post-mortem room* (Second edition 2002).

Note 3:

- In hospital cases, the doctor certifying death, in consultation with ward nursing staff, is asked to sign this Notification sheet.
- Where a post-mortem examination has been undertaken, the pathologist is asked to sign this Notification Sheet.
- In non-hospital situations, the doctor certifying death is asked to sign this Notification Sheet.

## Supporting Document 1 – Equality Impact Assessment Form

Equality and Health Inequalities Impact Assessment (EHIA) Tool

**Herefordshire & Worcestershire STP - Equality and Health Inequalities Impact Assessment (HEIA) Form**
**Please read HEIA guidelines when completing this form**

**Section 1 - Name of Organisation** (please tick)

| | | | | | |
|---|---|---|---|---|---|
| Herefordshire & Worcestershire STP | | Herefordshire Council | | Herefordshire CCG | |
| Worcestershire Acute Hospitals NHS Trust | ✓ | Worcestershire County Council | | Worcestershire CCGs | |
| Worcestershire Health and Care NHS Trust | | Wye Valley NHS Trust | | Other (please state) | |

| | |
|---|---|
| **Name of Lead for Activity** | **Liz Watkins** |

| | | | |
|---|---|---|---|
| **Details of individuals completing this assessment** | **Name** | **Job title** | **e-mail contact** |
| | **Liz Watkins** | **DIPC** | **Liz.watkins@nhs.net** |
| | | | |
| | | | |
| **Date assessment completed** | **9.04.2026** | | |

**Section 2**

| | | | | |
|---|---|---|---|---|
| Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.) | **Management of Patients with Proven or Suspected Transmissible Spongiform Encephalopathies (TSEs) Policy** | | | |
| What is the aim, purpose and/or intended outcomes of this Activity? | The policy aims to provide guidance and advice around CJD and other transmissible spongiform encephalopathies (TSEs). | | | |
| Who will be affected by the development & implementation of this activity? | X<br>X<br>X<br>❑ | Service User<br>Patient<br>Carers<br>Visitors | X<br>❑<br>❑<br>❑ | Staff<br>Communities<br>Other _____ |
| Is this: | X Review of an existing activity | | | |

| | |
|---|---|
| | ❑ New activity<br>❑ Planning to withdraw or reduce a service, activity or presence? |
| What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc. | Government guidance as listed in the references |
| Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required) | Trust consultation process followed |
| Summary of relevant findings | |

**Section 3**

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Age** | | X | | |
| **Disability** | | X | | |
| **Gender Reassignment** | | X | | |
| **Marriage & Civil Partnerships** | | X | | |
| **Pregnancy & Maternity** | | X | | |
| **Race including Traveling Communities** | | X | | |
| **Religion & Belief** | | X | | |
| **Sex** | | X | | |

| Equality Group | Potential positive impact | Potential neutral impact | Potential negative impact | Please explain your reasons for any potential positive, neutral or negative impact identified |
|---|---|---|---|---|
| **Sexual Orientation** | | X | | |
| **Other Vulnerable and Disadvantaged Groups** (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.) | | X | | |
| **Health Inequalities** (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies) | | X | | |

**Section 4**

| What actions will you take to mitigate any potential negative impacts? | Risk identified | Actions required to reduce / eliminate negative impact | Who will lead on the action? | Timeframe |
|---|---|---|---|---|
| | | . | | |
| | | | | |
| | | | | |
| **How will you monitor these actions?** | | | | |
| **When will you review this EIA?** (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation) | **As per policy review every 3 years unless changes in guidance** | | | |

**Section 5** - Please read and agree to the following Equality Statement

## 1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics:

Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

| | |
|---|---|
| **Signature of person completing EIA** | Liz Watkins |
| **Date signed** | 09.04.2026 |
| **Comments:** | |
| **Signature of person the Leader Person for this activity** | |
| **Date signed** | |
| **Comments:** | |

## Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and included when the document is submitted to the appropriate committee for consideration and approval.

| ID | Financial Impact: | Yes/No |
|---|---|---|
| **1.** | Does the implementation of this document require any additional Capital resources | No |
| **2.** | Does the implementation of this document require additional revenue | No |
| **3.** | Does the implementation of this document require additional manpower | No |
| **4.** | Does the implementation of this document release any manpower costs through a change in practice | No |
| **5.** | Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff | No |
| Other comments: | | |
| [Insert comments here] | | |