Document Type:	**Policy**	
Reference Number: **2028**	Version Number: **2**	Next Review Date: **11 January 2022**
Title:	**Pharmacological Management of Acute Alcohol Withdrawal and Relapse Policy**	
Document Author:	Clinical Team Leader, Alcohol Torbay, Drug and Alcohol Service	
Applicability:	All staff working within Torbay Drug and Alcohol Service	

Policy Descriptor

This policy sets out the standards and procedures that all staff working within Torbay Drug and Alcohol Service must adhere to in order to ensure the provision of safe, timely and personalised care in an appropriate setting for individuals accessing this service.

The intention of the policy is to support staff and ensure that the correct processes are followed prior to the initiation of a prescribing intervention. This document should be read alongside the Trust Prescribing Policy for the clinical Management of Alcohol-Use Disorders in Community.

The policy reflects current legislation, best practice recommendations and professional codes for registered practitioners.

Contents

Pharmacological Management of Acute Withdrawal and Relapse Prevention in Alcohol-Use Disorders in Community

Clinicians using this prescribing guideline must also refer to Trust Policy for the Clinical Management of Alcohol-Use Disorders in Community (Ref 1898)

The aim of these guidelines is to promote evidenced based, cost effective prescribing and support adherence to:

- *NICE Clinical Guidelines 100 Alcohol-Use Disorders (Feb 2011)*
- *NICE Clinical Guidelines 115 Alcohol dependence and harmful alcohol use (June 2010)*
- *British Association for Psychopharmacology Guidelines for the management of substance misuse, addiction and co morbidity (2012)*

These guidelines are NOT intended to replace prescribing information contained in the BNFor Summary of Product Characteristics.

The Trust supports the use of Maudsley Prescribing Guidelines (current edition) as an evidenced based prescribing resource for mental health specialists; however clinicians must be aware that these guidelines contain prescribing recommendations not supported by local healthcare community.

In alcohol cessation, the pharmacological basis of withdrawal symptoms is over-excitation of the sympathetic nervous system centrally and peripherally, which may cause seizures and/or result in Delirium Tremens (DTs). Generally, the first 72 hours after cessation of alcohol presents the most difficult time, when both physical and psychological problems may be at their worst. In physical dependence, tremulousness begins at 8-12 hours after the last drink, seizures and hallucinations most commonly begin at 24 hours, the peak period for seizures is 24-72 hours, and for DTs is 72 hours. Most physical manifestations of withdrawal have ceased by 5 days, whilst psychological symptoms, e.g. craving, continue for indeterminate periods.

Pharmacological interventions are not always needed to achieve successful withdrawal. When planning a personalised detoxification treatment programme, a balance must always be made between unnecessary medication and sufficient treatment, to minimise withdrawal symptoms.

Psychological therapies and psychosocial interventions are integral to the successful treatment of these disorders and must be used/offered alongside drug treatment, but are beyond the scope of these guidelines.

CALCULATING UNITS OF ALCOHOL:

One unit of alcohol = 8g pure alcohol
1/2 pint of ordinary strength beer
= 1 glass of table wine (10-12%)
= 1 small glass of sherry (17.5%)
= 1 pub measure (25cl) of spirits (40%)

Number of units of alcohol = $\frac{\text{Volume (ml)}}{1000}$ x % alcohol by volume

e.g. 500ml can of 8% lager = 4 units

Levels of alcohol consumption associated with withdrawal*:*

- **Females:** >7.5units daily for 5–10years, or recent excessive intake of 15 units.
- **Males:** >10units daily for 10–20years, or recent excessive intake of 16units.
- **Elderly:** ≥2.5units daily. More susceptible to alcohol withdrawal, confusion and disorientation.
- **Adolescents:** Alcohol withdrawal is uncommon, but may occur especially with concomitant sedative use.

Choice and Duration of Medication for Acute Alcohol Withdrawal:

Symptoms of acute alcohol withdrawal are usually avoidable with **adequate** amounts of benzodiazepines at doses which do not impair vital functions, especially respiration.

Long-acting benzodiazepines should usually be the drugs of first choice for alcohol withdrawal.

Benzodiazepines, used for short periods have a good safety profile. The risk of adverse effects, including overdose in combination with alcohol is greater with Chlormethiazole and therefore this drug is no longer a first line choice. Benzodiazepines should be avoided if the individual has a concurrent medical condition(s) associated with adverse reactions, particularly sedation. These medicines can be addictive and create both physiological and physical dependence and tolerance when used long-term. For this reason, prescribing regimes for detoxification should not exceed 10 days.

Chlordiazepoxide

- Drug of choice for control of alcohol withdrawal in a community setting.
- Licensed in the UK for the management of acute alcohol withdrawals (for initial stabilisation following cessation of alcohol intake to prevent epileptiform seizures and minimise other symptoms of physical withdrawal).

Diazepam

- Whilst there is a good evidence base for diazepam, avoid where possible, due to its greater potential for addiction compared with chlordiazepoxide.
- May be prescribed for in-patient management of severe alcohol withdrawal due its' longer half-life, particularly where there is a history of alcohol-related seizures.

In moderate/severe liver disease, the use of lorazepam or oxazepam, should be considered if low dose chlordiazepoxide is over sedating, owing to shorter half-lives and absence of active metabolites with oxazepam.

The effect of dosages will vary from individual to individual due to genetic or other physiological variations in metabolism, cognitive/neurological deficits or sensitivity to medication. Women, the elderly and individuals with hepatic impairment are more susceptible to benzodiazepines. In the elderly usually 50% of the 'normal' dose should be used. In renal disease no special considerations are needed other than monitoring of renal function following baseline assessment.

Fixed dose regimes are preferable to front loading/symptom-triggered regimes for community detoxification treatment, due to practicalities and associated safety issues. If withdrawal symptoms become uncontrolled/more severe the individual should be reassessed medically.

Fixed dose regimes start at a 'best guess' dose, based on clinical presentation and assessment using the Severity of Alcohol Dependence Questionnaire (SADQ) *(see Appendix 1)*. The severity of withdrawal varies widely between individuals and the dose of benzodiazepines prescribed to manage symptoms must reflect this.

The most severe withdrawal symptoms should be managed in the first 3 days. A maximum dose of prescribed medication in 24hours will be agreed in advance and appropriately documented with alterations if required following discussion with the prescriber**.**

'When required' (PRN) medication may be necessary (usually for the first 48 hours) but should be minimised if the individual has been adequately assessed. If more than 5 doses of PRN medication are required within a 48 hour period during detoxification, the prescriber must be contacted to review treatment and amend the regimen if indicated. Individuals that appear over-sedated should be advised to omit a dose of benzodiazepine.

Doses above British National Formulary guidelines (e.g. chlordiazepoxide >100mg daily) should only be prescribed where medical opinion has been sought, and response to treatment is regularly monitored, to avoid overdose.

Assessment of withdrawal symptoms, and dose titration, will be guided by the use of the Clinical Institute Withdrawal Assessment (modified) (CIWA-Ar) Scale. **Where an individual presents in an acute confusional state, the prescribed detoxification treatment regimen must be urgently reviewed by the prescriber and/ or an ambulance called for the emergency management of the presenting symptoms. It may be appropriate to consider an in-patient detoxification programme (see Appendix 4 of the Trust Policy for the Clinical Management of Alcohol-Use Disorders in Community – Ref 1898).**

Symptomatic Treatment of Common Symptoms during Alcohol Withdrawal:

The individual should be reassured that many of the following symptoms are normal during withdrawal from alcohol and that they will improve:

Symptom	Management
Sleep difficulties	Advise on sleep hygiene. Consider loading the total daily dose of benzodiazepine towards the evening or increasing the evening dose for 1-2 days. Avoid hypnotic medication but, as a last resort, a time-limited course may be indicated.
Poor appetite	Diet encouraged. Consider nutritional and vitamin supplements if malnourished or at risk of malnourishment (see 'Vitamin supplementation').
Nausea	Prochlorperazine (buccal) 3-6mg up to BD PRN.
Diarrhoea	Loperamide (oral) 4mg STAT then 2mg PRN after each loose stool, maximum dose 16mg/24hrs.
Heartburn/ indigestion	Peptac® (oral) 10-20ml up to QDS PRN after meals/at bedtime. Not to be taken at the same time as other medication as may affect efficacy.
Itching	Check for signs of liver disease. Consider chlophenamine (oral) 2-4mg up to QDS PRN.
Headache	Paracetamol 500mg-1g up to QDS PRN. Use with caution in severe liver disease.
Anxiety	Very common, usually resolves after 3-4 days. Detoxification may unmask pre-existing anxiety which will need assessing in its own right.
Depression	Very common. Monitor for severe persistent symptoms and suicidal ideation. Detoxification may unmask pre-existing depression which will need assessing in its own right.

Wherever possible, avoid unnecessary pharmacological treatment and only treat if severe symptoms persist on a PRN basis if possible.

Vitamin Supplementation

Vitamin deficiency in alcoholism is common. There is a particular need for thiamine stores to be replenished due to its critical role as a co-factor for metabolic enzymes. The process of detoxification is liable to precipitate acute loss of thiamine (vitamin B1) stores in individuals who are often already chronically deficient. The acute effects are often subclinical, but many chronic memory problems in alcoholics may be the direct result of episodes of withdrawal, whether this is medically assisted or not.

The table below represents NICE Prophylactic vitamin supplementation for all harmful or dependent drinkers

Offer prophylactic ORAL Thiamine to harmful or dependent drinkers: 100mg thiamine TDS (QDS if more than one factor below) and Vit B co Strong one tablet daily	**Offer prophylactic PARENTERAL thiamine followed by oral thiamine to harmful and dependent drinkers:**
If they are malnourished or at risk of malnourishment **or** If they have decompensated liver disease **or** If they are in acute withdrawal **or** before and during a planned medically assisted alcohol withdrawal.	If they are malnourished or at risk of malnourishment **or** If they have decompensated liver disease **AND IN ADDITION** They attend an emergency department **or** are admitted for emergency inpatient treatment

Thiamine deficiency causes Wernicke's encephalopathy and is most commonly seen in heavy drinkers with a poor diet. Classical signs of Wernicke's encephalopathy are rarely all present but may include:

- Ataxia (failure of muscular co-ordination, irregular movement, tremor)
- Confusion
- Ophthalmoplegia/nystagmus (paralysis of eyeball, or involuntary, rapid rhythmic movement)

Wernicke's encephalopathy is initially reversible but, without adequate treatment, can result in Korsakoff's syndrome or death.

Where a diagnosis of Wernicke's encephalopathy is suspected or confirmed, (and/or treatment with i/v glucose is clinically indicated), admission to hospital for treatment with i/v Pabrinex® must be arranged immediately.

During detoxification:

Thiamine (oral)
100mg TDS.
Start immediately for all individuals undergoing uncomplicated alcohol detoxification in the community. Consider 50mg six times daily if poor absorption as it is possible that only ~1mg is absorbed from a single tablet, although consider likelihood of adherence to this regimen. Withhold whilst Pabrinex® is given.

Pabrinex® (i/m): high potency vitamin B complex

ONE PAIR i/m ampoules OD for 5 days.
Prophylactic Pabrinex® should be prescribed for the following individuals at high risk of developing Wernicke's encephalopathy:

Intercurrent illness	Korsakoff's psychosis (short-term memory loss, frontal lobe dementia)
Alcohol withdrawal seizures	Admitted for in-patient management of moderate/severe withdrawal symptoms
Drinking ≥20 units daily	Recent diarrhoea and/or vomiting
Significant weight loss	Signs of malnutrition/poor diet
Peripheral neuropathy	DTs or other alcohol related neurological condition

Administration must only occur where facilities for treating anaphylactic reactions are available as rarely (1 in 5million) potentially serious allergic adverse reactions may occur.

Following detoxification: If abstinence and a healthy diet is maintained, stop supplementation after 2 weeks. If relapse occurs prescribe supplementation as above for chronic drinkers

Management of Alcohol-Use Disorders in Pregnancy and Breast-feeding

Women of childbearing age should be offered a pregnancy test, and advised to avoid pregnancy/breast-feeding prior to initiation of pharmacological treatment, for maintenance of abstinence.

Management of Alcohol Withdrawal Seizures

The incidence of seizures in alcohol dependent individuals ranges from 1-15% however repeated withdrawal can increase the risk of fits and subsequent risk of cognitive impairment, particularly if the individual is unable to change. Adequate doses of benzodiazepines significantly reduce the risk of seizures for the first time episode. Anticonvulsants (e.g. carbamazepine) are equally efficacious as benzodiazepines in primary seizure prevention, but there is no advantage when these medications/drugs are combined. Pre-existing epilepsy that is non-alcohol related is unusual, but should be managed with antiepileptic medication currently prescribed, in addition to benzodiazepines for alcohol withdrawal.

If a seizure is witnessed, dial 999 and call an ambulance if:

- It is the person's first (known) seizure.
- The seizure continues for more than five minutes.
- One seizure follows another without any recovery between seizures.
- The person is injured during the seizure or where urgent medical attention is considered necessary (i.e. the person has trouble breathing after the seizure has stopped).

If alcohol withdrawal seizures develop in a person during treatment for acute alcohol withdrawal, their prescribed detoxification treatment regimen must be urgently reviewed by the prescriber and the care-coordinator. It may be appropriate to consider an in-patient detoxification programme.

Maintenance of Abstinence in Alcohol Dependence (following successful withdrawal)

For motivated individuals with a diagnosis of moderate to severe alcohol dependence who have successfully withdrawn from alcohol, medication may be offered in accordance with the Trust Policy for the Clinical Management of Alcohol-Use Disorders in Community.

Acamprosate (Campral EC®)

≥60kg: 666mg TDS or <60kg: 666mg MANE, 333mg midday, 333mg NOCTE.

Start with or soon after detoxification, particularly where craving is a factor in relapse, as it takes 5-7 days to reach therapeutic levels. Licensed for patients of ages between18-65 years. Recommended by NICE as an intervention to support individuals with moderate, or severe, alcohol dependence to help sustain abstinence after the successful withdrawal. Shown to reduce the amount and frequency of alcohol consumed compared to placebo by ~50%. Does not have a direct effect on acute alcohol withdrawal, but is thought to reduce the 'craving' by stabilising the imbalance of neurotransmitters that is seen in alcohol dependency. Side effects are usually gastrointestinal and tend to be mild and transient in nature.

Naltrexone

25mg OD increasing to 50mg OD the next day.

To improve compliance once stable, this may be changed to a three-times-a-week dosing schedule e.g.100mg on Monday and Wednesday and 150mg on Friday. Recommended by NICE as an intervention to support individuals with moderate or severe alcohol dependence, sustain abstinence after successful withdrawal. Evidence shows that it is effective in reducing drinking frequency and relapse rate and is thought to work by reducing the response of the opiate stimulated reward circuits.

Disulfiram (Antabuse®)

200mg OD or initial loading dose of 800mg OD reducing over 3 days to 200mg OD. Initiate after a minimum of 24 hours abstinence. Individuals who continue to drink and experience an insufficient response to act as a deterrent should increase to 400mg OD (and to a maximum of 800mg if this is repeated). Dose usually taken in the morning (when motivation is greatest), or in the evening if sedation is problematic. Daily supervision is recommended but once stable, may be changed to twice or thrice weekly administration (splitting the total weekly dose).

Recommended by NICE as a second line option for individuals with moderate or severe alcohol dependence, who wish to abstain but for whom acamprosate and naltrexone are not suitable, or who prefer disulfiram and understand the relative risks of taking it. Published evidence is scarce (less inherently amenable to blinding in research studies), therefore its comparative effectiveness of improving controlled drinking and abstinence may be under- rated. Useful if a period of abstinence is required (e.g. for reassurance of employers) but, due to the Disulfiram-Alcohol Reaction, should only be initiated by a specialist in the field of substance misuse.

Disulfiram acts as a 'blocker' so after alcohol intake there is an immediate and severe negative reaction. The individual may experience the effects of a severe "hangover" for a period of 30 minutes up to several hours. There is no tolerance to disulfiram: the longer it is taken, the stronger its effects. The effects may last for up to 2 weeks after the initial intake. It is an alcohol deterrent, acting by aversion**:** theoretically it is the fear of the Disulfiram-Alcohol Reaction rather than the experience.

It is good practice to continue treatment for 12 months, including during minor lapses for acamprosate or naltrexone. Liver and kidney function may be assessed before treatment is initiated as medication for abstinence should not be prescribed for individuals with severe hepatic/renal impairment. NICE state that treatment initiation should not be delayed and can be started prior to the results becoming available. During treatment with naltrexone and disulfiram periodic liver function tests (LFT's) should be carried out, frequency of these will be determined by the prescriber and based on individual's health, base line LFT's and efficacy. However the minimum frequency for LFT's would be initially at 3 months and then 6 monthly as long as treatment continues

User-Friendly Resources for Information about Medication in Alcohol-Use Disorders

These web-based links are recommended sources for user-friendly information about treatment for the management of alcohol dependence:

- **Choice and Medication website:** www.choiceandmedication.org.uk/devon (Last accessed 13/04/2018)
  Includes printable summaries for medication used for alcohol withdrawal and dependence, and 'Handy Charts' comparing the medication available.

- **Patient.co.uk website:** www.patient.co.uk (Last accessed 13/04/2018)
- **Links to Manufacturer Patient Information Leaflet:** www.medicines.org.uk (Last accessed 13/04/2018)
- **Naltrexone and Antabuse® cards** are available from Walnut Lodge

Alternative Pharmacological Intervention For Dependent Drinkers

Nalmefene (Selincro®)

18mg tablets – 1 tablet to be taken on days where there is a perceived risk of drinking alcohol (as needed). Preferably taken 1-2 hours before the anticipated drinking time.

Nalmefene (also known as Selincro) Is recommended by NICE as a possible treatment for people with alcohol dependence who:

- are still drinking more than 7.5 units per day (for men) and more than 5 units per day (for women) 2 weeks after an initial assessment **and**
- do not have physical withdrawal symptoms **and**
- do not need to either stop drinking straight away or stop drinking completely.

Nalmefene should only be taken if the person is also having on-going psycho-social support to change their behavior, continue to take their medication/ treatment and to reduce their alcohol intake. NB – Nalmefene is licensed for the reduction of alcohol consumption which may lead to abstinence, but not in all cases. Patients should be monitored regularly and the need for continued treatment assessed. Caution advised if treatment continues in excess for 1 year.

Nalmefene is an opioid antagonist and is believed to work by blocking reward systems in the brain which in turn reduces the urge for patients to continue drinking. Nalmefene exhibits antagonist activity at the mu and delta opioid receptors, and partial agonist activity at the kappa opioid receptors.

The most common side effects of Nalmefene (experienced by more than 1 in 10 people) include feeling sick, dizziness, inability to sleep and headache (see the summary of product characteristics).

A medical emergency card should be carried by the patient in case opioid treatment is required in an emergency situation.

References

National Institute for Health and Clinical Excellence (NICE) (2014) *Nalmefene for reducing alcohol consumption in people with alcohol dependence. [Online].* Available at*:* http://www.nice.org.uk/guidance/ta325 (last accessed 30 09 15)

Appendix 1

Severity of Alcohol Dependence Questionnaire

Severity of Alcohol Dependence Questionnaire – SADQ							
Name:		**Date:**		**Total Score:**			
AN	Almost Never	Score 0	**S**	Sometimes	Score 1		
O	Often	Score 2	**NA**	Nearly Always	Score 3		

First we want to know about the physical symptoms that you have experienced <u>first thing in the morning</u> during these typical periods of <u>heavy drinking.</u>

		AN	S	O	NA
1	The day after drinking alcohol, do you wake up feeling sweaty?				
2	The day after drinking alcohol, do your hands shake first thing in the morning?				
3	The day after drinking alcohol, does your body shake violently first thing in the morning if you don't have a drink?				
4	The day after drinking alcohol, do you wake up drenched in sweat?				

The following statements refer to moods and states of mind you may have experienced <u>first thing in the morning</u> during these periods of heavy drinking.

		AN	S	O	NA
5	The day after drinking alcohol, do you dread waking up?				
6	The day after drinking alcohol, are you frightened of meeting people first thing in the morning?				
7	The day after drinking alcohol, do you feel at the edge of despair when you wake up?				
8	The day after drinking alcohol, do you feel frightened when you wake up?				

The following statements also refer to the recent period <u>when your drinking was heavy</u>, and to periods like it.

		AN	S	O	NA
9	The day after drinking alcohol, do you like a drink in the morning?				
10	The day after drinking alcohol, do you gulp your first few drinks down as fast as possible?				
11	The day after drinking alcohol, do you drink to get rid of the shakes?				
12	The day after drinking alcohol, do you have a strong craving for drink when you wake up?				

Again these statements refer to the <u>recent period of heavy drinking</u> and the periods like it.

		AN	S	O	NA
13	During a heavy drinking period, do you drink more than 8 Units of alcohol per day?				
14	During a heavy drinking period, do you drink more than 15 Units of alcohol per day?				
15	During a heavy drinking period, do you drink more than 30 Units of alcohol per day?				
16	During a heavy drinking period, do you drink more than 60 Units of alcohol per day?				

Document Control Information

This is a controlled document and should not be altered in any way without the express permission of the author or their representative.

Please note this document is only valid from the date approved below, and checks should be made that it is the most up to date version available.

If printed, this document is only valid for the day of printing.

This guidance has been registered with the Trust. The interpretation and application of guidance will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using clinical guidance after the review date, or outside of the Trust.

Ref No:	2028		
Document title:	Pharmacological management of Acute Alcohol Withdrawal and Relapse Prevention in Alcohol		
Purpose of document:	To support staff and ensure that the correct processes are followed prior to the initiation of a prescribing intervention		
Date of issue:	11 January 2019	**Next review date:**	11 January 2022
Version:	2	**Last review date:**	
Author:	Clinical Team Leader, Alcohol Torbay, Drug and Alcohol Service		
Directorate:	Community		
Equality Impact:	The guidance contained in this document is intended to be inclusive for all patients within the clinical group specified, regardless of age, disability, gender, gender identity, sexual orientation, race and ethnicity & religion or belief		
Committee(s) approving the document:	Care and Clinical Policies Group Meeting Clinical Director of Pharmacy		
Date approved:	7 January 2019		
Links or overlaps with other policies:	1912 - Clinical Management of Substance Misuse in the Community 1898 - Clinical Management of Alcohol-Use Disorders in Community		

Have you identified any issues on the Rapid (E)quality Impact Assessment. If so please detail on Rapid (E)QIA form.	Yes ☐	
	Please select *Yes*	*No*
Does this document have implications regarding the Care Act? *If yes please state:*	☐	☐
Does this document have training implications? *If yes please state:*	☐	☐
Does this document have financial implications? *If yes please state:*	☐	☐
Is this document a direct replacement for another? *If yes please state which documents are being replaced:*	☐	☐

Document Amendment History

Date	Version no.	Amendment summary	Ratified by:
30 September 2015	1	Review	
2 November 2017	1	Review date extended – 6 months	Care and Clinical Policies Group
11 January 2019	2	Revised	Care and Clinical Policies Group Clinical Director of Pharmacy

The Mental Capacity Act 2005

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

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

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

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

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

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

Infection Control

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

Quality Impact Assessment (QIA)

	Please select			
Who may be affected by this document?	Patient / Service Users	☒	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☒
	NHS Organisations	☒	Police	☐
	Councils	☐	Carers	☐
	Staff	☐	Other Statutory Agencies	☐
	Others *(please state):*			

Does this document require a service redesign, or substantial amendments to an existing process?	☐
If you answer yes to this question, please complete a full Quality Impact Assessment.	

Are there concerns that the document could adversely impact on people and aspects of the Trust under one of the nine strands of diversity?	Age	☐	Disability	☐
	Gender re-assignment	☐	Marriage and Civil Partnership	☐
	Pregnancy and maternity	☐	Race, including nationality and ethnicity	☐
	Religion or Belief	☐	Sex	☐
	Sexual orientation	☐		
If you answer yes to any of these strands, please complete a full Quality Impact Assessment.				
If applicable, what action has been taken to mitigate any concerns?				

Who have you consulted with in the creation of this document? *Note - It may not be sufficient to just speak to other health & social care professionals.*	Patients / Service Users	☐	Visitors / Relatives	☐
	General Public	☐	Voluntary / Community Groups	☐
	Trade Unions	☐	GPs	☐
	NHS Organisations	☐	Police	☐
	Councils	☐	Carers	☐
	Staff	☒	Other Statutory Agencies	☐
	Details *(please state):*			

NHS South Devon and Torbay Clinical Commissioning Group Torbay and South Devon NHS NHS Foundation Trust

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

Policy Title (and number)		**Version and Date**	
Policy Author			

An (e)quality impact assessment is a process designed to ensure that policies do not discriminate or disadvantage people whilst advancing equality. Consider the nature and extent of the impact, not the number of people affected.

Who may be affected by this document?

Patients/ Service Users ☐	Staff ☐	Other, please state… ☐

Could the policy treat people from protected groups less favorably than the general population?
PLEASE NOTE: Any 'Yes' answers may trigger a full EIA and must be referred to the equality leads below

Age	Yes ☐ No☐	Gender Reassignment	Yes ☐ No☐	Sexual Orientation	Yes ☐ No☐
Race	Yes ☐ No☐	Disability	Yes ☐ No☐	Religion/Belief (non)	Yes ☐ No☐
Gender	Yes ☐ No☐	Pregnancy/Maternity	Yes ☐ No☐	Marriage/ Civil Partnership	Yes ☐ No☐

Is it likely that the policy could affect particular 'Inclusion Health' groups less favourably than the general population? (substance misuse; teenage mums; carers[1]; travellers[2]; homeless[3]; convictions; social isolation[4]; refugees)	Yes ☐ No☐

Please provide details for each protected group where you have indicated 'Yes'.

VISION AND VALUES: Policies must aim to remove unintentional barriers and promote inclusion

Is inclusive language[5] used throughout?	Yes ☐ No☐ NA ☐
Are the services outlined in the policy fully accessible[6]?	Yes ☐ No☐ NA ☐
Does the policy encourage individualised and person-centred care?	Yes ☐ No☐ NA ☐
Could there be an adverse impact on an individual's independence or autonomy[7]?	Yes ☐ No☐ NA ☐

EXTERNAL FACTORS

Is the policy a result of national legislation which cannot be modified in any way?	Yes ☐ No☐

What is the reason for writing this policy? (Is it a result in a change of legislation/ national research?)

Who was consulted when drafting this policy?

Patients/ Service Users ☐	Trade Unions ☐	Protected Groups (including Trust Equality Groups) ☐
Staff ☐	General Public ☐	Other, please state… ☐

What were the recommendations/suggestions?

Does this document require a service redesign or substantial amendments to an existing process? ***PLEASE NOTE: 'Yes' may trigger a full EIA, please refer to the equality leads below***	Yes ☐ No☐

ACTION PLAN: Please list all actions identified to address any impacts

Action	Person responsible	Completion date

AUTHORISATION: By signing below, I confirm that the named person responsible above is aware of the actions assigned to them			
Name of person completing the form		**Signature**	
Validated by (line manager)		**Signature**	

Please contact the Equalities team for guidance:

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

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

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

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

Clinical and Non-Clinical Policies – Data Protection

Torbay and South Devon NHS Foundation Trust (TSDFT) has a commitment to ensure that all policies and procedures developed act in accordance with all relevant data protection regulations and guidance. This policy has been designed with the EU General Data Protection Regulation (GDPR) and Data Protection Act 2018 (DPA 18) in mind, and therefore provides the reader with assurance of effective information governance practice.

The UK data protection regime intends to strengthen and unify data protection for all persons; consequently, the rights of individuals have changed. It is assured that these rights have been considered throughout the development of this policy. Furthermore, data protection legislation requires that the Trust is open and transparent with its personal identifiable processing activities and this has a considerable effect on the way TSDFT holds, uses, and shares personal identifiable data.

Does this policy impact on how personal data is used, stored, shared or processed in your department? Yes ☐ No ☐

If yes has been ticked above it is assured that you must complete a data mapping exercise and possibly a Data Protection Impact Assessment (DPIA). You can find more information on our GDPR page on ICON (intranet)

For more information:

- Contact the Data Access and Disclosure Office on dataprotection.tsdft@nhs.net,
- See TSDFT's Data Protection & Access Policy,
- Visit our Data Protection site on the public internet.