POLICY FOR IN-PATIENT AND OUT OF HOURS MANAGEMENT OF DRUG MISUSERS
### Policy Title:
POLICY FOR IN-PATIENT AND OUT OF HOURS MANAGEMENT OF DRUG MISUSERS

### Executive Summary:
This policy has been adopted from Cheshire and Wirral partnership NHS Foundation Trust, who are responsible for the review and approval of this policy. The Medicines Management Group at East Cheshire NHS Trust (ECT) approves this policy for adoption and implementation. The purpose of this policy is to ensure that good clinical practice is followed for patients with drug misuse problems.

### Supersedes:
Version 5 October 2013

### Description of Amendment(s):
1. Updated details for urine drug screen testing kits to...Jan 08.
2. The regular prescriber and community pharmacist should be contacted to prevent the patient and anyone else collecting their prescription whilst they are in hospital’ - Jan 08.
3. The regular prescriber should be informed if possible 48 hours before discharge so there should be no need to take a methadone supply home’ - Jan 08.
4. Updated details for urine drug screen testing kits to Conceteno by Altrix - March 10.
5. Many drug users are over the age of 40 years - March 10.
6. Wirral Drug Service, Central Cheshire drug service &West Cheshire Drug service changed to new service providers names - March 2015
7. The Clinical Director(s) of the Drug and Alcohol Services of the Cheshire and Wirral Partnership NHS Foundation Trust can be contacted out of hours through every hospital switchboard has been removed - March 2015
8. Clinical Director changed to pharmacist - March 2015
9. Appendix 1,2& 3 added - March 2015

### This policy will impact on:
All health professionals involved in prescribing for drug misuser patients admitted to the Trust.

### Financial Implications:

<table>
<thead>
<tr>
<th>Policy Area</th>
<th>Medicines Management</th>
<th>Document Reference:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Version Number:</td>
<td>6</td>
<td>Effective Date:</td>
</tr>
<tr>
<td>Issued By:</td>
<td>Chair of Medicines</td>
<td>Review Date:</td>
</tr>
<tr>
<td>Management Group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Author:</td>
<td>Deputy Chief Pharmacist</td>
<td>Impact Assessment Date:</td>
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### APPROVAL RECORD

<table>
<thead>
<tr>
<th>Committees / Group</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>ED Consultant lead</td>
<td>July 2015</td>
</tr>
<tr>
<td>Specialist Advice- Acute pain nurse specialist</td>
<td>July 2015</td>
</tr>
<tr>
<td>Medicines Management Group</td>
<td>July 2015</td>
</tr>
</tbody>
</table>

### Received for information:
Trust SQS Committee To be arranged
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Duties & Responsibilities

1. Chair of MMG

It is the responsibility of the chair to ensure that the minutes of the meetings reflect the approval process and that all reviews of the policy are timetabled within the work programme.

1.1 Author

Responsibility to seek consultation on the policy updates and then seeks approval of the policy via the appropriate Trust channels. Once approved, ensuring that the policy has been disseminated appropriately and raising staff awareness of the policy.

1.2 Line Managers

Have the responsibility to cascade information on the revised policy to all staff that they manage. Ensuring that any training required on the policy is included in staff's personal development plan and clinical supervision

1.3 Trust Staff

All Trust staff working in in-patient areas must be familiar with this policy and any subsequent updates, which will be annotated on the front page of the revised policies. It is the responsibility of staff to keep up to date with this policy and any training identified to go along with it.

2 Introduction

Opiate dependent people have a high level of medical morbidity and are often admitted to Accident and Emergency Departments or other hospital settings. The aim of this policy is to help clinicians prescribe safely, and manage opioid/opiate withdrawal, so that the patient can have appropriate treatment for the condition that has resulted in the hospital admission. Illicit drug use is common and asking about drug and alcohol use should form part of routine history taking on admission to hospital. The link between illicit drug use and the reason for admission may be simple or complex. Many opiate dependent patients are prescribed methadone or other drugs by their local drug service. Community pharmacists dispense the medication and can verify dosage and dispensing days, thus reducing the risk of double prescribing of medication occurring. CWP Drugs & Alcohol Services are only in East Cheshire, so contact must be made with the external locality services above.

Opiate withdrawal is NOT LIFE THREATENING and usually occurs 6-12 hours after the last heroin use or 18-48 hours after methadone.
3 Assessment

On identifying a patient with a drug misuse issue it is important to undertake an assessment. Take a careful history of recent drug use which should include:

- Name of all drugs used (prescribed, over the counter, purchased via the internet, ‘street’ drugs and alcohol and benzodiazepine use)
- Average daily amount taken
- Routes of administration (oral/IV/IM/SC/snorted/smoked)
- Does the patient report withdrawal symptoms? (If so what are they?)
- When were the substances last used?
- If prescribed substitute medication for dependency, check with the appropriate drug service and/or pharmacy for details of dose, medication, date last dispensed and whether patient currently on supervised consumption.

Additional confirmation of drug use can be obtained from:

- GP
- Drug & Alcohol Service
- Dispensing Community Pharmacy.

On examination look for:

- Signs of intoxication (includes euphoria / relaxation, constricted ‘pin point’ pupils, drowsiness/sedation, impaired balance, slurred speech, poor attention and concentration, decreased levels of consciousness)(appendix 5)
- Signs of Opioid withdrawal (appendix 4)
- Confirmatory evidence of drugs use (e.g. marks – check groin, thrombosed veins, cellulites, old scars)
- Use instant urine testing to check on opiate, stimulant, methadone and benzodiazepine usage
- Blood can be sent to the laboratory to confirm blood alcohol levels

4 Management Guidance

- Unless obvious opiate withdrawal characteristics are present, urgent prescribing is rarely necessary
- To avoid illicit drug use on the ward patients should be advised that it is against both hospital policy & the Law for them to bring in or use drugs on hospital property & that such activity would put them, other patients and staff at risk of harm
- Ingestion of prescribed medication should be observed. Urine screening can be used to check compliance with treatment
- During the admission, the patient should be given the opportunity to discuss post-discharge treatment with the local Drug & Alcohol Treatment Service
If the patient does not wish to engage further with the local Drug & Alcohol Treatment Service, then NO substitute medication is prescribed at discharge.

Some patients may also be dependent on a variety of other drugs—particularly alcohol and benzodiazepines which may lead to severe withdrawal states and may require a reduction programme using a substitute drug. Chlordiazepoxide is the drug of choice for treatment of alcohol. There is a separate alcohol detoxification guidance within the Trust available on Trust infonet: http://nww.eastcheshire.nhs.uk/clinical/Clinical%20pathwaysClerking%20proforma\%20/HALS\%20Alcohol\%20Management%20proforma.pdf

Some patients may request benzodiazepines or hypnotics such as zopiclone. Such requests may be for continuation of a regular prescription, for the treatment of opioid withdrawal symptoms or for the treatment of illicit benzodiazepine dependence. Such requests should always be treated with extreme caution. All claims as to current treatment should be checked before starting an inpatient prescription. Benzodiazepines and hypnotics should not be used for the treatment of opioid withdrawal symptoms. Benzodiazepine withdrawal requiring treatment is relatively rare and advice should be generally sought unless urgent treatment is required.

Advice and information can be sought from the Trust local pharmacy department and/or the mental health pharmacist.

4.1 Advice on patients admitted Monday to Friday 09:00-17:00

- Complete a drug history and take an instant urine to check for; opiate, stimulants, methadone and benzodiazepine
- Assess clinical state of the patient
- Contact the local Drug & Alcohol Treatment Service
- Unless there are contra indications, the patient should continue on the same dose of prescribed medication and the drug service can cancel any outstanding prescriptions
- The regular prescriber and community pharmacist should be contacted to prevent the patient and anyone else collecting their prescription whilst they are in hospital
- If the patient is not known to the service or has been out of contact with the service, the service can advise regards to safe substitute opioid prescribing
- Notice should be given to the drug service in good time prior to discharge so plans can be put in place for continuation of the patient’s medication on leaving hospital

4.2 Advice on patient’s admitted out of hours

It is essential that the following steps have been followed:

- In the rare event that substitute opioid prescribing is deemed necessary, then:
Confirm the history with an instant urine drug test

If there is any doubt about the dose of substitute opioid medication, give an initial dose of methadone mixture (1mg/1ml) of up to 30mg, & if withdrawal persists, a further dose of 10mg can be given 12 hours later

Continued efforts should be made to contact the patient’s Drug Service (contact is usually during office hours)

Follow algorithm for out of hours (appendix1)

Observe the patient closely for the first 72 hours to look for signs of over sedation and respiratory depression from the methadone

All wards must have rapid access to Naloxone Hydrochloride (Narcan) to enable reversal of respiratory depression from opiates such as methadone and heroin

4.3 Patients seen for treatment in Accident & Emergency

Patients attending at Accident & Emergency should not need replacement methadone unless they are admitted to hospital. Opiate withdrawal is NOT a medical emergency, as opposed to an alcohol withdrawal, which can be.

4.4 Treatment for stimulant withdrawal

Patients who use stimulants (amphetamines or cocaine) do not usually show a true withdrawal syndrome though they may exhibit intense drug craving behaviour and may become depressed.

4.5 Injectable prescribing

Some patients are on injectable rather than oral methadone and even fewer on prescribed heroin (diamorphine). Injectable drugs should NOT be administered in hospital unless there is some specific medical reason

4.6 Benzodiazepines

A small percentage of patients are prescribed benzodiazepines and this prescription may continue as an inpatient following confirmation by the local Drug Service.

4.7 Cautions

- Methadone can interact with other drugs. This especially applies to other medication sedative and enzyme inducers such as rifampicin and phenytoin
- It is important to remember that the half-life of methadone is about 24 hours

4.8 Discharge

- The regular prescriber should be informed if possible 48 hours before discharge so there should be no need to take a methadone supply home
 It is important to inform the patient about arrangements that have been made, as they will be anxious if left without medication.
 If a patient is discharged over the weekend a supply of medication can be obtained for a maximum of 2 days.
 There may be rare occasions e.g. Bank holidays where a 3 day prescription should be supplied as the local Drug Service may be closed on the Bank Holiday.

4.9 Atypical prescriptions:

 There is a minority of patients who are prescribed non methadone prescriptions for drug misuse. The four circumstances to phone the pharmacist if there are any problems are:
   1. Patients prescribed Buprenorphine as there may be complications with prescribing further analgesia.
   2. Patients under the age of 18 years, as very few will fall into the category of requiring a substitute prescription.
   3. Anyone prescribed diamorphine or any of its derivatives from the Drug Treatment Service may need to be converted to different medication on in-patient admission.
   4. There are special management issues in pregnancy due to the risk of withdrawal and advice should be obtained from the Community Drug Team and/maternity services and/or mental health pharmacist.

4.10 Analgesic Requirements

 Patients maintained on methadone may require additional medication for pain control, depending on their medical condition or procedure.
 If indicated opioid analgesia in the appropriate dosage and frequency should be given. Contact Acute Pain Service or Pharmacy for advice.
 Patients should be carefully observed for signs of over sedation.

Please not due to the mixed agonist/antagonist properties, specialist advice should be sought regarding pain control, for patients prescribed Buprenorphine (Subutex or Suboxone).

4.11 Naloxone Hydrochloride

Naloxone may be given for the reversal of opioid depression effects following overdose but should be used with caution in pregnancy. See BNF for dosages. The duration of action can last from 45 minutes up to 3-4 hours depending on route of administration, dose and individual variations in liver metabolism. The duration of action of certain opioids such as methadone, dihydrocodeine, buprenorphine and dextropropoxyphene can outlast a dose of naloxone. Patients who have been treated with naloxone should be observed for signs of recurrent overdose for up to 24 hours. If patient self-discharges they MUST be advised of the high risk of overdose when naloxone wears off and if they should take further opiate drugs.
4.12 Symptom control medication

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal cramps</td>
<td>Mebeverine 135mg tds</td>
</tr>
<tr>
<td>Diarrhoea:</td>
<td>Loperamide 4mg initially then 2mg with each loose stool</td>
</tr>
<tr>
<td>Muscle and joint pain:</td>
<td>Paracetamol or NSAIDS</td>
</tr>
<tr>
<td>Anxiety and agitation:</td>
<td>Promazine 25 mg tds prn (maximum 200mg/day) Quetiapine 25-50mg tds (second line)</td>
</tr>
<tr>
<td>Night muscle cramps:</td>
<td>Quinine sulphate 200mg nocte (should not be needed at the start of detoxification).</td>
</tr>
</tbody>
</table>

These can be given for a period of 7 to 10 days.

4.13 Summary

- Ask patient if they use illicit drugs & take a history
- Confirm with an instant urine test
- Check with the local Drug Service between Monday – Friday 09:00-17:00
- Telephone pharmacist if any further advice is required
- If the patient is showing signs of opiate withdrawal and the local Drug Service can not be contacted then methadone should be prescribed with care following the algorithm in (appendix1)
- Inform the Drug Service of admission at earliest opportunity and again prior to discharge
5 Local Drug Service Contact

Details:

East Cheshire Drugs Service: (CWP) Catherine House Crewe: Tel: 01270216118
Fax: 01270585412

East Cheshire Drugs Service: (CWP) Barnabas Centre Mac Tel 1625 422100
Fax: 01625669204

Cheshire & West Drug service: (Turning Point) Ellesmere Port & Chester Tel: 03001232679
Fax: 01244409418

Wirral Ways to Recovery: (CRI): Tel: 0151 556 1335
Fax: 0151 203 3111

6 References

Policy Adopted from CWP: Policy for in-patient and out of hours management of adult drug misusers version 4
1. Drug Misuse and Dependence – UK Guidelines on Clinical Management (last updated September 2007)
2. Quantum Diagnostics Ltd, Unit 9, Meridian Business Park, Fleming Road, Waltham Abbey EN9 3BZ. Tel: 01992 651 111.
3. Concateno PLC, Garrett House, Garrett Field, Birchwood Science Park, Warrington, WA3 7BP Tel: 01925 848900, Fax: 01925848949. email: info@altrix.com.
Appendix 1 Opiate Misuse
Algorithm for out of hours

Patient Reporting to be Opiate Dependent this may include illicit:
Heroin
Methadone

Where possible CONFIRM what the patient has taken, amount, route, and time last taken.
Confirm with the patient whether they are currently engaged with Drug Treatment Services, and confirm, medication prescribed, dosage, dispensing arrangements, pharmacy & when medication last taken.

As the substance may have been acquired illicitly, you need to keep in mind that they have been adulterated or substituted, they must be considered as UNKNOWN, until confirmed by urinalysis. The immediate concern in terms of management is cardiorespiratory maintenance. Consider the route, the amount taken & patient tolerance observe for any evidence of overdose and treat accordingly – using naloxone.
For those in treatment confirm with pharmacy or The Treatment Service patients: pick up days, dosage & medication as soon as possible.

Opiate use confirmed by urinalysis

**YES**

For patients in treatment once medication, dosage, pharmacy & collection days confirmed, provide medication for duration of the admission as prescribed by The Drug Treatment Service

Methadone Pathway: This is for patients not currently in treatment. Illicit usage confirmed Commence treatment if signs of withdrawal. THERE SHOULD BE NO URGENT NEED TO COMMENCE A SUBSTITUTE
If evidence of withdrawal in the first 12 hours of admission commence methadone mixture CD 1mg/1ml start at 10mgs/10ml increasing to a maximum initial overall dose of 30mgs/30ml
If withdrawal symptoms persist provide an additional 10mgs/10ml 12hours later. Observe patient on initiation for first 72 hours for signs of overdose or over sedation – adjust dose accordingly

**NO**

Observe for any signs of withdrawal & treat the signs. Consider Harm Reduction advice & overdose treatment advice.

Contact patient’s named worker & The Drug Treatment service to confirm patient’s admission at the earliest opportunity.
On discharge inform The Drug Treatment Service so that current prescription can be re-established in the community.

Referral to Drug Treatment Services & document arrangements for discharge regarding the transfer of medication provided during admission
Sign posting to mutual aid services / Provide Harm Reduction information

EAS Deputy Chief Pharmacist

Appendix 2 Subjective Opiate Withdrawal Scale (SOWS)

Instructions: Answer the following statements as accurately as you can. Circle the answer that best fits the way you feel now.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a bit</th>
<th>Extremely</th>
<th>How long after your last dose did THIS symptom begin? (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel anxious.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I feel like yawning.</td>
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<tr>
<td>I’m perspiring.</td>
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<tr>
<td>My eyes are tearing.</td>
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<tr>
<td>My nose is running.</td>
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<tr>
<td>I have goose flesh.</td>
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<tr>
<td>I am shaking</td>
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<tr>
<td>I have hot flashes.</td>
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<tr>
<td>I have cold flashes.</td>
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<tr>
<td>My bones and muscles ache.</td>
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<tr>
<td>I feel restless</td>
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<tr>
<td>I feel nauseous.</td>
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<tr>
<td>I feel like vomiting</td>
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<td></td>
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<td></td>
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<td></td>
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<tr>
<td>My muscles twitch.</td>
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<tr>
<td>I have cramps in my stomach.</td>
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<tr>
<td>I feel like using now.</td>
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</tbody>
</table>

The Subjective Opiate Withdrawal Scale (SOWS) consist of 16 symptoms rated in intensity by patients on a 5-point scale of intensity as follows:
0=not at all
1=a little
2=moderately
3=quite a bit
4=extremely

The total score is a sum of item ratings, and ranges from 0 to 64.

**Mild Withdrawal is considered to be a score of 1 - 10**

**Moderate withdrawal is considered to be a score of 11 – 20**

**Severe withdrawal is considered to be 21 - 30**

Source: Reprinted from Handelsman et al. 1987, p. 296, by courtesy of Marcel Dekker, Inc. Other Sources : Gossop 1990; Bradley 1987
Appendix 3 Symptoms of withdrawal

Appendix 3 Opioid withdrawal reactions are very uncomfortable but are not life-threatening. Symptoms usually start within 12 hours of last heroin usage and within 30 hours of last methadone exposure.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Grade</th>
<th>Physical Signs and Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Withdrawal (8-24 hours after last use)</td>
<td>1</td>
<td>Lacrimation Rhinorhhea Diaphoresis Yawning Restlessness Insomnia</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Piloerection Muscle twitching Myalgia Arthralgia Abdominal pain</td>
</tr>
<tr>
<td>Fully Developed Withdrawal (1-3 days after last use)</td>
<td>3</td>
<td>Tachycardia Hypertension Tachypnea Fever Anorexia Nausea Extreme restlessness</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Diarrhea Vomiting Dehydration Hyperglycemia Hypotension Curled-up position</td>
</tr>
</tbody>
</table>
Equality Analysis  
(Impact assessment)

1. What is being assessed?

<table>
<thead>
<tr>
<th>POLICY FOR IN-PATIENT AND OUT OF HOURS MANAGEMENT OF DRUG MISUSERS</th>
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<tbody>
<tr>
<td>Details of person responsible for completing the assessment:</td>
</tr>
<tr>
<td>• Name: Elisabeth Street</td>
</tr>
<tr>
<td>• Position: Deputy Chief Pharmacist</td>
</tr>
<tr>
<td>• Team/service: Pharmacy</td>
</tr>
</tbody>
</table>

State main purpose or aim of the policy, procedure, proposal, strategy or service:

This policy has been adopted from Cheshire and Wirral partnership NHS Foundation Trust, who are responsible for the review and approval of this policy. The Medicines Management Group at East Cheshire NHS Trust (ECT) approves this policy for adoption and implementation. The purpose of this policy is to ensure that good clinical practice is followed for patients with drug misuse problems.

2. Consideration of Data and Research

To carry out the equality analysis you will need to consider information about the people who use the service and the staff that provide it.

2.1 Give details of RELEVANT information available that gives you an understanding of who will be affected by this document

Cheshire East (CE) covers Eastern Cheshire CCG and South Cheshire CCG. Cheshire West & Chester (CWAC) covers Vale Royal CCG and Cheshire West CCG. In 2011, 370,100 people resided in CE and 329,608 people resided in CWAC.

Age: East Cheshire and South Cheshire CCG’s serve a predominantly older population than the national average, with 19.3% aged over 65 (71,400 people) and 2.6% aged over 85 (9,700 people).

Vale Royal CCGs registered population in general has a younger age profile compared to the CWAC average, with 14% aged over 65 (14,561 people) and 2% aged over 85 (2,111 people).

Since the 2001 census the number of over 65s has increased by 26% compared with 20% nationally. The number of over 85s has increased by 35% compared with 24% nationally.

Race:
• In 2011, 93.6% of CE residents, and 94.7% of CWAC residents were White British
• 5.1% of CE residents, and 4.9% of CWAC residents were born outside the UK – Poland and India being the most common
• 3% of CE households have members for whom English is not the main language (11,103 people) and 1.2% of CWAC households have no people for whom English is their main language.
• Gypsies & travellers – estimated 18,600 in England in 2011.
**Gender:** In 2011, c. 49% of the population in both CE and CWAC were male and 51% female. For CE, the assumption from national figures is that 20 per 100,000 are likely to be transgender and for CWAC 1,500 transgender people will be living in the CWAC area.

**Disability:**
- In 2011, 7.9% of the population in CE and 8.7% in CWAC had a long term health problem or disability
- In CE, there are c.4500 people aged 65+ with dementia, and c.1430 aged 65+ with dementia in CWAC. 1 in 20 people over 65 has a form of dementia
- Over 10 million (c. 1 in 6) people in the UK have a degree of hearing impairment or deafness.
- C. 2 million people in the UK have visual impairment, of these around 365,000 are registered as blind or partially sighted.
- In CE, it is estimated that around 7000 people have learning disabilities and 6500 people in CWAC.
- Mental health – 1 in 4 will have mental health problems at some time in their lives.

**Sexual Orientation:**
- CE - In 2011, the lesbian, gay, bisexual and transgender (LGBT) population in CE was estimated at 18,700, based on assumptions that 5-7% of the population are likely to be lesbian, gay or bisexual and 20 per 100,000 are likely to be transgender (The Lesbian & Gay Foundation).
- CWAC - In 2011, the LGBT population in CWAC is unknown, but in 2010 there were c. 20,000 LGB people in the area and as many as 1,500 transgender people residing in CWAC.

**Religion/Belief:**
The proportion of CE people classing themselves as Christian has fallen from 80.3% in 2001 to 68.9% in 2011 and in CWAC a similar picture from 80.7% to 70.1%, the proportion saying they had no religion doubled in both areas from around 11%-22%.
- **Christian:** 68.9% of Cheshire East and 70.1% of Cheshire West & Chester
- **Sikh:** 0.07% of Cheshire East and 0.1% of Cheshire West & Chester
- **Buddhist:** 0.24% of Cheshire East and 0.2% of Cheshire West & Chester
- **Hindu:** 0.36% of Cheshire East and 0.2% of Cheshire West & Chester
- **Jewish:** 0.16% of Cheshire East and 0.1% of Cheshire West & Chester
- **Muslim:** 0.66% of Cheshire East and 0.5% of Cheshire West & Chester
- **Other:** 0.29% of Cheshire East and 0.3% of Cheshire West & Chester
- **None:** 22.69% of Cheshire East and 22.0% of Cheshire West & Chester
- **Not stated:** 6.66% of Cheshire East and 6.5% of Cheshire West & Chester

**Carers:** In 2011, nearly 11% (40,000) of the population in CE are unpaid carers and just over 11% (37,000) of the population in CWAC.

2.2 **Evidence of complaints on grounds of discrimination:** (Are there any complaints or concerns raised either from patients or staff (grievance) relating to the
2.3 Does the information gathered from 2.1 – 2.3 indicate any negative impact as a result of this document?

No

3. Assessment of Impact

Now that you have looked at the purpose, etc. of the policy, procedure, proposal, strategy or service (part 1) and looked at the data and research you have (part 2), this section asks you to assess the impact of the policy, procedure, proposal, strategy or service on each of the strands listed below.

RACE:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, racial groups differently?

Yes □  No  x

Explain your response: Applies to all patients within the scope of the policy following completion of the relevant assessments. Where a person’s first language is not English, staff will follow the Trust’s interpretation and translation policy.

GENDER (INCLUDING TRANSGENDER):
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, different gender groups differently?

Yes □  No  x

Explain your response: Applies to all patients within the scope of the policy following completion of the relevant assessments. The Trust has a transgender policy and staff will be mindful of this.

DISABILITY:
From the evidence available does the policy, procedure, proposal, strategy or service affect, or have the potential to affect, disabled people differently?

Yes □  No  x

Explain your response: Applies to all patients within the scope of the policy following completion of the relevant assessments. Use of an interpreter may be employed where necessary for Deaf patients or deaf blind. The Trust is also implementing Signtranslate which is an online BSL interpretation system using a webcam, which may help with communication with patients and carers. Information can be provided in a variety of formats such as large print, audio, Braille and easy read. For patients with learning disabilities, picture communication books are available in ward communication boxes and staff have access to learning disabilities awareness training including Makaton.
AGE:
From the evidence available does the **policy, procedure, proposal, strategy or service**, affect, or have the potential to affect, age groups differently?
Yes ☐ No x
**Explain your response:** Applies to all adult patients within the scope of the policy following completion of the relevant assessments.

LESBIAN, GAY, BISEXUAL:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, lesbian, gay or bisexual groups differently?    Yes ☐ No x
**Explain your response:** Applies to all patients within the scope of the policy following completion of the relevant assessments.

RELIGION/BELIEF:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, religious belief groups differently?    Yes ☐ No x
**Explain your response:** Applies to all patients within the scope of the policy following completion of the relevant assessments. For patients of Muslim faith, then all drugs administered will be checked with the pharmacy for porcine content.

CARERS:
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect, carers differently?    Yes ☐ No X
**Explain your response:** Patient consent would be sought unless life threatening situation.

OTHER: EG Pregnant women, people in civil partnerships, human rights issues.
From the evidence available does the **policy, procedure, proposal, strategy or service** affect, or have the potential to affect any other groups differently?    Yes ☐ No x
**Explain your response:** Applies to all patients within the scope of the policy following completion of the relevant assessments..
4. Safeguarding Assessment - CHILDREN

<table>
<thead>
<tr>
<th>a. Is there a direct or indirect impact upon children?</th>
<th>Yes ☐</th>
<th>No x</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. If yes please describe the nature and level of the impact (consideration to be given to all children; children in a specific group or area, or individual children. As well as consideration of impact now or in the future; competing / conflicting impact between different groups of children and young people:</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------------------------------</td>
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</tr>
<tr>
<td>c. If no please describe why there is considered to be no impact / significant impact on children.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>This policy only relates to adult patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. Relevant consultation

Having identified key groups, how have you consulted with them to find out their views and that the made sure that the policy, procedure, proposal, strategy or service will affect them in the way that you intend? Have you spoken to staff groups, charities, national organisations etc?

Policy applies to all patient groups equally.

6. Date completed: 2/07/15 Review Date: September 2017

7. Any actions identified: Have you identified any work which you will need to do in the future to ensure that the document has no adverse impact?

<table>
<thead>
<tr>
<th>Action</th>
<th>Lead</th>
<th>Date to be Achieved</th>
</tr>
</thead>
</table>

8. Approval – At this point, you should forward the template to the Trust Equality and Diversity Lead lynbailey@nhs.net

Approved by Trust Equality and Diversity Lead: 

Date: 2.7.15