MANAGEMENT OF HYPERGLYCAEMIC HYPEROSMOLAR STATE IN ADULTS (HHS)

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.

Lead Clinician(s)

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Approved by Medicines Safety Committee on: *Where medicines are included in document.*	11th February 2026
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Key amendments to this guideline

Date	Amendment	By:
11/07/11	Title: Management of Hyperosmolar Non-Ketotic State (HONK)/ Hyperglycaemic Hyperosmolar State (HHS).	D. Jenkins
11/07/11	Change of mortality figure from 50% to 10%	D. Jenkins
November 2016	Documents extended for 12 months as per TMC paper approved on 22nd July 2015	TMC
November 2017	Document extended whilst under review	TLG
December 2017	Sentence added in at the request of the Coroner	
December 2017	Document extended for 3 months as per TLG recommendation	TLG
March 2018	Document extended for 3 months as approved by TLG	TLG
June 2018	Document extended for 3 months as approved by TLG	TLG
June 2019	Document extended for 6 months whilst review and approval process	Alison Hall
30/02/2019	Complete rewrite of guideline	Diabetes directorate
3rd November 2025	Rewrite of guideline	Dr Irfan Babar

Introduction

(Adopted from Joint British Diabetes Society Document on HHS)

This guideline is for the treatment of patients aged 18 years and over with confirmed HHS.

The hyperglycaemic hyperosmolar state (HHS) is a medical emergency.

HHS occurs much less frequently than the other hyperglycaemic emergency, diabetic ketoacidosis (DKA). HHS is different from diabetic ketoacidosis (DKA) and treatment requires a different approach.

HHS usually affects those with pre-existing type 2 diabetes mellitus (T2DM) but may sometimes be the first presentation of this condition.

The treatment differs as the population commonly affected by HHS is frequently elderly with multiple co-morbidities.

- It has a higher mortality than DKA because it may be due to, or complicated by, vascular events such as myocardial infarction, stroke or peripheral arterial thrombosis.

Neurological complications, such as cerebral oedema and central pontine myelinolysis (CPM) / osmotic demyelination syndrome are uncommon but can be seen as a complication of the rapid changes in osmolality during treatment of HHS

- DKA presents within hours of onset, HHS comes on over many days, and consequently the dehydration and metabolic disturbances are more extreme.

This guideline is for use by staff groups that who have the ability to:

- Assess the health-related needs of patients admitted with suspected or confirmed HHS.
- Assess, diagnose and treat patients with HHS in accordance to agreed nursing/medical guidelines.
- Work in collaboration with the multidisciplinary team so that continuity and consistency of care is being delivered to a high standard.

Definition and diagnosis

No definitive diagnostic criteria exist for HHS, but a few characteristics are prevalent
The characteristic features of a person with HHS are:

- marked hypovolaemia
- measured or calculated serum osmolality usually ≥320 mOsm/kg (2 x Na + glucose + urea)
- marked hyperglycaemia (≥30 mmol/L)
- without significant hyperketonaemia (ketones ≤3.0 mmol/L)
- without significant acidosis (pH ≥7.3 and blood or serum bicarbonate ≥15.0 mmol/L)

Clinical assessment and management

On admission assess patient, document following and please initiate management immediately without delay. Consider managing patients in MHDU/ITU for high risk patients.

The diabetes specialist team should be involved as soon as possible after admission.

- Full clinical examination.
- Pulse, BP, Temp, RR, O2 Sats, GCS
- Does history suggest sepsis/vascular event or a recent change in medication?
- Assess degree of dehydration
- Examine for source of sepsis or evidence of vascular event
- Capillary blood glucose, blood ketones, venous pH, venous bicarbonate, lactate
- Plasma glucose, U/E, FBC, CRP, measured or calculated serum osmolality (2 x Na + glucose + urea)
- Septic screen (where indicated) - Urinalysis and culture, Blood culture and CXR, ECG
- Mini-mental state assessment for cognitive assessment

High-dependency / level 2 care

Patients with HHS are complex and often have multiple co-morbidities so require intensive monitoring. The presence of one or more of the following may indicate the need for admission to a high dependency unit / level 2, where the insertion of a central venous catheter to aid assessment of fluid status and immediate senior review by a clinician skilled in the management of HHS should be considered. In the absence of an HDU based environment, the patient should be initially stabilised in A+E according to this guideline before moving to Acute Medical Unit for on-going management. It may be appropriate to get assessment from the ITU team while in A+E to see if patient will benefit from management in ITU instead. The patient should also be referred at the earliest opportunity to the diabetes team and the DSN for further advice. The patient should then be moved to the diabetes ward once a bed becomes available.

- Osmolality > 350 mosmol/kg
- Sodium > 160 mmol/l
- Hypokalaemia (< 3.5 mmol/l) or hyperkalaemia (> 6 mmol/l) on admission
- Glasgow Coma Scale < 12 or Abnormal AVPU (Alert, Voice, Pain, Unresponsive) scale
- Oxygen saturation < 92% on air (assuming normal baseline respiratory function)
- Systolic blood pressure below 90 mmHg
- Anticipated fluid balance difficulties
- Significant comorbidities
- Macrovascular event such as MI or stroke
- Hypothermia
- PH <7.1
- HR > 100bpm or < 60bpm
- Urine output < 0.5ml/kg/h
- Serum creatinine > 200umol/L

Goals of treatment

The goals of treatment of HHS are to treat the underlying cause and to gradually and safely:

- Normalise the osmolality
- Replace fluid and electrolyte losses
- Normalise blood glucose
- Prevent thrombosis, use prophylactic LMWH unless contraindicate
- Assess for neurological deterioration 1-2 hourly eg: cerebral oedema, osmotic demyelination
- Provide foot heel care and daily foot checks
- Patient should have continuous pulse oximetry and cardiac monitoring
- The mortality with HHS can be as high as 10-20% depending on the precipitating factors. It is therefore important to investigate the underlying cause such as sepsis, myocardial infarction, cerebrovascular accident, pancreatitis, mesenteric infarction etc.
- Seek early advice from the Diabetes Team

Management

(1) Fluid management

If SBP <90mmHg give 500ml of 0.9% sodium chloride infusion over 10-15minutes.

If SBP remains below 90mmHg this may be repeated.

If there has been no clinical improvement reconsider other causes of hypotension and seek immediate senior assessment. Consider involving the MHDU/Critical care team.

Once SBP is above 90mmHg follow fluid replacement as below:

0.9% Sodium Chloride: 1 Litre over 1 hour
1 Litre over 2 hours
1 Litre over 2 hours
1 Litre over 4 hours
1 Litre over 4 hours until rehydrated

Aim to achieve a gradual decline in osmolality 3 – 8mOsm/kg/hour

Aim for a positive fluid balance of:
2 – 3 litres by 6 hours
3 – 6 litres by 12 hours

Adjust fluids as follows:

- If plasma Na+ increasing but osmolality declining at appropriate rate, continue 0.9% sodium chloride
- If plasma Na+ increasing AND osmolality increasing (or declining at less than 3.0 mOsm/ kg/hr), check fluid balance. If positive balance is inadequate, then increase the rate of infusion of 0.9% sodium chloride solution
- If the osmolality is increasing and fluid balance adequate, then consider switching to 0.45% sodium chloride at same infusion rate
- If osmolality falling at rate exceeding 8.0 mOsm/kg/hr consider reducing infusion rate of IV fluids and/or insulin (if already commenced)

- If glucose falling less than 5.0 mmol/L per hour check fluid balance
- If positive balance inadequate, increase rate of infusion of 0.9% sodium chloride
- Fluid replacement should be adjusted for those who are <50kg in body weight or with pre-existing heart and renal disease. More cautious fluid replacement is necessary e.g. 0.25 ml/kg/hr as recommended by NICE

Rapid correction of hypernatraemia or hyperglycaemia may lead to marked osmotic shifts with the rare complication of cerebral oedema. Cerebral oedema is a life threatening complication. If suspected exclude hypoglycaemia and consider CT brain and admission to MHDU.

- Avoidance of hypoglycaemia
  - Aim to keep BG 10 – 15mmol/l in first 24hours
  - If BG falls below 14mmol/l commence 5% or 10% glucose at 125ml/hour AND CONTINUE 0.9% sodium chloride solution
- Continue IV fluid replacement to achieve remaining replacement of estimated fluid losses within 24 hrs. This will be dependent on factors such as initial degree of dehydration / body weight etc. and MOST IMPORTANTLY the response to treatment so far. Therefore, continue maintaining accurate fluid balance chart, plotting osmolality and make appropriate adjustments to fluid replacement rates
- Stop IV fluid if patient is eating and drinking normally

(2) Insulin management

Blood glucose levels will fall consistently for the first few hours with fluid replacement alone ALWAYS continue subcutaneous intermediate or basal insulin if patient already taking (e.g. Insulatard, Humulin I, Insuman basal, Lantus, Semglee, Abasaglar, Levemir, Tresiba, Toujeo).

First hour

ONLY commence insulin infusion immediately in the following circumstances:

- If there is HHS and ketonaemia (blood ketones 3ß-hydroxybutyrate >1.0 - ≤3.0 mmol/L or urine ketones < 2+) and not acidotic (venous pH >7.3 and bicarbonate >15.0 mmol/L) then use 0.05 units/kg/hr

OR

- If there is significant ketonaemia (3ß-hydroxybutyrate >3.0 mmol/L) or ketonuria (≥ 2+) with a pH <7.3 and bicarbonate <15mm0l/L (i.e. mixed DKA and HHS) and use the DKA guideline at 0.1 units/kg/hr (see intranet for Guidelines for the treatment of Diabetic Ketoacidosis WAHT-END-001)

First 6hr and onwards

- ONLY start IV insulin once fluid replacement is adequate and glucose concentrations have plateaued. Starting an IV insulin infusion too early could result in circulatory collapse
- If positive fluid balance is adequate, commence low dose IV insulin as a fixed rate intravenous insulin infusion (FRIII) at 0.05 units/kg/hr or if already running, increase rate to 0.1 units/kg/hr if glucose concentrations are not falling

- Continue IV insulin with or without 5 or 10% glucose solution to maintain BG 10-15 mmol/L
- Adjust insulin infusion rate hourly by 1 unit/hr increments or decrements to achieve desired blood glucose
- Change to Variable rate insulin if not eating and drinking and convert to appropriate subcutaneous insulin regime when biochemically stable

(3) Potassium replacement

- Maintain potassium in the normal range

Hypokalaemia (<3.5mmol/l) and Hyperkalaemia (>6.0 mmol/L) are life threatening conditions and warrant senior review. They are less common in HHS than DKA but monitoring and replacement are essential.

Use commercially prepared ready to use dilute infusions with added potassium wherever possible.

Potassium concentration in first 24 hr(mmol/L)	Potassium replacement in infusion solution
Over 5.5	Nil
3.5-5.5	40mmol/L
Below 3.5	Senior review as additional potassium required

(4) Treatment of underlying cause

- Does the history suggest sepsis/vascular event or a recent change in medication?
- Examine for a source of sepsis or evidence of vascular event
- Treatment of any underlying precipitant(s). If the person is not improving seek senior advice

(5) Monitoring

- Monitor vital signs (NEWs score) including degree of dehydration
- Check Glucose hourly for first 24 hours
- Check Na, Urea, K+ and calculated osmolality hourly for the first 6 hours, then 2 hourly for the next 6 hours if response satisfactory (i.e. a fall of 3 – 8mOsm/kg/hour) and then 4hrly if improvement maintained for first 24 hr
- Check ketone concentrations hourly until HHS resolution
- Keep a strict intake output chart (minimum urine output 0.5ml/kg/hour)
- Catheterisation usually required
- Assess foot risk score – assume high risk if the person is obtunded or uncooperative
  - Ensure heels are off-loaded
  - Ensure daily foot checks
  - Heel protectors and an appropriate mattress should be provided for those with immobility, neuropathy, peripheral vascular disease or lower limb deformity.
- Assess for complications of treatment e.g. fluid overload, cerebral oedema, cerebral pontine myelinolysis (e.g. indicated by deteriorating conscious level) every 1 – 2 hours

(6) Treatment targets

- Aim for following targets
- Fall in glucose < 5mmol/L/hour
- Fall in calculated osmolality (2xNa + Glucose + Urea) of 3-8 mosm/kg/hour
- Sodium fall must be < 10mmol/L per 24 hour
  Aim for glucose 10- 15 mmol/L
- When glucose fall < 14 mmol/L start 10% glucose at 125 mls/hour

(7) Criteria for resolution of HHS

HHS considered resolved when the following criteria are met:

- Osmolality < 300mOsm/kg
- Hypovolaemia corrected (urine output > 0.5ml/kg/hour)
- Cognitive status returned to pre-morbid state
- Blood glucose <15mmol/l

(8) After Care

Most people should go home on subcutaneous insulin (the regime being determined by their circumstances).

For those with previously undiagnosed diabetes or well controlled on oral agents, switching from insulin to the appropriate oral hypoglycaemic agent should be considered after a period of stability.

Ensure the individual has appropriate diabetes education prior to discharge and arrange follow-up by diabetes team.

Hyperosmolar Hyperglycaemic State (HHS) care pathway in adults

JBDS-IP Joint British Diabetes Societies for Inpatient care

Clinical features (all the below)		Aims of therapy	Criteria for resolution of HHS: Holistic assessment of the following:
1) Marked hypovolaemia	A mixed picture of HHS and DKA occurs relatively frequently	1) Improvement in clinical status and replacement of all estimated fluid losses by 24 hours	1) Clinical and cognitive status is back to the pre-morbid state
2) Osmolality ≥320 mOsm/kg		2) Gradual decline in osmolality: drop of 3-8 mOsm/kg/hr	
3) Marked hyperglycaemia (≥30 mmol/L)		3) Blood glucose: aim to keep to 10-15 mmol/L in the first 24 hours	2) Osmolality <300 mOsm/kg
4) Without significant ketonaemia (≤3.0 mmol/L)		4) Avoid hypoglycaemia and hypokalaemia	3) Hypovolaemia has been corrected (urine output ≥0.5 ml/kg/hr)
5) Without significant acidosis (pH ≥7.3) and bicarbonate ≥15 mmol/L		5) Prevent harm: VTE, osmotic demyelination, fluid overload, foot ulceration	4) Blood glucose <15 mmol/L

Theme / Time	0-60 minutes	60 minutes - 6 hours	6-12 hours	12-24 hours	24-72 hours
Clinical assessment and monitoring					
Clinical status / NEWS	History/Examination, NEWS, cardiac monitoring, urine output Establish adequate intravenous lines (preferably 2 large bore IV cannulas) Discuss with outreach/ICU team early if there are markers of high severity **(see Table 1 overleaf)**			Check for continuing improvement	Expect steady recovery, patient eating and drinking, and biochemistry as it was prior to HHS Ongoing management of the precipitating cause(s) Replacement of all estimated fluid losses by 24 hours Individual BG target 6-10 mmol/L
Precipitating cause(s)	Assess for precipitating cause(s): sepsis, diabetic foot infection, treatment omissions, vulnerable adult, vascular event (myocardial infarction, stroke)			Ongoing management of the precipitating cause(s)	
Osmolality (VBG/blood) Measure/calculate (2xNa$^+$) + Glucose + Urea Aim for gradual decline of 3-8 mOsm/kg/hr	Check every hour for 6 hours Until the urea is available, calculate using (2 x Na$^+$ + glucose). Recalculate osmolality once urea is available, and then use (2 x Na$^+$ + glucose + urea)		Check every 2 hours	Check every 4 hours (if no clinical improvement then check every 2 hours)	
How to interpret osmolality results	**Check Figure 1 overleaf**	**Check Figure 1 overleaf**	**Check Figure 1 overleaf**	**Check Figure 1 overleaf**	
Blood glucose (BG) (Aim for 10-15 mmol/L in the first 24 hours)	Check every hour Fall in BG should be up to 3.0 mmol/L per hour **(check Figure 2 overleaf for details)**		**Check every hour** **(check Figure 2 overleaf for details)**	**Check every hour** **(check Figure 2 overleaf for details)**	
Interventions					
Intravenous fluids (0.9% saline) (In IV line 1) (caution in HF/CKD/BW <50 kg)	1 litre over 1 hour (caution in HF/CKD/BW <50 kg)	Aim for 2-3 litres positive balance by 6 hours	Aim for up to 6 litres positive balance by 12 hours	Reassess fluid balance to plan fluids replacement for the next 12 hours	Can be stopped if patient is eating and drinking
Insulin infusion (FRIII 0.05 units/kg/hr using Actrapid®) (In IV line 2)	Use DKA guidelines if ketonaemia (>3.0 mmol/L) or ketonuria (≥2+) Start FRIII if ketonaemia (>1.0 - ≤3.0 mmol/L) or ketonuria (<2+)	*Only commence* if positive fluid balance and BG plateaued on repeated measurements (>2 occasions)		Rate may need adjustment to 1 unit/hr to achieve BG target 10-15 mmol/L	VRIII if not eating and drinking Otherwise convert to subcutaneous insulin
Glucose infusion: 5% or 10% @ 125ml/hr (In IV line 2)	Not required at this stage	Only initiate if BG <14 mmol/L		Continue infusion at 125 ml/hr	Can be stopped if patient is eating and drinking
Potassium	Senior review / ICU outreach If potassium <3.5 or >6.0 mmol/L	**Check Table 2 overleaf for potassium replacement guidelines**	**Check Table 2 overleaf for potassium replacement guidelines**	**Check Table 2 overleaf for potassium replacement guidelines**	Check U&Es daily
Assessments and prevention					
Prevent harm	VTE prophylaxis (low molecular weight heparin) Assess for complications e.g. fluid overload, cerebral oedema, osmotic demyelination (deteriorating conscious level)				VTE prophylaxis until discharge Daily feet checks
Prevent hypoglycaemia	Glucose 5% or 10% at 125 ml/hr if BG <14 mmol/L				Target BG 6-10 mmol/L
Prevent foot ulceration	Daily foot checks				Daily foot checks
Refer to the inpatient diabetes team early. Escalate management if there is clinical deterioration.					Review by inpatient diabetes team before discharge

Abbreviations: BG=blood glucose; BW=body weight; CKD=chronic kidney disease; FRIII=fixed rate intravenous insulin infusion; HF=heart failure; hr=hour; ICU=intensive care unit; IV=intravenous; kg=kilograms; NEWS=national early warning score; U&Es=urea and electrolytes; VBG=venous blood gas analysis; VRIII=variable rate intravenous insulin infusion; VTE=venous thromboembolism

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Hyperosmolar Hyperglycaemic State (HHS) care pathway in adults

JBDS-IP Joint British Diabetes Societies for inpatient care

Figure 1: Managing osmolality changes during treatment of HHS

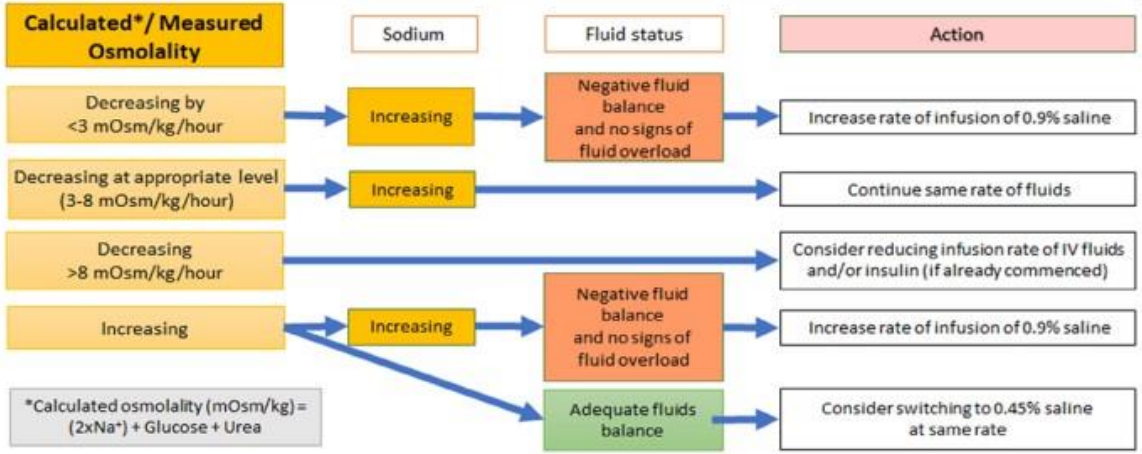
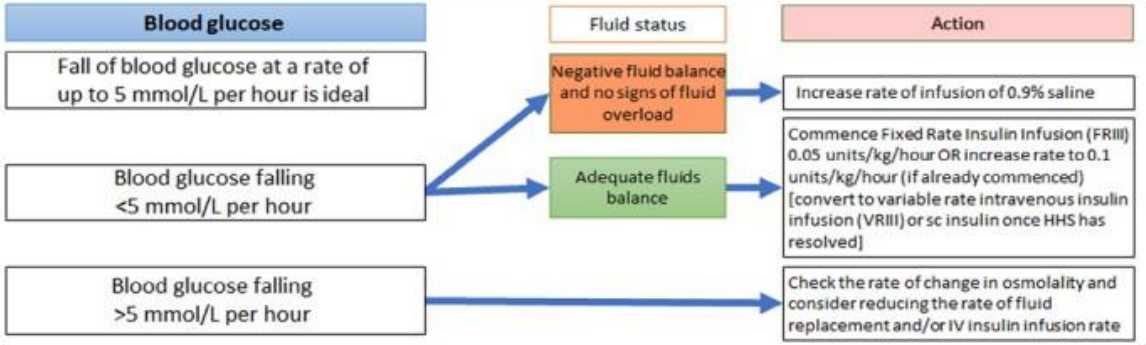


Figure 2: Managing glucose changes during treatment of HHS



If the parameters in Figures 1 and 2 above are not met, seek specialist input early to help tailor the management according to the individual's need

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Table 1: Escalate to ICU/outreach if any of the following is present:

- Osmolality >350 mOsm/kg
- Sodium >160 mmol/L
- Venous/arterial pH <7.1
- Hypokalaemia (<3.5 mmol/L) or hyperkalaemia (>6 mmol/L) on admission
- Glasgow Coma Scale (GCS) <12 or abnormal AVPU (Alert, Voice, Pain, Unresponsive) scale
- Oxygen saturation <92% on air (assuming normal baseline respiratory function)
- Systolic blood pressure <90 mmHg
- Pulse >100 or <60 beats per minute
- Urine output <0.5 ml/kg/hour
- Serum creatinine >200 µmol/L and/or Acute kidney injury
- Hypothermia
- Macrovascular event such as myocardial infarction or stroke
- Other serious co-morbidity

Table 2: Potassium replacement guidelines

Potassium level in first 24 hours (mmol/L)	Potassium replacement in infusion solution
≥6.0	Senior review ICU/outreach
5.5-5.9	Nil
3.5-5.5	40 mmol/L
<3.5	Senior review ICU/Outreach. Additional potassium is required

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Monitoring

Page/ Section of Key Document	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 check reported to: (Responsible for also ensuring actions are developed to address any areas of non-compliance)	Frequency of reporting:
	WHAT?	HOW?	WHEN?	WHO?	WHERE?	WHEN?
All	Adequate fluid replacement. Fluid balance recording. Monitoring of bloods and calculations of osmolality. Referral to specialist Diabetes team	Review of completion of monitoring chart completed for each episode of HHS	When HHS occur	DSN Inpatient team	Diabetes Directorate and Specialty Medicine Division	Quarterly to Diabetes directorate and yearly to SpMed DMB

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Contribution List

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

Designation
Dr Irfan Babar Consultant Physician & Endocrinologist
Dr. Theingi Zaw Clinical fellow ST3+
Bethan Knight Lead Pharmacist for Diabetes

This key document has been circulated to the chair(s) of the following committee's / groups for comments:

Committee
Diabetes Directorate
Specialty Medicine Directorate
Medicines Safety Committee

Supporting Document 1 - Equality Impact Assessment Tool

Equality and Health Inequalities Impact Assessment (EHIA) Tool

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

Section 1 - Name of Organisation (please tick)

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

Name of Lead for Activity	

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Irfan Babar	**Consultant Endocrinologist**	**Irfan.babar@nhs.net**
Date assessment completed	**06/03/26**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title: Document on management of HHS (complication of type 2 DM)**			
What is the aim, purpose and/or intended outcomes of this Activity?	Standardised management of HHS based on national guidelines.			
Who will be affected by the development & implementation of this activity?	❑ × ❑ ❑	Service User Patient Carers Visitors	❑ ❑ ❑ ❑	Staff Communities Other _____
Is this:	× Review of an existing activity ❑ New activity ❑ 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.				
Summary of engagement or consultation undertaken (e.g. who	Document reviewed by county-wide Diabetes Team (consultants and specialist nurses) and approved by MSC			

and how have you engaged with, or why do you believe this is not required)	
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		
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 /	Who will lead on	Timeframe

		eliminate negative impact	**the action?**	
		.		
How will you monitor these actions?				
When will you review this HEIA? (e.g in a service redesign, this HEIA should be revisited regularly throughout the design & implementation)				

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 HEIA	IrfanBabar
Date signed	06/03/26
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 attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	
2.	Does the implementation of this document require additional revenue	
3.	Does the implementation of this document require additional manpower	
4.	Does the implementation of this document release any manpower costs through a change in practice	
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	
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.