Worcestershire Acute Hospitals NHS Trust

GUIDELINES FOR MEDICINES MANAGEMENT FOLLOWING BARIATRIC SURGERY

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.

INTRODUCTION

This guideline covers medication issues in adult patients following bariatric surgery. Perioperative antibiotic prophylaxis is not included.

THIS GUIDELINE IS FOR USE BY THE FOLLOWING STAFF GROUPS :

All qualified healthcare professionals involved in prescribing, managing or administering medication to patients who have had bariatric surgery.

Lead Clinician(s)

Chris Parry	Senior Surgical Pharmacist
Keith Hinton	Clinical Team Lead Pharmacist, Critical Care, Surgery and Theatres
Approved by Surgical Divisional Quality Governance on:	30th June 2021
Ratified by Medicines Safety Committee on:	14th September 2022
Review Date: This is the most current document and is to be used until a revised version is available	31st December 2025

Key amendments to this guideline

Date	Amendment	By:
January 2018	Inclusion of advice for the management of diabetes for bariatric surgery patients Alternatives to Forceval included	Keith Hinton
August 2018	Relaxation of the necessity to use soluble/liquid preparations postoperatively Removal of ursodeoxycolic acid from the prescribing checklist	Keith Hinton
October 2020	Change ranitidine to PPI Addition of new supporting documentation Supplemental dose of iron updated in line with BOMSS	Keith Hinton
October 2021	Document extended for 3 months whilst reviewed and approved	MSC
February 2021	Document extended as per Trust agreement 11.02.2021	
July 2021	Document reviewed and approved	MSC
August 2022	Change of Adcal D3 to Calci-D in line with formulary status Addition of references to support change	Harry Tillott
October 2025	Document extended whilst review process is completed	Keith Hinton

GUIDELINES FOR MEDICINES MANAGEMENT FOLLOWING BARIATRIC SURGERY

BACKGROUND

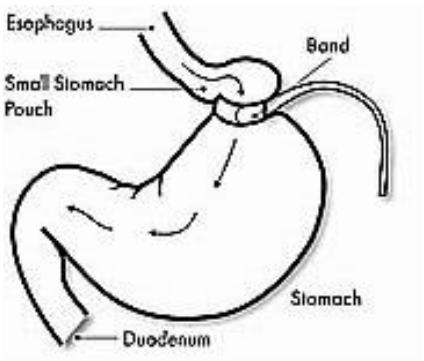
Within the context of an emerging obesity epidemic, healthcare professionals are increasingly encountering patients who have undergone bariatric surgery. This guideline explores some of the medicines management issues after bariatric surgery.

TYPES OF SURGERY

Bariatric surgery includes a range of different procedures, each with differing effects on drug therapy. This guideline focuses on the most commonly performed in Worcestershire:

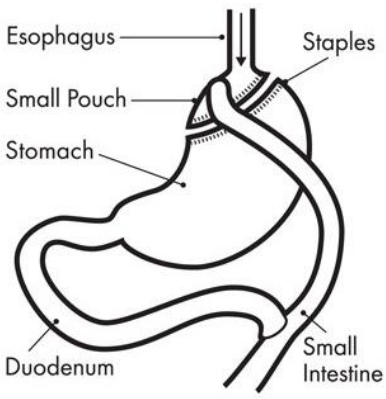
Laparoscopic adjustable gastric banding (LAGB)

RESTRICTIVE



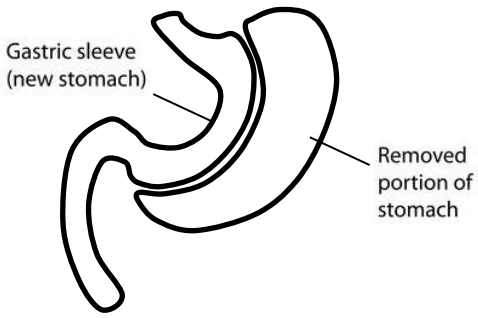
Roux-en-Y gastric bypass (RYGB)

RESTRICTIVE + MALABSORPTIVE



Laparopscopic sleeve gastrectomy (LSG)

RESTRICTIVE



The potential effects and consequences that bariatric procedures may have on absorption and action of medications should be carefully considered before surgery. Bariatric surgery may introduce anatomical and physiological changes in the gastrointestinal tract which may affect drug pharmacokinetics. Absorption of drugs is predominantly affected, but tissue distribution, drug metabolism and elimination may also be affected.

Theoretical pharmacokinetic effects of bariatric surgery include:

- Reduced surface area for absorption
- Quicker transit through gastric pouch
- Raised pH (less acidic environment) due to reduced stomach acid production
- Reduced pre-systemic metabolism may increase bioavailability (attributed to one reported fatal case of enalapril toxicity following RYGB). Caution should be exercised when restarting medications postoperatively, particularly with compounds known to be metabolized by the P450 cytochrome system.
- Reduced enterohepatic cycling.
- Reduced mixing of stomach contents leading to reduced disintegration and dissolution.
- Reduced bioavailability of those drugs which rely on food for their absorption e.g. carbamazepine, lithium and spironolactone.
- Altered pharmacokinetics due to significant weight loss.

Medicines that require plasma level monitoring should be checked more frequently after surgery to assess the effect of these potential altered pharmacokinetics.

PRE-OPERATIVE MEDICATION

- Oestrogen therapy should be stopped at least one month pre-operatively to reduce the risk of post-operative thromboembolism.
- Candidates for bariatric surgery may take several medicines to treat or prevent co-morbidities. Following LAGB, LSG or RYGB, most patients find they can stop or reduce their dose of:
    - Antihypertensives
    - Lipid-lowering agents
    - Diuretics
    - Analgesics
    - Insulin (for type 2 diabetes mellitus)
    - Oral hypoglycaemics. These may be discontinued postoperatively under the guidance of the diabetes team if there is clinical resolution of diabetes demonstrated by normalised blood glucose and HbA1c. See dedicated section below.
- If metformin is required to continue postoperatively consider using a reduced dose after RYGB due to the possible increased bioavailability.
- Patients must be closely monitored to titrate down doses or stop medication that is no longer required, thereby avoiding hypotensive or hypoglycaemic episodes.

These medicines may need to be restarted if weight is regained.

KEY PHARMACEUTICAL CONSIDERATIONS

There may be a problem swallowing certain tablets following surgery and each patient should have a medication review with their GP. Patients will be individually assessed as part of their pre-operative assessment with their medication and if appropriate some medications may need to be adjusted to aid swallowing after the surgical procedure.

If you require further advice in managing medication in a patient who has had bariatric surgery contact should be made with the ward pharmacist or Medicines Information (ext 30235). Out-of-hours: for urgent enquiries contact the on-call pharmacist via switchboard

Checklist for medication review

- **Up to 8 weeks after surgery:** Oral medication may need to be in a liquid, crushed or chewable form - crushing tablets or opening capsules is not always appropriate and is usually off-label (out of licence).
- **Liquid medicines**: Stagger doses to prevent overloading the small gastric pouch.
- Consider **non-oral routes** where possible.
- **Enteric-coated (gastro-resistant) or modified-release** oral preparations should be switched to immediate-release preparations or alternative drugs where possible.
- Peak plasma concentrations may occur quicker without changing overall amount of drug absorbed. Anecdotally, more frequent, smaller doses (e.g. of opioids) may circumvent this problem. This caution extends to alcohol.
- **Weight-based doses** of medicines may require adjustment e.g. infliximab.

There is very little evidence for these effects in practice so this guideline cannot make specific recommendations on individual drugs.

The effect of bariatric surgery on pharmacokinetics of medicines is a complex mix of the issues above. Changes should not be made to drug therapy based on just one of these effects. Instead, all patients should have frequent monitoring to identify decreased efficacy or adverse effects, particularly for drugs of narrow therapeutic index.

MANAGEMENT OF PATIENTS WITH DIABETES UNDERGOING BARIATRIC SURGERY

Establish and clearly document whether the patient has Type 1 or type 2 Diabetes

MANAGEMENT OF TYPE 2 DIABETES

PRE-OPERATIVE

Oral hypoglycaemic tablets

- Check HbA1c 1 – 2 months before surgery – if above 70mmols liaise with the diabetes team.
- All patients with Type 2 diabetes should stop all oral hypoglycaemic agents except metformin when starting the preoperative diet unless otherwise advised by the diabetes team.
- Patients who have continued on oral hypoglycaemic tablets (except metformin) need regular blood glucose monitoring. This should include a daily pre-breakfast blood glucose test, twice weekly pre meal and before bed tests (4 point profile) when commencing the pre op diet.
- All oral hypoglycaemic agents should be stopped on the day of surgery.

Injectable therapies

Continue taking GLP-1 agonists while on the pre op diet but stop on the day of surgery. If experiencing hypoglycaemia (blood glucose below 4mmols) or tight glycaemic control (blood glucose 4-7mmols) stop GLP1 agonist.

Insulin treated type 2 diabetes.

- Refer to Diabetes Specialist team by Tier 3 dietitian when patient is ready to attend the presurgery groups.
- Confirm with the Diabetes team that the patient has definitely not got Type 1 Diabetes
- Increase blood glucose monitoring to 4 times daily (before meals and before bedtime).
- Reduce the usual insulin dose by 50% once commenced on the preoperative diet. The insulin dose subsequently may need to be adjusted or stopped during the pre op diet depending on blood glucose monitoring results.
- On day of surgery stop all insulin therapy unless otherwise stated by the Diabetes team – but continue blood glucose monitoring 4 times daily.

MANAGEMENT OF TYPE 2 DIABETES

POST OPERATIVE.

Continue monitoring blood glucose 4 times daily before meals and before bedtime, stop if results are within normal range 4 – 7mmols.

If blood glucose consistently between 7 – 11mmols consider recommencing metformin as tolerated (restart at a reduced dose after RYGB due to possible increased bioavailability)

Check HbA1c 3 months post-surgery for patients:

- On insulin
- Remaining on multiple oral diabetes agents,
- On a GLP1 agonist
- Has had diabetes diagnosed for over 10 years duration
- blood glucose above 11mmols

MANAGEMENT OF TYPE 1 DIABETES

PRE-OPERATIVE

- All patients to be referred to the Diabetes Specialist Team by the Tier 3 dietitian.
- All patients must continue with insulin.
- If they are on basal insulin (Levemir, Lantus, Abasaglar, Tresiba, Toujeo) this will require a dose reduction of 20% when commencing the pre op diet. Titrate the dose according blood glucose levels.
- Quick acting insulin (Novorapid, Humalog, Apidra) will be required with meals but reduce by up to 50% when starting the pre op diet. Titrate the dose according blood glucose levels.
- Regular home blood glucose monitoring required (pre-meal and pre-bed) with access to ketone testing if blood glucose levels are elevated.

POST-OPERATIVE

- **Continue basal insulin** (reduce the dose by 20%) alongside CVRIII if indicated – see Guideline WAHT-END-011
- Quick acting insulin (Novorapid, Humalog, Apidra) will be needed once tolerating carbohydrates above 20 grams per meal, as advised by the DSN

Impact of surgery on nutrition

All patients will have a comprehensive nutritional assessment prior to bariatric surgery. Any nutritional deficiencies identified pre-operatively will be corrected as clinically indicated. Nutritional deficiencies may also occur as a result of the surgery (see below)

Surgical procedure	Impact on nutrition
Gastric band	No impact on absorption. Over tight gastric bands can affect nutritional quality of diet due to poor tolerance of healthy foods, particularly those rich in protein and iron.
Sleeve gastrectomy	May be some impact on absorption including iron and vitamin B12
Gastric bypass	Impacts on absorption of iron, vitamin B12, calcium and vitamin D Long limb bypasses may affect absorption of protein, fat, vitamin A and trace elements
Duodenal switch (DS)	Malabsorptive procedure with significant risk of nutrient deficiencies.

POST-OPERATIVE COMPLICATIONS

Thromboembolism – If VTE risk outweighs bleed risk, offer mechanical thromboprophylaxis and/or enoxaparin until mobility no longer significantly reduced (usually a minimum of 14 days after bariatric surgery but may be extended to 28 days on clinician advice) – dosing as follows (UKCPA 2010):

Weight	**50-100kg**	**100-150kg**	**>150kg**
Enoxaparin dose	40mg od	40mg bd*	60mg bd*
*unlicensed doses recommended by UK Medicines Information			

Post-operative nausea and vomiting – can be caused by analgesics, eating too much, eating too quickly or not chewing sufficiently. Due to the risks posed by vomiting to the post-operative gut, prophylactic antiemetics should be prescribed. A combination of two antiemetics working by different mechanisms may be needed. Severe vomiting may warrant electrolyte and/or vitamin supplementation.

Gout – high protein diets and weight loss can precipitate gout.

- In patients with a history of gout, consider prophylactic allopurinol. Initiate several weeks before surgery and continue until no longer clinically appropriate.
- In an acute attack, consider colchicine before NSAIDs.

Gallstones – rapid weight loss can precipitate gallstones. Ursodeoxycholic acid may be considered for treatment and prophylaxis

Ulceration and reflux – prescribe lansoprazole orodispersible 30mg daily and continue for 3 months post-op. In the case of ongoing reflux, consider continuation of lansoprazole beyond 3 months (Malone 2005).

Improved fertility –

- In women of child-bearing age, significant weight loss may restore ovarian function, menstrual cycle regularity and fertility. Menstruating women may require a greater dose of iron supplementation.
- It is generally recommended that pregnancy is avoided for 12 to 18 months post-operatively due to the risk of nutrient deficiencies. Recent bariatric surgery would not be grounds for termination.
- Contraceptive options should be discussed. RYGB *may* alter the pharmacokinetics of oral contraceptives due to disruption of enterohepatic recirculation. This may result in reduced efficacy although evidence of this is unclear. Since efficacy cannot be monitored like other medicines, it would be prudent to consider barrier methods, implantable contraceptives (medroxyprogesterone acetate), intrauterine device or vaginal rings. Limited evidence suggests these are not influenced by bariatric procedures or significant weight loss.
- Any patient who becomes pregnant in the 18 months after bariatric surgery should be referred to Obstetrics usually under the care of a consultant.

Patients are advised to contact the bariatric team when planning a pregnancy or becoming pregnant. Multivitamin and mineral supplements will need to be reviewed and changed to pregnancy suitable options. A full panel of bloods tests will need to be checked including vitamin B12 levels. British Obesity and Metabolic Surgery Society recommend:

- women with BMI <29.9kg m² should take an additional 400micrograms/day folic acid prior to conception and until the 12th week of pregnancy
- Women with type 2 diabetes, or a BMI >30kg/m² should take 5mg folic acid pre-conceptually and for 12 weeks post conception.

ADVERSE EFFECTS

Some drugs should be used with caution or avoided in patients who have had bariatric surgery.

Gastrointestinal toxicity

- Drugs which may cause nausea, vomiting, diarrhoea, reflux, gallstones, ulcers or obstructions should be used with caution or avoided where possible.
- Non-steroidal anti-inflammatory drugs (NSAIDs) increase the risk of marginal ulcer 11-fold. A marginal ulcer occurs in the duodenal lining and could be detrimental to the integrity of the surgical pouch. **Avoid NSAIDs if possible** – paracetamol ± codeine may be considered. Use caution with low-dose aspirin and COX-2 selective inhibitors.
- Bismuth salicylate should be avoided in the early postoperative period due to formation of black stools which may mask malaena.
- PPIs are used for gastroprotection, but there is little evidence for their use post-bariatric surgery.
- Drugs known to cause oesophagitis or acid reflux should be avoided where possible. These include doxycycline, bisphosphonates such as alendronate (see below), theophylline, nitrates and nifedipine.

Bone protection

- Bisphosphonates are commonly prescribed to offset the increased risk of osteoporosis due to rapid weight loss and/or calcium malabsorption. However, oral bisphosphonates have the potential to cause serious damage if lodged in the oesophagus and should be avoided.
- Consider early bone densitometry and check serum parathyroid hormone, total calcium and 25-hydroxyvitamin D levels.
- If bisphosphonate therapy is required, then intravenous route of administration is preferred.
- All RYGB/LSG patients should take calcium and vitamin D supplements (see below). Where possible minimise medication which may lower calcium, such as loop diuretics and carbamazepine.
- Glucosamine can cause nausea, vomiting and epigastric discomfort while chondroitin is better tolerated.

Simple sugars –

- Dumping syndrome occurs in around 75% of RYGB patients. This involves rapid gastric transit with mostly-undigested food entering the small intestine, leading to abdominal pain, diarrhoea, light-headedness, flushing, tachycardia and syncope.
- Simple sugars can exacerbate dumping syndrome. The total intake of oral medicines containing sucrose, sorbitol, corn syrup, maltose, fructose, lactose, honey and mannitol should be limited where possible.

Lactose intolerance

- Some patients may develop lactose intolerance post-operatively.
- The lactose content of medication does not usually cause problems, but should be considered in severe intolerance or where single doses exceed 400mg lactose. Liquid preparations are usually lactose-free.

NUTRIENT DEFICIENCY

- A dietitian and wider MDT must tailor the nutritional support of every patient to avoid under- or over-supplementation.
- As a minimum, all patients should take a complete multivitamin and mineral supplement indefinitely, e.g. Forceval once daily or two daily Sanatogen A-Z Complete, Superdrug A-Z multivitamins and minerals, Tesco Complete multivitamins and minerals, Lloyds pharmacy A-Z multivitamins and minerals. Supplements should include thiamine, iron, selenium, zinc and copper. Avoid chewable versions after the initial post-operative period as these are generally not complete.
- A minimum of 2mg copper and 15mg zinc per day is recommended following RYGB, LSG and DS patients.

  Calcium and Vitamin supplements, iron supplements, and 3 monthly vitamin B12 injections are recommended post SG, RYGB, BPD and DS.
- Life long nutritional monitoring will be needed since deficiencies can develop over a number of years. Suggested monitoring schedules:

Postoperative blood tests following bariatric surgery

Blood test / Procedure	Frequency
HbA1c and/or FBG in patients with preoperative diabetes	Monitor as appropriate
Lipid profile	Monitor in those with dyslipidaemia
U+E, LFT, FBC, ferritin, folate, calcium, vitamin D, PTH	3, 6 and 12 months in first year then at least annually. If PTH and calcium raised seek specialist guidance to investigate primary hyperparathyroidism
Thiamine	Routine blood monitoring of thiamine is not required but clinicians should be aware that patients with prolonged vomiting can develop acute thiamine deficiency, which requires urgent treatment. Also consider supplementation in cases of rapid weight loss, poor dietary intake, alcohol abuse, oedema or neuropathy. Prescribe oral thiamine 200-300mg daily, B co-strong 1 or 2 tablets three times daily
Vitamin B12 Patients following SG or RYGB and BPD/ DS	3, 6 and 12 months in first year then annually
Zinc, copper Gastric bypass, SG and BPD/DS only	Annually. Monitor zinc if unexplained anaemia, poor wound healing, hair loss or changes in taste acuity. Monitor copper if unexplained anaemia or poor wound healing. Note the zinc levels affect copper levels and vice versa. Serum copper should be monitored in patients taking zinc supplements and vice versa.
Vitamin A BPD/DS only Sleeve and RYGB in pregnancy	Measure every 3 months until stable and then annually for PBD/DS. Measure if concerns regarding steattorrhoea or symptoms of vitamin A deficiency e.g. night blindness Monitor more frequently in pregnancy e.g. each trimester
Vitamins E, K Gastric bypass and BPD/DS only	Measure vitamin E if unexplained anaemia, neuropathy. Measure Vitamin K1 & PIVKA levels annually post BPS/DS

	Consider measuring INR if excessive bruising / coagulopathy as may indicate vitamin K deficiency
Selenium Gastric bypass and BPD/DS only	Monitor if unexplained fatigue, anaemia, metabolic bone disease, chronic diarrhoea or heart failure
Magnesium	Routine monitoring not needed but those with hypocalcaemia should be investigated for hypomagnesaemia and treated prior to calcium Supplementation.

General considerations – not an exhaustive list:

Calcium and vitamin D

- Calcium deficiency after RYGB/LSG is common, increasing the risk of fracture. Calcium carbonate is poorly absorbed due to increased stomach pH post-operatively.
- All patients should take calcium with vitamin D3 long-term e.g. Calci-D Chewable one once a day. Titrate the dose to serum calcium and vitamin D plasma levels. If patients are taking a separate vitamin D supplement use calcium supplement only (i.e. not combination). Calcium supplements may also reduce the absorption of certain medicines, advice will be provided by the pharmacist.
- In patients who remain hypocalcaemic, use of calcium citrate (1200-1500mg/day) may be indicated as evidence exists that this is better absorbed than calcium carbonate in RYGB patients. Vitamin D supplementation will also be required.
- Patients identified as vitamin D deficient should be managed in line with the National Osteoporosis Society Guidelines: Vitamin D and bone health: A Practical Clinical Guideline for Patient Management. In people with severe vitamin D deficiency, high dose vitamin D injections might be required, which should be given following specialist consultation.
- Give at least 2 hours before or after iron or phosphate doses.

Iron

- Iron-deficiency anaemia occurs in up to 50% of RYGB patients, particularly premenopausal women.
- For SG, RYGB, BPD and DS patients, prescribe prophylactic supplementation with 200mg ferrous sulphate, 210mg ferrous fumarate, or 300mg ferrous gluconate once a day and twice a day in menstruating women. Fersamal (ferrous fumarate) syrup 5mL can be prescribed for patients not tolerating tablets.
- Advise patients to take iron and calcium supplements at least two hours apart as one may inhibit the absorption of the other.

- If oral supplements are not tolerated or anaemia persists, consider IV iron supplementation.
- For people over 12 years old and pregnant women diagnosed with iron deficiency anaemia, treat iron deficiency following NICE CKS Anaemia-iron deficiency

Vitamin B12 –B12-deficiency after SG, RYGB, BPD and DS is likely as absorption relies on stomach acid and intrinsic factor. Give hydroxocobalamin IM injection 1mg every 3 months to maintain normal range levels. Monitor Hb and mean corpuscular volume. Treat Vitamin B12 deficiency immediately using NICE CKS: Anaemia-B12 and folate deficiency

Folate – patients should choose a multivitamin preparation containing the recommended daily intake of 400 to 800 micrograms folic acid. If deficient check compliance with multivitamins and minerals. If compliant check for Vitamin B12 deficiency before recommending additional folic acid supplementation. Treat folic acid deficiency using NICE CKS Anaemia-B12 and folate deficiency. Oral folic acid 5mg daily should be given for a minimum of 4 months. Recheck in 4 months. Additional supplementation may be required due to increased requirements for preconceptual care, pregnancy and lactation.

Vitamin K – Deficiency may alter oral anticoagulant control. For all patients, check the INR if the patient experiences excessive bruising or bleeding and supplement if needed.

Zinc and copper – Forceval contains sufficient zinc and copper for supplementation. However if the patient elects to take an alternative preparation, ensure that the patient is taking 2mg of copper and 15mg of zinc each day.

Selenium - A complete multivitamin and mineral supplement, which contains selenium, should be sufficient to meet needs after bariatric surgery. If additional selenium is required, patients may prefer to eat two to three Brazil nuts a day as these are a rich source of selenium. Check A-Z supplement contains selenium.

Future admissions – consider nutrient deficiencies as a cause of presenting symptoms, eg bleeding due to Vitamin K deficiency, encephalopathy due to Vitamin B deficiency. Unexplained anaemia, poor wound healing, hair loss, neutropaenia, peripheral neuropathy or cardiomyopathy may be symptoms of zinc, copper or selenium deficiency and so levels should be checked if there are any concerns.
In patients who present with neurological symptoms, treat with thiamine, check for Vitamin B12, copper, and vitamin E deficiencies and treat. Refer to neurologist and haematologist.

Please attach patient sticker here or record:
Name:……
NHS No:
Hosp No:
D.O.B: …./…/……. Male Female
Consultant: ……... Ward: ……..

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CHECKLIST FOR MEDICINES OPTIMISATION IN INPATIENTS FOLLOWING BARIATRIC SURGERY

To be completed by responsible clinician within 24 hours of surgery and filed in patient notes.

Inpatient has been prescribed:

- Review medication for a form the patient is able to swallow……. ☐
- Antiemetics …….. ☐
- Gastroprotection (e.g. lansoprazole orodispersible 30mg OD) ……. ☐
- **No NSAIDS** …….. ☐
- Enoxaparin as appropriate (see VTE assessment/Op note)……. ☐
- Multivitamin + mineral supplement *1 OD* (Patients own)..... ☐
- Calci-D chewable 1 *OD* (or calcium citrate with vitamin D)..... ☐
- Ferrous sulphate 200mg OD (or fumarate syrup 5mL *bd)*.…..... ☐
- Hydroxocobalamin 1mg IM *3/12 added to EDS for GPs to initiate* ☐

Improved fertility and contraceptive options discussed (women only) ☐

MONITORING TOOL

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

STANDARDS	%	CLINICAL EXCEPTIONS	Person responsible
All patients planned for bariatric surgery will have a full dietetic review and follow up	100%	None	Emma White
All bariatric surgery patients will have a medication review by a pharmacist	90%	Patient stay that falls outside Monday to Friday ward service.	Keith Hinton

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CONTRIBUTION LIST

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NHS Worcestershire Acute Hospitals NHS Trust

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

Section 1 - Name of Organisation (please tick)

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

Name of Lead for Activity	**Keith Hinton**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
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Date assessment completed	**14.10.2020**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** GUIDELINE FOR MEDICINES MANAGEMENT FOLLOWING BARIATRIC SURGERY			
What is the aim, purpose and/or intended outcomes of this Activity?	This guideline covers medication issues in adult patients following bariatric surgery. It describes practical recommendations for medicines management together with monitoring and supplementation advice to prevent nutrient deficiencies.			
Who will be affected by the development & implementation of this activity?	✓	Service User	✓	Staff
	✓	Patient	❑	Communities
	❑	Carers	❑	Other _____
		Visitors		
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.	See reference list
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	See contribution list (i.e. service users)
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		✓		
Disability		✓		
Gender Reassignment		✓		
Marriage & Civil Partnerships		✓		
Pregnancy & Maternity	✓			Additional advice may prevent maternal iron deficiency anaemia and foetal neural tube defects.
Race including Traveling Communities		✓		
Religion & Belief		✓		
Sex		✓		
Sexual Orientation		✓		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless;		✓		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Social/Economic deprivation, travelling communities etc.)				
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)		✓		

Section 4

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

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

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

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

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

Signature of person completing EIA	Keith Hinton

Date signed	14.10.2020
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	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	No
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	

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