Worcestershire Acute Hospitals NHS Trust

Guideline on the management of high output stoma

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 the management of high output stoma in adult patients

This guideline is for use by the following staff groups:

All qualified healthcare professionals involved in the management of adult patients with high output stoma.

Lead Clinician(s)

Rhydian Power	Specialist Pharmacist, Surgery WAHT
Approved by Medicines Safety Committee on:	10th April, 2024
Approved by Surgical Divisional Governance on:	27th August 2024
Review Date : This is the most current document and is to be used until a revised version is available	27th August, 2027

Key amendments to this guideline

Date	Amendment	By:
8th July 2020	New Document approved.	Medicines Safety Committee
7th February 2024	Pharmacological management section amended as per current evidence, with reference to MHRA warning for Loperamide.	Rhydian Power
7th February 2024	Potential causes for high output stoma expanded.	Rhydian Power
7th February 2024	Follow up requirements post discharge clarified.	Rhydian Power
10th April, 2024	Approved at MSC	Medicine Safety Committee
27th August, 2024	Approved at Surgical Governance Meeting	Surgery Divisional Governance
6th September 2024	Incorporation of St Mark's guideline as appendix	Rhydian Power

Guideline on the management of high output stoma

Introduction

Patients with stomas (Ileostomy, jejunostomy or colostomy) can experience high-volumes of output. This may occur during the post-operative period following new stoma formation (as the body adapts to a reduced length of intestine and subsequent water absorption), but may also occur as a result of disease, damage to the intestine, infection, certain medicines and/or foods.
A stoma is typically classified as being "high output" when ≥ 1.5Litres of fluid is produced daily (although remember to take into account the patients recent oral intake). This can be problematic for a variety of reasons including, potential electrolyte disturbances, dehydration, malnutrition/weight loss and acute kidney injury (AKI)

Management

Management steps are listed below and include ruling out potential causes, the close monitoring of fluid output/intake, the replacement of electrolytes, ensuring adequate nutritional support and the initiation of antisecretory/antimotility medications.

X Ensure Stoma CNS's are aware of any patients identified to have a high stoma output X

Overview of Inpatient Management, When High Output Stoma Identified

(See individual sections below for more detailed information)

Step 1:

- Eliminate potential causes (see table below)
- Conduct a review of patients medication
- Monitor electrolytes daily and replace if required
- Start formal fluid balance and correct any fluid deficits
- Limit **oral** hypotonic fluids to 500mLs/day (Utilise St Mark's Solution for any additional fluid)
- Initiate Loperamide and Proton Pump Inhibitor (see pharmacological management section)
- Refer patient to dietitian for nutrition review

If output remains high despite the interventions listed above escalate to step 2.

Step 2:

- Limit oral fluid intake to 1Litre/day. A Litre of St Marks Solution should be utilised **alone** for this.
- To maintain the patients fluid balance any additional fluids should be administered Intravenously
- Initiate regular Codeine alongside existing Loperamide and Proton Pump Inhibitor (see pharmacological management section)
- If stoma output has remained over 2Litres for 5 days, refer patient to Nutrition team (if not already done so).

If output remains high despite the interventions listed above escalate to step 3.

Step 3:

- If appropriate, consider trialling the use of Octreotide, however this should be discontinued if no response is observed within 3 days (see pharmacological management section).
- Consider referral to a specialist/experienced senior member of the team if output remains high despite the interventions listed above.

Eliminating potential causes:

Potential cause	Action
Infection	Send stool for MC+S and C diff
Medications	Review use of laxatives, prokinetics, oral Magnesium supplements, cytotoxics and identify if any recent steroid/opiate withdrawal - Discuss medications with ward pharmacist for more information
GI disease (coeliac disease, inflammatory bowel disease, pancreatic insufficiency)	Check blood test for TTG and immunoglobulins; check faecal elastase and calprotectin in stool specimen
Hyperthyroidism	Request and review TFTs
Ischaemic segment of bowel	If suspected, utilise appropriate imaging (e.g. CT) to exclude
Overflow diarrhoea	Consider CT to exclude obstruction of bowel
Hypotonic fluid intake	Limit **oral** hypotonic fluid intake to no greater than 500 mL/day
Immune deficiency	Consider HIV test
Short Bowel Syndrome (either congenital or through surgical resection)	Estimate length of remaining small bowel in continuity (Increased risk of high output with less than 200cm)

Fluid Management:

- Apply high output pouch/free drainage system (liaise with Stoma CNSs).
- Daily weights if possible (weight loss may suggest dehydration)
- Ensure **strict** fluid balance recording daily (*Intake*: oral and IV; *Output*: stoma, exact urine volumes, vomit / NG aspirate, other).
  Descriptive comments like “Pu’d”, “OTT” and “active stoma” are not acceptable.
- Remember that some fluid losses (breathing, sweating etc.) cannot be measured and so the intake needs to be at least 250 ml/day greater than the measured output, if the patient is to remain in equal balance.
- Monitor fluid balance closely and administer additional fluids to correct any deficits.
- As part of **Management Step 1:**
  - Limit **oral** hypotonic fluids (e.g. water/tea/coffee) to no more than 500mLs/day as these can further increase stoma output. *Note: Hypertonic fluids can also contribute to an increase in stoma output and therefore intake should be limited.*
  - An additional 1Litre/day of **oral** St Mark’s solution* may be utilised in step 1 if required.
- As part of **Management Step 2:**
  - Limit **oral** intake to 1Litre/day utilising St Mark’s Solution* **ALONE**.

  *if St Mark’s isn’t tolerated, consider WHO oral rehydration solution or Dioralyte as alternative isotonic oral hydration options)

For further guidance on fluid management, refer to Appendix A - NICE Algorithms for IV Fluid therapy in adults
(This is also located on the reverse of the WAHT Prescription Sheet for Infusions)

Electrolyte replacement:

- Monitor blood tests daily (Refeeding profile including U+E, Mg, Ca, Phosphate, Bicarbonate)
- Replace electrolytes (Potassium, Magnesium and Phosphate) via the IV route where possible to avoid diarrhoea and facilitate absorption (refer to individual trust guidelines).
- Measure urinary sodium initially and once weekly thereafter (to identify sodium depletion, shown by urinary Na < 10mmol/L).

Nutrition:

- Refer **all patients** to dietitian for fluid and dietary advice (ensure patient on low fibre diet).
- Patients with prolonged high output can be at risk of trace element and vitamin deficiencies. Consider monitoring and replace as appropriate.

Pharmacological Management of Inpatients **(See page 5 for additional information on each medication)**		
Step 1	**+ Loperamide 4mg QDS** (Advise patient to take 30 to 60 minutes before meals)	Initiate at this dose and titrate upwards as necessary every 48 hours in increments of 2mg QDS. If needed, titrate up to 8mg QDS then consider progressing to step 2. *(See page 05 for MHRA report guidance)*
	+ Omeprazole 40mg BD	Can be given either oral or IV (dependent on likely absorption) (If PPIs are unsuitable/contraindicated Famotidine may be used as an alternative)
	+ St Mark's Solution **(A rehydration solution)**	See **Appendix B**. (Double strength Dioralyte (10 sachets dissolved in 1L water) may be used as an alternative if St Marks Solution not tolerated, however this has a high potassium content and may be unsuitable for certain patients)
Step 2	**+ Codeine 60mg QDS**	Caution advised due to risk of addiction, sedation and fat malabsorption. Side effects can be more prominent in the elderly and those with renal impairment.
	Continue to increase Loperamide dose (Advise patient to take 30 to 60 minutes before meals)	As before, increase dose as necessary in increments of 2mg QDS every 48 hours. If adequate response not achieved at a dose of 16mg QDS progress to step 3 and consider referral to an appropriate consultant for further guidance. *(See page 05 for MHRA report guidance)*
Step 3	**+ Octreotide S/C** **50micrograms TDS**	Initiated usually with very high stoma outputs >3L/day. Stop if no response is observed within 3 days. **IF** a beneficial response is observed, the dose may be titrated up to 200micrograms TDS (according to output).

Medication - Further Information:

Owing to the reduced gastrointestinal transit time of medication, absorption could be reduced. To overcome this issue, consider the following:

- Where possible, avoid enteric coated and slow release preparations.
- If undigested tablets/capsules are present in stoma output, consider the use of liquids if available (with consideration of sorbitol/lactose content) or seeking pharmacy advice on the opening of capsules and crushing/dispersing of tablets (note: this is an off-label method of administration).
- If output is significant, consider alternative routes of administration.
- Close monitoring of levels may be required with essential medications e.g. Warfarin, certain anti-rejection drugs or epilepsy medications.

- Regular medication review

With increasing stoma output comes an increase in the risk of AKI, therefore it may be appropriate to consider the following:

- ? Stop Diuretics
- ? Stop ACE Inhibitors (e.g. Ramipril) or Angiotensin II Receptor Blockers (e.g. Candesartan)
- ? Stop Laxatives

If blood pressure after stopping ACE Inhibitor / Angiotensin II Receptor Blocker rises (e.g. > 140mm/Hg systolic or > 90mm/Hg diastolic), consider treating with a Calcium Channel Blocker (**UNLESS** contraindicated or if already prescribed). Ask for pharmacist input if required.

- Loperamide

A synthetic opioid agonist which decreases intestinal motility. It is the preferred drug of choice for this indication (off label) as its not addictive or sedating and doesn't lead to fat malabsorption. Loperamide circulates through the enterohepatic circulation which is disrupted in patients with faster gastrointestinal transit time and therefore larger doses (above the licencing) are often required. Loperamide should be initiated at a dose of 4mg QDS and up-titrated if required up to 16mg QDS (higher doses may be used but under the guidance of an experienced clinician). It is recommended that these dose increases should occur in increments of 2mg QDS no less than 48 hourly.

Based on a drug safety update reported by the MHRA linking high doses of Loperamide with cardiac events the British Intestinal Failure Alliance recommend the following:

- **Perform ECG before initiation of doses above 4mg QDS.**
- **Repeat ECG after starting and at least 3 yearly if patients remain on high doses.**
- **Aim to keep total daily dose below 80mg.**
- **Consider toxicity if patient experiences fainting and/or QT prolongation *if unable to rule out other potential causes*)**

Patients should be advised to take the medication 30 – 60 minutes prior to food for optimal effect. If undigested capsules are discovered in the stoma output or to reduce the pill burden, Loperamide capsules may be opened and dispersed in water prior to administration. This is preferred to the liquid formulation, which has a high sorbitol content and is more cost effective than the orodispersible tablets.

Co-Phenotrope may be utilised as a 2nd line alternative to Loperamide, however this needs to be recommended by a specialist consultant who has experience using the medication.
(Note: This is an unlicensed medication)

- **Proton Pump Inhibitors (PPIs)**

Antisecretory medications reduce gastric acid production and consequently should decrease stoma output volume.
Omeprazole is the preferred option at a dose of 40mg BD and should be initiated alongside Loperamide (other PPIs may be used if intolerance is identified). If possible, administer 30 minutes to 60 minutes prior to meals.
Absorption of Omeprazole occurs rapidly in the duodenum and therefore administration via the oral route is often appropriate. If, however this is likely to be reduced significantly the medication can be administered IV as an alternative.
PPIs are known to cause electrolyte disturbances, specifically hypomagnesaemia. They should therefore be considered as a precipitating factor in patients with recurrent electrolyte disturbances. Other associated issues include LFT impairment and the risk of developing Clostridium difficile.

Although PPIs are reportedly better at reducing stoma output Famotidine at 40mg BD (A H_2-receptor antagonist) may be used as an alternative if there are issues with hypomagnesaemia or intolerance/allergy (*Note this is not available as an IV preparation*)

- **Codeine**

Codeine similarly to Loperamide reduces gastrointestinal motility and when used alongside the above is expected to reduce stoma output further.
The addition of Codeine 60mg QDS is a second line management step as it's potentially addictive, sedating and may lead to fat malabsorption. Side effects can be more prominent in the elderly and those with renal impairment.
Good practice is to annotate the indication "For High Output Stoma" on the drug chart to reduce the likelihood of inadvertent dose omissions.

- **Octreotide**

A somatostatin analogue, Octreotide reduces gastrointestinal secretions, delays gastric emptying and slows GI transit time which in turn could reduce stoma output. Evidence to support its use is weaker than the 1st/2nd line options and therefore should only be initiated as a 3rd line management step. If a positive response is not observed within 3 days, then discontinue the medication. However, if a benefit is observed then the dose may be increased further up to a maximum of 200micrograms TDS. Be aware that Octreotide can potentially lead to gallstone development, alter blood sugar levels and can be painful for the patient (when compared with other options).

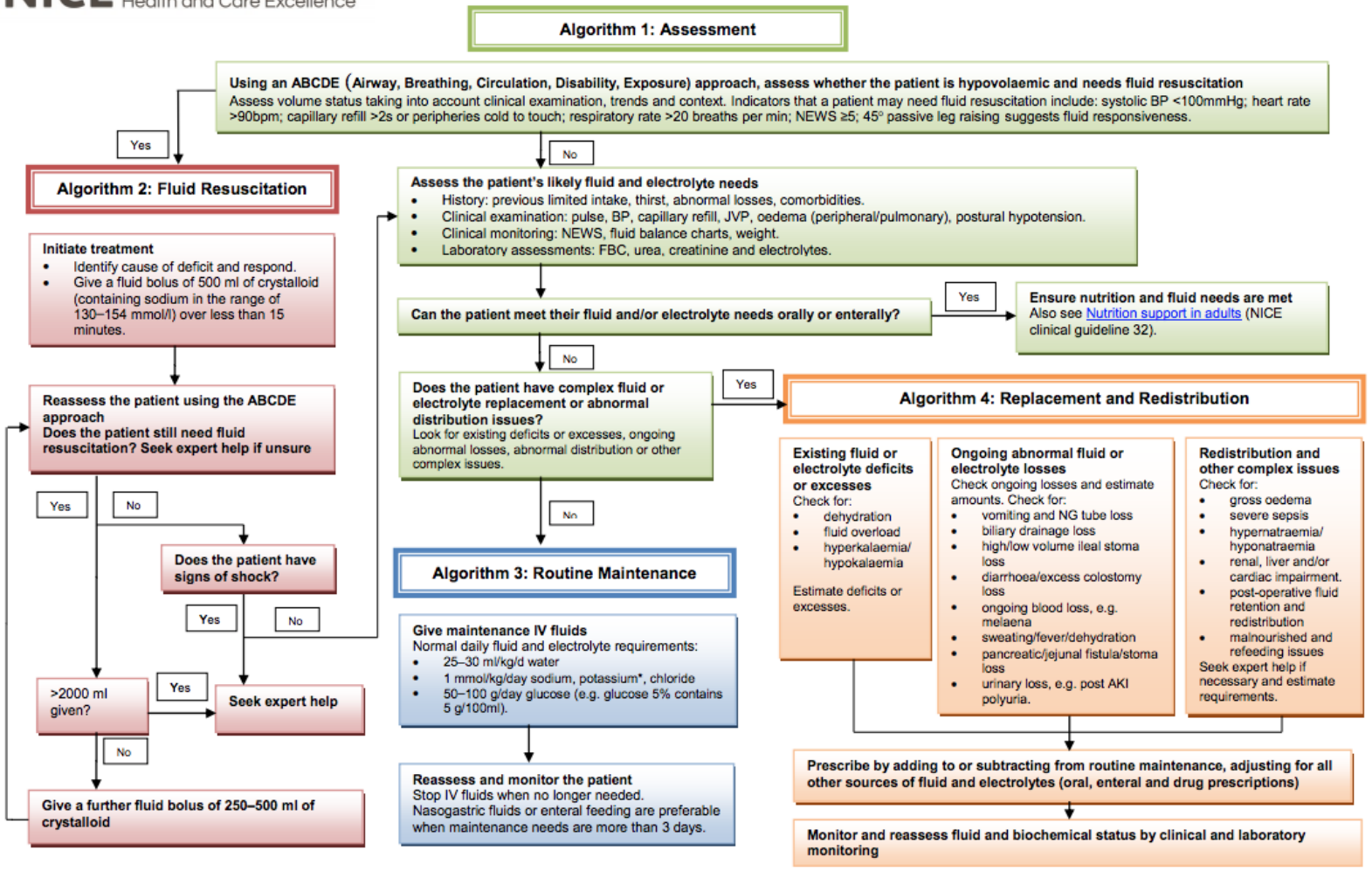
On Discharge:

- Ensure PRN Loperamide added to TTO for all ileostomy patients and patient instructed how to use.
- Liaise with the dietitians to ensure dietary advice is provided to the patient e.g. maintaining a low fibre diet.
- Educate patient on the use of St Marks Solution or alternatively, advice on purchasing Dioralyte (dispersing 10 sachets in 1Litre of water).
- Supply appropriate information resources e.g. Secure Start traffic light leaflet and other advice booklets.
- Inform the patient that the stoma team will contact them post discharge to manage their ongoing care. Importantly, encourage the patient to contact the Stoma Care department for advice if output increases/watery
- **Ensure that a regular review of the patients medication is undertaken at follow ups (whether this is increasing/decreasing doses or discontinuing medication which are no longer deemed necessary to control the patients stoma output).**

APPENDIX A

NICE National Institute for Health and Care Excellence

Algorithms for IV fluid therapy in adults



*Weight-based potassium prescriptions should be rounded to the nearest common fluids available (for example, a 67 kg person should have fluids containing 20 mmol and 40 mmol of potassium in a 24-hour period). Potassium should not be added to intravenous fluid bags as this is dangerous.

'Intravenous fluid therapy in adults in hospital', NICE clinical guideline 174 (December 2013. Last update December 2016)

APPENDIX B

St Mark's Solution

Introduction

St Mark's solution (containing 90mmol/L sodium) is a glucose-electrolyte solution, also known as an oral rehydration solution, which is used in the management of High Output Stoma.
In these patients the capacity of the intestine to absorb fluid and nutrients is likely to be reduced. This can lead to dehydration, weight loss, malabsorption of fluids, and electrolyte imbalance.

Unlike hypotonic fluids, oral rehydration solutions promote the intestinal absorption of both salt and water, which should in turn reduce the stoma output. This will help patients maintain an adequate fluid balance, with a reduced need for intravenous fluids.

Patients are required to sip the prescribed amount of St Mark's Solution throughout the day (not all at once). This is usually 1 Litre each day - but may vary according to the individual's needs.

To improve palatability, it is advised to store the mixture in a refrigerator and serve chilled. Patients can also sip the solution through a straw and/or add a little fruit cordial if desired (*Note: This should be added during the initial stage of preparation, not to each glass*).

Only 1 Litre of solution should be prepared at a time (regardless of the total volume prescribed).
Any solution remaining at the end of the day should be discarded and a fresh batch made the following day.

Composition

Composition of St Marks's Solution	Where to obtain
20g (6 level 5ml spoonfuls) glucose	Pharmacy
3.5g (1 level 5ml spoonful) salt	Kitchens
2.5g (1 heaped 2.5ml spoonful) sodium bicarbonate	Pharmacy
Add to 1 Litre of water	

Prescribing

St Mark's solution should be prescribed on the inpatient medication chart, where the dose to be given is the volume of St Mark's to be administered over a 24-hour period. The dose frequency should be stated as "over 24 hours" and a circle around all of the administration times indicates that the patient should continuously drink the solution throughout the day.

As mentioned in the main body of the High Output Stoma Guideline, Double strength Dioralyte (10 sachets dissolved in 1L water) may be used as an alternative if St Marks Solution is not tolerated, however this has a high potassium content and may be unsuitable for certain patients.

Monitoring Tool

This should include realistic goals, timeframes and measurable outcomes.

How will monitoring be carried out?

Who will monitor compliance with the guideline?

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?**
	Management of high output stoma is as per guideline	Audit	Annually	Surgical Directorate	Surgical Directorate	Annually

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Contribution List

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

Name	Designation
Keith Hinton	Lead Specialist Pharmacist - Surgery
Rachel Hodkinson	Specialist Pharmacist - Surgery
Donna Lewis	Stoma Clinical Nurse Specialist
Carl Robinson	Dietitian WRH
Hayley Ryan	Dietitian WRH
Joanna Senior	Dietitian WRH
Cara Douglas	Dietitian WRH
Dr Thea Haldane	Consultant Gastroenterologist WRH
Dr Martin Ferring	Consultant Renal Services WRH
Miss Deborah Nicol	Consultant Surgeon WRH
Mr Richard Lovegrove	Consultant Surgeon WRH
Miss Pamela Sivathondan	Consultant Surgeon WRH

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

Committee
General Surgery Directorate Clinical Governance
Surgical Divisional Governance
Medicines Safety Committee

Supporting Document 1 – Equality Impact Assessment form

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.
Please complete assessment form on next page;

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	**Rhydian Power**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Rhydian Power	**Pharmacist**	**Rhydian.power@nhs.net**
Date assessment completed	**20/07/20**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Guideline on the management of high output stoma			
What is the aim, purpose and/or intended outcomes of this Activity?	To facilitate the management of high output stoma in adult patients			
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.	The guideline was circulated to staff members of varying equality groups and their feedback was noted.
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	As above.
Summary of relevant findings	This guideline was not thought to have a significant impact on any of the equality groups identified below (see under pregnancy & maternity for exception).

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			√	The administration of medications in pregnancy/breastfeeding can often pose ethical challenges. Seek pharmacist input for advice on administration of medications in pregnancy.
Race including Traveling Communities		√		
Religion & Belief		√		
Sex		√		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Sexual Orientation		√		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; 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	Rhydian Power
Date signed	20/07/20
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