Guideline on the Medicines Management of Parkinson's Disease Patients with Compromised Oral Administration

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 patients with Parkinson's disease admitted to hospital that are unable to take their oral medications.

This guideline is for use by the following staff groups:

All qualified healthcare professionals involved in the care of patients with Parkinson's disease.

	Lead Clinician(s)
Sundus Irshad	Advanced Clinical Practitioner and Specialist Clinical Pharmacist in Acute Medicine
Ke Xin Tan	Rotational Specialist Pharmacist

Approved by Neurology Directorate/DMB	4th July 2025
Approved by Medicines Safety Committee	9th July 2025
Review Date	9th July 2028

This is the most current document and is to be used until a revised version is available

Key amendments to this guideline

Date	Amendments	Approved by:
1/5/2025 (Updated by: Ke Xin Tan)	- Produodopa has been added to Table 1. - The Drug Locator's link has been updated. - OPTIMAL CALCULATOR has been replaced with PDMedCalc as OPTIMAL CALCULATOR is being retired. - Section 3.1: CLIP has been added as a source of drug history sources for antiparkinsonian medications. - Section 3.1.2: This section has restructured and now includes guidelines for patients with swallowing difficulties, those admitted for surgery and patients with GI disruption.	Medicines Safety Committee

	- Section 3.1.3: New section added – Procedure for Conversion to Oro-dispersible Madopar or Transdermal Rotigotine. - Section 3.2: Instructions on how to apply the Rotigotine patch has been added. - Section 3.3: Guidance on prescribing Apomorphine infusion has been added. - Section 3.4: New section added – Produodopa Infusion. - Section 3.5: The administration route for Domperidone has been changed from PO/PR to PO only. - Section 3.6: Contact details have been updated. - The flow chart for antiparkinsonian medication prescribing in Appendix 1 has been redesigned to summarise Section 3.1.2. - References have been updated.	

TABLE OF CONTENTS

Guideline on the Medicines Management of Parkinson's Disease Patients with Compromised Oral Administration

1. INTRODUCTION

Parkinson's disease (PD) is a neurodegenerative condition affecting around 145,000 patients in the UK and is the fastest growing neurological condition across the world. Initial symptoms typically present with tremor, stiffness, slowness, balance problems, and gait disorders. Although there is no cure for Parkinson's disease at present, medications are used to help control symptoms and slow progression. Classes of medications used are outlined in Table 1.

1.1. BACKGROUND: COMPROMISED ORAL MEDICATION ADMINISTRATION IN PARKINSON'S DISEASE

Antiparkinsonian medications should not be withdrawn abruptly or allowed to stop suddenly due to dysphagia or other causes such as being made nil-by-mouth (NBM) peri-operatively. Antiparkinsonian medications are time critical and a delay of just 30 minutes can increase the likelihood of adverse effects and therefore increase hospital stay. Should serious delays occur, the patient can develop decreased mobility, increased risk of aspiration, acute akinesia or neuroleptic malignant syndrome, which can lead to coma or death (SPS, 2021; NICE, 2018). NICE 2018 quality standard states *'Adults with Parkinson's disease who are in hospital or a care home should take levodopa within 30 minutes of their individually prescribed administration time'.*

Dysphagia can be a common complication in Parkinson's Disease patients, but the extent of impairment depends on the individual's disease progression. Patients may also experience worsened swallowing during acute illness or present with other causes for a compromised oral route such as vomiting, or a requirement to be NBM peri-operatively. As this can affect administration of oral medications, the suitability of the formulations will need to be assessed depending on whether the patient is made nil by mouth, nasogastric fed or on a dysphagic diet.

This guideline is a decision aid for managing Parkinson's disease patients that present with or develop a compromised oral route of administration. A multi-disciplinary approach will be required for effective management to improve patient outcomes and reduce the length of hospital stay.

Table 1 *– Classes of medications*

Class of Medication	Examples
Levodopa	Co-beneldopa (Madopar) Co-careldopa (Sinemet) Produodopa
Levodopa (with carbidopa) + COMT inhibitors	Co-careldopa+Entacapone (Stalevo)
Dopamine Agonists	Pramipexole Ropinirole Rotigotine Apomorphine
MAO-B Inhibitors	Rasagiline Selegiline Safinamide
COMT inhibitors	Entacapone Opicapone
Glutamate antagonist	Amantadine

2. ROLES & RESPONSIBILITIES

The admitting speciality team has the overall responsibility of the patient however advice must be sought from the multi-disciplinary team where deemed appropriate such as Speech and Language Therapy Team (SLT), Pharmacists, Consultant Neurologists, Geriatricians (where Rockwood score is >5).

3. GUIDELINE

3.1. ORAL MEDICATION

Antiparkinsonian medications should not be stopped abruptly.

- It is recommended that the medication history is confirmed using two sources including the name, dose, frequency and specific timing of the antiparkinsonian medication regime.
- This specific timing can vary between patients therefore, where able, it is recommended to confirm timings with the patient or their carers/relatives.
- On admission, try to reinforce patients to take the usual PD medications on time as per the regular prescription schedule.

Drug history sources for antiparkinsonian medications can include:

- Patient/Carers/Relatives
- Summary Care Record (SCR)
- Bluespier or CLIP clinic letters (if recent)
- Previous discharge summaries (if recent)
- Patient's own medication boxes or dosette boxes

3.1.1. LOCATING MEDICATIONS

If the medications are not available on the ward during normal working hours, the pharmacist or pharmacy technician for the ward must be contacted immediately. Out of hours, the drug locator should be used where possible, or the on-call pharmacist should be contacted through switchboard.

3.1.2. COMPROMISED ORAL ROUTE

The following sections (3.1.2.1, 3.1.2.2 and 3.1.2.3) outline the guidelines for patients experiencing swallowing difficulties, those admitted for surgery and individuals with gastrointestinal (GI) disruption, which includes prolonged nil-by-mouth due to ileus, delayed gastric emptying, malabsorption or severe nausea and vomiting. A flowchart diagram is also provided in Appendix 1 for reference.

3.1.2.1. PATIENTS WITH SWALLOWING DIFFICULTIES

If a patient is unable tolerate their baseline swallow recommendations, **DO NOT SWITCH TO A ROTIGOTINE PATCH IMMEDIATELY**. Please note in the following steps, a Datix must be completed if PD medications are omitted or delayed more than 30 minutes, or the patient's PD control has been affected.

Please follow these steps:

- Step 1: A referral to SLT should be made via ICE for SLT input where there is a change from the patient's baseline swallow recommendations. Proceed to Step 2 whilst awaiting assessment from SLT.
- Step 2: Nursing staff can trial crushed tablets or opened capsule contents with 10mL yoghurt/custard (SPS, 2022). Alternatively, mix dispersible medication in 10mL of water, with or without thickener. Note that there is limited evidence in the literature about using thickener with crushed and dispersed medication and that taking PD medications with food may alter absorption (SPS 2021a, 2021b, 2022); monitor PD control if this option is used. Use PDMedCalc to aid conversion to suitable dispersible formulations (please ensure the converted dispersible Madopar doses match the patient's original time schedule).
- Step 3: If unsafe to swallow (coughing, choking, wet voice, altered breathing, complaints of food sticking, delayed or absent swallow initiation), insert an NG tube following the *NG Insertion Guidelines WAHT-NUR-065* and document the outcome. A junior doctor or staff nurse must confirm NG placement in the stomach before the administration of medications and document this in the medical notes. Administer usual medications via NG tube at usual scheduled times. Use PDMedCalc to aid conversion to suitable NG-compatible formulation, including oro-dispersible alternatives (please ensure the converted dispersible Madopar doses match the patient's original time schedule).
- Step 4: If there are any other challenges related to NG tube insertion, please notify the Neurology team promptly. Continue trialling the NG tube even if the PD meds are overdue.
- Step 5: If NG tube placement fails (e.g. the patient repeatedly removing the NG tube), switch to Rotigotine patch using PDMedCalc for dosage guidance. Inform the Neurology team of the change and ensure all decisions and outcomes are clearly documented in the medical notes.

- Step 6: When the patient's condition is improving and they can safely take oral medications, convert the patch back to their usual regime.
- Step 7: If there is persistent swallowing failure or focal neurological deficit explaining the patient's persistent swallowing failure, discuss with the neurology team for consideration of PEG tube insertion. Consider early referral to the PEG multi-disciplinary team that can advise on a variety of complex nutritional questions as well as PEG insertion (peg.mdt@nhs.net).

A referral should be made to a specialist team such as Neurologists, Parkinson's nurse specialists or Geriatricians (frail patients) if there is any concern regarding the patient's PD control. See Section 3.6 for contact information.

3.1.2.2. PATIENTS ADMITTED FOR SURGERY

Parkinson's medications should be continued in the peri-operative period, see *Nil by mouth (NBM) and peri-operative medicines use guideline WAHT-KD-017* on the Intranet. To minimise disruption to the patient's usual medication regime, Parkinson's medication can be given with a sip of water up until anaesthetic induction. **DO NOT SWITCH TO A ROTIGOTINE PATCH IMMEDIATELY**. A Datix must be completed if PD medications are omitted or delayed more than 30 minutes.

Resume postoperatively at patient's usual dose. If there is potential for swallowing difficulties post-operatively but an otherwise working gastrointestinal (GI) tract, please refer to Section 3.1.2.1. If a long nil by mouth (NBM) period is anticipated post-operatively due to GI disruption, please refer to Section 3.1.2.3.

3.1.2.3. PATIENTS WITH GI DISRUPTION (PROLONGED NIL-BY-MOUTH DUE TO ILEUS, DELAYED GASTRIC EMPTYING, MALABSORPTION OR SEVERE NAUSEA AND VOMITING)

A prescriber will need to convert their medications to a Rotigotine patch as per PDMedCalc. Please notify the Neurology team regarding this decision.

Parkinson's medication should be converted to a Rotigotine patch using the PDMedCalc. Consider converting to usual Parkinson's medications orally or via an NG tube as soon as clinically appropriate. Note that specialists may recommend an altered oral/enteral medication regime where the patient's PD has deteriorated. Ensure Rotigotine patches are removed once oral/enteral route is restarted.

A referral should be made to a specialist team such as Neurologists, Parkinson's nurse specialists or Geriatricians (frail patients) if there is any concern regarding the patient's PD control. See Section 3.6 for contact information.

NB - A Datix must be completed if PD medications are omitted or delayed more than 30 minutes, or the patient's PD control has been affected.

3.1.3. PROCEDURE FOR CONVERSION TO ORO-DISPERSIBLE MADOPAR OR TRANSDERMAL ROTIGOTINE

The PDMedCalc is a calculator to convert medications to a suitable formulation, such as dispersible medicines or a Rotigotine patch. Both prescribers and pharmacists are required to use this same calculator to minimise negative complications and ensure dosing consistency. Seek advice from the ward pharmacist or on-call pharmacist to support if needed.

- Go to the following website https://pdmedcalc.co.uk/. This website will ask you to put in the various PD medications that the patient takes and will calculate:
    - The total levodopa dose per day
    - A conversion for all usual medications in oro-dispersible form (i.e. Madopar aka co-beneldopa)
    - A conversion for all usual medications to a dopamine agonist delivered transdermally by a continuous 24-hour patch (i.e. Rotigotine patch).

- You must only prescribe EITHER the Madopar OR Rotigotine patch. **PLEASE DO NOT PRESCRIBE BOTH** as this will lead to a double dose of dopamine.
- Aim to return to the patient's usual medication routine as soon as clinically possible and do not forget to remove the Rotigotine Patch immediately after they have received the first dose of their usual medication.

3.2. ROTIGOTINE

Rotigotine patches are advised only where patients are unable to have oral dispersible formulations and fail to have an NG tube in place. It would be advantageous to seek specialist advice when converting oral levodopa to Rotigotine. See Section 3.6 for contact information.

Patches of different strengths can be applied to make up the total dose required. Beyond doses of 8mg, two patches must be applied each day. NB – Rotigotine patch must never be cut. If a patient is prescribed Rotigotine patches, some potential adverse effects to note include (see BNF for full list):

- Nausea
- Constipation
- Hypotension
- Headaches
- Anxiety
- Drowsiness
- Impulsive and convulsive behaviours
- Hallucinations, irritability, and delusions
- Skin reaction

Patches should only be applied to hair free skin and rotated to avoid skin irritation. Press the patch firmly against the skin for 30 seconds to ensure adherence. Document patch placement on the Transdermal Patch Placement Chart (please ensure to annotate “Refer to/ Use Transdermal Patch Chart” on the main drug chart). Remove the old patch just prior to administering the new patch in a new area of skin. As the backing layer of the patch contains aluminium, this would need to be removed temporarily prior to an MRI scan or cardioversion to avoid skin burns as the backing layer of the patch contains aluminium.

There are information packs available from community Parkinson's team and information for patients/carers about patch rotation, skin care etc. See Section 3.6 for useful contact numbers and information.

3.3. APOMORPHINE

Apomorphine is a dopamine agonist which is used in advanced Parkinson's Disease. It can be used alone or in combination with other antiparkinsonian medications. There are different modes of administration including pen injections or infusion pumps. This medication should never be started as an alternative to oral medications when oral route of administration is compromised. It is only started and reviewed by specialists.

The patient's apomorphine regime should be confirmed on admission and continued as an inpatient; a compromised oral route should not affect this medication. A placeholder should be added on drug chart/EPMA to indicate that Apomorphine infusion is prescribed on the infusion chart where the dose and flow rate are specified. Call Apo-Go helpline for advice out-of-hours (0844 880 1327) or speak to a pharmacist if needed. This is a critical medication and should not be omitted or delayed. See Section 3.6 for useful contacts and information.

3.4. PRODUODOPA INFUSION

Produodopa is a subcutaneous infusion of Foslevodopa with Foscarbidopa (prodrugs of Levodopa and Carbidopa) for treating advanced Parkinson's with motor symptoms (NICE, 2023). This medication should never be started as an alternative to oral medications when oral route of administration is compromised. It is only started and reviewed by specialists.

For all patients with PD admitted on Produodopa, please contact the Specialist Parkinson's Disease Nurse using the site-specific contact details in Section 3.6. Seek advice from the ward pharmacist or on-call pharmacist to support if needed.

Produodopa is not routinely stocked for inpatient use at any WAHT site. Supplies are ONLY stored specifically for patients scheduled to initiate treatment in the outpatient setting (named patients only). Therefore, patients should bring in their supply with them during hospital admission. In situations where the Produodopa pump fails or the patient arrives without a supply, they should be commenced on the emergency Parkinson's disease oral drug regime as outlined in their clinic letters in CLIP. Once the Produodopa supply is available, patients should return to the infusion treatment.

A placeholder should be added on drug chart/EPMA to indicate that Produodopa infusion is prescribed on the infusion chart, where the dose and flow rate are specified. Prescribers should note that some patients will have a different dose/flow rate for overnight and separate infusion charts would be required (please refer to *Clinical Guideline for the Initiation of Produodopa® for the Treatment of Parkinson's Disease* for detailed Produodopa prescribing information).

If the patient has compromised oral route while on the emergency Parkinson's disease oral drug regime, please refer to Section 3.1.2 for further instructions.

3.5. GENERAL PRESCRIBING IN PARKINSON'S DISEASE

A common cause for a compromised oral route in Parkinson's disease is nausea and vomiting and prescribing an anti-emetic can be indicated. Care is needed to select an appropriate anti-emetic due to the risk of side effects.

Antiemetic choice in Parkinson's Disease:

- Domperidone (PO only)
  OR ondansetron can be used safely for nausea and vomiting.
  (NB – These medications are associated with QT prolongation, see BNF cautions and contraindications)

Medications that can worsen Parkinson's disease include (not limited to):

- Metoclopramide
- Cyclizine
- Prochlorperazine (Stemetil)
- Haloperidol
- Avoid anticholinergics where possible

3.6. USEFUL INFORMATION AND CONTACTS

Neurology Consultants	Referrals can be made via email: WRH: wah-tr.wrh.neurologyreferrals@nhs.net ALX: wah-tr.neurologyreferrals@nhs.net **For urgent queries during working hours and on Sat-Sun 9:00am-3:00pm, the local Neurology team is available to provide support. Outside these hours, please contact the QE Hospital switchboard for the on-call Neurology Registrar.** Secretary: wah-tr.neurologysecs@nhs.net Secretary extension number: WRH – 38931, 38946, 38948, 38950 ALX – 44674
Specialist Parkinson's Disease Nurse (Worcestershire Acute Hospitals)	Contact: wah-tr.parkinsonsdiseaseadviceandguidance@nhs.net
Geriatrics Consultants	Via email: wah-tr.wrhgeriatricreferrals@nhs.net
Community Parkinson's Nurse Specialists	whcnhs.parkinsonsnurses@nhs.net whcnhs.dutyparkinsons@nhs.net
Parkinson's UK - Advisors For general enquiries from patients regarding the day-to-day impact of Parkinson's; benefits; grants; employment issues; emotional support; general support.	Tel: 0808 800 0303 Opening Times: Monday to Friday: 9am to 6pm; Saturday: 10am to 2pm. Helpline is closed on Sundays and bank holiday.

Speech and Language Therapy (SLT) Team	Opening Hours Monday to Friday, 08:00-16:30. Contact: via ICE referral
PEG MDT	peg.mdt@nhs.net
Apo-Go helpline (for apomorphine)	Tel: 0844 880 1327

Useful information:

PDMedCalc General information about medications and formulation conversion calculators.	https://pdmedcalc.co.uk/
Parkinson's UK Information and support for patients and professionals	www.parkinsons.org.uk
Apo-Go Resources Information on device set-up.	www.apo-go.com/hcp/resources

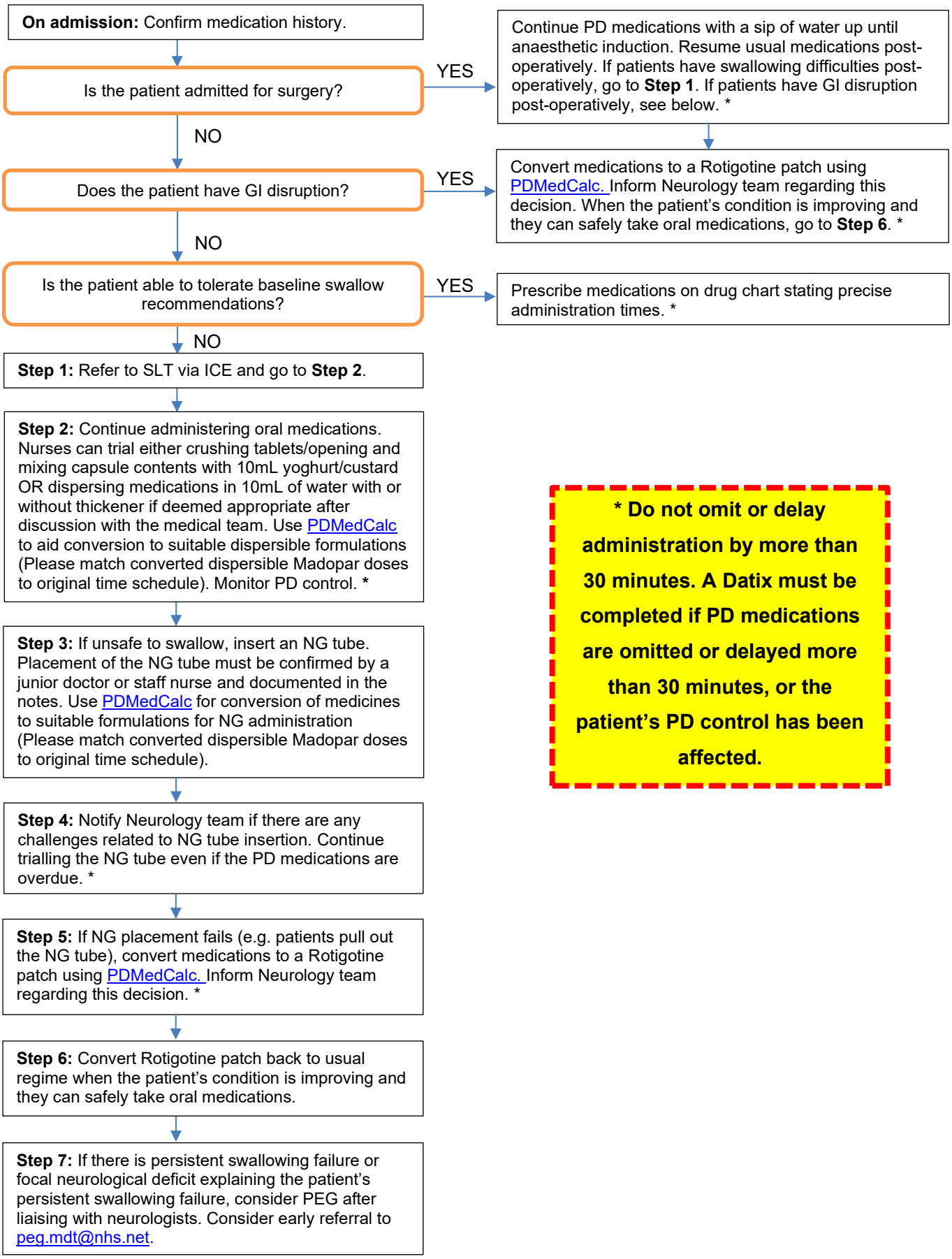
4. EDUCATION AND TRAINING

There is no mandatory training regarding this guideline. Information will be disseminated to relevant departments through electronic communication channels on approval. This guideline may be incorporated into induction training for new staff where required.

5. MONITORING COMPLIANCE

Monitoring of Datix incident reports will highlight any gaps in compliance to this guideline. Local clinical audits may be undertaken in the different multi-disciplinary departments.

APPENDIX 1: FLOW CHART FOR ANTIPARKINSONIAN MEDICATION PRESCRIBING



*** Do not omit or delay administration by more than 30 minutes. A Datix must be completed if PD medications are omitted or delayed more than 30 minutes, or the patient's PD control has been affected.**

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?**
Section 1.1	Antiparkinsonian medication should be given within 30 minutes of administration time.	By review of drug chart by ward based clinical pharmacists.	On completion of clinical pharmacy review of drug chart.	Ward based clinical pharmacists.	Deviations from guideline recommendations may be reported via DATIX.	Each time a reportable issue arises.
Section 1.1	Antiparkinsonian medication should not be omitted.	By review of drug chart by ward based clinical pharmacists.	On completion of clinical pharmacy review of drug chart.	Ward based clinical pharmacists.	Deviations from guideline recommendations may be reported via DATIX.	Each time a reportable issue arises.

REFERENCES

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KEY WORDS

Parkinson's disease, PD
Nil by mouth, NBM
Rotigotine
Levodopa, Co-beneldopa, Co-careldopa, Madopar, Sinemet

Contribution List

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

Name	Designation
Dr MTE Heafield	Consultant Neurologist
Julie Pittaway	Parkinson's Specialist Nurse
Dr Susan Powell	Consultant Geriatrician
Dr Claire Wilkes	Consultant Geriatrician
Dr Catherine Jackson	Consultant Geriatrician
Dr Ruma Dutta	Consultant Geriatrician
Morag Inglis	Dietetics and Speech & Language Therapy Manager
Mirjana Rasovic	Clinical Professional Lead and Macmillan Head and Neck Speech and Language Therapist
Alison Smith	Lead Pharmacist Medicines Safety/Medicines Safety Officer
Lindsay Stewart	Lead Pharmacist Speciality Medicine
Shane Kailla	Advanced Clinical Practitioner and Specialist Clinical Pharmacist Acute and Emergency Medicine
Sundus Irshad	Advanced Clinical Practitioner and Specialist Clinical Pharmacist in Acute Medicine
Ke Xin Tan	Rotational Specialist Pharmacist

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

Committee
Urgent Care Governance
Specialty Medicine DMB

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	**Dr Susan Powell, Dr MTE Heafield**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Sundus Irshad	Advanced Clinical Practitioner and Specialist Clinical Pharmacist in Acute Medicine	sundus.irshad@nhs.net
Date assessment completed	**04-10-2023**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** **Guideline: Medicines Management of Parkinson's Disease Patients with Compromised Oral Administration**			
What is the aim, purpose and/or intended outcomes of this Activity?	Implement a guideline to support staff in providing consistent and optimal medicines management for Parkinson's Disease patients with compromised oral administration.			
Who will be affected by the development & implementation of this activity?	❑ × ❑	Service User Patient Carers	× ❑ ❑	Staff Communities 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. There is no specific information for equality impact in the implementation of this guideline that is relevant for a review.			
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. No barriers identified or relevant to this guideline at present therefore no specific consultation about equality impact undertaken. The guideline covers all patients with Parkinson's Disease irrespective of any equality groups as listed below.			
Summary of relevant findings	No barriers or impact identified.			

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		The guideline covers all patients with Parkinson's Disease irrespective of age.
Disability		x		The guideline covers all patients with Parkinson's Disease irrespective of disability.
Gender Reassignment		x		The guideline covers all patients with Parkinson's Disease irrespective of gender reassignment.
Marriage & Civil Partnerships		x		The guideline covers all patients with Parkinson's Disease irrespective of marriage and civil partnerships.
Pregnancy & Maternity		x		The guideline covers all patients with Parkinson's Disease irrespective of pregnancy and maternity.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Race including Traveling Communities		x		The guideline covers all patients with Parkinson's Disease irrespective of race.
Religion & Belief		x		The guideline covers all patients with Parkinson's Disease irrespective of religion and belief.
Sex		x		The guideline covers all patients with Parkinson's Disease irrespective of sex.
Sexual Orientation		x		The guideline covers all patients with Parkinson's Disease irrespective of sexual orientation.
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		The guideline covers all patients with Parkinson's Disease irrespective of any vulnerable or disadvantaged group characteristics.
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		The guideline covers all patients with Parkinson's Disease irrespective of health inequalities.

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	Sundus Irshad
Date signed	04-10-2023
Comments:	
Signature of person the Leader Person for this activity	Dr MTE Heafield
Date signed	06/10/2023
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