Worcestershire Acute Hospitals NHS Trust

Guideline for Penthrox® administration in the Emergency Department

Introduction

This guideline describes the use of Penthrox® for analgesia and procedural sedation in patients attending the Emergency department who have sustained significant injuries.

This guideline is for use by the following staff groups:

Healthcare staff working within the emergency department who have undergone specific training in the use of Penthox®.

Lead Clinician(s)

Dr.Claudiu Visoiu Dr James France	EM ST6 in Emergency Medicine Consultant Emergency Medicine (A&E)
Approved by Urgent Care Divisional Governance Meeting on:	July 2023
Approved by Medicines Safety Committee on:	12th July 2023
Review Date: This is the most current document and should be used until a revised version is in place	12th July 2026

Key amendments to this guideline

Date	Amendment	Approved by:
2023	New document approved	Urgent Care Divisional Governance Meeting

Administration of Penthrox® in the Emergency Department

Introduction

- Penthrox®, the commercial name of Methoxyflurane, is a clear, almost colourless liquid with a characteristic “fruity” odour
- Methoxyflurane is a halogenated ether that belongs to the family of volatile fluorinated hydrocarbons. Other members of this family are anaesthetic agents, such as Sevoflurane and Desflurane.
- Penthrox® has been used in Australia and New Zealand for over 30 years with over 5 million administrations
- It has been considered a very good alternative to procedural sedation with fewer ED resources required for it.
- Currently Penthrox® had been approved by MHRA to be used in adults (over 18 years old) for pain relief. The result of the MAGPIE study, looking at the use of Methoxyflurane in children presenting to the ED with injuries is awaited.

Aims of Guideline

- This guideline is intended to aid the safe administration of Penthrox® when used for procedural sedation and/or immediate bridging analgesia prior to systemic pain relief in patients with traumatic injuries and a pain score of 7-10 or obvious severe pain.

Indications

- Penthrox® can be used to bridge analgesia for fractures, dislocation, amputations, burns, and chemical and soft injury, while other interventions are considered for their definitive management of them.

- Short-lasting painful procedures e.g. manipulation of fractures or joint dislocations.

Contraindications

- Penthrox® is contraindicated in patients with atraumatic pain and patients with mild pain (VAS < 4)
- Penthrox® is contraindicated in children/anyone under 18 years of age
- The 'CHECK ALLL' checklist may be used to screen for contraindications:

  - **C** Cardiovascular instability
  - **H** Hypersensitivity to Penthrox® or any fluorinated anaesthetic agent
  - **E** Established or genetically susceptible to malignant hyperthermia.
  - **C** Consciousness reduced due to any cause including head injury, alcohol or drugs
  - **K** Kidney impairment
  - ---
  - **A** Age < 18 years
  - **L** Lung / respiratory impairment
  - **L** Liver impairment
  - **L** Last administration of Penthrox® (maximum dose 6 ml (2 bottles)/24 hrs or 15 ml/7 days). Should not receive doses on consecutive days.

Hepatotoxicity:

Methoxyflurane is metabolised in the liver, therefore increased exposures in patients with hepatic impairment can cause toxicity. There is clinical evidence to show that methoxyflurane may cause hepatotoxicity in rare cases. Repeated exposure at frequent intervals and prior exposure to halogenated hydrocarbon anaesthetics (including methoxyflurane when used in the past as an anaesthetic agent), especially if the interval is less than three months, have been reported to increase the risk of liver toxicity.

- Only administer methoxyflurane to patients who do not have a history of showing signs of liver damage after previous use of methoxyflurane or halogenated hydrocarbon anaesthesia.
- Exercise care when using methoxyflurane in patients with underlying hepatic conditions or with risks for hepatic dysfunction (such as CYP enzyme-inducers drugs)
- Use cautious clinical judgement when administering methoxyflurane more frequently than once every 3 months (it has been reported that previous exposure, especially if the interval is less than three months, may increase the potential for hepatic injury).

Nephrotoxicity:

Methoxyflurane causes significant nephrotoxicity at high doses and therefore renal failure may occur if the recommended dose is exceeded. There may be an additive effect on nephrotoxicity when methoxyflurane is used concomitantly with

antibiotics which are known to have a nephrotoxic effect. Antibiotics with known nephrotoxic potential include tetracycline, gentamicin, colistin, polymyxin B and amphotericin B. Nephrotoxicity is also related to the rate of metabolism. The frequency at which methoxyflurane can be safely used is not established.

- Only administer methoxyflurane to patients that do not have clinically significant renal impairment, such as eGFR (<30mL/min)
- Always use the lowest effective dose of methoxyflurane, especially in the elderly or patients with other known risk factors of renal disease.
- Do not exceed the maximum dose of 6 mL methoxyflurane (2 x 3 mL bottles) in a single administration.
- Administration on consecutive days is not recommended and the total dose to a patient in a week should not exceed 15 mL.
- Only administer methoxyflurane to patients who are not concomitantly taking drugs known to have a nephrotoxic effect (tetracycline, gentamicin, colistin, amphotericin, polymyxin B).
- Factors that increase the rate of metabolism such as drugs that induce hepatic enzymes can increase the risk of toxicity as well as sub-groups of people with genetic variations that may result in fast metaboliser status.

Cardiovascular effects:

Potential effects on blood pressure and heart rate are known effects of high dose methoxyflurane used in anaesthesia and other anaesthetics. They do not appear to be significant at the analgesic doses. Hypotension was a common adverse drug reaction in clinical trials. The risk may be increased for older patients with hypotension and bradycardia.

- Only administer methoxyflurane to patients that do not have clinically evident cardiovascular instability.
- Use caution when administering methoxyflurane in elderly patients due to a potential reduction in blood pressure.

Respiratory effects:

Methoxyflurane has caused respiratory depression when used at a high dose to induce anaesthesia in pre-clinical studies. Coughing was a common adverse drug reaction in clinical trials.

- Only administer methoxyflurane to patients that do not have clinically evident respiratory depression.

Central nervous system (CNS) effects:

Methoxyflurane is a CNS depressant and can produce CNS effects, such as sedation, euphoria, amnesia, ability to concentrate, altered sensorimotor coordination and change in mood. It is likely to have additive effects when used concomitantly with other CNS depressants, such as opioids, alcohol etc.

- Only administer methoxyflurane to patients that do not have an altered level

of consciousness due to any cause including head injury, drugs or alcohol.
- Methoxyflurane should be administered under supervision.
- If opioids are given concomitantly with methoxyflurane, the patient should be observed closely.

Malignant hyperthermia:

Malignant hyperthermia is a rare genetic disorder which manifests clinically as a hypermetabolic crisis. It is usually triggered by an anaesthetic, including methoxyflurane.

- Only administer methoxyflurane to patients that do not have known or are genetically susceptible to malignant hyperthermia or do not have a history of severe adverse reactions in either patient or relatives.

Abuse potential:

Due to the potential CNS effects of methoxyflurane, such as sedation, euphoria or change in mood, it has some abuse potential. As a prescription-only medicine which is administered only in single doses under the supervision of a healthcare professional, the main risk group for abuse is healthcare professionals.

- Dispose of used methoxyflurane bottles and inhalers responsibly in the sealed plastic bag provided and place them in a designated waste container.

Interaction with CYP enzyme inducing drugs:

CYP 450 enzymes mediate methoxyflurane metabolism, particularly CYP 2E1 and to some extent CYP 2A6. Increasing the rate of methoxyflurane metabolism may increase its potential toxicity.

- Only administer methoxyflurane to patients that are not concomitantly taking CYP enzyme-inducing agents, particularly CYP 2E1 (e.g. alcohol or isoniazid) and CYP 2A6 (e.g. phenobarbital or rifampicin) or enzyme inducers [carbamazepine, isoniazid, phenobarbital, phenytoin, primidone, rifampicin].

Further information is available from the Summary of Product Characteristics available at the PENTHROX 99.9%, 3 ml inhalation vapour, liquid - Summary of Product Characteristics (SmPC) - (emc) (medicines.org.uk)

Precautions

- Inform the patient of potential TEMPORARY unwanted effects:
  - Dizziness
  - Headache
  - Tiredness
  - Nausea (and, very rarely, vomiting)
  - Taste disturbance
  - Dry mouth
  - Cough
  - Restlessness or agitation
  - Altered state of consciousness
  - Blurred vision
- Exercise caution with the use of Penthrox® in pregnancy, especially in the first trimester, and in breastfeeding

Dosage and administration

- Starting dose is one 3mL bottle Penthrox®. (See Appendix 2 for administration instructions)
- Onset of pain relief is rapid and should occur within 6 to 10 inhalations (wait 10 minutes after starting to ensure adequate analgesia level achieved for the procedure, even if inhalation is not continuous).
- If stronger analgesia is required, the patient can cover the dilutor hole on the AC chamber with a finger during use.
- Continuous inhalation provides analgesia for 25 to 30 minutes.
- Intermittent inhalation provides analgesia for one hour.
- Patients should be encouraged to assess their own level of pain and titrate the amount of Penthrox® inhaled for adequate pain control.
- A second bottle (3 mL dose of Penthrox®) can be given immediately if needed. No further doses should be given.

- Maximum doses:
  - 6 mL (2 bottles) for a single episode
  - 6 mL in a 24-hour period and it should not be administered on consecutive days.
  - 15 mL in a 7-day period (week).

See Appendix 1 for a description of the safe administration of Penthrox®

Please see links below for educational videos on administration of Penthrox®

- https://penthrox.co.uk/resources/how-penthrox-works/
- https://penthrox.co.uk/resources/how-to-use-penthrox/

Health and Safety & COSHH

- There have been reports of non-serious and transient reactions such as dizziness, headache, nausea or malaise, and reports of hypersensitivity reactions to methoxyflurane or other ingredients in healthcare professionals exposed to Penthrox®.
- Measurements of exposure levels to methoxyflurane in hospital staff showed levels significantly lower than those associated with nephrotoxicity.
- Effects on the ability to drive and use machines: Methoxyflurane may have a minor influence on the ability to drive and use machines. Patients should be advised not to drive or operate machinery if they are feeling drowsy or dizzy.
- National Exposure Standards: There is currently no established exposure standard for Methoxyflurane. Further information regarding Penthrox Safety data can be accessed at https://medicaldev.com/wp-content/uploads/2021/07/SDS_0001_R9_SDS_Penthrox.pdf
- Adverse events should be reported. Reporting forms and information can be found at www.mhra.gov.uk/yellowcard. Adverse events should also be reported to Galen Limited on 028 3833 4974 and select the customer services option, or e-mail customer.services@galen-pharma.com.
- Medical information enquiries should also be directed to Galen Limited.

Minimising Risks to Healthcare staff:

- Always ensure that the AC chamber is attached to the inhaler as this will adsorb any methoxyflurane exhaled through the inhaler.
- Ensure patients self-administer methoxyflurane correctly and always exhale through the mouthpiece of the inhaler.
- Once the contents of the methoxyflurane bottle have been tipped into the inhaler replace the cap on the bottle.

Disposal

- Place used methoxyflurane bottles and inhalers into the sealed plastic bag provided and dispose of them in the clinical waste bin.

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?**
	An internal audit looking into Penthrox® use after the first 6 months.	Internal audit	6-12 months	Dr Claudiu Visoiu	Governance meetings/ Medicine Safety Committee	1 year of Penthrox use.
	The ED governance team will review any reported issues associated with Penthrox® use.	The governance team looking at any reported incidents regarding the Penthrox® use	As needed	Governance team	Urgent Care Divisional Governance Meetings	As needed

References

- Royal College of Emergency Management of Pain in Adults RCEM_BPC_Management_of_Pain_in_Adults_300621.pdf (cloudinary.com)

- Coffey F, Wright J, Hartshorn S et al. STOP!: a randomized, double-blind, placebo-controlled study of the efficacy and safety of methoxyflurane for the treatment of acute pain. EMJ 2014;31:613-8.

- Nguyen NQ, Toscano L, Lawrence M et al. Patient-controlled analgesia with inhaled methoxyflurane versus conventional endoscopist-provided sedation for colonoscopy: a randomized multicenter trial. Gastrointest Endosc 2013;78:892-901.

- Young L, Bailey GP, McKinlay JAC. Service Evaluation of Methoxyflurane Versus Standard Care for Overall Management of Patients with Pain Due to Injury. Adv Ther. 2020 May;37(5):2520-2527.

- Frangos J and Mikkonen A. (2013). Penthrox - Assessment of Potential for Abuse & Dependency. Richmond, Australia: Golder Associates. Retrieved from https://tinyurl.com/y63qdwxp.

- Penthrox administration and dosages: https://tam.nhsh.scot/therapeutic-guidelines/therapeutic-guidelines/anaesthetics/penthrox-methoxyflurane-guideline/

- Penthrox Safety Data Sheet: Microsoft Word - MSDS - Penthrox April 2016 (medicaldev.com)

Contribution List

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

	Designation
Dr D Raven	DMD Urgent Care Division
Mrs C Bush	DND Urgent Care Division
Mr A Jalil	Clinical Lead, Emergency Department, AH
Dr R Hodson	Clinical Lead, Emergency Department, WRH
Mr M Tarrant	Matron, Emergency Department, AH
Mrs D Jeynes	Matron, Emergency Department, WRH
Mrs S Bloomer	Matron, Kidderminster Minor Injury Unit
Ms J Prosser	Lead ENP, Emergency Department, WRH
Mrs T Evans	Pharmacist, Emergency Departments
	Consultants of the AH & WRH Emergency Departments

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

Committee
Medicines Safety Committee
Medical Gas Committee

Worcestershire Acute Hospitals NHS Trust

Appendix 1 – Penthrox® Administration instructions

Administration instructions **Registered, trained staff only**

1. Insert the activated carbon chamber into the dilutor hole on the top of the inhaler

2. Use the base of the inhaler to loosen the vapour bottle cap with a ½ turn, then separate the bottle from the inhaler and remove the cap by hand

3. Tilt the inhaler to a 45° angle and pour the total contents of the bottle into the base of the inhaler whilst rotating it

4. Replace bottle cap bottle and place it in plastic bag from pack. Place bag on patient's trolley so it can later be used to safely dispose of inhaler.

5. Place loop over patient's wrist

6. After use, place inhaler in the plastic bag already containing the vapour bottle, seal and dispose of it in sharps bin

For spontaneous pain

Instruct patient as follows:

- Breathe in and out through the inhaler so the exhaled vapour is captured in chamber
- Breathe gently for the first few breaths and then breathe normally through inhaler (i.e. big breaths are **NOT** required)
- You will feel pain relief after 6-10 breaths
- Continuous inhalation provides pain relief for up to 25-30 minutes, but it is usually **NOT** necessary to inhale constantly and this might also cause unwanted drowsiness
- Inhale intermittently, at the lowest possible dose to achieve pain relief – you will soon get the hang of it!

NB: Patient must remain on trolley including during imaging or transfer as they might become unsteady

For procedural analgesia

Instruct patient as follows:

- Breathe in and out through the inhaler so the exhaled vapour is captured in chamber
- Breathe gently for the first few breaths and then breathe normally through the inhaler (i.e. big breaths are **NOT** required)
- Keep going like this for a few minutes to ensure the vapour reaches its maximum effect; we will then start the procedure

If patient becomes uncomfortable, stop procedure, deepen analgesia then restart; instruct them to do the following:

- Take deeper breaths now while covering the dilutor hole of the chamber with one finger
- Hold each breath in your lungs for a few seconds before breathing out
- You might become drowsy and loose awareness, but this will make you stop inhaling the vapour and you will then become fully conscious again very rapidly

NB: Trained staff to remain with patient throughout Penthrox use

Remove inhaler from their mouth if they are getting too sedated (recovery should then be rapid)

NHS Worcestershire Acute Hospitals NHS Trust

Appendix 2 - Training and competency

ASSESSMENT OF COMPETENCY FOR THE ADMINISTRATON OF PENTHROX®

ASSESSMENT SPECIFICATION: The candidate should be able to demonstrate competence in the administration of Penthrox® using the following knowledge evidence and performance criteria.

KNOWLEDGE EVIDENCE: The candidate should be able to:

a) Demonstrate knowledge of local guidelines for the administration of Penthrox®
b) Demonstrate a factual knowledge of indication/contraindications and adverse effects of Penthrox®
c) Discuss potential problems that may be encountered and how to prevent/resolve them
d) Identify the correct equipment for the administration of Penthrox®
e) Demonstrate skill in the correct administration of Penthrox®
f) Discuss responsibility and accountability with reference to the use of Penthrox®
g) Discuss safety aspects of the procedure and disposal of equipment
h) Discuss the environmental impact of the use of Penthrox®

You need a supervisor who is professionally accountable and competent to administer Penthrox® Assessment in Clinical Practice or equivalent Competencies may be assessed by individuals who have attended a training programme and are deemed competent by your supervisor

- For Any problems, please contact Professional Development on 01905 760825 or Ext 33743

Clinical Supervisor *(please print)* …… Signature …… Date: ……

Candidate *(please print)* …… Signature …… Date: ……

Ward/Department: ……Directorate …… Location: ……

Comments by Supervisor	**Comments by Candidate:**

Worcestershire Acute Hospitals NHS Trust

When you have completed your competencies, please send a PHOTOCOPY of this form to:
Professional Development Administrator, Charles Hastings Education Centre, WRH.

Worcestershire Acute Hospitals NHS Trust
Performance Criteria for Assessment of Competency for Administration of Penthrox®

PERFORMANCE CRITERIA	COMPETENT- Mentor Initial & Date		
	Observation of practice (May include video demonstration)	**Supervised practice 1**	**Supervisor initials**
1 **Patient identified correctly**			
2 Preparation of Equipment			
3 Procedure			
Assess Nature of injury or procedure to be carried out Assess the patient, and ensure no contraindications present Assess the level of understanding and ability to self-administer Assess the level of understanding of the procedure to be carried out Assess the need for any concurrent local, topical or systemic analgesia			
Plan Explain the procedure and use of Penthrox® as analgesia to patient/family/carers as appropriate Answer questions, provide reassurance Gain verbal consent Gather equipment and ensure all complete and in working order			
Administration Ensure patient comfort and safety. Demonstrate to patient the use of equipment Ensure the patient understands what to do and what to expect before the procedure commences Allow the patient to practice using equipment Explain about covering dilutor hole for stronger pain relief Encourage the patient to take a few gentle breaths before commencing the procedure to ensure effectiveness Encourage breathing normally throughout the procedure Observe the patient during and after the procedure to monitor the effects of Penthrox® and assess when the effects have worn off			
4 Correct Disposal of all equipment			
5 Patient reassured and comfortable			
7 Correct Documentation of all relevant information			

Main Clinical Mentor: *(please print)* **Signature:** **Date:**	**Candidate:** *(please print)* **Signature:** **Date:**

Appendix 3 - Environmental & Sustainability Issues

The introduction of methoxyflurane (Penthrox®) into the Emergency Department (ED) is one of many strategies to help the ED become more 'Green', specifically by reducing the use of Entonox®.

Used correctly, nitrous oxide (Entonox®) can be a very safe and effective analgesic medicine. For some patients, it may be the best option for pain relief. However, we should also be aware of some of the broader implications of this drug:

1. The ability of nitrous oxide to trap heat in the atmosphere (known as the global warming potential or GWP) is approximately 298 times that of carbon dioxide.
2. Nitrous oxide is also an ozone-depleting gas and has been labelled as one of the most significant ozone-depleting gases of the 21st century.
3. Nitrous oxide inactivates vitamin B12 and interferes with folate metabolism. Risks of occupational exposure in healthcare workers such as reduced fertility have been reported following repeated exposure in inadequately ventilated rooms and spaces.
4. Nitrous oxide can be used as a drug of abuse, with regular exposure leading to peripheral neuropathy, and subacute combined degeneration of the spinal cord.

The NHS in England has pledged to be carbon net zero by 2040. The NHS is responsible for 4- 5% of total UK carbon emissions, and anaesthetic gases have been identified as a 'carbon hotspot'. The 2019 NHS Long-Term Plan highlights these gasses as an area for action. Nitrous oxide use in the acute sector leads to more greenhouse gas emissions than any other anaesthetic gas, accounting for 75% of all anaesthetic gas emissions.

A significant proportion of these emissions originate from non-maternity nitrous oxide use (e.g. emergency departments). It is important to reduce nitrous oxide wastage and consider the use of alternatives, where feasible and safe to do so.

- It is estimated that 30 minutes of Entonox® use produces the equivalent emissions of approximately 38 kg of CO2. This is the same as driving a medium-sized petrol car over 120 miles.
- At present, partially empty and expired Entonox® cylinders are vented off directly to the atmosphere, further contributing to emissions.
- Some emergency departments may have piped Entonox® from a gas manifold. This has the potential to lead to leaks from pipework, and also wastage of large quantities of gas if the manifold is not correctly managed.

Alternatives to nitrous oxide, such as methoxyflurane (marketed as Penthrox®) are now available and may be suitable for some, but not currently all, patients. Methoxyflurane has a much lower ability than nitrous oxide to trap heat in the atmosphere (GWP of 4 vs 298) although the data to compare the total environmental impact of nitrous oxide and methoxyflurane as a life cycle analysis (incorporating manufacture, use and disposal of each product) is not yet available.

Reference:

Nitrous Oxide and Prehospital Emergency Medicine. Information Sheet for Emergency Care Providers. Royal College Emergency Medicine, College of Paramedics, Association of Ambulance Chief Executives, British Association for Immediate Care. May 2022. Nitrous_Oxide_and_Prehospital_Emergency_Medicine_v3.pdf (cloudinary.com) Accessed 02.05.2023

Supporting Document 1 - Equality Impact Assessment Tool

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	X	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Dr Claudiu Visoiu**

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

Section 2

The activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Guideline for Penthrox® use in ED			
What are the aim, purpose and/or intended outcomes of this Activity?	See the main body of the document			
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?	See the main body of the document
Summary of engagement or consultation was undertaken	See the main body of the document
Summary of relevant findings	See the main body of the document

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 boxes 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, the 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		X		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
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)		X		

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 the action?	Timeframe
	N/A	.		
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, carers 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	

Date signed	
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 the 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 which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.