Title: Shared care guideline for Apomorphine use in Parkinson's Disease.	Salford Royal NHS NHS Foundation Trust University Teaching Trust safe • clean • personal
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Authors Division: CSS & TM	
Departments/Groups This Document Applies to: Neurology, Pharmacy and Primary Care	
Scope: Neurology and Primary Care	**Classification: Shared Care Protocol**
Keywords: Apomorphine, Shared Care, Neurology	**Replaces Issue No: 1**
To be read in conjunction with the following documents: Current Summary of Product characteristics (http://www.medicines.org.uk) BNF	

Unique Identifier: MM6(05)	**Review Date: May 2015**	
Issue Status: Approved	**Issue No: 2**	**Issue Date: June 2013**
Authorised by: Medicines Management Group	**Authorisation Date: May 2013**	

Document for Public Display: Y

Required NHSLA Evidence **N**

If this policy is required for NHSLA evidence, then this document must have been checked against the current standards for compliance. If this is not known by the author, confirmation should be sought from the Risk and Health and Safety Department.

Contents Page

Introduction

Parkinson's disease is a progressive degenerative neurological condition that affects nerve cells in the substantia nigra and basal ganglia (the parts of the brain controlling movement). Parkinson's disease is caused by idiopathic degeneration of dopamine producing cells in this area. Three 'cardianal sins' of Parkinson's disease are resting tremor, cogwheel rigidity and bradykinesia. Postural instability, typically a late finding in Parkinson's disease is the fourth symptomatic response to L-dopa (levodopa).

Parkinson's disease is one of the commonest neurological conditions to affect older people. It is estimated to affect 160 per 100,000 of the general population.

Apomorphine is licensed for the treatment of disabling motor fluctuations ("on-off" phenomena) in patients with Parkinson's disease, which persist despite individually titrated treatment with levodopa (with a peripheral decarboxylase inhibitor) and/or other dopamine agonists.

Apomorphine treatment is to be initiated, and doses optimised by the hospital specialist team. Continutation of the therapy requires co-operation between the hospital and CCG teams with their roles defined by the shared care protocol.

Purpose

Shared care is an agreement between the GP and the Consultant. This form is a request by the Consultant to share the suggested care pathway of your patient. If you are unable to agree to the sharing of care and continued prescription of the suggested medication, please make this known to the Consultant within 14 days, stating the nature of your concern.

Scope

This document must be agreed by both organisations to which it is supplied. This document describes the necessary steps that must be taken to ensure the safe prescribing of apomorphine for patients suitable for shared care.

Policy Statement

This shared care protocol must be adhered to by all medical, nursing, pharmacy and other staff who are involved in the care of patients who are suitable for shared care as agreed by both the GP and hospital specialist caring for the patient.

Monitoring and review

This shared care protocol will be reviewed on a two-yearly basis or in the intervening period if new research is published that means an update is required before two years has passed.

Shared Care Guidelines

1. Licensed Indications	The treatment of disabling motor fluctuations ("on-off" phenomena) in patients with Parkinson's disease which persist despite individually titrated treatment with levodopa (with a peripheral decarboxylase inhibitor) and/or other dopamine agonists
2. Therapeutic use & background	Apomorphine is a directly acting dopaminergic agonist, licensed for use in patients with Parkinson's disease who have frequent and/or severe akinesia ("off periods") not controlled by levodopa or other dopamine agonists Apomorphine is a dopamine agonist, which acts directly on D_1 and D_2 receptors, stimulating areas of the brain where dopamine works. It produces a similar effect to levodopa, that is, the ability to prevent and reverse disabling "off" periods. Despite its name **it has no opiate or addictive properties**. Apomorphine cannot be used orally because it undergoes extensive first pass metabolism (in the liver) to an inactive metabolite; for this reason it is administered subcutaneously. • Apomorphine may be administered as a "rescue therapy" with intermittent subcutaneous bolus injections given via a prefilled Apomorphine Pen: **10mg/ml Solution for Injection 3ml Pen (Apomorphine Pen)** Patients selected for treatment with Apomorphine should be able to recognise the onset of their 'off' symptoms and be capable of injecting themselves or else have a responsible carer able to inject for them when required • For those patients who experience more complex motor fluctuations, including dyskinesias, a continuous subcutaneous infusion using an ambulatory Apomorphine pump may be used with the Apomorphine PFS: **5mg/ml Solution for Infusion in Pre-Filled Syringe 10ml syringe (Apomorphine PFS)** • Apomorphine Ampoules 10mg/ml is also available in 5ml ampoules for continuous infusion (solution for injection) **It is essential that the patient is established on Domperidone 20mg oral TDS daily, 72 hours prior to initiation of Apomorphine (or via rectal administration, dose as per BNF)** **Please see the MHRA drug safety alert for domperidone:** http://www.mhra.gov.uk/Safetyinformation/DrugSafetyUpdate/CON152725 There is a risk of serious ventricular arrhythmia and sudden cardiac death. Patients should not be given domperidone whilst on medications known to prolong the QT interval eg, ketoconazole or erythromycin. http://www.azcert.org/medical-pros/drug-lists/bycategory.cfm#
3a. Contraindications (please note this	• Children and adolescents (up to 18 years of age) • Known sensitivity to Apomorphine or any other ingredients of the product.

does not replace the SPC or BNF and should be read in conjunction with it).	• Respiratory depression • Dementia • Psychotic disease • Hepatic insufficiency • Intermittent Apomorphine HCl treatment is not suitable for patients who have an 'on' response to levodopa which is marred by severe dyskinesia or dystonia
3b With caution:	*With caution:* • Pulmonary, renal or cardiovascular disease • Persons prone to nausea and vomiting • Elderly and/ or debilitated patients • pre-existing cardiac disease or in patients taking vasoactive medicinal products such as antihypertensives, and especially in patients with pre-existing postural hypotension
4. Prescribing in pregnancy and lactation	This shared care protocol does not cover pregnant or breastfeeding women. Under these circumstances prescribing will remain the responsibility of Specialist
5. Dosage regimen for continuing care	**Route of administration:** Subcutaneously

- 5mg/ml Solution for Infusion in Pre-Filled Syringe 10ml syringe (Apomorphine PFS)
- 10mg/ml Solution for Injection 3ml Pen (Apomorphine Pen)
- Apomorphine Ampoules 10mg/ml is also available in 5ml ampoules for continuous infusion (solution for injection)

Apomorphine is occasionally used for patients with swallowing difficulties and at the palliative stage

- The optimal dosage of Apomorphine has to be determined on an individual patient basis and the threshold dose is determined by the specialist using incremental dosing schedules. Once the optimal dose for an individual patient has been determined and the patient is stable, the dose is likely to remain relatively constant
- The daily dose of Apomorphine varies widely between patients,
- **Intermittent injection** – typically 1-10 injections per day, each dose no more than 10mg
- **Continuous infusion** - typically 1–6 mg per hour (but may be higher, dependent upon individual response), mostly during waking hours but may be necessary for overnight infusion according to patients needs. Considered if the patient experiences so many 'off' periods that repeated bolus injections are inappropriate.
- **Maximum licensed daily dose by either route is 100 mg. Any doses prescribed over 100mg are with documented Consultant consent and the GP will be informed. This makes the dose unlicensed and the GP may no longer wish to be involved in shared care.**
- NB - Establish patient on Domperidone* 20mg oral TDS daily, 72 hours prior to initiation on Apomorphine (or via rectal administration, dose as per BNF)
- Apomorphine therapy is a treatment for a chronic disease and therefore course length can be many years. It is used in complex Parkinson's disease and when the disease is beginning to fluctuate, but is not controlled with oral medication.

* please refer to latest recommendations for Domperidone

Is titration required	**Yes**

- Titrate dosage up by 0.5mg-1mg increments hourly; however the time may vary depending on whether a patient is an inpatient or in the community. Judgement of specialist Consultant or PDNS.
- **Maximum daily dose by either route is 100 mg. Any doses prescribed over 100mg are with documented Consultant consent and the GP will be informed. This makes the dose unlicensed and the GP may no longer wish to be involved in shared care**

Adjunctive treatment regime:
N/A

Conditions which might require dose reduction depending on clinical judgment:

- Hypotension which is symptomatic to patient.

<table>
<tr><td></td><td>

- Cognitive impairment
- Hallucinations
- Obsessive compulsive disorder
- Impulse control disorder

</td></tr>
<tr><td></td><td>Usual response time:
Following a single dose, Apomorphine has an onset of action of 4-12 minutes and lasts for about one hour with the Apomorphine Pen or is continuous with the infusion with the Apomorphine PFS</td></tr>
<tr><td></td><td>Duration of treatment:
Apomorphine therapy is a treatment for a chronic disease and therefore course length can be many years. It is used in complex Parkinson’s disease and when the disease is beginning to fluctuate, but is not controlled with oral medication</td></tr>
<tr><td></td><td>Treatment to be terminated by:
Specialist Consultant or Parkinson’s Disease Nurse Specialist</td></tr>
<tr><td></td><td>NB. All dose adjustments will be the responsibility of the initiating specialist care unless directions have been specified in the medical letter to the GP.</td></tr>
<tr><td>6.Drug Interactions

For a comprehensive list consult the BNF or Summary of Product Characteristics</td><td>The following drugs must <u>not</u> be prescribed without consultation with the specialist:

Clozapine
NB This is a RED Drug and so GPs should not be prescribing; liaison may be required with mental health services.

Neuroleptic medicinal products may have an antagonistic effect if used with Apomorphine. There is a potential interaction between Clozapine and Apomorphine, however Clozapine may also be used to reduce the symptoms of neuropsychiatric complications.

The possible effects of Apomorphine on the plasma concentrations of other drugs have not been studied. Therefore caution is advised when combining Apomorphine with other medicinal products, especially those with a narrow therapeutic range.

It is recommended to avoid the administration of Apomorphine with other drugs known to prolong the QT interval.
Examples being: Amiodarone, Chlorpromazine, Cisapride, Citalopram, Clarithromycin, Clomipramine, Disopyramide, Erythromycin, Flecainide, Haloperidol, Mesoridazine, Moxifloxacin, Pentamidine, Procainamide, Sotalol, Vandetanib

See BNF for full details</td></tr>
<tr><td>7. Adverse drug reactions

For a</td><td>Specialist to detail below the action to be taken upon occurrence of a particular adverse event as appropriate. Most serious toxicity is seen with long-term use and may therefore present first to GPs.
<table>
<tr><th>Adverse Event</th><th>Action to be taken</th><th>By whom</th></tr>
</table>
</td></tr>
</table>

comprehensive list (including rare and very rare adverse effects), or if significance of possible adverse event uncertain, consult Summary of Product Characteristics or BNF	Localised discomfort at needle site		
	Nodules formation at needle or infusion site. Usually asymptomatic but may persist in patients on high doses. Severe nodule formation may lead to worsening of symptoms due to erratic absorption of Apomorphine	Rotate injection site. Massage to injection sites is recognised to reduce nodule formation. Ultrasound therapy has been anecdotally said to alleviate severe nodule formation Anecdotally Hirudoid cream can be used on nodules	Patient / carer
	Nausea & vomiting. Usually transient and resolved within 6-8 weeks	Treatment with Domperidone 20mg oral TDS daily, 72 hours before and during Apomorphine therapy is essential (or via rectal administration, dose as per BNF).Once treatment has been established Domperidone* therapy may be gradually reduced and can be successfully discontinued in most patients within 6-8 weeks * please refer to latest recommendations for Domperidone Where Domperidone is contraindicated, consider requesting secondary care to prescribe Ondansetron (oral,rectal, IV, IM) rectal, IV, IM),.	GP as advised by Consultant / PDNS Secondary care will prescribe Ondansetron as it is a red drug
	Allergic reactions including bronchospasm and anaphylaxis (due to sodium bisulphate)	Withhold and discuss with Consultant/PDNS	GP
	Light-headedness	Discuss with Consultant /PDNS	GP
	Postural hypotension is seen infrequently and is usually	Care should be exercised in patients with pre-existing cardiac disease or in	GP

	transient	patients taking vasoactive medicinal products such as antihypertensives, and in patients with pre-existing postural hypotension.	
	Dyskinesias during 'On' periods	Discuss with Consultant /PDNS	GP
	Coombs' positive Haemolytic anaemia	Coombs' test is carried out at baseline. If positive, the patient should have a further blood screen of the same parameters after one month's treatment and then have haemoglobin and reticulocyte count at 6 monthly hospital visits from then on but no requirement to keep doing Coombs' tests	Consultant/PDNS as required
	Eosinophilia in up to 10% of patients	Discuss with Consultant /PDNS	GP
	Dopamine dysregulation syndrome / Neuropsychiatric complications – hallucinations, euphoria, increased libido, confusion, personality changes, agitation, restlessness, psychosis, sleep disturbances, pathological gambling and over eating	Discuss with Consultant /PDNS	GP
	Sedation. Usually transient	Advise patients not to drive / operate machinery if affected. If persists discuss with Consultant / PDNS	GP
	Any adverse reaction to a black triangle drug or serious reaction to an established drug should be reported to the MHRA via the "Yellow Card" scheme.		
8.Baseline investigations	Baseline assessment should include lying and standing blood pressure, haemoglobin, reticulocyte count and a Coombs' test, which will be carried out by secondary care No requirement for ECGs on patients unless there is a history of cardiac dysrhythmia or severe ischaemic heart disease, if required secondary care will arrange. The patient should have a further blood screen of the same parameters after one month's treatment and then have haemoglobin and reticulocyte count at 6		

<table>
<tr><td></td><td colspan="5">monthly hospital visit from then on but no requirement to keep doing Coombs tests</td></tr>
<tr><td rowspan="3">9. Ongoing monitoring requirements to be undertaken by GP</td><td colspan="3">Is monitoring required?</td><td colspan="2">Yes or No (if yes complete following section)</td></tr>
<tr><td>Monitoring</td><td>Frequency</td><td>Results</td><td>Action</td><td>By whom</td></tr>
<tr><td>FBC</td><td>6 monthly</td><td>Communicated to Consultant/PDNS</td><td>Communicated to Consultant/PDNS</td><td>GP</td></tr>
<tr><td>10. Pharmaceutical aspects</td><td colspan="5">Do not store above 25°C. Store in the original package. Do not use if the solution has turned green. The solution should be inspected visually prior to use. Only clear, colourless solutions should be used</td></tr>
<tr><td rowspan="2">11. Secondary care contact information</td><td colspan="5">If advice is required please contact:
Parkinson’s Nurse Team:
Carol Miller Phone: 0161 206 1887
Patsy Cotton Phone: 0161 206 2438
Lucy Partington Jones Phone: 0161 206 2438
Between Monday and Friday

Acute Neurology Ward, Hope Hospital
Phone: 0161 206 4586
Open seven days a week.

Pharmacy Medicines Information Phone: 0161 206 5223
Between 9am and 5pm Monday to Friday
Apomorphine must not be stopped without seeking advice:</td></tr>
<tr><td colspan="5">Genus Pharmaceuticals 24/7 helpline for any problems with the Apomorphine PFS/Pump or PEN: 0844 880 1327</td></tr>
<tr><td>12. Criteria for shared care</td><td colspan="5">Prescribing responsibility will only be transferred when
• Treatment is for a specified indication and duration.
• Treatment has been initiated and established by the secondary care specialist.
• The patient’s initial reaction to and progress on the drug is satisfactory.
• The GP has agreed/not objected in each individual case that shared care is appropriate.
The patient’s general physical, mental and social circumstances are such that he/she would benefit from shared care arrangements</td></tr>
<tr><td>13. Responsibilities of initiating specialist: Consultant/PDNS</td><td colspan="5">• Patient suitability/selection
• Provision of information to patient & primary care team regarding Apomorphine therapy.
• Baseline tests as described above
• Provision of information to patient, carer (video, DVD and written material)
• To arrange prescription for /prescribe Domperidone* 20mg oral TDS daily, 72 hours prior to initiation/challenge of Apomorphine
• Arrange Apomorphine challenge/initiation within outpatient clinic, community</td></tr>
</table>

	setting or hospital inpatient clinic • Provide patient/carer education and training • Provision of information to primary care team • Arrange infusion pump training for District Nurses • Advise District Nurse as required on dose and titration • Agree with GP responsibility for 6 monthly FBC if required • Optimisation and evaluation of medication • Monitor and evaluate potential adverse drug reactions • Provision of information and support to patient, carers and primary care team as appropriate • Provide point of contact for community team and patients • Monitor blood results • Provide clear, documented advice about changes if necessary * please refer to latest recommendations for Domperidone
14. Responsibilities of the GP and District Nurses	**GPs:** • Reply to request for shared care within 14 days • Prescribe ongoing Apomorphine and any concomitant therapy i.e. Domperidone (FP10s). • Report side effects or issues relating to Apomorphine treatment to PDNS/treating Consultant • 6 monthly FBCs is advised by PDNS **District Nurses** • Provision of dressings, lines and sharps bins (if Homecare not applicable) • Supervision and support as required • Inform PDNS/GP/treating Consultant of any problems • Report side effects or issues relating to Apomorphine treatment to PDNS/treating Consultant and GP • Maintain appropriate level of knowledge and skills.
15. Responsibilities of the patient	• Collects prescription as per practices repeat prescription procedure for dispensing at community pharmacy • Attend Outpatient and GP appointments • Attend appointments for blood tests • Report concerns to GPs / PDNS / Specialist **NB: Ongoing prescribing will depend on attendance at clinics as requested by the clinicians**
16. Supporting documentation	The SCP must be accompanied by a patient information leaflet.
17. Patient monitoring booklet	N/A
18. Shared care agreement form	Attached below

FLOWCHART DEMONSTRATING THE USE OF APOMORPHINE IN PARKINSON'S DISEASE SHARED CARE PROTOCOL

Consultant / Parkinson's Disease Nurse Specialist (PDNS):

- For unclear diagnosis of idiopathic Parkinson's, refer patient to centre
- Patient suitability/selection
- Provision of information to patient & primary care team regarding Apomorphine therapy.

Primary Care Agreement:

- GP agrees to take the part in Shared Care and faxes acknowledgement slip to PDNS/Consultant as advised in covering letter within 14 days or implied consent applies (see Appendix for Form)

PDNS:

- Provision of information, education and training to patient, carer (video, DVD and written material)
- To arrange/prescribe domperidone* 20mg oral TDS daily, 72 hours prior to challenge/initiation of Apomorphine (or via rectal administration, dose as per BNF) (* please refer to latest recommendations for domperidone)
- Arrange Apomorphine challenge/initiation within outpatient clinic, community or hospital setting
- Provide patient/carer education and training
- Provision of information to primary care team
- Arrange infusion pump training for District Nurses
- Advise District Nurse as required on dose and titration
- Agree with GP responsibility for 6 monthly FBC if required

Primary Care:

GPs:

- Reply to request for shared care
- Prescribe ongoing Apomorphine & any concomitant therapy i.e. domperidone (FP10s). Provide prescriptions to Homecare Company if Homecare applicable
- Report side effects or issues relating to apomorphine treatment to PDNS/treating Consultant
- 6 monthly FBCs is advised by PDNS

District Nurses

- Provision of dressings, lines and sharps bins (if Homecare not applicable)
- Supervision and support as required
- Inform PDNS/GP/treating Consultant of any problems
- Report side effects or issues relating to apomorphine treatment to PDNS/treating

Pharmaceutical Company Nurse Advisors (if appropriate and applicable):

- Ongoing communication with PDNS/treating Consultant including documented communication about contact with patient and/or advised medication changes
- Work alongside all health care professionals in both primary and secondary

Homecare Delivery (if applicable):

- Prescription management & liaison with GP for repeats
- Direct delivery of Apomorphine and associated disposables to patient
- Removal and replacement of sharps bins

Patient (if Homecare not applicable):

- Collects prescription as per practices repeat prescription procedure for dispensing at community pharmacy
- Attend Outpatient and GP appointments
- Attend appointments for blood tests
- Report concerns to GPs / PDNS / Specialist
- NB: Ongoing prescribing will depend on attendance at clinics as requested by the clinicians

ONGOING CARE

Consultant / PDNS:

- Optimisation and evaluation of medication
- Monitor and evaluate potential adverse drug reactions
- Provision of information and support to patient, carers and primary care team as appropriate
- Provide point of contact for community team and patients
- Monitor blood results
- Provide clear, documented advice about changes if necessary

Appendix 1

Shared Care Agreement Letter and GP acknowledgement slip

Please complete information below and fax back to [insert fax number] within 14 days or implied consent applies

[insert patient's name and identifier such as DOB] is being considered for admission to hospital for an assessment of their response to Apomorphine in order to try and manage the symptoms of their Parkinson's Disease more effectively.
This medication would be administered via an intermittent subcutaneous infusion and may require the ongoing support of the District Nurses.
If this method of treatment should prove to be successful, the Apomorphine would need to be prescribed by yourself when your patient is discharged.
If you have any queries regarding this medication and its administration or if there is any reason why you do not wish this treatment to be undertaken, could you please contact myself, Dr *[insert Dr's name]* or Dr *[insert Dr's name]'s* secretary within the next seven days.
I will be happy to respond to any of your questions at any time.

Please find enclosed the Greater Manchester Interface Prescribing Group Apomorphine Shared Care Protocol and a DVD for your information.

Prior to Apomorphine treatment it is essential to pre-treat with Domperidone, 20mg oral TDS daily, 72 hours prior to admission. We would be grateful if you could provide your patient with this please.

Kind regards

Yours sincerely,

[insert PDNS' signature] *[insert Consultant's signature]*

[insert PDNS' name]
PARKINSON'S DISEASE SPECIALIST NURSE

Dr *[insert Dr's name]*
Consultant *[insert Dr's role]*

GP Response

Patient

Identifier (D.O.B or address)

I have received your request for shared care of this patient who has been advised to start *Apomorphine.*

A I am willing to undertake shared care for this patient as set out in the protocol
B I wish to discuss this request with you
C I am unable to undertake shared care of this patient.

GP signature: Date:

GP address/practice stamp:

APPENDIX 2

Patient Information Letter

Dear *[insert patient's name],*

As you are aware Dr *[insert Dr's name]* wants you to come in for treatment with Apomorphine.

To prevent the Apomorphine from producing sickness, we would like you to take the anti-sickness tablet Domperidone, 20mg three times daily, starting three days before your admission date.

We have written to your GP accordingly, so that you can collect a prescription.

If you have any queries please contact *[insert contact name and details],*

Kind regards

Yours sincerely

[insert PDNS' signature] *[insert Consultant's signature]*

[insert PDNS' name]
Parkinson's Disease Specialist Nurse

Dr *[insert Dr's name]*
Consultant *[insert Dr's role]*

APPENDIX 3

Discharge Form for GP
Copy to be given to patient

Dear Dr *[insert Doctors name here]*

Patient name: *[insert Patients name here]*
Date of birth: *[insert date of birth]*
Diagnosis: *[insert diagnosis here]*

This patient is suitable for treatment with Apomorphine (Apomorphine) for the treatment of Parkinson's

This drug has been accepted for Shared Care

Treatment was started on *[insert date started]*

- Dose is set at: *[insert dose mg/hr]*
- Flow rate: *[insert flow rate]*
- Syringe setting: *[insert 10ml or 20ml]*
- Bolus setting: *[insert bolus setting]*
- Time:
  - From: *[insert time]*
  - To: *[insert time]*

The patient was discharged with *[insert number of days of medication]* supply of Apomorphine

Please undertake prescribing and haemoglobin and reticulocyte count at 6 monthly intervals from *[insert date]*

Next review with this department: *[insert date]*

You will be sent a written summary within 14 days. The medical staff of the department are available at all times to give you advice.

The patient will not be discharged from out-patient follow-up while taking *[insert text here]*.

Ongoing prescribing will depend on attendance at clinics as requested by the clinicians

The Consultant or PDNS is responsible for any dose adjustment

Thank you.

Yours sincerely,

[insert Specialist signature]

[insert Specialist name and role]

Explanation of Terms Used

Not applicable.

References

Not applicable

Endorsed by:		
Name of Lead Clinician/Manager or Committee Chair	**Position of Endorser or Name of Endorsing Committee**	**Date**
Dr. Mark Kellett	Clinical Lead, Neurology	May 2013
Dr John MacDonald	Chair of SRFT Medicines Management Group	May 2013
Peter Jones	Head of Medicines Management Salford PCT	May 2013
Dr John MacDonald	SRFT Medicines Management Chair	May 2013

*** Please note – this protocol has been completely re-written. Please contact the authors of the policy if further information is Required ***

Record of Changes to Document - Issue number: 2				
Changes approved in this document by - MMG			Date: May 2013	
Section Number	Amendment (***shown in bold italics)***	Deletion	Addition	Reason

Screening Equality Analysis Outcomes (Policies/Procedures)

The Trust is required to ensure that all our policies/procedures meet the requirements of its service users, that it is accessible to all relevant groups and **furthers the aims of the Equality Duty for all protected groups by age, religion/belief, race, disability, sex, sexual orientation, marital status/civil partnership, pregnancy/maternity, gender re-assignment. Due consideration may also be given to carers & socio/economic.**

Have you been trained to carryout this assessment? YES **If 'no' contact Equality Team 62598 for details.**	
Name of policy or document : **: Shared care guideline for Apomorphine use in Parkinson's Disease.** **Key aims/objectives of policy/document (impact on both staff & service users):** To support the safe prescribing and monitoring of Apomorphine in patients with Parkinson's Disease. The guidelines are intended for use by the Neurology team at Salford Royal NHS Foundation Trust, and any GP who has responsibility for the care of such patients.	
1) a) Whom is this document or policy aimed at?	1a) The neurology team at SRFT and Primary Care Physicians
2) a) Is there any evidence to suggest that your 'end users' have different <u>needs</u> in relation to this policy or document; (e.g.health/employment inequality outcomes) (**NB If you do not have any evidence you should put in section 8 how you will start to review this data)**	2a) No
3) a) Does the document require any decision to be made which could result in some individuals receiving different treatment, care, outcomes to other groups/individuals?	3a) No
b) If yes, on what basis would this decision be made? **(It must be objectively justified)**	3b)
4) a) Have you included where you may need to make reasonable adjustments for disabled users or staff to ensure they receive the same outcomes to other groups ?	4a) Yes

5) a) Have you undertaken any consultation/involvement with service users or other groups in relation to this document?	5a) NHS Salford
b) If yes, what format did this take? face/face or questionnaire? (please provide details of this)	5b) face to face meeting (MMG)
c)Has any amendments been made as a result?	5c) No
6) a) Are you aware of any complaints from service users in relation to this policy?	6a) No
b) If yes, how was the issue resolved? Has this policy been amended as a result?	6b)

7) a) To summarise; is there any evidence to indicate that any groups listed below receive different outcomes in relation to this document?

	Yes		No	unsure
	Positive	Negative*		
Age			No	
Disability			No	
Sex			No	
Race			No	
Religion & Belief			No	
Sexual orientation			No	
Pregnancy & Maternity			No	
Marital status/civil partnership			No	
Gender Reassignment			No	
Carers *1			No	
Socio/economic2**			No	

1: That these two categories are not classed as protected groups under the Equality Act.
2: Care must be taken when giving due consideration to socio/economic group that we do
not inadvertently discriminate against groups with protected characteristics

Negative Impacts
*If any negative impacts have been identified you must either a) state below how you have eliminated these within the policy or b) conduct a full impact assessment:

8) How will the future outcomes of this policy be monitored?

9) **If any negative impact has been highlighted by this assessment, you will need to undertake a full equality impact assessment:**

Will this policy require a full impact assessment? No
(if yes please Contact Equality Officer on 206 7204, for further guidance)

High/Medium/Low Typed E Wilson, Clinical Pharmacist
date: 13th June 2013