Management of Acute Pancreatitis in Adults Clinical Guideline

V4.0

March 2020
Summary - Acute Pancreatitis Treatment Pathway

**Definition**
2 out of 3 of the following criteria:-
1) **Clinical:** Upper abdominal pain
2) **Laboratory:** Serum amylase > 3 times of upper normal limit
3) **Imaging:** Imaging proven (CT/MRI/USS)

**Detailed History & Examination**
- Previous pancreatitis
- History of gallstones
- Alcohol history
- Medication and drug intake
- Hyperlipidaemia
- Trauma
- Recent intervention (eg. ERCP)
- Co-morbidities (respiratory, cardiac, diabetes, high BMI)
- Family history

**Investigations**
- a) FBC, U+Es, LFTs, amylase, CRP, clotting, calcium and triglycerides +/- blood cultures.
- b) Consider arterial blood gas (to assess hypoxia or metabolic acidosis)
- c) Chest X-Ray (assess for effusion or ARDS)
- d) Upper abdominal ultrasound (assess aetiology)

**Immediate Management**

A  Ensure patent airway

B  **Oxygen** – target 94-98% saturation (88-92% if COPD)

C  **Intravenous fluids**
- Hartmanns solution
- Administer 30ml/kg for hypotension or lactate≥4mmol/l
- 5-10mls/kg/h first 24 hours until goals met
- Goals to meet :-
  - Heart rate <120/min
  - Mean arterial pressure = 65-85mmHg
  - Urine output = 0.5-1ml/kg/h

  Hourly urine output monitoring & consider urinary catheter

D/E  Nil by mouth initially
  Antibiotics – RARELY indicated. See below (section 2)
  **Nasogastric tube** – Only if vomiting or ileus suspected
Is Systemic Inflammatory Response Syndrome (SIRS) present?
- Any 2 of the following:
  - Respiratory rate > 20
  - Heart rate > 90
  - WCC < 4 or > 12
  - Temp < 36°C or > 38°C

Presence of SIRS on admission is a predictor of SEVERE pancreatitis and requires senior surgical review and discussion with ITU outreach.

Urgent senior surgical & ITU outreach review if any of below:

<table>
<thead>
<tr>
<th>Clinical signs</th>
<th>Bloods</th>
</tr>
</thead>
<tbody>
<tr>
<td>A: Airway not maintained</td>
<td>pH &lt; 7.1 or &gt; 7.7</td>
</tr>
<tr>
<td>B: Resp. rate &gt; 35/min</td>
<td>Sodium &lt; 110 or &gt; 170 mmol/l</td>
</tr>
<tr>
<td>B: Resp. rate &gt; 35/min</td>
<td>Potassium &lt; 2.0 or &gt; 7.0 mmol/l</td>
</tr>
<tr>
<td>B: Resp. rate &gt; 35/min</td>
<td>paO2 &lt; 6.7 kPa</td>
</tr>
<tr>
<td>C: HR &lt; 40 or &gt; 150/min</td>
<td>Calcium &gt; 3.75 mmol/l</td>
</tr>
<tr>
<td>C: HR &lt; 40 or &gt; 150/min</td>
<td>Glucose &gt; 44.4 mmol/l</td>
</tr>
<tr>
<td>C: HR &lt; 40 or &gt; 150/min</td>
<td>Systolic blood pressure &lt; 80 mmHg</td>
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<tr>
<td>C: HR &lt; 40 or &gt; 150/min</td>
<td>MAP &lt; 60 mmHg</td>
</tr>
<tr>
<td>C: HR &lt; 40 or &gt; 150/min</td>
<td>Diastolic blood pressure &gt; 120 mmHg</td>
</tr>
<tr>
<td>C: HR &lt; 40 or &gt; 150/min</td>
<td>Anuria</td>
</tr>
<tr>
<td>D: Coma (GCS &lt; 8)</td>
<td>Severity grading</td>
</tr>
<tr>
<td>D: Coma (GCS &lt; 8)</td>
<td>Severe pancreatitis</td>
</tr>
</tbody>
</table>

Severity Assessment (ATLANTA classification) – Assess at admission, 24 hours and 48 hours.

Severe: Persistent (> 48 hrs) organ failure*, local complications (e.g. necrosis, peripancreatic fluid collections, pseudocyst, splenic & portal vein thromboses) or exacerbation of coexistent disease

Moderate severe: As above but transient only (< 48 hours)

Mild: No organ failure, local complications or exacerbation of coexistent disease

NB: If SIRS or organ failure present at admission then classify as SEVERE. If resolved at 48 hours can be reclassified as moderately severe.

Consideration of HDU involvement where:
- Persistent SIRS > 48 h
- Elderly (aged > 70 yrs)
- Obese (BMI > 35)
- Moderately severe pancreatitis

* Organ failure definitions:
  - Cardiovascular: Hypotension requiring inotropes
  - Respiratory: Type 1 or 2 respiratory failure
  - Renal: Oliguria or creatinine > 177 µmol/L
  - Hepatic: INR > 1.5
  - Haematological: Platelets < 100 (10^9/L)
  - Neuro: Impaired consciousness
1. **Aim/Purpose of this Guideline**

1.1. This guideline is for the management of acute pancreatitis in adults. It has been benchmarked against national guidelines to provide a detailed guidance of clinical management of acute pancreatitis in line with best practice guidelines. This guideline applies to all healthcare professionals involved in the treatment of acute pancreatitis.

1.2. This version supersedes any previous versions of this document.

1.3. **Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation**

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

2. **The Guidance**

2.1. **Initial Management**

All patients should initially be admitted under the acute general surgical team on their index admission **UNLESS** known chronic alcohol-related pancreatitis without significant amylase rise, local complications or requirement for continuous patient controlled intravenous opiates (PCA) – these patients should instead be admitted under the medical gastroenterology team.

2.2. **Subsequent Management**

2.2.1. **ALL** inpatients with diagnosed acute gallstone pancreatitis will be subsequently referred to the **Upper GI Surgery team** using the Maxims internal referral system ‘Acute Gallstone Pancreatitis Inpatient Service’

2.2.2. Information relating to the patient’s medical history and results of biochemical studies and radiology should be available

2.2.3. Referrals will be reviewed each weekday morning on the daily upper GI surgery ward round and patients’ ongoing care taken over by the upper GI surgery team
2.2.4. Where patients are admitted over a weekend it is expected that they will stay in hospital for upper GI review on Monday, or if over a bank holiday weekend, for review on the next normal working day.

2.2.5. Since all referrals are recorded on the Maxims referral system, where patients take their own discharge against medical advice, these patients will be contacted by telephone and both the GP and patient contacted by post.

2.2.6. Inpatients will be reviewed within 24 hours of referral on a weekday.

2.2.7. Where a more expeditious review is required the referring team should contact the upper GI surgery team directly through switchboard.

2.3. **Antibiotic Therapy**

2.3.1. Antibiotics should **NOT** be routinely given to patients with pancreatitis, even in the presence of necrosis, except in these circumstances:

- Extra-pancreatic infection (e.g. pneumonia, urinary tract infection)
- Suspected cholangitis
- USS proven cholecystitis
- Suspected INFECTED pancreatic necrosis

2.3.2. Extra-pancreatic infection
Treat according to source of infection as per Trust antimicrobial guidelines.

2.3.3. Cholangitis / cholecystitis
- Amoxicillin IV 500mg 8 hourly + Gentamicin
- Add metronidazole IV 500mg 8 hourly if empyema or anaerobes suspected
- If penicillin allergy: Vancomycin + Gentamicin +/- metronidazole

2.3.4. Infected Pancreatic Necrosis
Meropenem IV 1g 8 hourly

2.4. **Imaging**

2.4.1. Gold standard first line investigation is USS abdomen

2.4.2. CT indications:

- Diagnostic uncertainty
- Failure to respond to initial treatment or clinical deterioration (Optimal timing for CT is AT LEAST 72-96 hours after onset of symptoms)

2.4.3. MRCP
This is only indicated in patients with abnormal LFTs and common bile duct dilatation that either progressively worsen or fail to settle, where a common bile duct stone is suspected.
2.5. Nutrition

- Oral nutrition is safe to start in mild pancreatitis once abdominal pain settling and inflammatory markers improving, or within 72 hours in severe or moderately severe pancreatitis unless vomiting.
- Enteral feeding is the gold standard for feeding in moderately severe/severe acute pancreatitis.
- Nasogastric tube feeding is tolerated in most patients as first line.
- Nasojejunal feeding is reserved for those unable to tolerate nasogastric feed.
- Parenteral nutrition should only be used as a second line where nasojejunal feed not tolerated.
- CREON – this should be considered in patients with diarrhoea where pancreatic insufficiency suspected and/or faecal elastase abnormal.

2.6. Use of ERCP and PTC for biliary drainage

2.6.1. Inpatient biliary drainage by ERCP or PTC (percutaneous transhepatic cholangiopancreatography) should be considered for:

- Severe gallstone pancreatitis with cholangitis (URGENT <24h)
- Gallstone pancreatitis with obstructing common bile duct stone, where surgical bile duct exploration not considered appropriate.
- Gallstone pancreatitis with non-obstructing common bile duct stone, where surgical bile duct exploration not considered appropriate.

2.7. Outpatient elective biliary drainage with ERCP should be considered for:

- Gallstone pancreatitis with non-obstructing common bile duct stone where not technically achievable during the index admission due to pancreatic swelling and surgical bile duct exploration not considered appropriate.
- Definitive treatment for gallstone pancreatitis where not surgically fit.

2.7.1. All requests for ERCP should be discussed with a Consultant gastroenterologist specialising in ERCP. All requests for PTC should be discussed with a Consultant interventional radiologist.

2.7.2. NB Patients with gallstone pancreatitis, who underwent ERCP and are fit for surgery, should have a cholecystectomy, as ERCP doesn’t prevent recurrence of cholecystitis or biliary colic.

2.8. Intervention in necrotising pancreatitis

2.8.1. Fine needle aspiration is NOT indicated routinely because clinical and imaging signs are accurate predictors of infected necrosis in the majority.

2.8.2. Endoscopic intervention should be used first line if available.

2.8.3. Image-guided percutaneous drainage should be used where endoscopic drainage is not available.
2.8.4. Surgical necrosectomy should be reserved for treatment failure once above measures trialled.

2.9. Indications for intervention (endoscopic / radiological / surgical) include:

- Clinical suspicion of, or documented, infected necrosis with clinical deterioration and once walled-off (wait at least 4 weeks from onset of pancreatitis)
- Ongoing organ failure for several weeks in absence of infected necrosis but walled off (wait at least 4 weeks)
- Ongoing gastric outlet, intestinal or biliary obstruction due to mass effect (ideally >4-8 weeks after onset of pancreatitis)
- Disrupted pancreatic duct (ideally >8 weeks after onset of pancreatitis)
- Persistent symptoms in walled off necrosis without infection (ideally > 8 weeks)

2.10. Discussion with hepatopancreaticobiliary unit

2.10.1. Consider discussion with the regional HPB centre at Derriford Hospital in patients with severe, necrotising, infective or haemorrhagic pancreatitis, that fail to respond to first line endoscopic and/or radiological treatment, or in whom surgical necrosectomy is being considered, or with pancreatic ascites & pleural effusion.

2.10.2. Paediatric patients with pancreatitis – consider discussion with Bristol Children’s Hospital

2.11. Pseudocysts

2.11.1. Offer EUS-guided drainage, or endoscopic transpapillary drainage for pancreatic head pseudocysts, to people with symptomatic pseudocysts (for example, those with pain, vomiting or weight loss).

2.11.2. Consider EUS-guided drainage, or endoscopic transpapillary drainage for pancreatic head pseudocysts, for people with non-symptomatic pseudocysts that meet 1 or more of the following criteria:

- they are associated with pancreatic duct disruption
- they are creating pressure on large vessels or the diaphragm
- they are at risk of rupture
- there is suspicion of infection.

2.11.3. Consider surgical (laparoscopic or open) drainage of pseudocysts that need intervention if endoscopic therapy is unsuitable or has failed.

2.12. Timing of cholecystectomy

2.12.1. The indication for and appropriate timing of surgery, outpatient review or other investigations will be decided & documented in the notes by the upper GI surgery team. In general:
- For mild biliary pancreatitis, cholecystectomy with on-table cholangiogram should be performed during the index admission or within two weeks of admission.
- In patients with moderately severe/severe acute pancreatitis with peripancreatic collections, cholecystectomy with on-table cholangiogram should be delayed until the collections either resolve or persist beyond 6 weeks.

2.12.2. Where surgery is deemed appropriate during the index admission:

Arrangements will be made with the CEPOD theatre list coordinator and the patient’s details entered into the electronic CEPOD theatre booking system.

2.12.3. Where surgery is deemed appropriate within 2 weeks of inpatient admission:

- An assessment of suitability for West Cornwall or Royal Cornwall Hospital will be made by the upper GI surgery team. Where uncertainty exists, the CEPOD anaesthetist will assess the patient and make that decision.
- All patients must have a Group and Screen prior to discharge.
- The patient will be placed on the ‘add to waiting list’ electronic referral system, to maintain an electronic record, with the date of surgery documented in order to ensure that pre-operative assessment clinic (POAC) can triage the need for further tests, or book face to face assessment.
- The patient will be informed of the proposed date of surgery prior to discharge.

2.12.4. Where surgery should be delayed longer than 2 weeks for clinical reasons, the patient will, dependent on the advice of the upper GI surgeon, either:

- Have an outpatient clinic appointment booked within 6 weeks of discharge and the date will be made available to the patient prior to discharge OR
- Have a suitable date for surgery arranged, the patient informed of this prior to discharge and an ‘add to waiting list’ electronic form completed (including this date of surgery), enabling the Pre-Operative Assessment Clinic (POAC) to identify the need for further triage or face to face review prior to surgery.

2.12.5. During a week where there is no Consultant upper GI surgeon either on call or covering the CEPOD list:

- It is expected that those patients requiring surgery during their index admission will instead undergo surgery on a planned ‘hot gallbladder list’ on Friday morning delivered by an upper GI surgeon. Patients will be booked for this by completing an ‘add to waiting list’ form.
- Where deemed appropriate to undergo surgery within 2 weeks of admission, patients will be assessed for suitability for WCH or RCH by the upper GI surgeon and if necessary by the CEPOD anaesthetist, with surgery performed either on a Friday morning 'hot gallbladder list' or WCH day case operating list. An ‘add to waiting list’ form will be completed as part of this process.

2.13. Idiopathic pancreatitis - investigation

2.13.1. If gallstones and alcohol have been excluded as the cause, investigate other possible causes such as:

- Metabolic causes (such as hypercalcaemia or hyperlipidaemia)
- Prescription drugs
- Microlithiasis
- Hereditary causes
- Autoimmune pancreatitis
- Ampullary or pancreatic tumours
- Anatomical anomalies (pancreas divisum).

2.13.2. In patients where no aetiology has been identified, the following investigations should be performed in sequential order:

1. Repeat abdominal USS (at 6 weeks)
2. If no gallstones then for IgG4 – to exclude autoimmune pancreatitis
3. If above normal then for MRCP
4. If above normal then for endoluminal ultrasound (EUS)
5. If above normal consider hereditary causes through genetic testing

2.14. Alcohol-related pancreatitis

2.14.1. **ALL** patients require assessment of harmful drinking and alcohol dependence

2.14.2. Support should be provided for alcohol cessation

2.14.3. For **acute** alcohol-related pancreatitis treat according to above pathway

2.14.4. For **chronic** alcohol-related pancreatitis diagnosis requires:

- Person's symptoms
- Imaging to determine pancreatic structure (CT scan first line investigation)
- Tests of pancreatic exocrine and endocrine function

2.14.5. If steatorrhoea or poor nutrition – for pancreatic enzyme supplements (e.g. Creon)
2.14.6. If pain only symptom – no enzyme supplements

2.14.7. Patients with pain:

- Offer surgery if large duct (obstructive) pancreatitis
- Offer coeliac plexus block, splanchnicectomy or surgery if small duct (non-obstructive) chronic pancreatitis and pain poorly controlled

2.15. Patient Information

All patients should receive written and verbal information regarding pancreatitis. The Trust’s ‘Pancreatitis’ information leaflet should be provided.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Management of Acute Pancreatitis in Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Mr Michael Clarke</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit and review tool using patient documentation.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Adult acute pancreatitis patients who are reviewed by specialist teams. Audit 6 monthly</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Involved specialties governance committees. Repeated non-compliance to be reported via Datix.</td>
</tr>
</tbody>
</table>
| Acting on recommendations and Lead(s) | **Hospital Working Group**  
Michael Clarke (Consultant upper GI surgeon) - Chair  
Mohamed Abdelrahman (ST3 General Surgery)  
Ian Finlay (Consultant upper GI surgeon)  
Hyder Hussaini (Consultant gastroenterologist)  
Bill Stableforth (Consultant gastroenterologist)  
Madeline Strugnell (Consultant radiologist)  
Dushyant Shetty (Consultant radiologist)  
John Hancock (Consultant interventional radiologist)  
Mike Spivey (Consultant in Intensive Care)  
Jog Simantini (Consultant microbiologist)  
Neil Powell (Consultant microbiologist) |
| Change in practice and lessons to be shared | Required changes to practice will be identified and actioned within 6 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons learned or changes to practice will be shared with all stakeholders. |

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Inclusion & Human Rights Policy’ or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Management of Acute Pancreatitis in Adults Clinical Guideline V4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>11th June 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>March 2020</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>March 2023</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Mr Michael Clarke (Consultant Upper GI and Bariatric Surgeon)</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252373</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline is for the management of acute pancreatitis in adults. This guideline applies to all healthcare professionals involved in the treatment of acute pancreatitis.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Pancreatitis</td>
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<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>11th June 2019</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical Guideline for Management of acute pancreatitis in Adults V3.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Audit and Gastroenterology Governance Meeting</td>
</tr>
<tr>
<td>Care Group General Manager confirming approval processes</td>
<td>Roz Davies</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name: Suzanne Atkinson</td>
<td></td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
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<tr>
<td>🟢 Intranet Only</td>
<td></td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / General Surgery</td>
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Links to key external standards

<table>
<thead>
<tr>
<th>Related Documents:</th>
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<tbody>
<tr>
<td>4. NICE. Pancreatitis. 2018</td>
</tr>
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Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>01 09 15</td>
<td>V1.0</td>
<td>Draft for consultation</td>
<td>Michael Clarke – Consultant Upper GI and Bariatric Surgeon</td>
</tr>
<tr>
<td>23 Feb 16</td>
<td>V2.0</td>
<td>Approved for implementation</td>
<td>Michael Clarke – Consultant Upper GI and Bariatric Surgeon</td>
</tr>
<tr>
<td>18/05/17</td>
<td>V3</td>
<td>Incorporated changes regarding subsequent ownership of patients as well as timing of cholecystectomy</td>
<td>Michael Clarke Consultant Upper GI Surgeon</td>
</tr>
<tr>
<td>25/06/19</td>
<td>V4</td>
<td>Updated reference 4 (NICE. Pancreatitis 2018), section 4 on nutrition (&lt;72 hrs in severe or moderately severe), section 6 (endoscopic drainage first line for infected necrosis), section 7 (discussion of haemorrhagic pancreatitis and paediatric with specialist centre), new section 8 on pseudocysts, adjusted investigation section 10, section 11 (support provided for alcohol cessation), new section 12 (patient info leaflet), change wording flowchart ('consider' ABG and urinary catheter), section 1 responsible specialty (rather than ownership)</td>
<td>Ji Tham (upper GI registrar) &amp; Michael Clarke Consultant Upper GI Surgeon</td>
</tr>
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### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Management of Acute Pancreatitis in Adults Clinical Guideline V4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>General Surgery</td>
</tr>
<tr>
<td><strong>New or existing document:</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Mr Michael Clarke</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 252373</td>
</tr>
</tbody>
</table>

1. **Policy Aim**
   
   **Who is the strategy / policy / proposal / service function aimed at?**
   
   To provide detailed guidance on the clinical management of acute pancreatitis in line with best practice guidelines.

2. **Policy Objectives**
   
   - To provide a consistent approach to the management of acute pancreatitis at RCHT sites.
   - To maintain patient safety and improve outcomes for patients experiencing acute pancreatitis whilst inpatients at RCHT sites.

3. **Policy – intended Outcomes**
   
   - Consistent management of acute pancreatitis at RCHT sites.
   - Prompt and safe management of acute pancreatitis and follow up care.

4. **How will you measure the outcome?**
   
   - Audit
   - Datix Reporting
   - Review of nursing/ medical documentation as required

5. **Who is intended to benefit from the policy?**
   
   All patients who experience acute pancreatitis in hospital at RCHT sites.

6a. **Who did you consult with?**

   - **Workforce**
   - Patients
   - Local groups
   - External organisations
   - Other
   - X

   **Please record specific names of groups**
   
   - General surgery team (Audit meeting). Consultants (Radiology, Gastroenterology, Microbiology, Intensive care)

   **What was the outcome of the consultation?**
   
   Agreed

7. **The Impact**

   Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

<table>
<thead>
<tr>
<th>Equality Strands</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td><strong>Are there concerns that the policy could have differential impact on:</strong></td>
<td></td>
<td></td>
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Management of Acute Pancreatitis in Adults Clinical Guideline V4.0

Page 14 of 15
<table>
<thead>
<tr>
<th>Age</th>
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</thead>
<tbody>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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<tr>
<td>Race / Ethnic communities /groups</td>
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<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>X</td>
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<tr>
<td>Religion / other beliefs</td>
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<td>Marriage and Civil partnership</td>
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<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   | Yes | No | X |

9. If you are not recommending a Full Impact assessment please explain why.

Not indicated

<table>
<thead>
<tr>
<th>Date of completion and submission</th>
<th>25/06/19</th>
<th>Members approving screening assessment</th>
<th>Policy Review Group (PRG)</th>
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</thead>
</table>

This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.