Chronic Kidney Disease (CKD) in Adults
Clinical Guideline
V4.0
October 2018
Summary (Algorithm A) Identifying Patients with CKD, and which investigations should follow.

Identification of CKD

Offer testing for CKD using eGFR/creatinine and ACR to people with any of the following risk factors:
- diabetes
- hypertension
- acute kidney injury
- cardiovascular disease (ischaemic heart disease, chronic heart failure, peripheral vascular disease or cerebral vascular disease)
- structural renal tract disease, recurrent renal calculi or prostate hypertrophy
- multisystem diseases with potential kidney involvement - for example, systemic lupus erythematosus
- family history of end-stage kidney disease (GFR category G5) or hereditary kidney disease
- opportunistic detection of haematuria.

Monitor eGFR at least annually in people prescribed drugs known to be nephrotoxic.

(see recommendations 1.1.27 and 1.1.28)

https://www.nice.org.uk/guidance/cg182/resources/algorithms-pdf-498987181
1. Aim/Purpose of this Guideline

1.1 This guideline is intended to assist decision making in all clinical areas admitting or caring for patients with CKD.

NICE defines CKD as abnormalities of kidney function or structure present for more than 3 months, with implications for health. This includes all people with markers of kidney damage and those with a glomerular filtration rate (GFR) of less than 60 ml/min/1.73 m² on at least 2 occasions separated by a period of at least 90 days (with or without markers of kidney damage).

2. The Guidance

CKD Chronic Kidney Disease
GFR Glomerular Filtration rate. eGFR estimated Glomerular Filtration rate
ACR Albumin creatinine ratio i.e. level of proteinuria
ACEi Angiotensin Converting Enzyme Inhibitor
A2RB Angiotensin-2 Receptor Blocker

2.1 This guidance is the updated RCHT CKD guidance. This update takes into account and uses many passages from the new NICE CKD guidance (CG 182) published in July 2014.

The classification of CKD has been updated by NICE. Table 1 illustrates the new classification of CKD using GFR and proteinuria (ACR) categories.

2.2 Table 2 illustrates the recommended frequency of monitoring of GFR for people with, or at risk of, CKD.

2.3 Algorithm A, from the NICE guidance for local use, illustrates how patients should be identified as having CKD, and which investigations should follow.

2.4 Algorithm B also offers clear advice on which patients should be referred to the Renal clinic.

2.5 Algorithm C illustrates clinical priorities at each stage of CKD.

2.6 Algorithm D illustrates how to introduce a prescription of an ACEi or A2RB.

2.7 Managing isolated invisible haematuria. NICE recommends:

- When there is the need to differentiate persistent invisible haematuria in the absence of proteinuria from transient haematuria, regard 2 out of 3 positive reagent strip tests as confirmation of persistent invisible haematuria.
- Persistent invisible haematuria, with or without proteinuria, should prompt investigation for urinary tract malignancy in appropriate age groups (i.e. age over 40)
- Persistent invisible haematuria in the absence of proteinuria should be followed up annually with repeat testing for haematuria, proteinuria or albuminuria, GFR and blood pressure monitoring as long as the haematuria persists.
2.8 Offer a renal ultrasound scan to all people with CKD who:
- have progression of CKD
- have visible or persistent invisible haematuria
- have symptoms of urinary tract obstruction
- have a family history of polycystic kidney disease and are aged over 20 years
- have a GFR of less than 30 ml/min/1.73 m$^2$ (GFR category G4 or G5)

Advise people with a family history of inherited kidney disease about the implications of an abnormal result before a renal ultrasound scan is arranged for them.

2.9 Proteinuria
- patients to be tested
- those with eGFR < 60
- people with diabetes with any level of eGFR
- **a confirmed ACR of 3mg/mmol or more is clinically important proteinuria**
- For the initial detection of proteinuria, if the ACR is between 3 mg/mmol and 70 mg/mmol, this should be confirmed by a subsequent early morning sample. If the initial ACR is 70 mg/mmol or more, a repeat sample need not be tested.

2.10 Defining progression of CKD:
- Define accelerated progression of CKD as:
  - a sustained decrease in GFR of 25% or more and a change in GFR category within 12 months *or*
  - a sustained decrease in GFR of 15 ml/min/1.73 m$^2$ per year.
- Take the following steps to identify the rate of progression of CKD:
  - Obtain a minimum of 3 GFR estimations over a period of not less than 90 days.
  - In people with a new finding of reduced GFR, repeat the GFR within 2 weeks to exclude causes of acute deterioration of GFR – for example, acute kidney injury or starting renin–angiotensin system antagonist therapy
- Be aware that people with CKD are at increased risk of progression to endstage kidney disease if they have either of the following:
  - a sustained decrease in GFR of 25% or more over 12 months *or*
  - a sustained decrease in GFR of 15 ml/min/1.73 m$^2$ or more over 12 months.

When assessing CKD progression, extrapolate the current rate of decline of GFR and take this into account when planning intervention strategies, particularly if it suggests that the person might need renal replacement therapy in their lifetime.

2.11 The Renal team are happy to discuss any case. For CKD queries please use the email account renal@cornwall.nhs.uk in the first instance. We would also like to be notified of any significant event affecting a dialysis or renal transplant patient.
Table 1.

<table>
<thead>
<tr>
<th>GFR and ACR categories and risk of adverse outcomes</th>
<th>ACR categories (mg/mmol), description and range</th>
</tr>
</thead>
</table>
| G1  
≥90 Normal and high  | <3 Normal to mildly increased A1             |
| G2  
60–89 Mild reduction related to normal range for a young adult | 3–30 Moderately increased A2 |
| G3a  
45–59 Mild–moderate reduction | >30 Severely increased A3 |
| G3b  
30–44 Moderate–severe reduction |                     |
| G4  
15–29 Severe reduction |                     |
| G5  
<15 Kidney failure |                     |

1 Consider using eGFRcystatinC for people with CKD G3A1 (see recommendations 1.1.14 and 1.1.15)

Abbreviations: ACR, albumin:creatinine ratio; CKD, chronic kidney disease; GFR, glomerular filtration rate

Table 2. Frequency of monitoring of GFR (number of times per year, by GFR category) for people with, or at risk of, CKD. With permission from NICE
https://www.nice.org.uk/guidance/cg182

The table below has been produced by NICE. RCHT Renal Consultants would advise that this is the **minimum** number of tests required to monitor i.e. the majority of patients with CKD stage G4 will need checks of their renal function **at least** 4 times a year, not 2 times a year as recommended in the NICE table shown below. If unsure please contact the renal department.

NICE recommends use table 2 to guide the frequency of GFR monitoring for people with, or at risk of, CKD, but tailor it to the person according to:
- the underlying cause of CKD
- past patterns of eGFR and ACR (also be aware that CKD progression is often nonlinear)
- comorbidities, especially heart failure
- changes to their treatment (A2RB, NSAIDs and diuretics)
- intercurrent illness

<table>
<thead>
<tr>
<th>ACR categories (mg/mmol), description and range</th>
<th>A1 &lt; 3 Normal to mildly increased</th>
<th>A2 3–30 Moderately increased</th>
<th>A3 &gt; 30 Severely increased</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1 ≥ 90 Normal and high</td>
<td>≤ 1</td>
<td></td>
<td>≥ 1</td>
</tr>
<tr>
<td>G2 60–89 Mild reduction related to normal range for a young adult</td>
<td>≤ 1</td>
<td>1</td>
<td>≥ 1</td>
</tr>
<tr>
<td>G3a 45–59 Mild–moderate reduction</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>G3b 30–44 Moderate–severe reduction</td>
<td>≤ 2</td>
<td>2</td>
<td>≥ 2</td>
</tr>
<tr>
<td>G4 15–29 Severe reduction</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>G5 &lt; 15 Kidney failure</td>
<td>4</td>
<td>≥ 4</td>
<td>≥ 4</td>
</tr>
</tbody>
</table>

Abbreviations: GFR, glomerular filtration rate, ACR, albumin creatinine ratio

NB: ACR is an important indicator of cardiovascular risk and progression.

Algorithm B: Classification of CKD and when to refer for specialist assessment with permission from NICE https://www.nice.org.uk/guidance/cg182

<table>
<thead>
<tr>
<th>ACR categories (mg/mmol)</th>
<th>Description and range</th>
<th>A1</th>
<th>A2</th>
<th>A3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal to mildly increased</td>
<td></td>
<td>&lt;3</td>
<td>3-30</td>
<td>&gt;30</td>
</tr>
<tr>
<td>Moderately increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severely increased</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **G1** Normal and high
  - >90
  - No CKD in the absence of markers of kidney damage
  - Manage in primary care according to recommendations (see algorithm C)
- **G2** Mild reduction related to normal range for a young adult
  - 60-89
  - Refer for specialist assessment if the person has:
    - a sustained decrease in GFR of 25% or more and a change in GFR category or sustained decrease in GFR of 15 ml/min/1.73 m² or more within 12 months
    - hypertension that remains poorly controlled despite the use of at least 4 antihypertensive drugs at therapeutic doses (see also ‘hypertension’ NICE clinical guideline 127)
    - known or suspected rare or genetic causes of CKD
    - suspected renal artery stenosis
- **G3a** Mild–moderate reduction
  - 45-59
  - Refer for specialist assessment if the person has any of the criteria in A2, or:
    - ACR 70 mg/mmol or more, unless known to be caused by diabetes and already appropriately treated
    - haematuria
- **G3b** Moderate–severe reduction
  - 30-44
  - Refer for specialist assessment
- **G4** Severe reduction
  - 15-29
  - Refer for specialist assessment
- **G5** Kidney failure
  - <15
  - Refer for specialist assessment

For guidance on frequency of GFR monitoring, see recommendation 1.3.2 in the NICE guideline. For guidance on referral, see also recommendations 1.5.1 to 1.5.5

Abbreviations: ACR, albumin creatinine ratio; CKD, chronic kidney disease; GFR, glomerular filtration rate.

Chronic Kidney Disease: early identification and management of chronic kidney disease in adults in primary and secondary care NICE clinical guideline 182 (July 2014). © National Institute for Health and Care Excellence 2014. All rights reserved.
Algorithm C: Clinical priorities at each stage of CKD - With permission from NICE [https://www.nice.org.uk/guidance/cg182]

<table>
<thead>
<tr>
<th>GFR category (ml/min/1.73m²)</th>
<th>Identify and delay progression [see section 1.1 of the NICE guideline]</th>
</tr>
</thead>
<tbody>
<tr>
<td>GFR 260</td>
<td>Identify those at risk of progression (presence of cardiovascular disease, proteinuria, acute kidney injury, hypertension, diabetes, smoking, African-Caribbean or Asian family origin, chronic use of NSAIDs, untreated urinary outflow tract obstruction) and work with them to optimise their health (recommendation 1.7 in the NICE guideline).</td>
</tr>
<tr>
<td>GFR 45–59</td>
<td>Assess risk of adverse outcomes using GFR and ACR category.</td>
</tr>
<tr>
<td>GFR 30–44</td>
<td>Offer a low-cost renin-angiotensin-aldosterone system antagonist (see recommendation 1.6.3 in the NICE guideline) to people with CKD and:</td>
</tr>
<tr>
<td></td>
<td>• diabetes and ACR of 3 mg/mmol or more (ACR category A2 or A3)</td>
</tr>
<tr>
<td></td>
<td>• hypertension and an ACR of 80 mg/mmol or more (ACR category A4)</td>
</tr>
<tr>
<td></td>
<td>• an ACR of 70 mg/mmol or more (irrespective of hypertension or cardiovascular disease).</td>
</tr>
<tr>
<td>GFR 15–29</td>
<td>Control blood pressure (see recommendations 1.8.1 and 1.8.2 in the NICE guideline) to target of:</td>
</tr>
<tr>
<td></td>
<td>• 120–135/80 mmHg in people without diabetes with ACR &lt; 70 mg/mmol</td>
</tr>
<tr>
<td></td>
<td>• 120–125/80 mmHg in people with diabetes or with ACR ≥ 70 mg/mmol</td>
</tr>
<tr>
<td>GFR &lt;15</td>
<td>Modify comorbidities [see sections 1.3 and 1.4 of the NICE guideline]:</td>
</tr>
<tr>
<td></td>
<td>Reduce risk of cardiovascular disease (control blood pressure; use antplatelet therapy when indicated) (see recommendations 1.5.3, 1.6.5 and 1.6.16).</td>
</tr>
<tr>
<td></td>
<td>Follow the recommendations in Lipid modification (NICE clinical guideline 183) for the use of statins in CKD.</td>
</tr>
<tr>
<td></td>
<td>Manage diabetes according to Type 1 diabetes and Type 2 diabetes (NICE clinical guidelines 15 and 87).</td>
</tr>
<tr>
<td></td>
<td>Encourage people to exercise, achieve a healthy weight and stop smoking (recommendation 1.4.5).</td>
</tr>
<tr>
<td></td>
<td>Prevent and treat osteoporosis (recommendation 1.7.3) in people with CKD (offer bisphosphonates if indicated in people with a GFR of 30 ml/min/1.73 m² or more [GFR category G1, G2 or G3]).</td>
</tr>
<tr>
<td></td>
<td>If vitamin D supplementation is indicated (recommendation 1.7.5 and 1.7.6) in people with CKD:</td>
</tr>
<tr>
<td></td>
<td>• offer calcitriol (1α-hydroxycholecalciferol) or calcitriol (1,25-dihydroxycholecalciferol) to people with GFR &lt;30 ml/min/1.73 m² if vitamin D deficiency has been corrected and symptoms of CKD-mineral and bone disorders persist.</td>
</tr>
<tr>
<td></td>
<td>Offer education and information (see recommendation 1.4.2 of the NICE guideline) to enable people with CKD to understand:</td>
</tr>
<tr>
<td></td>
<td>• What CKD is and how it can affect them.</td>
</tr>
<tr>
<td></td>
<td>• What questions they should ask about their kidneys.</td>
</tr>
<tr>
<td></td>
<td>• The advantages and disadvantages of the treatments that are available.</td>
</tr>
<tr>
<td></td>
<td>• How they can manage their own condition.</td>
</tr>
<tr>
<td></td>
<td>• The social and financial impact of CKD and the benefits/alternatives available.</td>
</tr>
<tr>
<td></td>
<td>• How to adjust psychologically to a diagnosis of CKD and where to find help.</td>
</tr>
<tr>
<td></td>
<td>Secure systems are in place to enable people to share in decision-making about their care, and support self-management (recommendation 1.4.16).</td>
</tr>
</tbody>
</table>

Prevent uraemia complications [see recommendation 1.7.8 of NICE guideline]:

- Check haemoglobin in people with GFR <5 ml/min/1.73m² to identify anaemia.
- Consider oral sodium bicarbonate supplementation for people with both a GFR <30 ml/min/1.73m² and a serum bicarbonate concentration <20 mEq/litre.
- Measure serum calcium, phosphate and parathyroid hormone concentrations in people with a GFR <30 ml/min/1.73m² (recommendation 1.7.2).

Education about treatment options for CKD G5 CKD and preparation for renal replacement therapy (see section 1.8 of the NICE guideline):

- Explain to people the importance of:
  - Informal choice
  - Creating a fistula or inserting a peritoneal catheter
  - Timely renal replacement treatment [recommendation 1.4.2]
  - Conservative management and when it may be considered.

Abbreviations: ACR, albumin creatinine ratio; CKD, chronic kidney disease; GFR, glomerular filtration rate.
Algorithm D: Guidelines on the use of ACEi and A2RB

1. Baseline eGFR within 4 weeks and also check potassium
   - Potassium ≤ 5.0
   - Start ACE-I / A2RB
   - Repeat eGFR at 1-2 weeks
   - No decrease in eGFR
     - If required, consider increasing the dose of ACE-I / A2RB in stepwise fashion, and follow this algorithm again from the beginning
   - Decrease in eGFR less than 25% or creatinine decrease less than 30% of baseline
     - Do not modify the dose if the change in GFR is less than 25% or the change in serum creatinine is less than 30% of the original baseline. Repeat GFR in 6-8 weeks to reassess.
   - Decrease in GFR more than 25% (eGFR) or 30% (serum creatinine) of baseline
     - Decrease in GFR more than 25% (eGFR) or 30% (serum creatinine) of baseline
     - If no other cause for the deterioration in renal function is found, stop the ACE-I / A2RB or reduce the dose to a previously tolerated lower dose, and add an alternative antihypertensive medication if required.
   - If potassium > 5.0 do not routinely offer ACE-I / A2RB- consider causes of hyperkalaemia, address these and recheck
   - With permission from NICE https://www.nice.org.uk/guidance/cg182

*Stop ACE-I / A2RB if potassium > 6.0mmol/l if other drugs known to promote hyperkalaemia have been discontinued.*
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>A component of the algorithm is contacting the renal consultant who will be informed on the action taken at that time - and this will be considered at the time.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Dr Steve Dickinson, Consultant Renal Physician</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit: it will be straightforward to assess concordance with this guideline</td>
</tr>
<tr>
<td>Frequency</td>
<td>Due to resource constraints, it is not possible to carry out routine monitoring of this guideline. Therefore, monitoring will be carried out on an opportunity basis when resources are available.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Reports will be provided to the department lead for onward reporting as necessary.</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The department lead will take responsibility for deciding what actions are necessary to achieve compliance with this guideline (if necessary) and the production/dissemination of action plans.</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within a suitable time frame. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders</td>
</tr>
</tbody>
</table>

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, Diversity & 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>Chronic Kidney Disease (CKD) in Adults Clinical Guideline v4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>Feb 2018</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; October 2018</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>17&lt;sup&gt;th&lt;/sup&gt; October 2021</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr Steve Dickinson, Consultant Renal Medicine, Renal Unit, RCHT</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 253241</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>Summary of the initial management of adult patients with CKD</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>CKD, chronic kidney disease, hyperkalaemia, ACEi, renal, ultrasound, proteinuria haematuria</td>
</tr>
<tr>
<td>Target Audience</td>
<td>CHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>June 2018</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Clinical Guideline for Management of Chronic Kidney Disease (CKD) V3.0.</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Renal Consultants</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Tim Mumford, Divisional Lead for Medicine, ED and WCH</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed} Roz Davies</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>Tim Mumford</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
</tbody>
</table>
All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

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## Appendix 2. Initial Equality Impact Assessment Form

*This assessment will need to be completed in stages to allow for adequate consultation with the relevant groups.*

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Chronic Kidney Disease (CKD) in Adults Clinical Guideline v4.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Renal</td>
</tr>
<tr>
<td><strong>Is this a new or existing Policy?</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>S. Dickinson</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 253241</td>
</tr>
</tbody>
</table>

1. **Policy Aim***
   - **Who is the strategy / policy / proposal / service function aimed at?**
   - To raise awareness and improve management of adult patients with CKD

2. **Policy Objectives***
   - To develop common diagnostic terminology and to provide guidance on management

3. **Policy – intended Outcomes***
   - To harmonise treatment of CKD in Cornwall, aligned to NICE guidance

4. **How will you measure the outcome?**
   - Review of referrals for CKD pre and post introduction of guideline

5. **Who is intended to benefit from the policy?**
   - Patients

6a **Who did you consult with**
   - Workforce
   - Patients
   - Local groups
   - External organisations
   - Other
   - X

**Please record specific names of groups**

- Renal doctors and nurses treating patients with CKD
- Radiologists

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

Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
<td>This guideline applies to all relevant patients</td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

Signature of policy developer / lead manager / director
S. Dickinson

Date of completion and submission
07/12/2018

Names and signatures of members carrying out the
1. S. Dickinson
2. Human Rights, Equality & Inclusion Lead
Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,
Truro, Cornwall, TR1 3HD

This EIA will not be uploaded to the Trust website without the signature of the
Human Rights, Equality & Inclusion Lead.

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

Signed S. Dickinson
Date ___07 December 2018____________