

ANTIMICROBIAL PRESCRIBING POLICY

POLICY

Reference	CPG-MM/P-APP		
Approving Body	Antimicrobial Prescribing Working Group (APWG)		
Date Approved	September 2025		
For publication to external SFH website	Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:		
	YES	NO	N/A
	X		
Issue Date	19-January-2026		
Version	V7.0		
Summary of Changes from Previous Version	6.0 – Whole document review, highlighting the addition of new drug and key changes of antimicrobial prescribing on EPMA.		
Supersedes	Version 5.1, Issued November 2024 to Review Date September 2025		
	Version 6.0 Issued September 2025 to Review Date September 2026		
Document Category	Clinical		
Consultation Undertaken	APWG December 2025		
Date of Completion of Equality Impact Assessment	27 August 2025		
Date of Environmental Impact Assessment (if applicable)	N/A		
Legal and/or Accreditation Implications	N/A		
Target Audience	Trust wide		
Review Date	January-2029		
Sponsor (Position)	Medical Director		
Author (Position & Name)	- Siew Quen Lim, Antimicrobial Pharmacist - Alex Madeley, Antimicrobial Pharmacist		
Lead Division/ Directorate	Clinical Support, Therapies and Outpatients		
Lead Specialty/ Service/ Department	Medicines Management (Pharmacy)		
Position of Person able to provide Further Guidance/Information	- Siew Quen Lim, Antimicrobial Pharmacist; - Alex Madeley, Antimicrobial Pharmacist and - Dr Shrikant Ambalkar, Cons Medical Microbiologist		
Associated Documents/ Information		Date Associated Documents/ Information was reviewed	
Not Applicable		Not Applicable	
Template control		June 2020	

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1.0 INTRODUCTION

It is estimated that about 20% of antimicrobial prescribing occurs in hospitals, with 20–50% considered unnecessary.

Prudent prescribing of antibiotics is essential. This means they are given only when clinically justified, with the correct drug, route, dose, frequency, and duration, considering diagnosis, evidence of effectiveness and safety, cost, and the risk of resistance.

While antibiotics can be lifesaving, unnecessary use can lead to serious consequences such as:

- Adverse drug effects
- Disruption of normal flora, leading to superinfections (e.g. *Pseudomonas aeruginosa*, *Candida spp.*, and *Clostridium difficile*)
- Increase selection of resistant organisms (e.g. MRSA, ESBL-producing gram negative bacilli; *Enterobacteriaceae*)
- Increased rates of cross-infection
- Unnecessary costs

The Health and Social Care Act 2008 (updated December 2022): Code of Practice on the Prevention and Control of Infections, sets out the 10 criteria against which the Care Quality Commission (CQC) will judge a registered provider on how it complies with the infection prevention requirements. Guidance on meeting Criterion 3 states that providers must ‘*ensure appropriate antimicrobial use and stewardship to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance*’.

This will include:

- To have systems in place to manage and monitor the use of antimicrobials
- To have an antibiotic stewardship committee to be responsible for developing, implementing and monitoring the organisations stewardship programme
- To have an antimicrobial policy which will be monitored through regular audit
- To ensure that prescribers receive training in prudent antimicrobial use

A “Start Smart-then Focus” ([Appendix B](#)) approach is recommended for all antimicrobial prescriptions.

2.0 POLICY STATEMENT

The purpose of this policy is to provide a framework to ensure that antimicrobials are used appropriately throughout Sherwood Forest Hospitals NHS Foundation Trust (SFHFT). This will be overseen and monitored by Antimicrobial Prescribing Working Group (APWG), which is a subgroup of the Joint Drugs and Therapeutics/ Medicines Management Committee.

Adherence to the framework specified within this document will enable the SFHFT to achieve compliance with the required healthcare standards as specified in The Health and Social Care Act 2008 Code of Practice of the prevention and control of infections and related guidance (2022)

This clinical policy applies to:

Staff group(s)

- All staff involved in the prescribing, administration and monitoring of antimicrobial agents within SFHFT

Clinical area(s)

- All in-patient and ambulatory units where patients can be prescribed antimicrobial agents
- All hospital sites

Patient group(s)

- All in-patients prescribed antimicrobial agents
- Ambulatory patients (including OPAT, SDEC, Virtual wards, Day Case units)
- Adult, maternity and paediatric patients

Exclusions

- Outpatient units (Emergency Department, Minor Injuries Unit, Clinics) are excluded from this policy, but all antimicrobial prescriptions from these areas must follow local or national antimicrobial guidelines.

3.0 DEFINITIONS/ ABBREVIATIONS

The Trust:	means the Sherwood Forest Hospitals NHS Foundation Trust
Staff:	All employees of the Trust including those managed by a third-party organisation on behalf of the Trust.
Antimicrobial agent	Antibacterial (or antibiotic), antiviral, and antifungal medications are used to treat bacterial, viral, and fungal infections, respectively.
Prescriber	A registered practitioner who is legally authorised to undertake independent or supplementary prescribing according to current legislation (medical doctor or a registered nurse, pharmacist or other healthcare professional who has successfully undertaken a non-medical prescribing qualification).
Antimicrobial resistance (AMR)	Antimicrobial resistance (AMR) occurs when microorganisms—bacteria, viruses, fungi, or parasites—become resistant to drugs that were previously effective, reducing the effectiveness of antibiotics, antivirals, antifungals, and antiparasitic treatments
Antimicrobial stewardship (AMS)	Coordinated interventions designed to improve and measure the appropriate use of antimicrobials by promoting the optimal selection of drug, dose, duration, and route of administration. The goal of AMS is to achieve the best clinical outcomes while minimizing the emergence and spread of antimicrobial-resistant strains.
Antimicrobial stewardship ward round:	This is a regular multi-disciplinary ward round undertaken by a microbiologists, junior doctors and antimicrobial pharmacist. The purpose of the ward round is to clinically assess the appropriateness of the antimicrobials prescribed for individual patient. Any recommendations to change antimicrobial therapy are discussed with the ward clinical staff and documented in the patient's medical notes by the clinical team.
Antimicrobial Prescribing Working Group (APWG)	A multidisciplinary team, which includes consultant microbiologists, antimicrobial pharmacists, sepsis lead consultant, consultants from various specialties (acute care, surgeon, frailty, paediatrics), sepsis nurse and senior IPC nurse to ensure a multidisciplinary approach and improve engagement across the organisation.
Local Antimicrobial Prescribing guidelines	Guidelines for treatment of specific infections and guidelines for surgical prophylaxis that can be found on the Trust's Antibiotics Website
EPMA	Electronic Prescribing and Medicines Administration system – NerveCentre
MRSA	Methicillin Resistant <i>Staphylococcus aureus</i>
ESBL	Extended Spectrum β -lactamase

4.0 ROLES AND RESPONSIBILITIES

Medical doctors and non-medical prescribers must be familiar with and adhere to this policy in addition to local antimicrobial prescribing guidelines.

4.1 Medical Director will:

- Act as a Board level champion to promote prudent prescribing throughout the organisation.

4.2 Divisional Directors will:

- Work collaboratively with prescribers, pharmacists, ward leaders and heads of nursing to ensure that antimicrobial prescribing standards are followed within the division and antimicrobials are prescribed and reviewed in accordance with local antimicrobial guidelines.
- Support the implementation of the antimicrobial audit programme.
- Ensure that antimicrobial prescribing and antimicrobial consumption data are reviewed regularly at divisional governance meetings and appropriate action taken as required.

4.3 Antimicrobial Prescribing Working Group (APWG) will:

- Ensure that evidence-based local antimicrobial guidelines are in place and reviewed regularly.
- Ensure regular auditing of the guidelines, antimicrobial stewardship practice and quality assurance measures.
- Formally review the organisation's retrospective antibiotic consumption data (especially highlighting the use of broad-spectrum antibiotics such as cephalosporins, quinolones and carbapenems), and report to divisions as appropriate.
- Identify actions to address: non-compliance with local guidelines; general antimicrobial stewardship issues; and other prescribing issues.
- Identify and review themes of incidents and near miss events relating to the use of antimicrobial agents and feedback to the relevant speciality or escalated to Trust-wide communications.

4.4 Antimicrobial Pharmacist will:

- Coordinate audits to assess compliance with the Antimicrobial Prescribing Policy and Trust's local antimicrobial prescribing guidelines.
- Coordinate the antimicrobial stewardship ward rounds.
- Investigate cases of non-compliance referred by the ward pharmacists and resolve through education or escalation as appropriate.
- Produce reports of antimicrobial consumption data for review by APWG.

4.5 Prescribers will:

- Prescribe antimicrobials using EPMA, or in the dedicated antimicrobial section of the medication chart where EPMA is not yet in use, following the standards in this policy and the relevant local antimicrobial prescribing guidelines. See [Section 6.4](#) for documentation requirements
- Document all antimicrobial prescriptions in the medical notes, ensuring any deviations from established guidelines are clearly noted.

- Where a Trust guideline does not exist, prescribing should follow recognised practice supported by appropriate professional bodies or recognised references.
- Prescribing of Restricted Antimicrobials should follow [Appendix E](#).
- Take ownership over the reviewing of IV antibiotics following 48 hours of treatment and to either stop antibiotics, focus antibiotic choices, discuss with microbiology or set a new course length with a suitable review.

4.6 Registered nurses will:

- Ensure that antimicrobial treatment is started as soon as possible and that doses are not omitted or delayed.
- Ensure reviews are completed promptly to avoid delayed or missed doses. For hard reviews, immediately contact the prescriber and do not administer further doses until the review is completed. For soft reviews, continue administration if clinically appropriate while awaiting the review
- Where a prescribed antimicrobial is not routinely kept on the ward, nursing staff must ensure that pharmacy staff are informed immediately to prevent delays in treatment.
- Ask a doctor to review if a number of doses have been missed during the prescribed course, especially if the patient is still unwell or approaching a weekend where regular review is unlikely.
- Check completion of allergy status and check for allergies before giving antibiotics.
- Request that prescribers document a clear indication and a valid duration or review date for all antimicrobials on EPMA, see section 6.4 (or the medication chart if EPMA is not in use, see [Appendix A](#)).
- “Ensure administration of Intravenous (IV) antibiotics in adults follows [Appendix F](#) or, if not listed, other recognised information sources (Medusa, product literature/ SPC)”

4.7 Clinical pharmacists will:

- Ensure that antimicrobial prescribing is in line with Trust policy and local antimicrobial prescribing guidelines.
- Ensure that documentation of antimicrobial prescribing in accordance with the policy (see [Section 6.4](#) and [Appendix A](#))
- Liaise with pharmacy department to ensure the timely supply of antimicrobial medications to wards where appropriate.
- Escalate non-compliance with the Antimicrobial Prescribing Policy and/or local antimicrobial guidelines to the Antimicrobial Pharmacist.

4.8 The Microbiologists will:

- Provide expert advice to prescribers and pharmacists on the use of antimicrobial medicines and the management of infections.
- Liaise with clinicians to produce and update antimicrobial prescribing policies and local guidelines as required.
- Carry out regular multi-disciplinary ward rounds in collaboration with the antimicrobial pharmacist, with the aim of improving antimicrobial prescribing and providing interactive education on the wards.

5.0 APPROVAL (v6.0)

Contributors	Via	Timing
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Consultant Microbiologist, Antimicrobial Pharmacist	In-person discussion	August/December 2025
Members of the Antimicrobial Prescribing Working Group	APWG	December 2025

6.0 DOCUMENT REQUIREMENTS

- 6.1 The standards for general prescribing (refer to [The Medicines Policy](#), Section 9) must be adhered to when prescribing antimicrobial medication.
- 6.2 Antimicrobial therapy should not be prescribed until the allergy status of the patient has been confirmed and documented in the medical notes and EPMA (or on the prescription chart if EPMA not in use).
- 6.2.1 The allergy status should be suitably informative of the nature of the allergy if this can be ascertained and must not be left blank. If the nature is unknown, it is good practice to document what information source was checked e.g. “Unknown reaction – patient” or “Unknown reaction- GP record”. This record should be amended if further information becomes available.
- 6.2.2 If the allergy status for the patient cannot be confirmed, antimicrobial therapy can be given if the clinical circumstances dictate that a delay in treatment may be detrimental to the patient. The prescriber must document this information in the allergy box e.g. “Unable to confirm allergy status – Signature + Date” and the allergy status confirmed as soon as possible. For guidance on antibiotic use in patients with a penicillin allergy, see [Appendix D](#).
- 6.3 Relevant clinical specimens for culture and sensitivity testing must be obtained prior to antimicrobial administration unless immediate empirical treatment is indicated.
- 6.4 Antimicrobial therapy should only be prescribed if clinically indicated according to the patient’s clinical signs/symptoms of infection. The following information must be documented in the medical notes and on EPMA (or the medication chart if EPMA not in use): (See [Appendix A](#)).
- 6.4.1 In medical notes:
- Indication for prescription/diagnosis (suspected diagnosis). This must be a sensible and specific working, differential or confirmed diagnosis and **must NOT** utilise vague, non-specific terminology, such as ‘sepsis ?source’ or ‘occult sepsis’.
 - Evidence of assessment of severity (may include temperature, heart rate, respiratory rate, blood pressure, full blood count, CRP)
 - Details of samples taken for culture and sensitivity
 - Name of antimicrobial agent, dose and route of administration
 - Duration of treatment or treatment review date
- 6.4.2 On EPMA (or patient’s medication chart if in area where EPMA is not in use)
- Name of antimicrobial agent, dose and route of administration

- Indication for antimicrobial treatment. This must be a sensible and specific working, differential or confirmed diagnosis and **must NOT** utilise vague, non-specific terminology, such as 'sepsis ?source' or 'occult sepsis'
- Duration of treatment or treatment review date if this is established at the point of prescribing.

6.5 The prescriber must write a review date or specify the duration of treatment. All antibiotics now require a mandatory duration at the point of prescribing on EPMA. For IV antibiotics, if a specific duration is not entered then, EPMA will automatically default to a 72-hour prescription with a 48-hour hard review.

If IV antibiotics are intended to continue beyond the review date, the prescriber must:

- Complete the hard review.
- Amend the duration of treatment on EPMA.
- Set a new hard review at a suitable interval if the overall course length is not yet finalised.
- Update the plan according to the patient's clinical condition.

6.6 Patients with high-risk sepsis must have the first dose of antimicrobial therapy administered as soon as possible and no later than one hour after recognising high risk sepsis ([NICE Guideline NG51](#))

6.7 Empirical antimicrobial prescription must be reviewed on a daily basis after starting treatment and the prescription promptly changed to narrow spectrum agent to reflect culture & sensitivity results where appropriate. All antimicrobial treatment must be reviewed at 48-72 hours after initiation and there should be clear documentation of the antimicrobial prescribing decision on EPMA (or the medication chart if EPMA not in use) and in the medical notes.

6.8 If therapy is to continue longer than 7 days, this must be clearly documented in the patient's medical notes and a new review date documented on EPMA (or the medication chart if EPMA not in use).

The following conditions normally require an extended course of antimicrobial treatment and advice should be sought from microbiology (NB this is not a comprehensive list):

- Acute prostatitis
- Endocarditis
- Septic arthritis
- Empyema
- Osteomyelitis
- Meningitis/brain abscess
- *Staphylococcus aureus* bacteraemia
- Tuberculosis (Respiratory consultant advice)

6.9 Intravenous antimicrobial therapy should be reviewed daily, but no later than 48 hours after commencing treatment. If possible, the patient should be switched to oral antimicrobial treatment. Advice on switching to oral treatment can be found at [Appendix C](#). If continuation of intravenous treatment is required, this must be clearly documented

in the patient's medical notes along with a date for further review. OPAT patients to be reviewed at a weekly MDT in accordance with the 'OPAT Antimicrobial Therapy Policy'.

- 6.10 Antimicrobial treatment should be prescribed in accordance with local prescribing guidelines. When local guidelines are not available, the BNF or national guidelines should be followed or the advice of a specialist sought.
- 6.11 Antimicrobial therapy should be prescribed at the dose and frequency appropriate for the site, severity of infection and co-existing clinical factors (i.e. impaired renal or hepatic function).
- 6.12 Antibiotic doses may be missed for several reasons (i.e. no cannula, unable to swallow). This should be clearly documented on EPMA (or the medication chart if EPMA not in use) and patients should be reviewed clinically and consideration given for re-prescribing additional doses if required.
- 6.13 Antimicrobial prophylaxis for surgery should be prescribed in line with the Trust's surgical prophylaxis guidelines (see [Antibiotic Website](#) for details).
 - The clinical indication for antimicrobial prophylaxis must be recorded in the patient's medical notes and EPMA (or the medication chart if EPMA not in use) or the anaesthetics record; whichever is most practical at the time.
 - Established infection discovered during surgery is an indication for converting antimicrobial prophylaxis into antimicrobial treatment.
- 6.14 Restricted antimicrobials should be prescribed in line with [Appendix E](#).

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

- 7.1 Audit of antimicrobial prescribing and use will be facilitated and monitored on a quarterly basis by each speciality. The current electronic data collection tools are hosted via the AMaT system. Results and actions from the audit will be reported to the Divisional Directors and Director of Infection Prevention and Control (DIPC) via Divisional Clinical Governance meetings and the Infection Prevention and Control Committee respectively.
- 7.2 Antimicrobial stewardship ward round will be undertaken three times a week by a Microbiology consultant, Rotational junior doctors, and Antimicrobial Pharmacist. One of the objectives for this MDT-round will be to assess the appropriateness of antimicrobial prescribing, compliance with this Policy and address poor prescribing practice. Direct feedback will be given to the clinical teams.
- 7.3 Incidents monitoring (via DATIX) will be done ad-hoc in response to incidents. Datix handler can escalate through organisational management structure as needed.

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring i.e. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Documentation of allergy status. Documentation of indication and duration of antibiotic treatment. Evidence of review within 72 hrs	Each Specialty (via their respective Specialty Clinical Governance Lead / Specialty Clinical Audit Lead	Antimicrobial prescribing audit (via AMaT)	Audit is done on a quarterly basis	Results are discussed in Speciality / Divisional Clinical Governance meetings; Infection Prevention and Control Committee (IPCC) and APWG
Appropriateness of antibiotic prescribing.	Microbiology consultant, Antimicrobial Pharmacist and Rotational junior doctors.	Antimicrobial stewardship ward round	3 times a week	MDT members feedback directly to prescribers

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring i.e. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Incidents related to antibiotic treatment – for example incorrect prescribing or administration; omitted allergy status	Datix handler	Review of individual incidents via the Datix system on a monthly basis.	Ad-hoc, in response to incidents	Datix handler can escalate through organisational management structure. Datix trends are discussed at APWG quarterly

8.0 TRAINING AND IMPLEMENTATION

- 8.1 All antimicrobial prescribers need to familiarise themselves with the Trust's local Antimicrobial Prescribing guidelines available on the intranet via the Trust [Antibiotic website](#).
- 8.2 All new medical staff will receive antimicrobial prescribing guidance from the Trust's Antimicrobial pharmacist or Consultant microbiologist as part of their induction programme.
- 8.3 Education and training covering appropriate prescribing of antimicrobials and the management of the patients with infections will be part of the mandatory training for F1/F2 junior doctors. This training will be delivered by consultant microbiologist, antimicrobial pharmacist and/or education and training pharmacist.
- 8.4 Nursing staff will receive an annual update on Infection Control, sepsis and antimicrobial stewardship as part of the Mandatory Update programme.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at [Appendix G](#).
- This document is not subject to an Environmental Impact Assessment.

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Wise *et al.* Antimicrobial resistance. BMJ 1998; 317:609-610
- Optimising the clinical use of antimicrobials: Report from the Clinical Prescribing Subgroup of the Interdepartmental Steering Group on Antimicrobial Resistance June 2001 ([link here](#))
- Antimicrobial Stewardship – Start smart then focus: antimicrobial stewardship toolkit for inpatient care settings. 2023 UK Health Security Agency.
<https://www.gov.uk/government/publications/antimicrobial-stewardship-start-smart-then-focus/start-smart-then-focus-antimicrobial-stewardship-toolkit-for-inpatient-care-settings>
- The Health and Social Care Act 2008 (Updated December 2022): Code of practice for the prevention and control of healthcare associated infections
<https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance> Accessed 21/05/2024.
- Winning Ways: Working together to reduce Healthcare Associated Infection in England, Dec 2003.
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/browsable/DH_4095070
- NICE Guideline NG51 Sepsis: recognition, diagnosis and early management (2016) updated 2024.
- NICE NG125 Surgical site infections: prevention and treatment (2019)

Related SFHFT Documents:

- Trust's Local Antimicrobial Prescribing Guidelines (located on the [Antibiotic website](#))
- Medicines Policy - [Medicines Policy \(nnotts.nhs.uk\)](https://nnotts.nhs.uk)
- Outpatient Parenteral Anti-Microbial Therapy (OPAT) Policy

11.0 KEYWORDS

Antibiotic, infection, prophylaxis, treatment, prescription, prescribe, therapy, guidance notes for switch switching from IV to oral antibiotics, antibiotics in penicillin allergy,

12.0 APPENDICES

- [Appendix A](#) – Example Antimicrobial Prescription on EPMA and Medication Chart
- [Appendix B](#) – UK Health Security Agency (UKHSA) Antimicrobial Stewardship – Start Smart then Focus Clinical Management Algorithm
- [Appendix C](#) – Guidance notes for switching from IV to Oral antibiotics
- [Appendix D](#) – Antibiotics in Penicillin Allergy
- [Appendix E](#) - Restricted Antimicrobials List
- [Appendix F](#) – Methods of IV administration of commonly used antibiotics in adults
- [Appendix G](#) – Equality Impact Assessment Form (EQIA)

Appendix A: Example Antimicrobial Prescription on EPMA and Medication Chart

1. Initial empirical prescription – prescriptions must include:

- Name of antimicrobial agent, Dose and Route of administration
- Indication for antibiotic treatment. The indication must be a sensible and specific working, differential or confirmed diagnosis and **must NOT** utilise vague, non-specific terminology, such as 'sepsis ?source' or 'occult sepsis'.
- Review date (within 48-72hrs) – on EPMA this will pre-populate at 48 hours. If necessary, this review can be moved to a more suitable time of day by cancelling the review and setting another.

Antimicrobial			DATE	15/5	16/5	17/5	/	/	/	/	/	/	/	/
Flucloxacillin			Circle or state time	Day 1	Day 2	Day 3 Sign for 72 hour review	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11
Dose	Route	Start Date	06											
2g	IV	15/5	08											
Indication/Additional Instructions		Stop/Review Date	12											
cellulitis		17/5	14											
Micro approved?	Signature	Print Name	18											
	AD	A-Doctor	22											
Pharmacist check	Source of Supply	If for infusion state:	Fluid	0.9% NaCl			Volume (ml)	100ml			Rate (ml/hour)	100ml/h		

Piperacillin + Tazobactam		✓	6:00		+	+	+
Intravenous, 4.5g three times a day at 06:00, 14:00 and 22:00 for 3 days		New	14:00		+	+	+
Prescriber: Siew quen Lim - Pharmacist		-	22:00	+	+	Ⓡ Review	
Prescribed start time: Thu 27-Nov-2025 22:00							
Indication: Urosepsis							
Instructions: Infuse over at least 30 minutes ***CRITICAL MEDICINE - Risk of worsening infection if delayed***							
Show all 5 prescriptions for Piperacillin + Tazobactam							

2. IV to PO switch – prescriptions must include:

- Name of antimicrobial agent, Dose and Route of administration
- Indication for antibiotic treatment. The indication must be a sensible and specific working, differential or confirmed diagnosis and **must NOT** utilise vague, non-specific terminology, such as 'sepsis ?source' or 'occult sepsis'.
- Duration of treatment or further review date

Antimicrobial			DATE	15/5	16/5	17/5	/	/	/	/	/	/	/	/
Flucloxacillin			Circle or state time	Day 1	Day 2	Day 3 Sign for 72 hour review	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11
Dose	Route	Start Date	06											
2g	IV	15/5	08											
Indication/Additional Instructions			12											
cellulitis			14											
Micro approved?	Stop/Review Date		18											
☐	17/5		22											
Signature	Print Name													
AD	A. Doctor													
Pharmacist check	Source of Supply													
Antimicrobial			If for infusion state:	Fluid	0.9% sodium chloride	Volume (ml)	100ml	Rate (ml/hour)	100ml/h					
Flucloxacillin			DATE	/	/	17/5	18/5	19/5	20/5	21/5	22/5	/	/	/
Dose			Circle or state time	Day 1	Day 2	Day 3 Sign for 72 hour review	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11
1g			06											
Route			08											
PO			12											
Indication/Additional Instructions			14											
cellulitis			18											
Micro approved?	Stop/Review Date		22											
☐	22/5													
Signature	Print Name													
AD	A. Doctor													
Pharmacist check	Source of Supply													
Antimicrobial			If for infusion state:	Fluid		Volume (ml)		Rate (ml/hour)						

Medicine	Ph	Today	Fr 06-May	Sa 07-May	Su 08-May	Mo 09-May	Tu 10-May
Flucloxacillin capsule	✓ Morning		+	+	+	+	+
Oral, 1000 mg four times a day for 5 days	New Afternoon	Due	+	+	+	+	
Prescriber: epma idoc1	Evening	+	+	+	+	+	
Prescribed start time: 11:05-May-2022 13:00	Night	+	+	+	+	+	
Indication: cellulitis							

3. Prescribing "stat" infusions of antibiotics on prescription chart must include:

- Entry on the infusion side of the prescription chart

DATE	INFUSION FLUID		ROUTE	ADDITIVES (if any)		DURATION or RATE	Prescribers Signature	Pharmacy Check	Additive added by:	Checked by:
	APPROVED NAME, STRENGTH	VOLUME (ML)		APPROVED NAME	DOSE					
27/4/18	Sodium Chloride 0.9%	100 ml	IV	Gentamicin	320mg	60min	AD			

- Reference on the "Stat" side of the drug chart

ONCE ONLY MEDICINES, PREMEDICATION, ANTIBIOTIC PROPHYLAXIS and PATIENT GROUP DIRECTIONS									
Date	Medicine	Dose	Route	Instructions	Time req'd	Prescriber's Sig. Print Name (& 'PGD' if required)	Time Given	Sig(s). Given	Pharm. Check
27/4/18	Gentamicin	see infusions section			11:30				

4. Prescribing Vancomycin using supplementary auto-prescription:

- On EPMA – prescribe a "placeholder" then use the auto-prescription available on the Antibiotic website to generate a supplementary paper prescription (as shown overleaf)

Vancomycin infusion - see paper supplementary chart Intravenous, 1 dose four times a day Prescriber: Prescribed start time: Tue 30-May-2023 22:00 Instructions: Refer to Vancomycin supplementary chart to check if administration is due. Ensure administration is recorded fully on the supplementary chart.	✓	Morning					
	New	Afternoon					
	S	Evening					
		Night					

- If using prescription chart, refer to the additional chart on the front of the main 'Medicine Prescription and Administration Record' as shown below

Other medicine charts/sections in use (TICK)	
Insulin ☐	Ophthalmology ☐
TPN/Nutrition ☐	Intrathecal ☐
SC Syringe Driver ☐	Chemotherapy ☐
IV Heparin ☐	Critical Care Infusion ☐
Anticoagulation ☐	
Additional 'Prescriptions for Infusions' ☐	
PCA/Epidural/Regional anaesthesia ☐	
Midwives Exemption Record ☐	
Others (specify) <u>Vancomycin</u>	☒

- Prescribe Vancomycin on the Antimicrobials section of the 'Medicine Prescription and Administration Record' as shown below

Antimicrobial		DATE	15/5	16/5	17/5	/	/	/	/	/	/	/	/
<u>Vancomycin</u>		Circle or state time ☒	Day 1	Day 2	Day 3 Sign for 72 hour review	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11
Dose <u>APC</u>	Route <u>IV</u>	Start Date <u>15/5</u>	06										
		Time prescribed <u>20:00</u>	08										
Indication/Additional Instructions <u>cellulitis</u>		Stop/Review Date <u>17/5</u>	12										
Micro approved? ☐			14										
Signature <u>AD</u>	Print Name <u>A. Doctor</u>		18										
			22										
Pharmacist check	Source of Supply	If for infusion state:	Fluid			Volume (ml)		Rate (ml/hour)					

- The signature for administration should appear on the additional prescription chart

Vancomycin auto-prescription

Sherwood Forest Hospitals
NHS Foundation Trust

Creatinine: 100 micromol/L
Age: 50 years
Weight: 50 kg
Sex: f (m or f)
Height if obese: cm
Aiming for: ☒ 10-15mg/L ☐ 15-20mg/L

Name: *Example Patient*
DOB: *01/01/50*
D num: *D012345*
Patient ID sticker

Calculated GFR: 47 mL/min

Ward: *X*

Attach to the drug chart and
write "vancomycin - see chart"

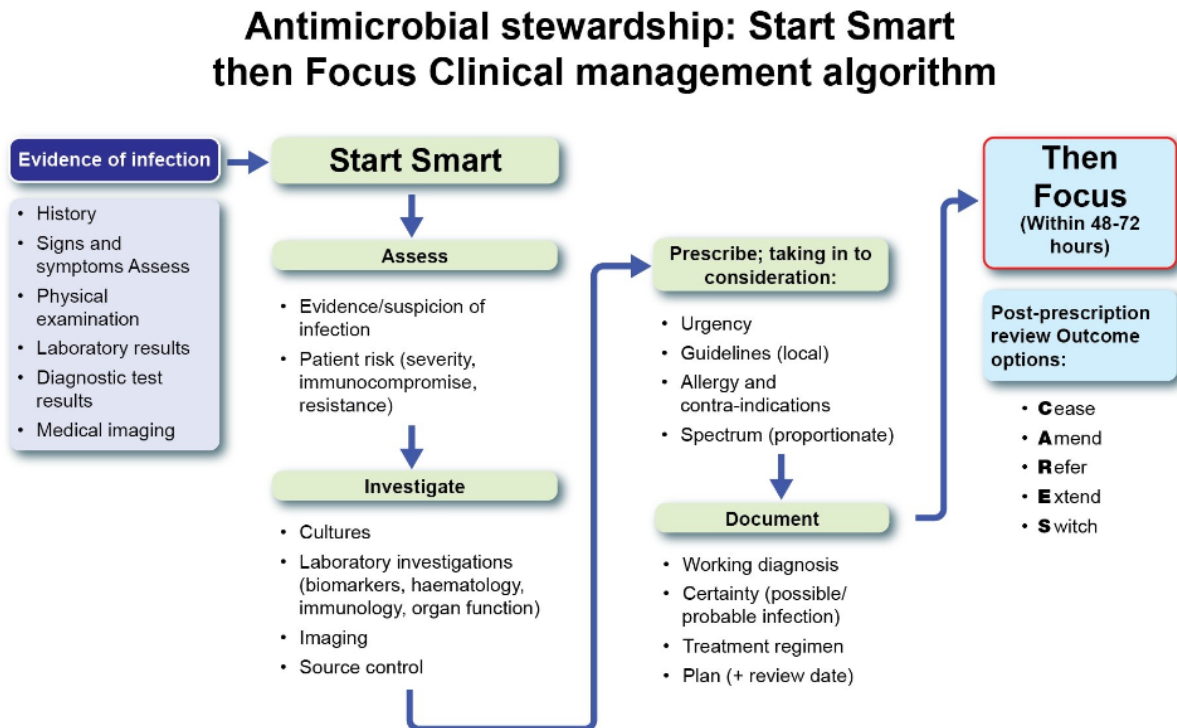
☐ tick for glucose not saline

☐ tick if on dialysis

Date	Time due	Dose & admin details	Time given	Nurse sigs
Loading dose				
Loading dose	15-May-18	Due now - approx 20:08 1200mg in 250ml sodium chloride 0.9% over 120 minutes (=125ml/hr)		
Maintenance doses				
Maint dose 1	16-May-18	8:00		
Maint dose 2	16-May-18	20:00		
Maint dose 3 *	17-May-18	8:00		
		750mg 12hrly band 6		
		750mg in 250ml sodium chloride 0.9% over 90 minutes (=167ml/hr)		
		*Take blood for vanc level just before maintenance dose 3: Time taken: _____ Sig: _____		
Doctor sig: <i>AD</i> name: <i>A. Doctor</i> (for loading dose and maintenance 1,2,3)				
Give dose after level taken. When result back... Vancomycin level result?: _____ mg/L				
...interpret level (see dose adjustment table) and prescribe 3 more doses				

Appendix B: UK Health Security Agency (UKHSA) Antimicrobial Stewardship – Start Smart then Focus Clinical Management Algorithm

Figure 1: AMS clinical management algorithm



Antimicrobial stewardship: Start smart - then focus

Appendix C: IV to PO Switch

Review IV antibiotics within 48 hours

Does your patient have an infection that may require special consideration?

Infections that may require special consideration include: deep-seated infections, infections requiring high tissue concentration, infections requiring prolonged intravenous antimicrobial therapy or critical infections with high risk of mortality.

To note: on specialist advice, an IVOS within 48 hours may still be indicated for some patients with these infections.

Infections for special consideration include, but are not limited to, those listed below:

- | | | | |
|-------------------------|-----|--|-----|
| • bloodstream infection | Y/N | • osteomyelitis | Y/N |
| • empyema | Y/N | • severe or necrotising soft tissue infections | Y/N |
| • endocarditis | Y/N | • septic arthritis | Y/N |
| • meningitis | Y/N | • undrained abscess | Y/N |

If **YES** → check for clearly documented plan or seek specialist advice
If **NO** → continue

1a. Enteral route

- 1.1. Is the patient's gastrointestinal tract functioning with no evidence of malabsorption? Y/N
1.2. Is the patient's swallow or enteral tube administration safe? Y/N

If **NO** → reassess in 24 hours
If **YES** → continue

1b. Enteral route continued

- 1.3. Are there any significant concerns over patient adherence to oral treatment? Y/N
1.4. Has the patient vomited within the last 24 hours? Y/N

If **YES** → reassess in 24 hours
If **NO** → continue

2. Clinical signs and symptoms

- 2.1. Are the patient's clinical signs and symptoms of infection improving? Y/N

If **YES** → continue
If **NO** → reassess in 24 hours

3. Infection markers

- 3.1. Has the patient's temperature been between 36-38°C for the past 24 hours? Temp: Y/N
3.2. Is the patient's Early Warning Score (EWS) decreasing? EWS: Y/N
3.3. Is the patient's White Cell Count (WCC) trending towards the normal range?* WCC: Y/N
3.4. Is the patient's C-Reactive Protein (CRP) decreasing?* CRP: Y/N

If **NO** → reassess in 24 hours
If **YES** → prompt or assess for switch

PROMPT FOR SWITCH:

Nursing/pharmacy teams to prompt prescriber or infection specialist to consider IV to oral switch.

ASSESS FOR SWITCH:

Prescriber or infection specialist to consider IV to oral switch. Identify whether a suitable oral switch option is available, considering for example oral bioavailability, any clinically significant drug interactions, patient allergies or contra-indications.

* NB: these infection markers could also indicate inflammation or could be affected, for example, by steroid treatment. IV to PO switch may still be considered if they are the only markers not met

NB. Wherever possible, use positive culture results to guide therapy. Where there are NO positive cultures refer to the table below or the specific guideline for the infection being treated.

Recommended oral alternatives

IV	ORAL
Co-amoxiclav 1.2g tds	Co-amoxiclav 625mg tds
Amoxicillin 500mg-1g tds	Amoxicillin 500mg-1g tds
Flucloxacillin 1-2g qds	Flucloxacillin 1g qds
Clindamycin 600mg qds	Clindamycin 300-450mg qds (can use a maximum of 600mg qds if severe infection, N.B. unlicensed)
Piperacillin/Tazobactam 4.5g tds	Choice of oral antibiotic depends on microbiology sensitivities. For oral choice if negative cultures, refer to the specific guideline for the infection being treated.
Cefuroxime 1.5g tds + / - Metronidazole 500mg tds	
Meropenem 1g tds	
Vancomycin / Teicoplanin	

Appendix D

Antibiotics in Penicillin Allergy

All medication allergies MUST be documented on drug chart or EPMA (NerveCentre), along with the type of reaction. Consult the antibiotic guidelines on the SFHT intranet for any further information. Note: This is not a comprehensive list

SEVERE PENICILLIN ALLERGY Within 72 hours;

Anaphylaxis
Urticaria—itchy rash
even after 72 hours
Hives
Laryngeal oedema
Bronchospasm
Hypotension

NON-SEVERE PENICILLIN ALLERGY After 72 hours;

Minor non-itchy rash restricted to a small area of the body

INTOLERANCE: GI Upset including vomiting, nausea, diarrhoea

Contra Indicated

IN PATIENTS WITH
SEVERE AND NON-
SEVERE PENICILLIN
ALLERGY

Amoxicillin
Benzylpenicillin
Co-amoxiclav (Augmentin®)
Flucloxacillin
Penicillin V (Phenoxymethylpenicillin)
Piperacillin/Tazobactam (Tazocin®)
Pivmecillinam
Temocillin

Caution

USE WITH CAUTION IN
NON-SEVERE AND
AVOID IN SEVERE
PENICILLIN ALLERGY

Cephalosporins

Cefalexin
Cefixime
Cefotaxime
Cefuroxime
Ceftazidime
Ceftriaxone

Other beta-lactam

Ertapenem
Meropenem—May be used in severe penicillin allergy after desensitization (on consultant microbiologist advice only)
Aztreonam—May be used with caution in severe penicillin allergy

Considered Safe

Amikacin
Azithromycin
Chloramphenicol
Ciprofloxacin
Clarithromycin
Clindamycin
Colistin
Co-trimoxazole
Daptomycin
Doxycycline
Erythromycin
Fosfomycin
Gentamicin

Levofloxacin
Linezolid
Metronidazole
Nitrofurantoin
Ofloxacin
Rifampicin
Sodium fusidate
Teicoplanin
Tetracycline
Tigecycline
Tobramycin
Trimethoprim
Vancomycin

Updated by: Desi Milanova
Approved by: APWG
Approved date: Aug 2021

In cases of INTOLERANCE to penicillins (e.g. gastrointestinal upset), penicillin related antibiotics should not be withheld unnecessarily in severe infection but the patient must be monitored closely after administration.

Appendix E – Restricted antimicrobials list and procedure for obtaining microbiology approval

Before prescribing a restricted antimicrobial, the prescriber should first consider all other antimicrobial options (in line with SFH Antimicrobial Guidelines) and prescribe alternative agent(s) whenever possible.

If the required use of the restricted antimicrobial falls within the exception criteria (as listed below), the agent may be prescribed. The prescription must be endorsed with the approved clinical indication.

If the prescriber considers that there is no alternative therapy to the restricted antimicrobial and no exception criterion applies:

During weekday working hours (09.00 to 17.00 Monday to Friday)

- The prescriber must contact a Microbiologist to discuss the patient and seek approval
- The prescriber must be of adequate seniority to undertake an informed clinical discussion and wherever possible, the case should have been discussed with the patient's consultant

Out-of-hours (After 17:00 Monday to Friday, Saturday, Sunday and Bank Holidays)

- Pharmacy may supply minimum required doses of a restricted antimicrobial without microbiologist approval after exercising judgement and discussion with prescriber for clinical indication.
- This allows therapy to continue until the following day, when the patient must be reviewed by their own team and the case discussed with a Microbiologist

Restricted Agent	Exception criteria / Approved Clinical indications ALL other indications require <u>documented</u> Medical Microbiologist approval
<u>Liposomal Amphotericin B</u> (Gilead previously known as Ambisome® or Tillomed)	• Approval by Consultant Medical Microbiologist or Haematologist only
<u>Amikacin IV</u>	• Cystic fibrosis in children (Paediatric Consultant approval) • Otherwise, approval by Consultant Medical Microbiologist only
<u>Aztreonam</u>	• Severe HAP incl. aspirational HAP if severe penicillin allergy or allergic to cephalosporins and failed (or resistant to) levofloxacin • Obstetric infections in patients with severe penicillin allergy • Cystic fibrosis • Otherwise, approval by Consultant Medical Microbiologist
<u>Aztreonam/Avibactam (Emblaveo)</u>	• Approval by Consultant Medical Microbiologist only
<u>Anidulafungin</u>	• Second-line antifungal. Approval by Consultant Medical Microbiologist only
<u>Caspofungin</u>	• First-line antifungal. Approval by Consultant Medical Microbiologist only
<u>Cefazolin</u>	• Approval by Consultant Medical Microbiologist only
<u>Cefiderocol</u>	• Approval by Consultant Medical Microbiologist only

Cefixime	- Gonococcal infection if IM injection is contra-indicated or refused by patient (GUM use only) - Otherwise, approval by Consultant Medical Microbiologist
<u>Ceftazidime/Avibactam</u> (Zavicefta®)	Approval by Consultant Medical Microbiologist only
Ceftolozane/Tazobactam (Zerbaxa)	Approval by Consultant Medical Microbiologist only
<u>Cefuroxime</u> PO (Oral)	Approval by Consultant Medical Microbiologist only
<u>Chloramphenicol</u> IV/PO	- Bacterial meningitis for patients <60 years of age and severe penicillin allergy or allergy to cephalosporins - Otherwise, approval by Consultant Medical Microbiologist
<u>Colistimethate Sodium</u> (as Colomycin) IV	Infective exacerbations of bronchiectasis in patients with <i>Pseudomonas aeruginosa</i> infection and a penicillin allergy, and only on the advice of a Respiratory Consultant.
<u>Dalbavancin</u>	Approval by Consultant Medical Microbiologist only
<u>Daptomycin</u>	Approval by Consultant Medical Microbiologist only
<u>Ertapenem</u>	Approval by Consultant Medical Microbiologist only. For use in OPAT / SDEC (Meropenem – 1st line carbapenem for inpatients)
<u>Fosfomycin</u> IV	Approval by Consultant Medical Microbiologist only
Ganciclovir	Approval by Consultant Medical Microbiologist or Haematologist only
Imipenem–cilastatin	Multi-drug resistant tuberculosis (MDR-TB) on approval by Respiratory or Consultant Medical Microbiologist only
<u>Isavuconazole</u>	Approval by Consultant Medical Microbiologist or Haematology consultant
<u>Moxifloxacin</u>	- Multi-resistant TB or where other first line TB treatments are considered inappropriate by ID/Respiratory Consultant 2nd line agent for treatment of Pelvic inflammatory disease or other sexually transmitted infections (GUMed) by GUM/ Sexual Health consultant - Otherwise, approval by Consultant Medical Microbiologist
<u>Ofloxacin</u>	Approval Microbiology Consultant only
<u>Rifampicin</u>	- Combination therapy in TB and leprosy treatment. - Post-exposure prophylaxis for Meningococcal and <i>Haemophilus influenzae B</i> infections. - Treatment of serious Staphylococcal infections (eg. Endocarditis, epidural abscess). <i>NB Rifampicin should not be used as a single agent (except in meningitis post-exposure prophylaxis)</i>
<u>Temocillin</u>	Approval by Consultant Medical Microbiologist only

<u>Tigecycline</u>	Approval by Consultant Medical Microbiologist only
<u>Tobramycin</u> IV	- Cystic fibrosis - Otherwise, approval by Consultant Medical Microbiologist
<u>Voriconazole</u>	- Treatment of Aspergillosis (Approval by Respiratory consultant) - Otherwise, approval by Consultant Medical Microbiologist or Haematologist

APPENDIX F - Methods of IV administration of commonly used antibiotics in adults

For antimicrobials not listed in the table below, please refer to the [Medusa](#) guide via Trust Intranet

Antibiotic	Option 1 (bolus)	Option 2 (infusion)	High-risk patients: - critically ill or - if high MIC* as per microbiology
Amoxicillin	Bolus 3-5min [C]	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml NS [C]	Option 2 preferred
Aztreonam	Bolus 3-5min	Gravity/pump infusion (100ml NS over 30-60min) and flush* giving set with 25ml NS OPAT – elastomeric pumps available	Option 1 or 2
Benzylpenicillin	Bolus doses ≤ 1.2g over 5min; doses >1.2g, max rate 300mg/minute	Gravity/pump infusion (100ml NS over 30-60min) and flush* giving set with 25ml NS	Option 1 or 2
Ceftazidime	Bolus doses ≤ 2g over 3-5min	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml NS. OPAT – elastomeric pumps available; can bolus 3g doses as well	Option 1 or 2
Ceftriaxone	Bolus doses ≤ 2g over 5min	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml NS	Option 2 preferred
Cefuroxime	Bolus 3-5min	Gravity/pump infusion (50-100ml NS over 30-60min) and flush* giving set with 25ml NS	Option 1 or 2
Chloramphenicol	Bolus 3-5min	Gravity/pump infusion (100ml NS over 30-60min) and flush* giving set with 25ml NS	Option 1 or 2
Ciprofloxacin	N/A	Gravity/pump infusion (400mg over 60min) and flush* giving set with 25ml NS [C]	Option 2 only
Clindamycin	N/A	Infusion, preferably using a pump (volume and duration depending on dose) and flush* giving set with 25ml NS. If pump not available can use gravity infusion	Option 2 only
Co-amoxiclav	Bolus 3-5min [C]	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml NS [C]	Option 1 or 2
Daptomycin	IV bolus min 2 min [C]	Gravity/pump infusion (50ml over 30 min) and flush* giving set with 25ml NS [C]	Option 1 or 2
Flucloxacillin	Bolus doses 1g (or less) over 3-4 min and doses of 2g over at least 8 min	Gravity/pump infusion (100ml NS or G over 30min) and flush* giving set with 25ml NS	Option 1 or 2
Fosfomycin	N/A	Infuse using pump (volume and duration depending on dose; dilute with G) and flush* the giving set with 25ml NS [C]	Option 2 only

Antibiotic	Option 1 (bolus)	Option 2 (infusion)	High-risk patients: - critically ill or - if high MIC* as per microbiology
Gentamicin	Local practice up to 80mg IV bolus min 3 min [C]	For once daily regimen - infuse using pump (100ml NS over 60min and flush* giving set with 25ml of NS [C]	Depending on regimen - Option 2 for Once daily dosing
Levofloxacin	N/A	Infusion using a pump (250mg over 30min; 500mg over 60min; 750mg (unlicensed dose) over 90 min) and flush* giving set with 25ml NS [C]	Option 2 only
Meropenem	Bolus doses up to and including 1g min 5 min	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml NS	Option 2 preferred or Extended Infusion (see separate guidance)
Metronidazole	N/A	Gravity/pump infusion (ready diluted over 30-60min) and flush* giving set with 25ml NS	Option 2 only
Tazocin (Piperacillin/ Tazobactam)	N/A	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml on NS OPAT – elastomeric pumps available	Option 2 or Extended Infusion (see separate guidance)
Teicoplanin	Bolus up to 800mg over 3 – 5 min	Gravity/pump infusion (100ml NS over 30min) and flush* giving set with 25ml NS	Option 1 or 2 depending on dose
Vancomycin	N/A	Infusion using a pump (volume and duration depending on Trust protocol) and flush* giving set with 25ml NS [C]	Option 2 or Continuous Infusion (see separate guidance)

*Flush the set at the same speed as the main infusion

[C] – Administration via central route is preferable. If a central venous access device is unavailable, administer via a large peripheral vein, monitoring closely, and re-site cannula at first signs of inflammation.

G – Glucose 5%

MIC – Minimum Inhibitory Concentration

NS – 0.9% Sodium Chloride

NB: Alternative infusion fluids and volumes may be acceptable in certain circumstances (i.e. fluid restriction) – check [Medusa](#) or contact pharmacy

Last updated: June 2021

APPENDIX G - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Equality Impact Assessment (EIA) Form (Please complete all sections)

EIA Form Stage One:

Name EIA Assessor: Siew Quen Lim		Date of EIA completion: 27 August 2025
Department: Medicines Management (Pharmacy)		Division: Clinical Support, Therapies and Outpatients
Name of service/policy/procedure being reviewed or created: Antimicrobial Prescribing Policy		
Name of person responsible for service/policy/procedure: Siew Quen Lim		
Brief summary of policy, procedure or service being assessed: Policy as above.		
Please state who this policy will affect: Patients or Service Users, Carers or families, Commissioned Services, Communities in placed based settings, Staff, Stakeholder organisations, Others (give details) (Please delete as appropriate)		
Protected Characteristic	Considering data and supporting information, could protected characteristic groups' face negative impact, barriers, or discrimination? For example, are there any known health inequality or access issues to consider? (Yes or No)	Please describe what is contained within the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening. Please also provide a brief summary of what data or supporting information was considered to measure/decipher any impact.
Race and Ethnicity	No	
Sex	No	
Age	No	
Religion and Belief	No	
Disability	No	
Sexuality	No	
Pregnancy and Maternity	No	

Gender Reassignment	No	
Marriage and Civil Partnership	No	
Socio-Economic Factors (i.e. living in a poorer neighbour hood / social deprivation)	No	

If you have answered 'yes' to any of the above, please complete Stage 2 of the EIA on Page 3 and 4.

What consultation with protected characteristic groups including patient groups have you carried out? N/A
As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? No.

On the basis of the information/evidence/consideration so far, do you believe that the policy / practice / service / other will have a positive or negative adverse impact on equality? (delete as appropriate)						
Positive			Negative			
High	Medium	Low	Nil	Low	Medium	High
If you identified positive impact, please outline the details here:						

EIA Form Stage Two:	les of evidence and data, what the impact of the Policy, Procedure or Service/Clinical Guideline will be on the protected characteristic group.	Please outline any further actions to be taken to address and mitigate or remove any in barriers that have been identified.
----------------------------	---	--

Race and Ethnicity		
Gender		
Age		
Religion		
Disability		
Sexuality		
Pregnancy and Maternity		
Gender Reassignment		
Marriage and Civil Partnership		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)		

Signature: Siew Lim

I can confirm I have read the Trust's Guidance document on Equality Impact Assessments prior to completing this form

Date: 27 August 2025