Royal Cornwall Hospitals
NHS Trust

Dermatology Procedure Room Clinical Guideline

V2.0

July 2024

1. Aim/Purpose of this Guideline

1.1. This guideline is written for members of the RCHT dermatology department who are responsible for managing patients undergoing a surgical procedure as an outpatient or as a day-case appointment. 'Surgical procedures' within the Dermatology Department include (but are not limited to) punch biopsy, curettage and cautery, shave excision, surgical excision, wound closure, complex reconstruction with a local flap or skin graft and Mohs surgery. **This guideline relates to procedure rooms at RCH and at any peripheral site where dermatology patients attend for their planned surgical procedure, as all clinicians operating within this remit should read and comply with these guidelines.**

The aim of this document is to outline the recommended practice for managing patients from the time they enter the procedure room until they leave.

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

1.3. This guideline should be read in conjunction with the following documents:

1.3.1. Clinical guideline for the pre-operative management of patients who require a surgical procedure in the dermatology department (waiting ratification).

1.3.2. Dermatology unit practice standards clinical guideline (waiting ratification).

1.3.3. Dermatology unit surgical practice standards clinical guideline (waiting ratification).

1.3.4. Dermatology excision of skin lesion procedure specific consent form (waiting ratification).

1.3.5. LOCAL PROCEDURE FOR: Nurse Led Diagnostic Biopsies.

1.3.6. RCHT Five steps to safer surgery.

1.3.7. RCHT CONSENT POLICY.

1.3.8. RCHT Infection Prevent and Control (IPAC) Policy.

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

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 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 cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. Staffing Levels

2.1.1. The minimum safe staffing level for:

Same day simple biopsy with responsible clinician onsite (e.g. punch biopsy, shave biopsy, curettage, and cautery) is one competent Registered Nurse (RN) and one Healthcare Assistant (HCA).

Simple biopsy as day-case procedure is two RN's, one of whom should be band 6 or above.

Excision of a skin lesion, wound closure, or more complex procedures (e.g. skin grafting) is one operating clinician (Doctor or Qualified Nurse Specialist), one competent RN and one competent HCA.

2.1.2. If these minimum levels of experience and staff numbers cannot be met for any reason, a procedure should not be performed.

2.2. Team Pre-Brief

This should take place at the start of the clinical session, before calling the first patient into the procedure room. It is a verbal discussion, led by a designated member of the team and recorded on the dermatology WHO briefing form and should be stored electronically. "Silent cockpit" principles should be observed, and all elements of the form must be considered and recorded against. These elements include.

- Staffing levels and any other relevant personnel-related factors,
- List order and timings.
- Available equipment.
- A brief discussion of each surgical case and the planned procedures reviewed.

- Any specific equipment or patient-related requirements should be discussed.
- All staff given the opportunity to raise any concerns of any nature.
- Any changes or alterations to the list order should be agreed and a new list printed once these have been confirmed by the team.
- The list should not proceed until any concerns have been addressed to the satisfaction of the whole team.

2.3. Air Exchange/Ventilation Units

All procedure rooms within the dermatology department require a minimum of 10 air exchanges per hour as standard. However not all the procedure rooms in the department meet this requirement. Where they do not meet the requirement through a permanent piped ventilation system, then a mobile ventilation unit is required within the procedure room and must be operating **whilst any procedure is carried out**. Therefore, staff must:

- **Turn on the mobile air exchange unit at the beginning of the day and**
- **Switch off the mobile air exchange unit at the end of the day's clinical activity.**

2.4. Pre-Operative Preparation

All patients should receive preoperative instructions. The Dermatology unit patients will be consented using the procedure specific consent form (PSCF) wherever possible and will be given the dermatology day-case procedures patient information leaflet, which provides specific details regarding washing, anticoagulants, anti-platelets and other preoperative advice regarding smoking, alcohol etc.

2.5. "Sign In"

2.5.1. All members of the team must introduce themselves and observe "silent cockpit," whilst a designated member of the team performs the WHO "sign in." This includes:

- Patient identity check.
- Questions regarding allergy status.
- Risk factors for bleeding.
- Presence of an implanted cardiac device.

2.5.2. Following confirmation of the patient's details these should be added to the procedure room white board.

2.6. Verification of Surgical Site(s) and Procedure(s)

2.6.1. The operator must review the patients' electronic and paper-based medical records **to ensure that all medical records align with planned surgical procedure, specifically**:

- The day-case booking form.
- Preoperative digital images.
- First stage consent (where this has been performed) +/- previous correspondence, where relevant.

2.6.2. Once satisfied with the intended site and procedure, this should be confirmed with the patient and the procedure room staff. The patient should be asked to confirm the site visually, with the aid of a mirror where appropriate. If possible, the discussion regarding site and nature of procedure should also involve those close to the patient.

2.7. Change to Intended Booked Procedure.

2.7.1. It is not uncommon for skin lesions to change in the time between booking and day-case surgery. On the day of surgery, the operator should make a clinical assessment as to whether the booked procedure remains appropriate. If the operator feels a change in plan is required for example, if a lesion booked for excision appears to be resolving and the operator feels a biopsy or conservative management is more appropriate or a different lesion should be excised as a clinical priority, then, this should be discussed with the patient and written consent for the revised procedure obtained. If the referring clinician is available, they can be invited to be involved in the pre-operative discussion. Otherwise, provided the operator and patient agree with the revised procedure, and then this should be performed. Following the procedure a letter must be dictated to the referring clinician, with a copy also being sent to the patient's General Practitioner (GP), explaining the rationale for the change in plan.

2.7.2. If there is any doubt in the operator's mind as to the correct procedure to perform and the referring clinician is not available to discuss the case, the procedure should be cancelled, and an urgent letter dictated to the referring clinician.

2.7.3. If a lesion is amended to be biopsied rather than excised, then a digital image with the biopsy site clearly marked should be obtained and uploaded to the patient's electronic medical record.

2.8. Marking of Surgical Site

2.8.1. The appropriate surgical margin should be inked on the patient with a semi-permanent surgical marker pen and should outline the lesion to be operated on.

2.8.2. Following marking, a further discussion with the patient takes place regarding the intended surgical procedure. This discussion must include a summary of the pros and cons of the various potential forms of wound management / closure, including e.g., where appropriate; primary closure, second intention healing and complex repair with skin flap or graft.

2.8.3. Extra markings to facilitate the agreed procedure can be made at this point, or later under sterile conditions once the patient has undergone antiseptic skin preparation and draping.

2.9. Patients with an Implanted Cardiac Device

Patients with an implanted cardiac device should be identified during the WHO "sign in" process and by review of the electronic booking information. Essentially to note, Bipolar electrocautery is the only form of electrocautery that should be used on these patients. The operator should check that the nature of the cardiac device has been assessed in advance by a member of the dermatology team and an appropriate comment made on the operating list. If the device is an implantable cardiac defibrillator or the procedure might require electrocautery within 5cm of the device, a cardiac technician must be present during the procedure to deactivate/monitor the device. This should have been arranged in advance, but it remains the responsibility of the operator to check on the day and should be identified at the pre-list brief. At this point the cardiac department should be contacted if required. If a technician is not available on the day, then the procedure must be cancelled and rebooked when one can be available.

2.10. Patients taking Anticoagulants and Antiplatelet Medication

Anticoagulant and anti-thrombotic medication increases the risk of peri and postoperative bleeding, however the risk of vascular events on stopping these medications usually outweighs this. These factors should have been considered preoperatively by the referring clinician, with reference to the BSDS guidance on anti-thrombotic medication and skin surgery (where necessary). The operator needs to further consider these risks on the day of surgery and amend or postpone the procedure if they feel that there is an unacceptable bleeding risk. Patients on warfarin, with an INR >3.5, or those without an INR performed within the preceding week may need to be postponed. This decision should be made by the operator on the day, following an open discussion with the patient.

2.11. Consent

Once the surgical plan has been agreed with the patient and procedure room staff, the skin marked and all other risk factors considered, then informed consent must be obtained according to the RCHT consent policy. Where a PSCF has been given to the patient in advance, this should be used. Otherwise, the relevant RCHT consent form should be used. Once the procedure has been agreed and the patient consented, the procedure to be performed should be clearly stated on the procedure room whiteboard (exactly as articulated on the consent form).

2.12. Antiseptic Skin Preparation and Draping

The following should be used for antiseptic skin preparation:

- First choice: Chloraprep for non-hair bearing skin distant to any mucous membranes (including eyes, internal ear, mouth, or genitalia).

- Chloraprep should be painted onto the skin for 30 seconds and allowed to air-dry for at least 2 minutes.

- Second choice: 4% Aqueous Chlorhexidine (e.g. Hibiscrub) for hair bearing areas or around the mouth, excluding those below.

- Third choice: 7.5-10% Aqueous Povidine-iodine (e.g. Videne) for skin around the eyes and internal ear or genitalia.

- Chlorhexidine and iodine aqueous solutions should be painted onto the skin and allowed 2 minutes of contact time before drying with sterile gauze prior to surgery.

- Sterile drapes should be used to exclude all but the surgical field.

- (More detailed guidance regarding skin preparation and draping is available in the Dermatology Unit Surgical Practice Standards – Clinical Guideline).

2.13. Local Anesthetic

"Dental" cartridges containing 2% lidocaine with 1:80,000 Adrenaline are appropriate for most small to moderate sized dermatology procedures. The reported maximum safe dose of lignocaine varies from source to source. The BNF states that the dose for local infiltration should be given according to patient's weight and nature of procedure. They quote a maximum of 200mg without adrenaline, 500mg if solutions contain adrenaline. Five hundred mg = 25ml of 2% solution. Solutions containing adrenaline should be avoided in circumferential blocks e.g. digital nerve block. Bupivacaine can be used if longer acting anesthesia is required. Maximum safe dose is up to 150mg (BNF). One hundred and fifty mg = 30ml of 0.5% solution (60ml of 0.25% solution).

2.14. "Time Out"

This stage of the WHO checklist should be performed **after** verification of the surgical site, marking and consent **but before** administration of local anaesthetic. A "silent cockpit" must be observed, and a designated member of the team asks the relevant questions out loud. Provided the team and patient all agree then the procedure can be performed. The 'scrub nurse' should read the consent form and confirm that it has been completed in full and confirm the procedure with the operator, as part of "time out".

2.15. Sterile Trolley Preparation

The scrub/circulating nurse opens the outer wrapper of the instrument set onto a clean trolley and the scrub nurse sets up the trolley. Any tracing labels should be removed and inserted into the patient's paper medical record. Instruments are counted into the sterile field by both individuals visually and verbally and the circulating nurse ticks them off on the set list. Additional items such as blades, sutures, additional swabs, surgical marker pen are added to the trolley and recorded on the Procedure room white board. The scrub nurse should be aware of the location of all items within the sterile field at all times during the procedure. Counts should be recorded in the paper medical record at the time they are performed.

2.16. Specimen Processing

At the time of specimen retrieval, the specimen will be placed into an appropriate specimen pot by the operating surgeon. It is the responsibility of the circulating nurse to accurately label the pot. Before the specimen is placed in the pot, patient details must be confirmed verbally with the patient and a patient identifier label placed on the pot. The circulating nurse must handwrite the nature and site of the specimen on the pot immediately. These details should be dictated to the circulating nurse by the operator.

2.17. Removing Swabs/Instruments during the Procedure

Anything removed from the sterile field during the procedure (e.g. used swabs) must be placed in a designated area, within sight of the scrub nurse, to facilitate accurate counts.

2.18. Final Counts

Further counts of all the items named on the instrument list and the Procedure room white board are made at the commencement of wound closure and at the end of the procedure, **before** "sign out." If an item is missing from the count, this must be clearly vocalised by the scrub nurse. Wound closure must pause until the wound is checked and a thorough search of the surroundings made. If an item is still missing, the patient must be informed, and an incident report completed. Further action (for example, X-Ray for radio-opaque items) should be considered and the incident reported to the dermatology Sister or deputy at the time.

2.19. Histology

2.19.1. The histology request form should be completed by the operator **before** "sign out." As the dermatology department runs "shared" lists, it is very common for the operator and referring clinician to be different people. On the day of surgery, the operator should mark themselves as the requesting clinician, but the referring dermatologist as the responsible clinician. This will ensure that the result goes to the referring clinician for ongoing action and patient management.

2.19.2. The clinical diagnosis, site, size, macroscopic margin taken, and method of closure must be recorded in the clinical details part of the form. For example, for a BCC on the right forearm measuring 6mm in diameter, removed with a 4mm margin and closed primarily one would write: "4mm wide local excision of 6mm BCC right forearm, primary closure." For sites where deeper excision might be problematic, the deep surgical margin should also be documented – e.g. whether the cranial aponeurosis has been resected and whether an excision on the dorsum of the hand has been completed down to fascia/tenovium.

2.19.3. The specimen pot details should be checked against the form before the patient leaves the procedure room.

2.20. Post-Procedure Information

Post-procedure care should be agreed with the Operator and nursing staff and communicated clearly to the patient, checking that they understand the information and aftercare required. Verbal advice should be supplemented with a written information leaflet. If community nurse input (beyond simple suture removal is required, a referral document should be completed and given to the patient. A record of written information given to the patient should be made in the medical record. A nominated individual close to the patient can be invited to be part of this discussion, if appropriate.

2.21. Procedure Note

This should be completed by hand or electronically and filed in the patient paper medical record, **before** the next case begins and should include, at a minimum, the following information:

- Patient identifiers (e.g. patient label).
- Name of Operator(s).
- Name and site of procedure.
- Type, concentration and volume of local anesthetic used.
- Method of removal and surgical margin (where appropriate).
- Relevant intra-operative findings.
- Type of wound closure.
- Type of sutures used for deep layers.
- Type of sutures used for superficial layers.
- Salient post-operative instructions, including proposed timeframe for removal of sutures.
- Type, and dose of perioperative or postoperative antibiotic prophylaxis.

2.22. Discharge Summary

In addition to the procedure note, an electronic discharge summary should be completed for the patient's paper medical record and a copy forwarded to the patient's GP. This should include:

- Date and type of admission (usually day-case).
- Indication for the procedure.
- Nature of procedure.
- Type of closure.

- Postoperative instructions, with reference to suture removal or wound management in primary care.

- If further lesions are listed or relisted for treatment at a future date, this should be noted.

2.23. Re-listing Multiple or New Lesions

2.23.1. It is departmental practice that multiple lesions are booked on a single day-case booking form, even if it is anticipated that treatment will require more than one visit. The operator should perform the most urgent procedure(s) on the day and relist any remaining procedures on a new day-case booking form. The aim of this practice is to prevent a situation where there are multiple booking forms in play for a patient at one time. The exception is Mohs surgery, which should be booked on a separate booking form.

2.23.2. If a new lesion is identified as requiring treatment at a future date, a digital image should be captured for upload to the medical record, as per ‘the clinical guideline for the pre-operative management of patients who require a surgical procedure in the dermatology department’.

2.24. Antibiotic Prophylaxis

Antibiotic prophylaxis is not warranted routinely for patients undergoing surgical procedures in the dermatology unit. Patients with high risk factors may be considered for perioperative parenteral or postoperative oral antibiotic prophylaxis on an individual basis. Any antibiotics must be prescribed on the electronic patient record and recorded on the procedure note and GP summary.

2.25. Personal Protective Equipment (PPE)

2.25.1. Minimum PPE for “minor” procedures, (including punch biopsy, curettage and cautery and shave excision) should include:

- Sterile gloves.
- Splash proof face mask.
- Eye protection.
- Non-sterile plastic apron.

2.25.2. Any more extensive procedure, (including excision of skin lesion or reconstruction of a surgical wound) should be performed with:

- Sterile gown.
- Gloves.
- Splash-proof face mask.
- Eye protection.

2.25.3. Gown and gloves should be donned in an aseptic manner, as described in “Dermatology Surgical Practice Standards – Clinical Guideline.”

2.26. “Sign out”

2.26.1. This final part of the WHO checklist should be performed by a designated member of the surgical team at the **end** of the procedure before the patient or any of the team leaves the procedure room. “Silent cockpit” must be observed.

2.26.2. Sign out includes:

- Verbal confirmation that the name and site of the procedure have been accurately recorded.
- That any specimens have been labelled correctly.
- That instrument and swab counts are correct.
- Postoperative instructions have been given and understood by the patient.

2.27. Post-List Briefing

This should take place at the **end** of the session, before any member of staff leaves the procedure room and recorded on the relevant paper or electronic WHO briefing form. “Silent cockpit” should be observed. All members of the procedure room team should be involved in the discussion, which aims to identify factors which went well during the session and any safety or efficiency issues which came to light which might require attention.

Antibiotic prophylaxis is not warranted routinely for patients undergoing surgical procedures in the dermatology unit. Patients with high risk factors may be considered for perioperative parenteral or postoperative oral antibiotic prophylaxis on an individual basis. Any antibiotics must be prescribed on the electronic patient record and recorded on the procedure note and GP summary.

2.28. Post Infection Cleaning and Decontamination

There may on occasion, be a patient who is operated on that has a communicable infection. Ideally this patient will be last on the operating list (AM or PM lists), to avoid disruption secondary to post procedure cleaning and decontamination requirements.

If this should be identified, then the RCH IPAC Policy for environmental cleaning and decontamination must be followed. This will include:

- The use of cleaning with detergent.
- Decontamination with actichlor.
- Essential drying time post actichlor.
- Further cleaning with detergent.

2.29. Air cooling systems

As there is no piped air-cooling system in the procedure rooms, the temperature can become uncomfortable for working in. Within the procedure rooms there are wall mounted air-cooling units which are serviced annually by an external company through our internal estates team.

There is a potential of increased infection risk using these units (Risk number 9107 on the departmental risk register). Therefore, these units must only be used when:

- The working temperature in the procedure rooms exceeds what is comfortable and tolerable to work in.
- The patient is unable to tolerate the temperature.
- There must be an agreement between colleagues in the procedure room that the unit needs to be switched on to reduce the environmental temperature.

The air-cooling unit must be switched off if the temperature reduces sufficiently to allow continued working without the machine being on.

To Note: Post surgical site infection rates are monitored and should a rise be identified, following investigation then this SOP would be reviewed.

3. Monitoring Compliance and Effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Procedure Room in Dermatology.
Lead	Dermatology Sister and Dermatology Governance Lead.
Tool	Trust wide WHO Audits Tool.
Frequency	Monthly Audit.
Reporting arrangements	WHO auditing feeds into the Safer Surgery Committee, that informs the Care Group.
Acting on recommendations and Lead(s)	Dermatology Sister and Clinical Lead. Required actions will be identified and completed in a specified timeframe.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within appropriate. 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.

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 And Inclusion 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

Information Category	Detailed Information
Document Title:	Dermatology Procedure Room Clinical Guideline V2.0
This document replaces (exact title of previous version):	Dermatology Procedure Room Clinical Guideline V1.0
Date Issued/Approved:	March 2024
Date Valid From:	July 2024
Date Valid To:	July 2027
Directorate/Department responsible (author/owner):	Dr Alexander Anderson (Dermatology Clinical Lead). Sarah Carswell (Dermatology CNS).
Contact details:	01872 252859.
Brief summary of contents:	Dermatology Procedure Room Standards.
Suggested Keywords:	Dermatology Procedure Room Standards.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Dermatology specialty Tri, Dermatology Business and Governance Members, Care Group Governance Meeting, Care Board meeting.
Manager confirming approval processes:	Roz Davies, Specialist Services and Surgery (SSS) General Manager.
Name of Governance Lead confirming consultation and ratification:	Maria Lane.
Links to key external standards:	None.
Related Documents:	Dermatology Unit Practice Standards Clinical guideline V1.0. Dermatology Unit Surgical Practice Standards Clinical guideline V1.0.
Training Need Identified?	No.

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet.
Document Library Folder/Sub Folder:	Clinical Dermatology.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2021.	V1.0	Initial issue.	Dr Alexander Anderson (Dermatology Clinical Lead). Sarah Carswell (Dermatology CNS).
July 2024.	V2.0	Update on ventilation units, air cooling systems and procedure room post infection cleaning.	P Hunkin with agreement from JT (IPAC).

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy/policy/proposal/service function to be assessed:	Dermatology Procedure Room Clinical Guideline V2.0
Directorate and service area:	Dermatology, Specialist Services and Surgery.
Is this a new or existing Policy?	Existing.
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sarah Carswell (Dermatology CNS).
Contact details:	01872 252859.

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed).	This guideline is written for members of the RCHT dermatology department who are responsible for managing patients undergoing a surgical procedure as an outpatient or as a day-case appointment.
2. Policy Objectives	To standardise practice.
3. Policy Intended Outcomes	Reflect the policy standards in practice - all staff.
4. How will you measure each outcome?	WHO Audit.
5. Who is intended to benefit from the policy?	Staff and patients.
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/visitors: No • Local groups/system partners: No • External organisations: No • Other: No

Information Category	Detailed Information
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/groups:** Safer Surgery Group.
6c. What was the outcome of the consultation?	Approved.
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** Safer Surgery Group.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sarah Carswell, Dermatology CNS

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here: Section 2. Full Equality Analysis