INFANTILE HAEMANGIOMA – PROPRANOLOL CLINICAL GUIDELINE

Infantile Haemangioma

Complicated e.g. by position or ulceration

Review by consultant Dermatologist or Paediatrician

Contra-indications to Propranolol

Yes → Consult dermatology

No

Commencement of propranolol

Propranolol to commence as an inpatient on Polkerris

Age

< 8 weeks or complex patient

≥ 8 weeks and otherwise well

Propranolol to commence as a day case on Harlyn

Refer to guideline for propranolol commencement: clerking to ensure still appropriate for treatment, prescription and plan for observations

Discharge: Usually there are no complications so plan for discharge: prepare TTO and talk through the patient information leaflet with the family
1. **Aim/Purpose of this Guideline**

1.1. This guideline is designed to support clinical staff, both medical and nursing, involved in the care of an infant diagnosed with an infantile haemangioma.

2. **The Guidance**

2.1 **Overview of infantile haemangiomas**

**Introduction:** Infantile haemangiomas (IH) are common, benign vascular tumours, affecting around 5% of infants. Their typical natural history is appearance in the first few days of life, followed rapid proliferation for the first 8 weeks or so, then slower proliferation until about 1 year of age, and then gradual involution, which can take up to 10 years. Around one third are present at the time of birth in some premonitory form such as a blanched macule, a telangiectatic patch or a cluster of red papules.

2.2 **Epidemiology:** IH are more common in:

- Girls
- Caucasian
- Preterm
- Low birth weight

2.3 **Features:** IH predominate on the head and neck (80%) but may occur anywhere on the body. They can be superficial, deep or mixed and all three types undergo the same natural history. Deep, or cavernous, IH are skin-coloured or bluish purple and less well circumscribed than their superficial counterparts. Lesions can also be focal or segmental, the latter being larger, plaque-like and distributed in a developmental region.

2.4 **Pathogenesis:** IH represent localised or regional areas of abnormal vascular development and proliferation. The explanation as to why this happens is not fully understood. One theory is that they may be of placental origin – e.g. via embolisation – because haemangioma and placental cells are phenotypically very similar. Another theory is the role of *in utero* hypoxia. This is supported by the association with hypoxic placental changes, e.g. prematurity, low birth weight and retinopathy of prematurity (which is hypoxia-induced neovascularisation).

2.5 **Complications:** These occur in up to 12% and include:

- Ulceration
- Infection
- Bleeding
- Impairment of function e.g. vision, airway compromise.
- Permanent disfigurement e.g. nasal tip haemangioma
- Thrombocytopenia (*rare*)
- High output cardiac failure (*rare*)

2.6 **Associations:**

- Visceral haemangiomas can rarely occur, typically in the liver. These are
usually harmless but may become large and cause problems similar to those experienced with large cutaneous IH (high output cardiac failure, thrombocytopenia). They are more common in infants with more than 5 cutaneous haemangiomas and are imaged using ultrasound.

- **Spinal dysraphism and/or anogenital anomalies** can occur in infants with segmental or larger (>2.5cm) focal haemangiomas overlying the lumbosacral region. The association with smaller focal haemangiomas is unclear.

- ** Syndromes:** Large haemangiomas, particularly on the face, can be associated with extracutaneous anomalies, especially in female infants. The term PHACE(S) syndrome was coined for the spectrum of findings:

  - P: Posterior fossa and other structural brain malformations
  - H: Haemangioma
  - A: Arterial anomalies of cervical and cerebral vessels
  - C: Cardiac defects, especially coarctation of the aorta
  - E: Eye anomalies
  - S: Sternal defects and subra-umbilical raphe

**2.7 Treatment.** Oral propranolol is the most effective treatment for IH. Laser is only effective in treating ulcerated lesions which are not responding to propranolol. Complex lesions where there is airway compromise may be co-treated with oral steroids, usually following advice from a specialist centre.

**2.8 Overview of oral propranolol treatment for infantile haemangiomas**

**Responsibility of decision to treat**
- Decision to treat is made by consultant dermatologist or paediatrician (usually both)
- In agreement with the parents or caregivers

**Information about propranolol**
- Target dose 1-3 mg/kg/day in 3 divided doses, most commonly 2mg/kg/day
- Peak effect on BP and HR at 2 hours post oral dose, effect most prominent after 1\(^{st}\) dose.

**Timing of treatment:** Optimal referral is < 8 weeks, but treatment can still be beneficial < 9 months of age.

<table>
<thead>
<tr>
<th>Indications for treatment</th>
<th>Contraindications to treatment</th>
<th>Potential side effects of propranolol</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Ulceration +/- infection</td>
<td>- Cardiogenic shock</td>
<td>- Bradycardia</td>
</tr>
<tr>
<td>- Bleeding</td>
<td>- Sinus bradycardia</td>
<td>- Hypotension</td>
</tr>
<tr>
<td>- Pain</td>
<td>- Hypotension</td>
<td>- Heart failure</td>
</tr>
<tr>
<td>- Impairment of function e.g. vision or airway</td>
<td>- 2(^{nd}) or 3(^{rd}) degree heart block</td>
<td>- Cardiac conduction disorder</td>
</tr>
<tr>
<td>- Risk of permanent disfigurement e.g. nasal tip</td>
<td>- Asthma</td>
<td>- Bronchospasm</td>
</tr>
<tr>
<td>- Risk of permanent anatomical disarrangement e.g. nipple</td>
<td>- Hypersensitivity to propranolol</td>
<td>- Peripheral vasoconstriction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Weakness and fatigue</td>
</tr>
</tbody>
</table>
Identification or risk of other concerning complication such as high output cardiac failure or thrombocytopenia

- Sleep disturbance
- Hypoglycaemia

Drug interactions

Drugs that increase blood levels of propranolol:
- Amiodarone
- Cimetidine
- Fluoxetine
- Quinidine
- Imipramine
- Theophylline

Drugs that decrease blood levels of propranolol:
- Rifampicin
- Ethanol phenytoin
- Phenobarbitone

Drugs that enhance effect of propranolol (making side effects more likely):
- Salbutamol: This is another selective beta agonists (therefore in case of bronchoconstriction requiring treatment aim to manage with ipratropium bromide instead of salbutamol)

Drugs that propranolol enhance the effect of:
- Lidocaine – such as in Bonjela, Denitox and Calgel teething gels. Propranolol increases the risk of lidocaine toxicity.

Checklist: Before starting Propranolol

Ensure the following checks have been completed as required prior to commencement of propranolol therapy.

<table>
<thead>
<tr>
<th>Clinical photograph</th>
<th>This must be taken in every case where treatment with propranolol is commenced.</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Take a full history including, in particular, presence of:</td>
</tr>
<tr>
<td></td>
<td>- Poor Feeding</td>
</tr>
<tr>
<td></td>
<td>- Dyspnoea</td>
</tr>
<tr>
<td></td>
<td>- Tachypnoea</td>
</tr>
<tr>
<td></td>
<td>- Diaphoresis</td>
</tr>
<tr>
<td></td>
<td>- Wheezing</td>
</tr>
<tr>
<td></td>
<td>- Heart Murmur</td>
</tr>
<tr>
<td></td>
<td>- Family history of heart block or arrhythmia</td>
</tr>
<tr>
<td>Examination</td>
<td>Perform a full examination. This should be done by ‘a care provider</td>
</tr>
</tbody>
</table>
experienced in evaluating infants’. Include, in particular:
- Cardiac and pulmonary assessment
- Heart rate
- Blood pressure

**Blood tests**

These are *only* necessary if there is concern for thrombocytopenia such as in very large lesions, in which case take a Full Blood Count.

**ECG**

This is *only* required in the following circumstances (to rule out heart block):
- Heart rate is below normal
- Family history of congenital heart conditions or arrhythmia
- Maternal history of connective tissue disease
- Arrhythmia on auscultation

**ECHO**

This is *not* a necessary screening test prior to propranolol use (unless there are concerns that would normally warrant an ECHO such as heart murmur).

**Abdominal USS**

This is *only* necessary if there is specific concern for visceral involvement such as presence of >5 focal cutaneous haemangiomas.

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**Additional safety notes about propranolol**

<table>
<thead>
<tr>
<th>What to do during a procedure that requires or will involve periods of fasting?</th>
<th>Ensure on-going oral or IV intake of glucose and test preoperative blood glucose levels</th>
</tr>
</thead>
</table>
| Heart Rate monitoring | Significant bradycardia defined as:
  - Babies under 12 months of age: <80bpm
  - Child over 12 months of age: <70 bpm |
| Blood Pressure monitoring | Accurate BP measurements are difficult, use correct cuff size on right arm
  5th centiles for systolic BP on oscillometry are:
  - Neonate <57 mmHg
  - 6 months < 85 mmHg
  - 1 year <88 mmHg |

**Protocol for commencement of propranolol for the management of infantile haemangioma**

**For babies more than 8 weeks old without co-morbidity or airway haemangioma**

<table>
<thead>
<tr>
<th>Before the day of initiation</th>
<th>Book patient in to Harlyn Ward to come in for propranolol initiation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Talk parents through initiation</td>
</tr>
<tr>
<td>Discuss with parents:</td>
<td><em>The process of pre-initiation checks, administration, post-initiation checks and preparation for discharge will take a minimum of 5 hours, if there are no complications at all.</em></td>
</tr>
</tbody>
</table>
### INFANTILE HAEMANGIOMA – PROPRANOLOL PROTOCOL NEONATAL CLINICAL GUIDELINE

| Protocol |  
| --- | --- |
| • This is to ensure the safety of the treatment for their baby.  
• It may also be useful for them to know that propranolol is optimally commenced during or soon after a feed (to allow them to plan for this). |  

### On the day of initiation

| Admit to Harlyn Ward |  

### Pre-initiation checks

| Complete pre-treatment checklist  
Take history  
Examine the baby  
Take full set of observations |  
| • Complete pre-treatment checklist, or ensure it has been completed and documented.  
• If pre-treatment checklist has already been performed, the focus of this encounter is a brief confirmation that the baby is well with no significant intercurrent illness or new cardiovascular pathology.  
• Propranolol should not be given during significant intercurrent illness. (i.e. not mild viral illnesses unless causing feeding problems)  
• Pre-treatment heel-prick or serum blood glucose is not necessary unless there are specific reasons to believe this may be low. |

### Propranolol initiation

| Starting dose 0.33mg/kg/dose  
Give soon after a feed (or in the middle of a feed if more convenient) |  
| • Initiate propranolol at starting dose of 0.33mg/kg/dose propranolol hydrochloride (solution strength is 50mg in 5ml).  
• Propranolol should be given (on this initiation and on every subsequent administration by the parents) soon after or even during a feed, to minimise the risk of hypoglycaemia.  
• The parents should be talked through the drawing up and administration of the propranolol because (if all goes well) they will be expected to perform all future administrations. |

### Immediately after initiation

| Monitor for side effects |  
| • Monitor, and ask parents to monitor, for any signs of intolerance such as shortness of breath, feeding intolerance, sweating, reduced alertness (i.e. not waking to stimulation or for feed), reduced tone, change in colour or ‘anything of concern’. |

### Post-initiation checks

| Check heart rate and blood pressure at 1 and 2 hours after the dose |  

### In case of complication

| Take full set of observations |  
| • Perform a full set of observations and examination if any concerns following |
## INFANTILE HAEMANGIOMA – PROPRANOLOL PROTOCOL NEONATAL CLINICAL GUIDELINE

### Reduce subsequent doses
- propranolol administration.
  - Consider checking blood glucose
  - Monitor until observations normalised
  - Discharge the patient once well.
  - Rearrange the propranolol initiation for another day (usually at half the dose).

### Once patient stabilised on initiation dose

<table>
<thead>
<tr>
<th>Post-initiation</th>
<th>Once patient stabilised on initiation dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe TTO</td>
<td>If initial dose has been tolerated well, prepare for discharge.</td>
</tr>
<tr>
<td>Give sufficient 1ml syringes</td>
<td>Prescribe 0.33mg/kg/dose TDS (i.e. a total of 1mg/kg/day) propranolol hydrochloride (solution strength 50mg in 5ml) to take home.</td>
</tr>
<tr>
<td>Talk through ‘Advice to Parents’</td>
<td>Ensure parents are happy with propranolol administration.</td>
</tr>
<tr>
<td>Book into Harlyn Ward in 1 week</td>
<td>Supply parents with sufficient 1ml syringes.</td>
</tr>
<tr>
<td></td>
<td>Talk through ‘advice to parents’ leaflet and give it to them to take home. If you feel the parents need more support in the use of the propranolol at home, inform their health visiting team with the parents’ permission.</td>
</tr>
</tbody>
</table>

### Dose increase visits to Harlyn Ward at 1 week and 2 weeks after initiation

<table>
<thead>
<tr>
<th>On arrival</th>
<th>Check parents happy to proceede</th>
<th>Ask briefly about any new concerns e.g. new side effects or significant intercurrent illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administer the increased dose, if previous doses tolerated well</td>
<td>1 week after initiation: Give dose 0.5mg/kg/dose</td>
<td>If previous dose tolerated well, increase in the first week to 0.5mg/kg/dose propranolol hydrochloride (solution strength is 50mg in 5ml) and in second week to 0.66mg/kg/dose.</td>
</tr>
<tr>
<td></td>
<td>2 weeks after initiation: Give dose 0.66mg/kg/dose</td>
<td>These dose increases should be given as close as possible to the time when the baby’s next dose was due, and not within 6 hours of the last dose.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Propranolol should always be given soon after or even during a feed, to minimise the risk of hypoglycaemia.</td>
</tr>
<tr>
<td>Post-treatment checks</td>
<td>Check heart rate and blood pressure at 1 and 2 hours</td>
<td>Perform these observations sooner if parents raise any concerns.</td>
</tr>
<tr>
<td>In case of complication</td>
<td>Take full set of observations</td>
<td>Consider blood glucose</td>
</tr>
<tr>
<td></td>
<td>Discharge on previous dose</td>
<td>Monitor observations until normalised</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge once well, on previous dose, and</td>
</tr>
</tbody>
</table>
### Further dose increases
- Dose should be adjusted to baby’s weight increase monthly.
- Further dose increases may be necessary if response of the haemangioma to the current dose is insufficient. This will usually be directed by the Consultant Dermatologist at outpatient review.

### Protocol for commencement of propranolol for the management of infantile haemangioma

**For babies less than 8 weeks old corrected gestational age or with co-morbidity (e.g. cardiorespiratory pathology or specific risk of hypoglycaemia) or airway haemangioma**

<table>
<thead>
<tr>
<th><strong>Before the day of initiation</strong></th>
<th>Book patient in to Polkerris ward for propranolol initiation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Talk parents through initiation protocol</td>
</tr>
</tbody>
</table>

**Advise parents:**
- They will usually stay for 1-2 days
- This is to ensure the safety of the treatment for their baby.
- It may also be useful for them to know that propranolol is optimally commenced during or soon after a feed (to allow them to plan for this).

<table>
<thead>
<tr>
<th><strong>On the day of initiation</strong></th>
<th>Admit to Polkerris ward</th>
</tr>
</thead>
</table>

**Pre-initiation checks**
- Complete pre-treatment checklist
- Take history
- Examine the baby
- Take full set of observations

**Complete pre-treatment checklist, or ensure it has been completed and documented.**
- If pre-treatment checklist has already been performed, the focus of this encounter is a brief confirmation that the baby is well with no significant intercurrent illness or new cardiovascular pathology.
- Propranolol should not be given during significant intercurrent illness. (i.e. not mild viral illnesses unless causing feeding problems)
- Pre-treatment heel-prick or serum blood glucose is not necessary unless there are specific reasons to believe this may be low.

**Propranolol initiation**
- Starting dose 0.33mg/kg/dose
- Give soon after a feed (or in the middle of a feed if more convenient)

- Initiate propranolol at starting dose of 0.33mg/kg/dose propranolol hydrochloride (solution strength is 50mg in 5ml).
- Propranolol should be given (on this initiation and on every subsequent administration by the parents) soon after or even during a feed, to minimise the risk of hypoglycaemia.
### Infantile Haemangioma – Propranolol Protocol

#### Neonatal Clinical Guideline

- The parents should be talked through the drawing up and administration of the propranolol because (if all goes well) they will be expected to perform all future administrations.

| Immediately after initiation | Monitor for side effects | Monitor, and ask parents to monitor, for any signs of intolerance such as shortness of breath, feeding intolerance, sweating, reduced alertness (i.e. not waking to stimulation or for feed), reduced tone, change in colour or ‘anything of concern’.

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### Post-initiation checks

- Check heart rate and blood pressure at 1 and 2 hours

### If no complications following propranolol initiation:

| Dose increase | Increase dose to 0.66mg/kg/dose
| | Give the 2nd dose 8 hours after the 1st dose

### Post-dose increase checks

- Check heart rate and blood pressure at 1 and 2 hours post dose
- If HR or BP is borderline or there are other concerns, also perform these measurements after the 2nd and 3rd doses.

### In case of complication following initiation or dose increase

| In case of complication | Take full set of observations
| | Reduce subsequent doses
| | Perform a full set of observations and examination if any concerns following propranolol administration
| | Monitor until normalised
| | Consider checking blood glucose
| | Once well, recommence propranolol at lower dose:
| | Following initiation:
| | If propranolol has not been tolerated at the starting dose of 0.33mg/kg/dose, reduce dose (usually by half) until tolerated. Usually doses can then be increased more slowly with monitoring.
| | Following dose increases:
| | If propranolol has not been tolerated at the increased dose, reduce to the previous dose with monitoring. Usually doses can then be increased more slowly with monitoring.

### Once patient stabilised on maximum tolerated dose (up to 0.66mg/kg/dose)

| Post-stabilisation | Prescribe TTO
| | Give sufficient 1ml syringes
| | Prescribe propranolol hydrochloride (solution strength 50mg in 5ml) at the maximum dose tolerated by the patient (up
Subsequent monitoring
If there are any further significant dose increases (more than 0.5mg/kg/day) – this does not include increases by weight – consider admission to Harlyn ward for BP and heart rate monitoring at 1 and 2 hours post dose.

Further dose increases
- Dose should be adjusted to baby’s weight increase monthly.
- Further dose increases may be necessary if response of the haemangioma to the current dose is insufficient. This will usually be directed by the Consultant Dermatologist at outpatient review.

The British Association of Dermatologists has a guide for parents on the use of propranolol which is linked here. Otherwise copy and paste link below

Useful telephone numbers
Dr V Jones’ secretary in Dermatology  01872 252308
Dr Munyard secretary in Paediatrics  01872 252681
Gwithian Unit Paediatric outpatients  01872 253004
Mr P Dale Paediatric Pharmacist  01872 250000 bleep 2139

Cornwall Congenital Haemangioma Service.
Dr Vandana Jones Consultant Dermatologist
Dr Paul Munyard Consultant Paediatrician
3. Monitoring compliance and effectiveness
This part must provide information on the processes and methodology for monitoring compliance with, and effectiveness of, the policy using the table below.

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Key Changes to practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Dr. Paul Munyard</td>
</tr>
<tr>
<td>Tool</td>
<td>Audit</td>
</tr>
<tr>
<td>Frequency</td>
<td>As dictated by audit findings</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>Include in neonatal clinical audit programme, findings reported to the directorate audit meeting / Governance meeting</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Dr. Paul Munyard. Consultant Paediatrician and Neonatologist</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Required changes to practice will be identified and actioned within 3 months. 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

a. 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.

b. 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>INFANTILE HAEMANGIOMA – PROPRANOLOL PROTOCOL NEONATAL CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>APRIL 2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>APRIL 2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>APRIL 2020</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr Paul Munyard Consultant Paediatrician and Neonatologist Dr Vandana Jones. Consultant Dermatologist Julia Fordham. ST2</td>
</tr>
<tr>
<td>Contact details:</td>
<td>(01872) 252667</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>This guideline outlines the clinical responsibilities of staff involved in the management of an neonate presenting with an infantile haemangioma</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Neonatal. Neonate. Newborn. Infantile haemangioma</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>07 April 2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>New document</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Consultant approval. Child Health Directorate Audit. Neonatal Clinical Guidelines Group</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>David Smith</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
</tbody>
</table>
Publication Location (refer to Policy on Policies – Approvals and Ratification): Internet & Intranet ✓ Intranet Only


Links to key external standards None


Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2016</td>
<td>V1.0</td>
<td>Initial issue.</td>
<td>Paul Munyard. Consultant Paediatrician and Neonatologist Dr Vandana Jones. Consultant Dermatologist Julia Fordham. ST2</td>
</tr>
</tbody>
</table>

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Appendix 2. Initial Equality Impact Assessment Form

Name of the strategy / policy /proposal / service function to be assessed (hereafter referred to as policy) : INFANTILE HAEMANGIOMA – PROPRANOLOL PROTOCOL. NEONATAL CLINICAL GUIDELINE
1. **Policy Aim**
   Who is the strategy / policy / proposal / service function aimed at?
   
   This guideline is aimed at clinical staff responsible for the management of infants presenting clinically with an infantile haemangioma

2. **Policy Objectives**
   
   As above

3. **Policy – intended Outcomes**
   
   Audit

4. **How will you measure the outcome?**
   
   Audit

5. **Who is intended to benefit from the policy?**
   
   Patients. Medical and nursing staff.

6a) **Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?**
   
   No. Consultant approved.

   b) If yes, have these groups been consulted?
   
   N/A

   C) Please list any groups who have been consulted about this procedure.
   
   N/A

7. **The Impact**

   Please complete the following table.

   **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>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, transgender / gender reassignment)</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability - learning disability, physical disability, sensory impairment and mental health problems</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marriage and civil partnership</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td>x</td>
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You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

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

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

No area indicated

| Signature of policy developer / lead manager / director | Dr Paul Munyard | 07 April 2017 |
| Names and signatures of members carrying out the Screening Assessment | 1. | 2. |

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
A summary of the results will be published on the Trust’s web site.
Signed ______ kim smith ______

Date ____07/04/2017________________