



STAFFING AND FACILITIES GUIDANCE

FOR SKIN SURGERY DERMATOLOGY

SERVICES

SERVICE GUIDANCE

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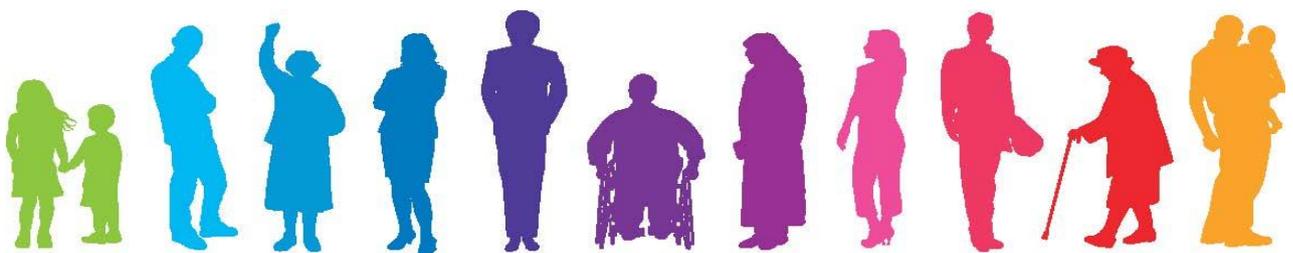


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Preface

These guidelines offer advice to providers, Commissioners and Local Health Authorities on the required staffing and facilities to run a skin surgery unit in the community or in secondary care. They should be read in conjunction with the [BAD's Staffing and Facilities for Dermatological Units 2012](#).

Skin surgery units are used to carry out Dermatological surgical procedures that do not require general anaesthetic.

The requirements outlined in this guidance apply to any service offering these procedures, irrespective of the location of the unit.

Skin surgery services can be provided by a range of trained surgical practitioners in community and secondary care. A community service will provide minor surgical procedures (intermediate level of care). These services and skills of the surgical Practitioner will differ to the surgical procedures and services provided in District General hospitals (DGH), and teaching hospitals and again at a tertiary hospital.

More complex Dermatological surgery, such as Mohs Micrographic surgery and reconstructive skin surgery with flaps and grafts are undertaken in a secondary care skin surgery unit. Dermatology secondary care services work jointly with other surgeons, for example Oculoplastics, Plastic and Maxillo-Facial surgery departments for more complex reconstructive procedures particularly for skin cancer patients.

Further guidance which should be read in conjunction with the above:

- [Consultant Physicians working with patients: Dermatology, Royal College of Physicians \(2013\)](#)
- [Standards for Mohs Micrographic Surgery Services, The British Society of Dermatological Surgery \(2011\)](#)
- [DH Revised GPwSI Curriculum 2011](#)
- [Specialised Services National Definition Set \(3rd Edition\) - Dermatology](#)

1. Staffing

The procedures undertaken will vary according to the surgical expertise of the operator, support staff and Clinical Governance of the appropriate service framework.

Consultant Dermatologists

All Consultant Dermatologists in the UK are trained in the diagnosis and management of skin lesions, both benign and malignant, and are familiar with the various modalities available for treatment. All have trained to a basic level in Dermatological surgery and most will have attended the basic training course run by the British Society of Dermatological Surgery (BSDS). They carry out surgical procedures in everyday practice and may develop a specialist interest and undertake training in more complex procedures, such as [Mohs Micrographic surgery](#).

Speciality Doctors & Associate Specialists

Speciality Doctors must be supervised by accredited Consultants (although they may occasionally work alone in the event of sickness or annual leave). They will undertake procedures within their skill base in general Dermatology and/or skin surgery clinics.

Associate Specialists may work independently, without such supervision, but should be part of a Consultant Led Dermatology team.

Specialist Registrars in Dermatology

Specialist Registrars will require supervision and time for teaching and assessment of surgical skills, in line with the Dermatology specific training curriculum.¹

Surgical lists for Registrar should be carefully planned to allow progression of surgical competence to the required level. The Registrar should have access to senior advice and support within the unit in case they run into difficulties.

Dermatology Nurses

Nurses and particularly Clinical Nurse Specialists (CNS) have an important role in skin surgery units both in supporting skin surgery lists, and performing procedures. Nurses in surgery units should have their competency in agreed surgical procedures 'signed off' by their clinical supervisor and should have the necessary training and experience in procedural skills, dressings, wound care and infection control. Nurses should be appropriately supported during surgical sessions and, like Specialist Registrars, should have access to senior advice and support within the unit, in case they run into difficulties.

General Practitioners with Specialist Interest (GPwSI)

All Dermatology GPwSIs involved in the care of people with skin disease and skin lesions should be able to demonstrate that they meet the core competencies set out in 'Revised

Guidance and Competences for the Provision of Services using GPs with Special Interests (GPwSIs) 2011'.² This guidance also provides recommendations for GPs that provide skin surgery services under a Directed Enhanced Service or Local Enhanced Service (DES/LES).

All GPwSIs are expected to maintain a personal development portfolio to identify their education requirements, matched against the competences required for the Dermatology surgical service and evidence of how these have been met and maintained. For skin surgeons this may include a clinical attachment with a Plastic Surgeon or Maxillo-Facial Surgeon, and attendance at their Local Skin Cancer Multidisciplinary Teams (LSMDT) meetings held 4 times a year. They will work locally with Dermatology Consultants and skin cancer CNS.

Secretarial and Support Staff

Any skin surgery unit will also need secretarial and administrative support sufficient to manage waiting lists, book surgery times, track histology results and type reports. This should include the services of a receptionist to check patients in and book any follow-up appointments. In some cases it may be cost effective to share non-clinical staff with other services based in the same building.

2. Facilities^{3,4}

Reception and waiting area

A receptionist should be available to check patients in and book follow-up appointments. There should be a waiting area near the operating room for use by patients before and after surgery. This should be of a sufficient size to accommodate accompanying relatives and carers, who may have to wait to drive or accompany the patient home after surgery. Access to drinking water should be made available in the reception area.

Operating room suite

The operating room should be a dedicated facility (not doubling up as a wound dressing room or an outpatient clinic room). The operating room must be of an adequate size to accommodate the couch with space around for free movement of staff. Double doors are required for wheelchair and trolley access if needed.

The Dermatological surgery operating room does not require the same level of sterility as a main operating theatre because skin surgery is superficial and does not involve penetrating body cavities. However, a clean room used solely for surgery is essential, the floors, walls and ceiling should be wipe-clean, durable and clear of clutter for infection control.

A sink with hot and cold water (ideally a theatre-style sink operated via hands-free taps) should be located in the operating room together with wall-mounted antiseptics and scrub materials.

It is important that the room is equipped with a telephone and emergency call buttons in case of an emergency. There should also be access to a computer with, if located in the operating room, a washable/cleanable keyboard.

Room temperature in the operating room suite should be maintained at a comfortable level for both staff and patients. An air-conditioned unit is ideal to maintain a consistent level of comfort.

Patient changing room

At the time of any procedure or treatment being carried out, the privacy and dignity of the patients must be maintained at **ALL** times. This requires a room specifically designated as a patient changing room with facilities for hanging and storing clothes during procedures.

Clean and dirty utility rooms

There should be a room for the storage and preparation of operating packs (clean utility) and another for the cleaning, packing or disposal of used instruments (dirty utility) adjacent to the operating room.

General clinical rooms and utility areas

There should be adjacent rooms to the operating theatre and treatment rooms for checking wounds and consultations. This will increase throughput and provide more opportunities for teaching.

These will be supported by a range of utility areas as follows:

- Suitable clean and dirty utility rooms, as above.
- A locked, separate room will be available for the cleaning and storage of cleaning materials and equipment. To also contain means to dispose of used solutions of detergent/water.
- A safe storage area for waste and used sharps bins to protect others from harm.
- Separate staff changing, catering and toilet facilities.

Mohs Micrographic Surgery Unit

Special facilities are required when Mohs surgery is undertaken in a skin surgery unit. A Mohs laboratory is required for preparation of tissue sections and histological slides. Ideally the lab should be in close proximity to the operating room(s).

The Mohs laboratory should have:

- Adequate space to allow the Mohs laboratory staff and surgeon to work together.
- If liquid nitrogen is being used then a designated area for storing liquid nitrogen dewars⁵ (containers) is required.

- Adequate ventilation and fume extraction compliant with COSHH requirements.⁶
- A cryostat, which is needed for the Mohs technician to cut the sections and prepare the histological slides. Ideally there should be provision for a suitable/appropriate back up cryostat in case of machine failure.
- An area for preparation of the tissue sections, including mapping, dyeing and freezing of the specimens. There should be provision of microscopes within the laboratory area to check section quality.
- An automated slide staining system to stain the tissues for viewing under the microscope as this is faster than staining by hand.

In addition, the unit should be equipped with a microscope, preferably multi-headed to allow collaborative viewing and teaching.

Mohs surgery is usually and safely performed in a Dermatological surgery operating/procedure room as described above.

Recovery area

A recovery area and comfortable waiting room is important for patients undergoing more complex procedures such as Mohs surgery or for those feeling faint or unwell. Patients undergoing Mohs surgery may have to visit the operating room on multiple occasions during their procedure and again for repair of the resultant defect. Between visits, the patient has to wait for results with a wound dressing, often on the face. Usually the patient will require a companion to keep them company and assist them home afterwards.

Reclining chairs provide sitting accommodation for patients and step-down facilities for patients prior to discharge. Use of reclining chairs for later stages of recovery can help to increase turnaround of day-case beds⁷ and may be more comfortable for patients requiring longer recovery periods.

Laser surgery

If laser treatments are undertaken in the skin surgery unit, there are specific requirements for safe use and storage of medical grade lasers⁸ that should be adhered to (see BAD Staffing and Facilities Guidance).

Rooms must be available which comply with the rigorous medical laser guidelines⁹ including, for example:

- Warning signs on doors.
- Lockable doors to treatment areas.
- Provision and strict use of appropriate protective eyewear for staff and patients (these may differ for each laser used).
- Adequate ventilation and plume extraction.
- Covering of all reflective surfaces.

- Provision of tissue cooling equipment, if indicated.

Cryosurgery

Cryosurgery is often used in addition to or instead of surgical treatment of skin lesions. Special equipment and requirements for cryosurgery include:

- CryAc or similar dispenser.
- Various specialised nozzles.
- Personal protection equipment.
- Safe and secure storage facilities for a reservoir of liquid nitrogen, which is a hazardous substance.
- Well-ventilated areas.

A current COSHH risk assessment must be in existence for all work with liquid nitrogen.

Latex-free operating room

Some people are severely allergic to latex (a protein found in rubber products) and for these patients even contact at very low concentration can trigger anaphylactic allergic reactions. A 'latex-free' policy should be agreed to provide an operating room where no contact with equipment containing latex or staff using latex gloves is possible.

As well as strict protocols around storage and use of latex products if this is part of a larger skin surgery unit, a latex-free operating room will require a range of alternative equipment, from surgical gloves to major fittings.¹⁰

3. Equipment

Operating couch

A skin surgery unit does not need a fixed theatre table. Instead, it needs a reclining chair, couch or bed that:

- Can be adjusted in height and position (including immediate tilt, e.g. into Trendelenburg's position in the case of hypotension);
- Is moveable;
- Can be wiped clean;
- Has some support (arms or cot-sides) for infirm or less co-operative patients.

This is to ensure that the patient can be raised to a comfortable height for the operator and to make it as safe as possible to move the patient in the event of an emergency such as a cardiac arrest or evacuation of the unit during a procedure.¹¹

Haemostasis

Effective haemostasis is essential and is best provided with either a hyfrecator or a radiosurgical unit with both unipolar and bipolar modes. Hot-point cauterisation is no longer generally used as it is difficult to ensure sterility.

Lighting

The primary task of a surgical light is to provide adequate illumination of the surgical field. The surgical site requires much higher illumination than provided by general room lighting.

The widely recognized international standard for surgical lighting specifies that a single surgical luminaire should produce between 40,000 and 160,000 lux.¹²

The variety of surgical procedures also requires flexibility in the positioning and control of the lighting system.¹³ An adjustable diffused ceiling-mounted operating light is generally preferred to high-quality freestanding theatre lights, which are less versatile and may cause obstruction.

Suction

Suction equipment may be helpful in improving visibility of the operative field in a bleeding wound. It can be either permanently mounted or mobile. Wall or ceiling-mounted suction is effective and a multi-feed console supplying suction, oxygen and light, such as is used in main theatres may be used. Mobile suction units are also available with easy-to-use disposable attachments, although these can be obstructive in smaller surgical units.

Smoke extraction

An extractor should be available to remove the smoke plume produced by electrosurgical devices and some lasers. This not only smells unpleasant but in theory may carry infective particles.¹⁴

Resuscitation trolley and emergency drugs and policies for their use

All members of clinical staff must have up-to-date Cardiopulmonary Resuscitation Skills and know the location of their nearest resuscitation trolley, in line with the Trust's resuscitation policy. It is also essential they are familiar with its operation and the procedure for calling the local emergency resuscitation team.¹⁵

Resuscitation trolleys must be regularly maintained according to guidelines and checked daily. There should be an emergency drug box in the immediate vicinity of the surgical suite, regularly maintained with drugs for anaphylaxis, hypotension and hypertension, including glucose and an IV-fluid-giving set.

Personal protection equipment

Protective eyewear masks and sterile surgical gloves act as a protective barrier to prevent possible transmission of blood-borne diseases during surgical procedures. Appropriate protection should be available for use when needed and should always be of good quality. Surgical gloves should be ordered to the various surgical operators' requirements (i.e. size, material, hypoallergenic, etc). It is important that these items are ordered in adequate numbers and a secure supply is maintained.

Surgical instruments

It is important to have good-quality instruments that are appropriate for the site and nature of the procedure. The instruments also need to be correctly sterilised if not disposable and should be stored in an easily accessible and cleanable cupboard close to or within the operating room.

An appropriate range and adequate supply of instruments is vital and should be dictated by caseload and case mix.

Instrument disposal and sharps containers

Disposable surgical instruments, made of both plastic and metal, are now commonly used.

Contaminated plastic instruments (where there is no threat of sharps) can be safely disposed of as infectious waste (orange bag waste stream). Metal disposable instruments deemed as infectious but where there are no risks of sharps should be put into a yellow rigid bin marked "for incineration only" unless the manufacturer provides instrument recycling facilities.¹⁶

Ample sharps containers, complying with British Standards 7320:1990 must also be available for disposal of sharps. Sharp boxes should be sealed and collected when three quarters full and never exceed the permissible mass mark. If the sharp box is seldom used, it should be collected after a maximum of three months regardless of the filled capacity.¹⁷

Histopathology specimens

All surgical specimens, excluding those for immunofluorescence (IMF) testing must be placed immediately into fixative solution: 10 per cent buffered formaldehyde (formalin).¹⁸ Tissue samples for immunofluorescence (IMF) should first be bisected and one half placed into 10% formalin for routine histological processing.

The other half should be placed into a container of Michel's tissue fixative and clearly labelled with the patient I.D. Aliquots of this fixative are supplied by the histology laboratory and may be requested by contacting the trusts main laboratory. Please note: Michel's tissue fixative must be stored in a refrigerator.

Specimen containers must be of adequate size; tissue must never be crammed into a container and the volume of fixative should be preferably ten times that of the specimen (BS 5213:1975). Fresh Tissue specimens should be sent as fresh unfixed tissue wrapped in saline-dampened gauze.

Specimens should be placed on ice and sent to the laboratory within 24 hours of the sample being taken. Very small biopsies i.e. needle biopsies, should be placed in sterile saline.

All specimens must be entered into the operating room log, along with details of the procedure and a note of when to check/chase the histology results. Both the specimen and the accompanying request card should have a minimum of the patient's name, hospital number, Consultant's name, NHS number, relevant clinical details and date of the procedure.¹⁹

If there is a discrepancy in this data or it is incomplete this is likely to result in a delay in the material being processed and a delay in diagnosis. The NHS number is required to help prevent the duplication of medical computer records which is a potential clinical risk.

If multiple specimens are removed, each is to be placed in a separate container and labelled with the usual demographic data as above.

Urgent specimens should be discussed with laboratory staff and the request form marked appropriately.

4. Management of Surgical Lists

List planning

The selection of patients for each operating list should be appropriate to the competence of the operator carrying out the list. All members of the clinical staff should be trained in the procedures they are expected to undertake, and should not carry out activities for which they are not judged competent.

The time allocated to each procedure should allow for:

- Explanation of the procedure.
- Informed consent.
- The operation itself.
- Dressing the wound.
- Delivering post-operative advice.

The length of time taken at each stage will depend on the complexity and scale of the surgery.

Most operations under local anaesthetic should be completed within 60 minutes or less. Procedures requiring longer operating times may be more suited to day surgery or general theatres. Mohs surgery is a special case, as repeated short visits to the operating room are required as tissue layers are taken for histological examination. For prolonged procedures the operator must ensure that the safe maximum dose of local anaesthetic is not exceeded.²⁰

Individual responsibilities of operator

For all procedures, the operator is responsible for:

- Confirming patient's medical history (including allergy) and current medications.
- Explaining the planned procedure and proposed benefits in terms that the patient can understand.²¹
- Discussing alternatives to the proposed treatment (which may include no treatment).
- Informing the patient about possible complications, both common and rare, where appropriate.²²
- Gaining the patient's informed consent to the procedure (see 'Clinical Governance' below).²³
- Identifying the correct operative site and confirming of the need for surgery with the patient.
- Explaining to the patient what to expect post-operatively and what care they will need.
- Ensuring they have a contact number in case of problems (see below).
- Keeping a fail-safe surgical log to record all procedures undertaken and specimens sent for histological analysis.
- Chasing histology results to ensure that appropriate further management is arranged.
- Recording the results of surgery for use in audits.
- Reporting any untoward incidents.

Deferring treatment

The operator is responsible for ensuring they are competent for the procedure undertaken. If a patient is inadvertently placed on the list of a less experienced practitioner, the patient must be informed and the operation deferred. This is particularly important where a department runs a generic waiting list when the operator may not have met the patient beforehand. They are also responsible for ensuring the correct lesion is operated on.

In the event the lesion has changed while the patient is on the waiting list, the operator is then responsible for ensuring the procedure undertaken is appropriate. If there is uncertainty in either instance the operation should be deferred and the patient reviewed.

If a patient is on Warfarin, the INR should be checked within a few days of the procedure. Usually skin surgery should not be undertaken if the INR is above 3.5 depending on the site of the lesion, the complexity of the procedure and the urgency of the operation.^{24,25}

Individual departments should have a written agreed policy for the management of platelet inhibitors and anticoagulants in patients undergoing skin surgery.

Pre and postoperative information for patients

It is essential to give patients undergoing surgical skin procedures information about what to expect *before* they attend their appointment. They may need to make arrangements for a carer to accompany them home after the procedure and for time off work. All patients and carers should be given advice on wound care and follow-up. This should be provided in a format that is accessible to the patient and include telephone number in case of post-operative problems.

Informed consent

It is a legal and ethical principle that valid consent must be obtained before starting treatment for a person. For consent to be valid, it must be given voluntarily by an appropriately informed person who has the capacity to consent to the intervention either verbally or in writing.

The person also needs to understand the nature and purpose of the procedure as well as the techniques, benefits, risks and alternatives. Any misrepresentation of these elements will invalidate consent.

Clinicians should check, before the procedure starts that the person still consents. If a person is not asked to signify their consent until just before the procedure is due to start, at a time when they may feel particularly vulnerable, the validity of consent may be questioned.

Although written consent is in most cases not a legal requirement (exceptions include certain requirements of the Mental Health Act 1983) the use of forms is good practice where an intervention such as surgery is to be undertaken. Details of the assessment of capacity, and the conclusion reached, should be recorded in the case notes.

5. Clinical Governance ²⁶

The service provider is responsible for ensuring that the standards of the facility and the training of staff are in accordance with current Department of Health (DH) guidance and monitoring frameworks, or where appropriate, with standards expected by other regulatory bodies. Audit should be undertaken regularly to ensure the service attains required standards and demonstrates continued improvement.

Infection control policy

An up-to-date Infection Control Policy document should be kept in the skin surgery suite and all members of staff must be familiar with its contents; in particular the procedure to follow in case of sharp injury. One member of the surgical unit (usually a nurse) should be

nominated as the Infection Control Officer for the unit. They will be responsible for keeping the members of their team informed and recording any adverse events or near misses in line with the Trust's Infection Control Policy.²⁷

References

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3. [DH Core elements - Health Building Note 00-03: Clinical and clinical support spaces](#)
4. [NHS Estates HBN 12 Out- patients department](#)
5. [BCGA Code of Practice CP30 THE SAFE USE OF LIQUID NITROGEN DEWARS UP TO 50 LITRES](#)
6. [Health and Safety Executive \(HSE\) Local exhaust ventilation workplace fume and dust extraction \(Fume cupboards BS 7258 Parts 1-4 1994\)](#)
7. [NHS Data Model and Dictionary definition of a day case](#)
8. [Health Protection Agency \(HPA\) Safe Use of Lasers and Intense Pulsed Light \(IPL\) Sources in Healthcare](#)
9. [Health and Safety Executive \(HSE\) - A Non-Binding Guide to the Artificial Optical Radiation Directive 2006/25/EC](#)
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11. [Resuscitation Council \(UK\): Guidance for safer handling during resuscitation in healthcare settings 2010](#)
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23. [General Medical Council: Consent Guidance: patients and doctors making decisions together \(2008\)](#)
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25. British National Formulary: 61st Edition (March 2011) British Medical Association and Royal Pharmaceutical Society of Great Britain, London [\(link to current BNF\)](#)
26. [DH Clinical Governance guidance](#)
27. [Health & Social Care Act 2008 and Associated Code of Practice for the Prevention and Control of Health Care Associated Infection](#)
<http://www.hps.scot.nhs.uk/haic/ic/guidelines.aspx>
http://www.nhsprofessionals.nhs.uk/download/comms/CG1_NHSP_Standard_Infection_Control_Precautions_v3.pdf

DH Health Building Notes

Health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities.

They provide information to support the briefing and design processes for individual projects in the NHS building programme.

Publications of Interest to Dermatology Departments

1. Guidance for infection control in the built environment
<https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment>
2. Guidance for facilities for providing primary and community care services
<https://www.gov.uk/government/publications/guidance-for-facilities-for-providing-primary-and-community-care-services>
3. Guidance on flooring, walls and ceilings and sanitary assemblies in healthcare facilities
<https://www.gov.uk/government/publications/guidance-on-flooring-walls-and-ceilings-and-sanitary-assemblies-in-healthcare-facilities>
4. Design and layout of generic clinical and clinical support spaces
<https://www.gov.uk/government/publications/design-and-layout-of-generic-clinical-and-clinical-support-spaces>
5. Guidance on the design and layout of sanitary spaces
<https://www.gov.uk/government/publications/guidance-on-the-design-and-layout-of-sanitary-spaces>
6. General design principles for health and community care buildings
<https://www.gov.uk/government/publications/general-design-principles-for-health-and-community-care-buildings>
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11. Hospital accommodation for Children and young people
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12. Guidance on the design of an out-patients department
<https://www.gov.uk/government/publications/guidance-on-the-design-of-an-out-patients-department>