

National Institute for Health and Clinical Excellence

Improving outcomes for people with skin tumours including melanoma (update):

The management of low-risk basal cell carcinomas in the community

Stakeholder Comments

<p>Please enter your name and the name of your registered stakeholder organisation below. If you are a non-registered organisation, please register via the NICE website before submitting the proforma. If you are an individual then please contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.</p>	
Stakeholder Organisation:	British Association of Dermatologists (BAD)
Name of commentator:	Overview from the British Association of Dermatologists prepared by the Clinical Services Skin Cancer Committee
<p>The draft GDG update on the management of low risk BCC in the community is complex and confusing regarding the proposed new models of care. It is unclear how the governance will ensure patient safety. The document does not appear to focus on patients.</p> <p>The introduction of the new 'GP Expert' practitioner with no guidance as to the recommended training and assessment of these individuals invites inappropriately trained GPs to manage BCCs. The first step in the appropriate management of skin cancer has to be correct diagnosis and no guidance is given on the training of these 'GP Experts' in diagnosis. Misdiagnosis will lead to mismanagement. This appears to be an invitation for untrained GPs to do surgery unsupervised and unlinked to secondary care or the local MDT.</p> <p>We feel strongly that any practitioner treating skin cancer should be a member of the local MDT, with an attendance requirement. This is to the benefit of the patient as the practitioner will establish links with the team members and gain better understanding of their local Cancer Network protocols and pathways.</p> <p>The definition of SS1 and SS2 GPSI surgeons is not clear in the original IOG, the DH Dermatology GPSI guidance or the Quality Measures; this needs to be properly defined regarding training requirements, competencies and governance of each level.</p> <p>The DES (Directed Enhanced Service) GP surgeons offer patients a wide range of operations such as vasectomy, hernia repair etc. but have not specifically included skin cancer surgery. Skin cancer should not be included in the DES as these practitioners although skilled surgeons are not trained in the diagnosis and management of skin cancer. Referral to Model 2 practitioners via appropriate Peer Reviewed routes is a safer management pathway for patients.</p> <p>Although the remit of this GDG update is the management of low risk BCC in the community, it highlights the issue of the management of high risk BCC by good experienced GPSIs. The current guidance makes it difficult for these doctors to manage more complex BCCs which are within their capability. Some attention needs to be given to allow these experienced doctors, trained in cancer diagnosis</p>	

and management, to manage more complex cases while maintaining links with secondary care and being member of the local MDT.

Below are the individual comments returned by our members following the publication and circulation of the Draft GDG update:

Order number (for internal use only)	Document Please indicate which document your comments refer to	Page Number Number only (do not write the word 'page/pg'). Alternatively write 'general' if your comment relates to the whole document.	Line Number Number only (do not write the word 'line'). See example in cell below	Comments Please insert each new comment in a new row. Please do not paste other tables into this table, as your comments could get lost – type directly into this table.
Example		116	15	My comments are as follows
PROFORMAS THAT ARE NOT CORRECTLY SUBMITTED AS DETAILED ABOVE MAY BE RETURNED TO YOU				
		General		Throughout, it is insufficiently clear how this guidance sits with the IOG & to what extent the frameworks for training and accreditation are superseded
		General		<ul style="list-style-type: none"> • Potential confusion of referring GP as to exact demarcation of high (H zone) and low (intermediate) risk areas on the face. Patients inappropriately referred to a primary care service will then have an unnecessary delay before ultimately seeing the dermatological surgeon. • Lack of evidence that surgery performed by GPwSI is cosmetically equal to that performed by Dermatological surgeons. • General evidence that margins of surgery performed on 'like for like' lesions are poorer for GPwSIs than Dermatological surgeons. • Risk of SCCs on face being excised as 'BCCs'. A scenario that often occurs in my area. • Risk of badly planned flaps/grafts leading to future problems with narrowly excised facial lesions which then have to be widely excised by Plastic or Dermatological surgeons who are trained to constantly think of the next step. • Lack of continued experience of GPwSIs operating on facial areas as numbers of patients will be lower. Surgical expertise is built up not only by initial training but also by continued practice. More complex surgery is inevitably going to be better performed by individuals who are routinely operating in this area.

				<ul style="list-style-type: none"> Lack of sterile operating environment in Primary care practice rooms with potential increase in infection risk. Lack of follow up structure in Primary care.
		6	32	Patients surely want practitioners who treat them to be doing a sufficient number per annum to maintain skills. This number should be mentioned to avoid operators doing too few procedures.
		7	13	This terminology could include consultant dermatologists and so seems misleading
		7	21-29	You refer to 3 key documents – yet there is no document dealing IN DETAIL with the non-dermatology GPwSI who wishes to perform surgery including cancer work.
		8	11	The most striking omission is that no definition of low risk BCC is provided. This seems to be assumed that anything not high risk is low risk. A definition of low risk BCC should be included. E.g. well defined, primary, nodular BCC, no more than 10mm in diameter on the trunk and limbs
		8	11	The simple definition of low risk bcc is much more helpful, though histology is still mentioned at one point.
		8	27	'might' instead of 'would'
		9	4	I think that morphoeic, infiltrative and micronodular BCCs should be specified as lesions that GPs should not attempt to excise if they have done a diagnostic biopsy or reexcise if they have done an incomplete excision.
		9	4	This definition of high-risk BCC is very straightforward and less open to interpretation by unskilled GPs. All skilled surgeons will still be able to do complex ops if patients referred via MDT. Difficult for skilled cancer trained GPSIs who would now be more restricted.
		9	4	The definition of high risk seems reasonable, but there appears to be no flexibility in the text to loosen this definition for good accredited GPWSIs who are very experienced to progress and take on more difficult cases where the definition of high risk using the H zone might be more appropriate.
		9	4	The High-risk BCC definition is excellent and very helpful.
		9	4	I think I would also suggest that any patient who is under 30-40 should also be immediately referred to secondary care with a suspected bcc (regardless of any other factors).
		9	4	<p>Definition of High Risk:</p> <p>First, I think that the neck should be included as it is difficult to operate on in some areas, so the term should be head and neck. However, I think that if the system were worked differently it would be as follows in the GP referral system:</p> <p>The lesion has to have a tick in ALL boxes to be referred to the primary care skin cancer service:</p>

				<table border="1"> <tr> <td>Tick if true</td> <td></td> </tr> <tr> <td></td> <td>New primary tumour (not recurrence)</td> </tr> <tr> <td></td> <td>Not on the head or neck</td> </tr> <tr> <td></td> <td>Be less than 2cm across, unless it is very superficial</td> </tr> <tr> <td></td> <td>Be well defined</td> </tr> <tr> <td></td> <td>Be located away from important arteries or nerves</td> </tr> <tr> <td></td> <td>The patient must have normal immunity(not be immunosuppressed)</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td></td> <td>Refer to primary care skin cancer service if ALL are ticked</td> </tr> </table> <p>The reason I make this point is because it enables the GP to make a positive conscious process to refer to primary care rather than to make the decision one based on not picking out exclusion. So secondary care is the default, but can be altered through doing the check list.</p>	Tick if true			New primary tumour (not recurrence)		Not on the head or neck		Be less than 2cm across, unless it is very superficial		Be well defined		Be located away from important arteries or nerves		The patient must have normal immunity(not be immunosuppressed)				Refer to primary care skin cancer service if ALL are ticked
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		9	5	Incompletely excised BCC needs to be added as a separate item.																		
		9	5	Also suggest the addition of "incompletely excised bcc" to the definition of high risk- these are difficult to excise and form one of the criteria nice suggested in 2/06 for referral for mohs surgery																		
		9	6	I would also like 'head' sites to include neck and not just scalp.																		
		9	6	"Face and scalp"- This definition will potentially exclude bccs on the ear and neck and these are still high risk sites difficult surgical sites esp ear bccs. I would suggest "head and neck"																		
		9	7	<p>BCCs greater than 2cm (can be treated as low risk provided the other criteria mentioned are addressed.) Why 2cm? Why not 2.2cm or 1.8cm? Where is the evidence for 2cm being a safe cut off point?</p> <p>Size matters when it comes to BCC recurrence risk (irrespective of site).</p> <p>References:</p> <ul style="list-style-type: none"> • Mohs FE. Chemosurgery. Microscopically controlled surgery for skin cancer. Springfield, Ill, Charles C Thomas Publisher 1978 • Sweet RD. The treatment of basal cell carcinoma by curettage. Brit J Dermatol 1963, 75:137-148. • Breuninger H; Schippert W; Black B; Rassner G The margin of safety and depth of excision in surgical treatment of basalioma. Use of 3-dimensional histologic study of 2,016 tumors Hautarzt; 1989 Nov; 40(11); P 693-700 <p>The evidence is of course incomplete but the Mohs and Sweet data both show that the bigger the tumour the greater the risk of recurrence. The Breuninger data shows that there</p>																		

				is a clinically important difference in subclinical tumour extent between 1cm and 2cm wide BCCs. I do not believe there is sufficient evidence to reassure a patient that a 2cm BCC – even one on the trunk- should be treated by a non expert. I would recommend reducing this size to 1cm.
		9	15	The issue of whether all sup BCCs should be referred needs to be clarified; it is not clear in the text.
		9	19	Why the term healthcare professional – are they thinking of not using doctors? I would recommend sticking with the term doctor.
		9	27	Healthcare professionals dealing with skin lesions should be trained and experienced in their diagnosis and management – not just have access to training. Wording is vague and in theory could allow non-trained personnel to manage skin lesions.
		9	27	Simply stating that all GPs must have access to training is very different to providing mandatory training. Any training and assessment must be carefully costed for.
		9	30	There is no clear guidance on how to be an assessor of surgical competence - I would suggest a BSDS member/ BAPRAS member. It should be a core member of an LSMDT who undertakes at least one surgical list a week.
	1	9	32	There is no mention of MDT or minimum number of cases. Will the PCT or Peer Review teams be tasked with making sure practitioners meet minimum requirements
	1	9	32	There is no mention of MDT or minimum number of cases. Will the PCT or Peer Review teams be tasked with making sure practitioners meet minimum requirements
		10	1-36	Thus whole section is a very watered down version of the nice initial guidance. GPs excising bccs should attend MDTs. The addition of a new type of educational meeting will only serve to confuse the management of skin cancer –there are already 3 levels of existing MDT- and it is a backward quality move that GP-excised BCCs do not need to be discussed at an MDT or even listed at an MDT
		10	14	Log should be used to ensure operator reaches an acceptable minimum number of procedures on skin cancer per annum to maintain skills. Previous minimum number 40 seems reasonable – less than one per week.
		10	24	It is good that the audits should be presented to the MDT quarterly – this could be a good time for the community practitioner to attend the MDT – i.e. 4 per year.
		10	32	There is a burden on secondary care to provide two 4-hour sessions on CPD for community practitioners per year. However the community practitioner could join the NSSG meetings to present audit and provision of CPD for them could be included – duty shared between secondary care practitioners probably manageable.
	1	10	24	Happy with all community data to PCT and thereby MDT quarterly. This needs to be highlighted as something that

				must be looked at as part of peer review
		10	27	No total numbers of BCC excisions per year are mentioned. This undermines our previous efforts over the last 2 years to establish quality standards in BCC management. There has to be a minimum number: 20-40 at least. This was a key driver in establishing a small, highly experienced group of GP operators.
	1	10	32/32	Twice yearly meetings big time commitment for secondary care who already stretched with MDTs and the other meeting requirements for Peer Review etc
	1	10	24	Happy with all community data to PCT and thereby MDT quarterly. This needs to be highlighted as something that must be looked at as part of peer review
		11	17	This sentence should make it clear that primary care accreditation includes training in diagnosis and surgery of skin lesions
	1	11	4	Important
	1	11	17/18	Does this accreditation still include minimum number of cases?
		11	23	The PCTs in my area (Greater Manchester) are just not equipped to commission this complexity of services. In my view the area most in need of support is the PCT commissioning and accreditation process.
		11	23-29	We have tried this and the amount of relevant data is limited for projection. Firstly, histological records that are available from hospital services only illustrate the ones that were treated surgically, and many may not be treated this way. Secondly, they do not illustrate the number patients that might be referred with lesions that give rise to concern but do not turn out to be skin cancer. So although it sounds good to do this kind of modeling, I don't think that it will give PCTs much of a true idea.
		11	23-32	It emphasizes the duty of the pct's to get their GPs in order and doing regular audit submission etc. However, I think it is really important that we in secondary care resist the suggestion that we 'shop' our GP colleagues and send copies of histology reports etc to the pct (as has just been suggested by the pct to our hospital!!). My favoured view regarding commissioning is that it should be consultant led right from the start.
		12	8	Diagnostic skills should be assessed as well as surgical skills which are to be assessed by DOPS
		12	11	This sentence is vague. Should mention teledermatology or photography if that is what is intended.
		12 13	17-36 1-20	The methods by which GPs can be accredited to work in primary care remain confusing. The guidance seems to imply that even for low risk BCC the same complicated methods of accreditation apply. Is this the intention? I'm sure it should be, but if this is the case I don't see really how this guidance

				simplifies the current situation.
		12	19	Model 1 stays the same - the old rules, requirements still valid?
		12	19-36	I am very happy with the first two bullet points which requires a GP to have a special interest and undertake SS1/2 and be accountable to the MDT, but I am very worried about the remaining bullet points referring to those GPs who are already performing minor surgery - some excellent and some dangerous. They only need to be accountable to the PCTs, and I would urge that just one route of service approval be given for all i.e. the same as the first two point and they should satisfy the local MDT and NOT the PCT.
		12	20-22	Model 3 stays the same – but now incorporates Model 2 - or is this just grouped together for convenience? If they are not core members can they treat without scrutiny or must this be in a joint clinic setting? What does “new model 2” mean? For “old” model 2: <ul style="list-style-type: none"> • Does it still exist? Do they still function under the old rules, requirements? • Can they now see-and-treat low risk BCCs without it going via the MDT – the general surgical GP below apparently can? • Does the 40 BCC rule still apply – should this be looked at if they can treat anything sent by the MDT not only BCCs? Not a new question but as things are changing is this the time to visit this as well? • Following on from this – should they also have ACSTraining? They could in theory be treating MMs and SCCs in the community. They would have to break bad news initially and transfer to the secondary care thereafter.
		12	23	What is the ‘New GP expert in skin lesions’? Is this a GPSI in skin cancer? SS1 and SS2 have surgical skills but not diagnostic skills. Is it proposed to offer modular training in recognition and management of skin lesions to accredit this group?
		12	23	Where is the definition, and what is the remit of the “new GP expert” Is this a new model? Where does governance sit? How does this differ from GPs below (or is it the same just new to the service) and model 2 above? What is the definition/criteria/training and prowess expected of SS1/SS2? How is accreditation achieved?
		12	23	Dermatologists are skin experts, using the terminology proposed will confuse the public and ultimately undermine the dermatology profession when the public, in time, will no doubt perceive that these GPs are the skin experts!
		12	23	Page 12 line 23 ‘new GP expert’: we strongly object to the potential provision of this new provider; we can foresee this becoming labelled as a ‘skin cancer expert’; this should only apply to accredited specialists or GPWSI who have undergone the appropriate training, accreditation, continued CPD,

				governance and liaison with the MDT; this term is very woolly and seems an unnecessary confusing addition i.e. keep to GPWSI, outreach specialists and accredited GPs who work with the local MDT. It is paramount that any individual who wishes to undertake skin cancer work is appropriately trained with appropriate CPD & governance measures as well as working in conjunction with the local MDT.
		12	26	The definition of GP performing minor surgery within the DES is quite thorough but does not mention minimum number of lesions (40) or attendance at MDT. The value of MDT needs to be stressed somewhere in this document – it is not just to discuss individual patients but is important in forming links and relating to colleagues in secondary care.
		12	26	Simply saying GP need to be properly accredited is v weak the precise requirements need to be more specific- I note under commission it says GPs need to have competencies S1 and S2 but the document also then seems to indicate that anyone already doing excisions can simply keep a log and only new GPs need to demonstrate competency- all GPs excising BCCs should be competent in S1 and S2 and should undergo a DOPS and be signed off competent by the LSMDT lead
		12	26	Using GPs in our patch and their DES is a recipe for disaster as so few of them know what they are doing (as shown in my audit).
		12 13	26-36 1-20	This part of the proposal contradicts the “Patient Perspective” of the same document pg 6 lines 26-32
		12 13	26-36 1-20	<p>This section contradicts and reverses the basis of the 2006 IOG regarding Clinicians working in the community Guidance on cancer services: IOG for people with skin tumours including melanoma Feb 2006 pgs 63+64</p> <p>“All doctors and specialist nurses working in the community who knowingly treat skin cancer patients should be approved by, and be accountable to, the local LSMDT/ SSMdT skin cancer lead clinician. They should work closely together to agreed local clinical protocols for referral, treatment and follow-up. These should be coherent with network-wide clinical protocols and signed off by the network site-specific lead for skin cancer.</p> <p>Any doctor or specialist nurse who wishes to treat patients with skin cancer should have specialist training in skin cancer work, be a member of the LSMDT and undergo ongoing education (see section on ‘Structure and clinical governance’). In the absence of a national body to determine the surgical training within the remit of skin cancer, this should be determined by the network site-specific group for skin cancer and be consistent with the NICE <i>Referral guidelines for suspected cancer</i>. All doctors participating in the MDT should have a letter of appointment from the MDT lead clinician. Ideally all doctors treating patients with skin cancer should have attended a recognised skin surgical</p>

				course. They should also work at least one session per week as a clinical assistant, hospital practitioner, associate specialist or staff-grade doctor in the local hospital department. This should be in a parallel clinic with an appropriate hospital specialist, normally a dermatologist, who is a member of the LSMDT/SSMDT. This applies to GPwSIs as well, as specified in the joint recommendations by the DH, RCGP and BAD. This is considered essential to maintain skills and promote dialogue with the specialist.”
		12	35	A DOPS is not a substitute for a log book or list of previous operations and histology reports.
		12	26-36	<p>This is very loose and low skill in comparison with the GPwSI service. The level of proof of competence should be much higher than one DOPS. There is no framework for them to “satisfy their PCT they can make the diagnosis” There is plenty of scope for collusion between the PCT and primary care.</p> <p>There is no statement of the need for a certain number to be done per year.</p> <p>I would suggest that the GP wishing to excise a low risk BCC registers the case prospectively on a web based database that brings the case to the attention of the MDT and hence makes it included in the MDT assessment. The active process of registering the case will make the GP think about the MDT as they register it and there could be a checklist for them on the website as well as guidance. The histology will be automatically reviewed. Where GPs yield skin cancer histology without registering their cases, then there will be a case for asking them why and if it is frequent, some form of penalty – removal of all DES status?</p>
	1	12	30	These should be able to demonstrate dermatology training i.e. be GPSI
	1	12	30-32	These should demonstrate by being a group 3 GPwSI
	1	12	33-36	They should have to go back and obtain retrospective excision data
	1	12-13		It is very unclear from this update whether the ‘levels’ in the previous document remain and if so how these recommendations fit. No-one has issue with competent GPs doing a good job but it is difficult to see how these recommendations will ensure only those who practice consistently well can continue if there is potentially no need for:- minimum case numbers, that practitioners only have to do a single DOPS if they have no previous data to present, and that there seems to be no requirement implied for either GP 3 training or if this hasn’t been completed and signed off no need for surgeons (previous level 2) to only treat pre-diagnosed lesions (be they BCC SCC or Melanoma)

		13	23	There does not appear to be any mention of how these various practitioners receive their referrals. Has the need for referral by MDT member gone? Do GPs now refer straight to SS1/2, or new expert GP, or GP DES surgeon – none of whom are trained in the diagnosis of skin lesions (including the referring GP)?
		13	23	The model of a 'surgeon in the community' such as Mr. X X at x Medical Centre, X who sees patient referred direct by GPs for excision, does excisions of lesions including cancers and does not follow up any patients himself is inappropriate and poor patient care. Our local skin cancer MDT picks up the pieces in these cases.
	1	13	1-2	Should have to demonstrate met group 3 (i.e. have dermatology training to ensure adequate diagnostic ability) or that will only treat pre-diagnosed lesions if level 2 practitioner
		13	8	There should be specific guidance as to what these robust measures of notifying patients are. In our dept we have v precise robust histology databases with automated warnings when histology has not been reviewed after a certain time.
	1	13	15-20	Large time undertaking for MDT core members already stretched by MDTs. MDT for GPs seems to have been dropped <i>but no such reconciliation for secondary care practitioners in any tumour group</i>

Please add extra rows as needed

Please email this form to: SkinCancerUpdate@nice.org.uk

Closing date: 5pm on 21 December 2009

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.