**Skin cancer quality standard**

NICE National Institute for Health and Care Excellence

**Consultation on draft quality standard – deadline for comments** 5pm on 24/03/16 **email:** QSconsultations@nice.org.uk

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| | Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly.<br>We would like to hear your views on these questions:<br>1. Does this draft quality standard accurately reflect the key areas for quality improvement? If the systems and structures were available, do you think it would be possible to collect the data for the proposed quality measures? Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted. |
| **Organisation name – stakeholder or respondent** (if you are responding as an individual rather than a registered stakeholder please leave blank): | [**British Association of Dermatologists**] |
| **Disclosure**<br>Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry. | [**N/A**] |
| **Name of commentator person completing form:** | [**Dr Pamela McHenry**] |
| **Supporting the quality standard -** Would your organisation like to express an interest in formally supporting this quality standard? More information. | [**No**] |
| **Type** | [office use only] |

| Comment | Section | Statement | Comments |
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| number | | number | Insert each comment in a new row.<br>Do not paste other tables into this table because your comments could get lost – type directly into this table. |
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| Example 1 | Statement 1 (measure) | | This statement may be hard to measure because… |
| 1 | Statement 2 | 2 | We have some concerns over statement 2 regarding how the word "removed" may be interpreted.<br><br>"People with low-risk basal cell carcinoma have the lesion removed in community skin cancer clinics only by clinicians linked to the local skin cancer multidisciplinary team".<br><br>One alternative is:<br><br>"People with newly presenting, nodular, definitely, clearly delineated low-risk basal cell carcinoma have the lesion(s) treated by an accredited community skin cancer clinician who is an extended member of their local skin cancer multidisciplinary team".<br><br>Changes to this statement have been made due to the interpretation over how the word "removed" may be applied. If removal equates with excision, then we have lost viable alternative treatment options as surgery is not always the optimum therapeutic modality.<br><br>Would it be possible to rephrase statement 2 as: "People with low-risk basal cell carcinoma have the lesion removed by a suitable treatment modality in community skin cancer clinics only by clinicians linked to the local skin cancer multidisciplinary team" |
| 2 | Table 1 | | Table one NHS Outcome Framework 2015-2016 Life expectancy "75" is inaccurate male 78-82 depending on which part of the country. Female 82-86 again pending area of country. Lack of accuracy reduces credibility! |
| 3 | Statement 2 | 2 | Also need to emphasise that even low risk BCCs need an experienced clinician to correctly diagnose lesions as low risk and decide the optimal pathway to treat? Does this wording need reconsidering? |
| 4 | | | Need a Quality statement for category of high risk tumours that are not MM/SCC/BCC, e.g. merkel cell carcinoma malignant appendage tumours and atypical fibroxanthoma, that these also need a 2/52 pathway, balanced against NICE NG12 recommendation 1.7.6 2/52 wait referral if delay would produce significant impact with a BCC because of site or size. This needs to be even more specific as the pathway is already subject to abuse and if use increases may cause collapse of services which are already strained due to only 5-8% of lesions being referred accurately fitting the existing |

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| | | | target diagnosis for pathway use. (? Tighten up to periocular BCC and high risk BCC's greater than 5cm in diameter.) |
| 5 | Definitions of terms used in this statement | Specialist | This should say ……normally a dermatologist on the specialist register, who is a member of either a local ……. The words specialist register are necessary as there is no definition of who can call themselves a dermatologist. |
| 6 | | | We are very concerned that the skin cancer quality standard does not map onto the NICE IOG and DoH guidelines for community and GP treatment of skin cancer. |
| Page 2 | | How this quality standard supports delivery of outcome frameworks | "The following 2 outcomes frameworks":<br><br>**NHS England Five-year action plan for cancer services - why is this not included?** |
| Page 5 | | Coordinated services | "The quality standard for skin cancer specifies that services should be commissioned from and coordinated across all relevant agencies encompassing the whole skin cancer care pathway."<br><br>**The IOG guidance outlines a structured approach to the organisation of the management of patients with skin cancers, with firm recommendations on which types of skin lesions can be diagnosed and treated in the community, local hospitals and specialist centres. This includes the two levels of multidisciplinary teams – local hospital skin cancer multidisciplinary teams (LSMDTs) and specialist skin cancer multidisciplinary teams (SSMDTs). All health professionals who knowingly treat patients with any type of skin cancer should be members of one of these teams, whether they work in the community or in the hospital setting.** |
| Page 5 | | Coordinated services | "Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality skin cancer service are listed in Related quality standards."<br><br>**This is misleading and factually incorrect. All two week waits services are not commissioned on the basis of choice as are LEVEL 3 Care skin cancers which include high risk BCCs referred under an 18 week wait pathway. This statement itself breaches the NICE IOG. Please refer to the models of care which commissioners are responsible for commissioning and the appropriate governance arrangements for the levels of care. See Skin Measure 2014 which are based on the NICE IOG.** |
| Page 5 | | Training and | "The quality standard should be read in the context of national and local guidelines on training and competencies. All |

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| | | competencies | healthcare professionals involved in assessing, caring for and treating people with skin cancer should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard."<br><br>**All healthcare professionals must be appropriately trained and formally accredited to treat skin cancer patients within the levels of care and models specified by the NICE IOG. Statement needs revising as it is open to interpretation.** |
| Page 6 | List of quality statements | Statement 2 | People with low-risk basal cell carcinoma have the lesion removed in community skin cancer clinics only by formally accredited dermatology clinicians who are extended members of their local skin cancer multidisciplinary team (LSMDT). They are required to attend 4 meetings a year in each locality where they hold a community services contract. |
| Page 6 | List of quality statements | Statement 3 | People presenting to primary care with a suspected squamous cell carcinoma or malignant melanoma are referred directly to their LSMDT/SSMDT under a 2 week wait suspected cancer pathway.<br><br>**Amended to reflect the requirements for these skin cancers and local provision. Previous statement is factually incorrect.** |
| Page 6 | List of quality statements | Statement 4 | People with pigmented skin lesions referred for an assessment under a 2 week wait should have the lesions examined by a specialist using dermoscopy.<br><br>**Why? People should be referred for an assessment full stop and diagnosed by a specialist under a 2 week wait service. Where's the 7 point checklist being used by the GP to help determine the appropriate referral pathway?** |
| Page 6 | List of quality statements | Statement 5 | "People with squamous cell carcinoma or malignant melanoma are supported by a skin cancer clinical nurse specialist as they progress through their care pathway".<br><br>**Changes made to the original statement as these do not accurately reflect the role of the skin cancer nurse or their interaction with the patient across their care pathway.** |
| Page 10 | Quality Statement 2 | Quality Statement 2 | See previous comments for changes. |
| Page 10 | Quality Statement 2 | Rationale | Community skin cancer clinics provide the opportunity for patients to have low-risk basal cell carcinoma removed in settings more local and convenient than hospitals. It is important that the management of these common skin cancers is performed by suitably trained and accredited specialists who are extended members of their local skin cancer multidisciplinary team in order to ensure integrated patient care and optimal outcomes. |
| Page 10 | Quality Statement 2 | Structure a) | Evidence of local arrangements for local or specialist skin cancer multidisciplinary teams and appropriately commissioned community skin cancer services are in place. |
| Page 10 | Quality | Structure b) | Evidence of local skin cancer network arrangements and skin cancer clinical protocols to ensure that low-risk |

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| | Statement 2 | | basal cell carcinomas are removed in community skin cancer clinics by dermatology clinicians who are extended members of their local skin cancer multidisciplinary team.<br><br>***Data source:*** Local data collection and network clinical audit |
| Page 10 | Quality Statement 2 | Structure c) | Evidence of local arrangements and skin cancer clinical protocols to ensure an annual review of skin cancers removed by each dermatology clinician in community skin cancer clinics. |
| Page 10/11 | Quality Statement 2 | Structure d) | Evidence of local audit arrangements to ensure that clinicians removing low-risk basal cell carcinomas in the community have their skin cancer clinical practice audited by their LSMDT lead and network annually. |
| Page 12 | Quality Statement 2 | Outcome a) | a) Skin cancer survival<br><br>**Skin cancer diagnostic accuracy would be more appropriate, survival outcomes is not really applicable for low risk BCCs.** |
| Page 12 | Quality Statement 2 | Outcome d) | Complications post excisions and scarring |
| Page 12 | Quality Statement 2 | What the quality statement means for service providers, healthcare professionals and commissioners | Service providers (LES/DES minor surgery GP practices (level 3) and GPwSIs, secondary and tertiary care providers) ensure clinicians removing low-risk basal cell carcinoma in community skin cancer clinics are extended members of their local skin cancer multidisciplinary team. They should ensure high quality skin cancer clinical practice in the community via annual audits and educational meetings.<br><br>**This whole statement is incorrect and does not reflect the levels of care, services, and governance responsibilities of the commissioner and acute service providers. All model one services must be approved by the network and local MDT lead with the CCG commissioner. LSMDT and SSMDT core members may provide model one services in the community as part of their hospital service.** |

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| Page 12 | Quality Statement 2 | Commissioners | **Commissioners** (clinical commissioning groups) ensure that community skin cancer services they commission are linked to the local skin cancer multidisciplinary team and are within recognized models of care<br><br>**Again see above comments** |
| Page 13 | Quality Statement 2 | What the quality statement means for people | People with skin lesions have confidence that the lesions are removed in community skin cancer clinics only if they are low-risk and dermatology clinician performing the removal is an extended member of their local skin cancer specialist team. |
| Page 13 | Quality Statement 2 | Source guidance | • NICE IOG 2006 needs to be included as the core information underpinning these services is contained within this document. |
| Page 13 | Quality Statement 2 | Low-risk Basal Cell Carcinoma | The service provided under the **'DES/LES'** contracting system and the **Model 1** service are to allow doctors in the community to diagnose and surgically treat low risk BCCs at two **levels of risk, under two different levels of training/ other requirements.** |
| Page 13 | Quality Statement 2 | Low-risk Basal Cell Carcinoma | Only those low-risk BCCs in anatomical sites where excision is easy and in patients who do not have other associated risk factors should be managed by GPs with no special interest or training in skin cancer. The types of low-risk BCC that these GPs can excise and the requirements for their accreditation are as follows:<br><br>**Remove; this is inappropriate - all GPs require training and accreditation for both models** |
| Page 13/14 | Quality Statement 2 | Low-risk Basal Cell Carcinoma | GPs acting within the DES or LES NHS statutory framework under the 'minor surgery' will undertake excisions (or according to clinical judgement, curettage), only of BCCs on the 'DES/LES' list, diagnosed by the practitioners themselves, either *de novo* or following referral for both diagnosis and management, from other practitioners. Competencies include the local anaesthetics, punch biopsy, shave excision, elliptical excision with closure, and curettage. (Surgical procedures and related skills as in the 2011 DH guidance, Ref: Guidance and Competencies for the Provision of Services Using GPs with special interests [GPwSIs]: Dermatology and Skin Surgery.p13.)<br><br>**Service Model 1 Practitioners are either** 'Group 3 GPwSIs', trained and competent according to the DH Guidance Ref: Guidance and Competencies for the Provision of Services Using GPs with special interests [GPwSIs]: Dermatology and |

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| | | | Skin Surgery. (2011)<br><br>**Or** a separate class of practitioners **'**GPwSIs in skin lesions', trained and competent according to the above DH guidance.<br><br>*Note on GPwSIs: The status of 'Group3 GPwSI', as trained and appointed prior to 2011, according to the previous DH guidance for GPwSIs is still valid for these measures.*<br><br>**The Lists of Low Risk BCCs, on Clinical Criteria.**<br><br>**1. The list of clinically defined BCCs suitable for excision (or according to clinical judgement, curettage) by practitioners under the DES/LES service model:**<br>**Patient.**<br>Adult, 25 and over, with normal immunity and without any genetic predisposition to BCCs.1<br>**Lesion.**<br>Newly presenting2, nodular, definitely, clearly delineated BCC3, up to 1 cm.<br>**Site.**<br>Below the clavicle but only in cosmetically and surgically straightforward areas.4<br><br>**2. The list of clinically defined BCCs suitable for excision (or according to clinical judgement, curettage) by practitioners under service model 1:**<br><br>The DES/LES list as above with the addition of the following, only:<br>An increase in size up to 2cm but only when *below* the clavicle.<br><br>Lesions *above* the clavicle up to 1 cm but only in the permitted area—the chin, cheeks, forehead, temples, neck and sides of face.5<br><br>***Notes to the reference numbers on the lists of BCCs.***<br>***1.*** *Refer on patients with immunosupression (including transplant patients) or Gorlin's syndrome.*<br>***2.*** *Refer on patients with BCCs recurrent after previous excision and BCCs persistent (i.e. having histologically positive resection margins) after excision.*<br>***3.*** *Refer on BCCs of other morphological appearances, but see note on superficial BCCs, below.*<br>***4.*** *Refer on patients with BCCs which are sited such that excision poses a potential risk* |

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| | | | *to important underlying structures, areas where difficult excision may lead to a poor cosmetic result and areas where primary closure may be difficult.*<br>***5.*** *Refer on patients with BCCs on the lips, nose, nasofacial sulci, nasofacial folds, periorbital areas and ears.*<br>**6.** All children and young people (aged 24 or below) with a suspected skin cancer, including BCC, should be referred to a member of the skin cancer multidisciplinary team (MDT) regardless of suspected lesion diagnosis, size or anatomical location. |
| Page 14 | Quality Statement 2 | Low-risk Basal Cell Carcinoma | **If the BCC does not meet the above criteria, or there is any diagnostic doubt, following discussion with the patient they should be referred to a member of the local skin cancer multidisciplinary team. [Skin Tumours including melanoma (2006 and 2010) NICE cancer service guidance, Section 4: Models of care (page 32).** |
| Page 15 | Quality Statement 3 | Quality Statement 3 | **People presenting to primary care with a suspected squamous cell carcinoma or malignant melanoma are referred directly to their hospital local or specialist MDT specialist under a 2 week wait referral.**<br>This principle of a given primary care practice stating that patients will be referred to a given MDT is not intended to restrict patients or GP choice. A rational network of local and specialist MDTs can only be maintained if;<br>i) there is an agreement on which MDT the patients will normally be referred to and<br>ii) the resulting referral catchment populations are counted once for planning purposes.<br>**All patients with a suspicious pigmented skin lesion, with a skin lesion that may be a high-risk BCC, a squamous cell carcinoma (SCC) (or a malignant melanoma (MM), or where the diagnosis is uncertain, should be referred to a doctor trained in the specialist diagnosis of skin malignancy, normally a dermatologist, who is a member of either an LSMDT or an SSMDT.** |
| Page 15 | Quality Statement 3 | Structure a) | Evidence of local arrangements and skin cancer network clinical protocols ensuring that all suspected cancer pathways are in place.<br>***Data source:*** Local data collection and skin cancer network clinical policy guidance. |

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| Page 15 | Quality Statement 3 | Structure b) | Evidence of local referral arrangements and clinical protocols ensuring that people presenting to primary care with a suspected squamous cell carcinoma or malignant melanoma are referred to a specialist under 2 week wait rules in accordance with NICE IOG.<br><br>***Data source:*** Local data collection and MDT cancer waiting times audit |
| Page 16 | Quality Statement 3 | Process | Proportion of referrals that were for suspected squamous cell carcinomas and malignant melanomas.<br><br>**This doesn't make sense- is this supposed to be conversion rates for these cancer from all referrals?** |
| Page 17 | Quality Statement 3 | Numerator/Denominator | Numerator – number in the denominator referred for suspected squamous cell carcinomas and malignant melanomas.<br><br>Denominator – number of skin cancer referrals that come through a suspected cancer pathway.<br><br>**These two points do not make sense. All referrals will be under 2 week wait rules for these skin cancers. The outcomes should be the diagnostic outcome of what was referred** |
| Page 17 | Quality Statement 3 | Outcome b) | 2ww Time between GP referral and specialist assessment (first seen)<br><br>*Data source*: **Local trust and MDT data collection and National Cancer Intelligence Network** |
| Page 17 | Quality Statement 3 | Outcome c) | a) Time between GP referral to first definitive treatment (31 DAYS) or 62 days<br><br>*Data source*: **Local trust and MDT data collection and National Cancer Intelligence Network** |
| Page 17 | Quality Statement 3 | What this quality statement means for service providers, healthcare | Service providers (GP practices, local hospital skin cancer multidisciplinary teams) ensure that systems are in place for people presenting to primary care with suspected squamous cell carcinomas or malignant melanomas to be referred to a specialist through a suspected cancer pathway. |

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| | | professionals and commissioners | **Please ensure terminology is correct and consistent with pervious comments made.** |
| Page 17 | Quality Statement 3 | What this quality statement means for service providers, healthcare professionals and commissioners | Commissioners (clinical commissioning groups) ensure that the primary care services they commission refer people presenting with squamous cell carcinomas or malignant melanomas through a suspected cancer pathway.<br><br>**Commissioners are commissioning les of des services of model one you need to be specific and again the use of 2 week wait is required. There is no such reference to a suspected cancer pathway this makes no sense.** |
| Page 18 | Quality statement 3 | Definitions of terms used in this quality statement: Specialist | **A** skin cancer specialist **is a doctor trained in the specialist diagnosis of skin malignancy, normally a consultant dermatologist, who is a core member of either a local hospital skin cancer multidisciplinary team or a specialist skin cancer multidisciplinary team. [Improving outcomes for people with skin tumours including melanoma (2006) NICE guideline CSG8, key recommendations (page 8)]**<br><br>Please note all the LSMDT and SSMDT core membership requires consultant dermatologists and surgeons to be compliant based on the NICE IOG. These were recommendations made by the NICE IOG which are now part of standard cancer service structure and peer review. NICE quality standards must be made in the present state to reflect the implementation of its own recommendations since 2008. |
| Page 19 | Quality statement 4 | Quality statement 4 | **People with pigmented skin lesions referred for diagnostic assessment should have the lesions examined by a specialist trained in the use of dermoscopy.** |

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| Page 22 | Quality statement 5 | Quality statement 5 | **See previous comments and amendments** |
| Page 22 | Quality statement 5 | Structure | **Evidence of peer review documentation for the LSMDT/SSMDT and written skin cancer network clinical protocols to ensure that designated clinical nurse specialists are accessible to people with squamous cell carcinoma or malignant melanoma.** |
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Insert extra rows as needed

**Checklist for submitting comments**

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include section number of the text each comment is about eg. introduction; quality statement 1; quality statement 2 (measure).
- If commenting on a specific quality statement, please indicate the particular sub-section (for example, statement, measure or audience descriptor).
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons).We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance and quality standards that we have produced on topics related to this quality standard by checking NICE Pathways.

**Note:** We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

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