NICE National Institute for Health and Care Excellence

2019 surveillance – Improving outcomes for people with skin tumours including melanoma (2006) NICE guideline CSG8

Stakeholder consultation comments form - proposal 'to withdraw the guideline'

Consultation on the proposal 'to withdraw the guideline' opens at: 9am, Tuesday 19 March 2019

Comments on proposal to be submitted: no later than 5pm, Monday 1 April 2019

Please enter the name of your registered stakeholder or respondent organisation below.

Please use this form for submitting your comments to NICE.

1. Please put each new comment in a new row.
2. Please note – we cannot accept comments forms with attachments such as research articles, letters or leaflets. If we receive forms with attachments, we will return them without reading the comments. If you resubmit the comments on a form without attachments, this must be by the consultation deadline.
3. If you wish to draw our attention to published studies, please supply the full reference.
4. If you're commenting for an organisation, your organisation needs to be registered as a stakeholder.

   Not eligible? Contact the registered stakeholder organisation that most closely represents your interests and pass your comments to them.

   We can accept comments from individuals. These will be considered, but you won't get a formal response and they won't be posted on the NICE website. Wherever possible we encourage you to submit your comments through a registered stakeholder organisation.

Organisation name – Stakeholder or respondent (if you are commenting as an individual rather than a registered stakeholder or respondent organisation, please leave blank):	British Association of Dermatologists
Disclosure Please disclose whether the organisation has any past or current, direct or indirect links to, or receives funding from, the tobacco industry.	No

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Name of commentator:	Tania von Hospenthal, Head of Clinical Services and Development

Developing NICE guidelines: the manual gives an overview of the processes used in surveillance reviews of NICE clinical guidelines.

ID	Questions	Overall response yes / no	Comments Please insert each new comment in a new row
1	Do you agree with the proposal to withdraw the guideline?	No	1.1 Quality is systemic. Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals, provider organisations, commissioners, systems and professional regulators and other national bodies such as NICE. It is not the responsibility of any one part of the system alone, but a collective endeavour requiring collaboration at every level of the system. *References:* *Review of early warning systems in the NHS, National Quality Board, February 2010.* *Quality in the new health system – maintaining and improving quality from April 2013, draft report, National Quality Board, August 2012.* 1.2 The organisation of skin cancer services set out by the NICE IOG underpins the current infrastructure and quality outcomes for patient care. Without an updated version of the NICE IOG the commissioning of services would become fragmented and create inequity of care for patients. 1.3 Updating the clinical guidelines for melanoma, SCCs and BCCs without the NICE IOG or replacement guidance recommendation would remove national infrastructure for the treatment pathways for patients.

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			1.4 The evidence review fails to recognise the peer review and outcome measures for the provision of skin cancer services. These are based on the requirements of the NICE IOG.
2	Do you have any comments on areas excluded from the scope of the guideline?	Yes	2.1 The IOG 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. 2.2 The IOG describes at least six mutually exclusive levels of specialisation which, for the purposes of service organisation and for peer review are best dealt with by the 'levels' model. 2.3 Commissioners are required to demonstrate compliance with the commissioning principles and procure services within the required NICE guidance frameworks for BCC. The management of low-risk basal cell carcinomas in the community AND recommendations in this section of the guideline are all current requirements for the commissioning of these services. CSG8 remains relevant to clinical practice. 2.4 The revalidation of GPwER individual practice requires these areas to be met. The RCGP training curriculum and credentialing of these individual requires this evidence of practice to be demonstrated. https://www.rcgp.org.uk/training-exams/practice/guidance-and-competences-for-gps-with-extended-roles-in-dermatology-and-skin-surgery.aspx 2.5 Local arrangements for the commissioning of community skin cancer services has not changed.

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			2.6 The guidance recommended that research be undertaken on teledermatology in the triage of patients with suspicious skin lesions (including clinical accuracy, cost-effectiveness, patient confidentiality and patient acceptability). There must be an updated reference for the use of teledermatology in the NICE IOG as this area of diagnostic screening increases. It is important for the NICE IOG to provide best practice in the use of this tool in skin cancer pathways. 2.7 The NICE IOG made a key recommendation for two levels of multidisciplinary teams – local hospital skin cancer multidisciplinary teams (LSMDTs) and specialist skin cancer multidisciplinary teams (SSMDTs). The MDT structure is there to standardise care regardless of where the patient is treated and should minimise the risks to patients, because all clinicians who treat patients with skin cancers will be working to the same protocols and have their outcomes audited. It encourages some treatments for patients with precancerous skin lesions and low-risk BCCs to be carried out in the community but ensures that patients with MM, SCC and high-risk BCC have their care managed by a hospital-based MDT with specialist skills. The BAD's Clinical Standards Unit are currently updating their BCC and SCC guidelines, and in the narratives for Linking Evidence To Recommendations (LETR) they have cited CSG8 and its partial update in the "Other Considerations" section. 2.8 A rational network of local and specialist MDTs can only be maintained if; i) there is an agreement on which MDT the patients will normally be referred to and

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			ii) the resulting referral catchment populations are counted once for planning purposes. 2.9 The NHS England National Cancer Strategy, *Achieving World-Class Cancer Outcomes*, was published in 2015 by the Independent Cancer Taskforce. This includes the establishment of 16 Cancer Alliances across the country to lead implementation of the strategy locally. Cancer networks have been replaced by Cancer Alliances to bring together the key organisations in an area to coordinate cancer care and to plan for and lead delivery of improved outcomes for patients locally. 2.10 Each organisation that provides cancer services will have a distinctive leadership structure (the core cancer management team). One size will not fit all and there is no best structure for staffing NHS cancer services. What is essential is that organisations develop local governance structures that reflect the complexities of their organisations. It is essential that: • the remits and level of authority of the core cancer management team and individuals within the team are clear and communicated across the organisation; • accountability for cancer delivery is clearly identified; • board level support for the structure is articulated; • sufficient time is made available for individuals to enact their roles; • a clear governance framework is in place. 2.11 Peer review skin measure are based on the outcomes recommended by the NICE IOG. The Quality Surveillance

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			Team (QST), formerly National Peer Review Programme, lead an Integrated Quality Assurance Programme for the NHS. The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and specialised commissioned services within NHS England. The programme has taken the best elements of the former National Peer Review Programme and other NHS functions to develop an integrated process for quality assurance which covers all aspects of quality in particular; patient safety, patient experience, clinical effectiveness and outcomes. 2.12 Follow up care: The IOG series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up management agreed within their respective LSMDT/SSMDT and Cancer Alliance to ensure patients have a follow up plan.
3	Do you have any comments on equalities issues?	Yes	3.1 Without the IOG in place equality of care across the UK could differ and therefore not all patients would necessarily get the same care. Discrimination may also occur due to lack of regulation of required pathways and processes. Commissioning of services could be fragmented as not all services may be re-commissioned if not deemed essential. 3.2 Equality of opportunity may also be breached in levels of care and employment of those required for each level. In particular the need for a clinical nurse specialist as part of the IOG is essential for guarding against discrimination and equality issues.

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

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Closing date: 5pm, Monday 1 April 2019

PLEASE NOTE:
NICE reserves the right to summarise and edit comments received during consultations, or not to publish them at all, if NICE's reasonable opinion is that the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.