NICE guidance on cancer services update

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

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

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

1. Background
   - The epidemiology of basal cell carcinoma

2. Burden of disease

3. Patient perspective

4. Training and accreditation

5. Existing guidance

6. Definition of low- and high-risk basal cell carcinoma

7. Recommendations
   - Training and education
   - Quality assurance
   - Clinical governance
   - Commissioning
   - Models of care
   - Data collection
   - Communication

8. Research recommendations

9. Linking evidence to recommendations

10. Evidence summary

11. References for evidence summary

12. Appendices
   - Appendix 1.0: People and organisations involved in production of the guidance
   - Appendix 1.1: Members of the Guideline Development Group (GDG)
   - Appendix 1.2: Organisations invited to comment on guidance development
The management of low-risk basal cell carcinomas in the community

Background

In February 2006, the National Institute for Health and Clinical Excellence (NICE) published service guidance on skin cancer, ‘Improving outcomes for people with skin tumours including melanoma’ (NICE guidance on cancer services). Many of the recommendations in this guidance were converted into peer review measures published in the ‘Manual for cancer services 2008: skin measures’.

Early in 2009, NICE was made aware of concerns about the implementation of some aspects of its guidance. These were in relation to the arrangements under which GPs could remove ‘low-risk’ basal cell carcinomas (BCCs) and how services for skin cancer patients were being commissioned. Following a meeting at NICE in April 2009, an update to the 2006 NICE guidance was commissioned to address the management of low-risk BCCs in the community.

The epidemiology of basal cell carcinoma

The importance of BCC is underestimated, probably because it is rarely fatal. BCC is the commonest type of cancer in the UK, with at least 49,815 cases registered in England in 2006 – although this is likely to be a significant underestimation. Even with this underestimate, the incidence of BCC in England is still 1.8 times higher than that of lung cancer. It not only affects many individuals but also places a significant burden on NHS resources.

Accurate data on the true prevalence and incidence of BCC in the UK is difficult to obtain because some cancer registries do not register BCCs or do not register multiple BCCs in the same individual, so the total number of BCCs is probably much higher than stated in the published literature. Data from Northern Ireland, where the cancer registry does capture information, documented age-adjusted incidence rates of 104 and 71 per 100,000 population for males and females respectively. One study, based on a UK primary care database cohort study, estimates about 53,000 new cases of BCC per year in the UK.

Furthermore, not all ‘low-risk’ BCCs are subject to histology before medical treatment; one audit submitted under the 2009 skin cancer peer review process in England indicated that up to 50% of GPs removing suspected BCCs do not submit them for histology (National Cancer Action Team: personal communication 2009). This contravenes the NICE guidance on skin cancer services.

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3 Available from the United Kingdom Association of Cancer Registries (UKACR): http://82.110.76.19/
4 Available from the National Cancer Intelligence Network (NCIN): http://www.ncin.org.uk/index.shtml
The main risk factor for BCC is sun (ultraviolet light) exposure. This is reflected in the multiplicity of tumours that patients develop and the predominance of tumours in sun-exposed areas, for example the head, neck, forearms, hands, lower legs and feet, and trunk.

Superficial BCCs are seen on the trunk, especially in men. Individuals with fair skin are more at risk. Age-standardised rates of BCC in the south west of England are much higher than in England overall (121.3 per 100,000 population compared with 93.72 per 100,000 population).

BCCs also arise in patients with a genetic predisposition, for example Gorlin’s syndrome or xeroderma pigmentosum. These patients have large numbers of BCCs, should be referred to and managed by the local skin cancer multidisciplinary team (LSMDT) or the specialist skin cancer multidisciplinary team (SSMDT) and should not have their BCCs treated with radiotherapy (as recommended in the NICE guidance on skin cancer services).

The incidence of BCC increases with age and it is more common in men. Using 2002–06 age-standardised rates, at ages up to 50 years, men have lower incidence rates (p < 0.01) than women, or there is no significant difference. In those aged 50 years and over the incidence rate is higher for men (p < 0.01). The largest difference is for the 80–84 age group, where the incidence rate for men is 66% higher than that for women.

Patients diagnosed with one BCC are at increased risk of having further BCCs diagnosed at the same time, or of developing them subsequently. Studies suggest that the risk of developing a second BCC within 3 years of the first presentation is approximately 44%.

Where epidemiological studies have been undertaken, it has been shown that the incidence of BCC is rising, with evidence suggesting a 3% year-on-year increase. The largest reported increase in incidence was seen in the 30–39 age group. Unless population attitudes to sun exposure and skin protection change, the numbers of BCCs will continue to rise. The rise in incidence is predicted to be particularly great up to 2030 because of the large increase in the elderly population that will arise as the ‘baby boom’ population ages.

Thus numbers would rise even if incidence rates stayed static.

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9 Available from the United Kingdom Association of Cancer Registries (UKACR): http://82.110.76.19/
12 Available from the United Kingdom Association of Cancer Registries (UKACR): http://82.110.76.19/
14 Marcil and Stern (2000) Archives of Dermatology 136, 1524
BCC is rarely fatal. Moreover, the majority of BCCs can be treated in an out-patient, day-case setting or community/primary-care setting. However, failure to diagnose early and/or inadequate treatment can result in tumours that erode important anatomical structures. Such tumours are very challenging to treat, making it difficult to obtain a good cosmetic result. The number of in-patient bed days devoted to managing BCCs is roughly comparable to those devoted to in-patient management of malignant melanoma. Increased public awareness of the risk of excess sun exposure, combined with a change in behaviour towards greater skin protection, could reduce the incidence of BCC. Raising public awareness as advocated in the National Awareness and Early Diagnosis Initiative (NAEDI) programme could reduce the proportion of patients presenting with advanced disease.

11 **Burden of disease**

The epidemiology and health services epidemiology of BCC, described above, demonstrates that the number of cases is rising significantly. These cases of BCC impose a significant workload on both primary and secondary care services and their management (if they are of a high-risk type) and require expertise to ensure curative resection is combined with a good cosmetic result and low risk of complications.

It is estimated that 24% of primary care workload is related to the diagnosis and management of skin conditions, including skin lesions. The burden of skin lesion management in dermatology out-patient services is also great, with 35–45% of specialist referrals relating to the diagnosis and management of skin lesions. This figure is as high as 60% in some areas. Furthermore, approximately 88% of two-week wait urgent referrals for suspected skin cancer turn out to be non-malignant, highlighting a need for better training in primary care on the recognition of skin cancer. The epidemiology of BCC, especially the predictions for the next two decades, means that there will be a requirement for better trained healthcare professionals to diagnose and manage BCCs.

12 **Patient perspective**

Patients and their carers want BCCs to be accurately diagnosed and then to be treated by healthcare professionals who:

- have been fully and adequately trained
- have met prescribed standards
- participate in audit
- undertake continuous professional development (CPD) in this clinical area.

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18 South West Public Health Observatory (www.swpho.nhs.uk/)
20 Schofield J, Grindlay D and Williams H (2009). Skin conditions in the uk: a health care needs assessment. Centre of Evidence Based Dermatology, University of Nottingham
21 Schofield J, Grindlay D and Williams H (2009). Skin conditions in the uk: a health care needs assessment. Centre of Evidence Based Dermatology, University of Nottingham
Patients want their BCC(s) to be treated effectively the first time, with minimal risk of recurrence. They want to have the best cosmetic result achievable and surgery that, if undertaken, minimises the risk of damaging important, proximate anatomical features, such as nerves, where possible. Most importantly, they want to be clearly informed of their diagnosis and involved in the decision on choice of treatment and where this is delivered. The healthcare professional's advice and choice of treatment should not be influenced by a patient's age, gender or other disabilities unless the latter has a direct clinical relationship with the success of certain forms of treatment.

Patients are also keen to have their care provided close to home, which should not mean a compromise on the quality of care they receive. This emphasis on equity of access to high quality care is reinforced in the recent Darzi review.

Training and accreditation

It is recognised that the training of healthcare professionals in dermatology is limited. This includes undergraduate and postgraduate medical, nurse and pharmacy training. In particular, undergraduate medical training may be as little as 2 weeks, with no formal training or assessment of skin surgery. There is also no mandatory postgraduate training in dermatology or skin surgery for GPs, with no further requirement currently for formal assessment in these skills, or a mandatory system of accreditation including ongoing CPD and participation in audit.

Existing guidance

There are three key national documents that guide service development and quality assessment for services for patients with BCC. These are the NICE ‘Improving outcomes for people with skin tumours including melanoma’ guidance, the Department of Health ‘Guidance and competencies for the provision of services using GPs with a special interest (GPwSIs)’ and the ‘Manual for cancer services: skin measures’. Early results from the peer review of skin cancer services in England (National Cancer Action Team: personal communication 2009) show generally poor levels of compliance to the standards, especially with respect to the primary care component and commissioning, although there are many notable exceptions across the country.


The management of low-risk basal cell carcinomas in the community: NICE guidance on cancer services update DRAFT (November 2009)
Key obstacles identified from the 2009 skin cancer peer review process include:

- weak commissioning
- clinical governance arrangements across the primary/secondary care interface
- issues with finance transfer across the primary/secondary care interface
- inadequate understanding of the models under which GPs can manage ‘low-risk’ BCCs
- in some circumstances, adherence to the appropriate guidance on ‘high-risk’ BCCs.

This updated guidance will seek to address these areas and provide clarification for patients, commissioners of services and providers of care.

**Definition of low- and high-risk basal cell carcinoma**

The review of the systems for classifying high- and low-risk BCCs showed that some incorporate histological features that would only be available after biopsy or excision. However, for the purposes of the clinical recognition of high-risk BCCs, criteria were defined for the ‘Manual for cancer services 2008: skin measures’31. There is a need for a clear clinical triage definition for high- and low-risk BCCs to ensure simple and efficient referral to appropriate healthcare professionals for management.

To aid clinical assessment of patients in the community with suspected BCC, and for clinical triage to the appropriate level of expertise for intervention, a range of definitions and criteria for defining high- and low-risk BCC were reviewed by the Guideline Development Group (GDG). These definitions had been summarised in a review paper prepared by Dr Dafydd Roberts and presented to the meeting at NICE in April 2009. The GDG concluded that the clinical triage definitions for the face and scalp (head) needed to be simplified because:

- there is a lack of precision regarding the H-zone (the high-risk zone on the face)
- a 10 mm low-risk BCC resected with the recommended 4 mm margins would lead to tissue removal of at least 18 mm diameter, which even on the cheek would result in a poor cosmetic result and make primary closure challenging
- proximity to facial structures presents a challenge to achieving a good cosmetic result and adequate resection margins.

These factors are not independent, particularly in lesions on the face and head. Therefore the GDG decided to recommend that new criteria be adopted for the definition of high- and low-risk BCC presenting in the community that take into account:

- risk of recurrence (incomplete excision)
- the skill and experience required by the healthcare professional to achieve a good cosmetic result
- risk caused by underlying anatomical structures

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• other management risks (for example, recurrent BCC, Gorlin’s syndrome, immunosuppression).

**Recommendations**

The following definition of high-risk BCC should be used for clinical triage in primary care:

- recurrent BCCs
- BCCs on the head (face and scalp)
- BCCs greater than 2 cm in diameter, unless they are superficial BCCs that can be managed non-surgically
- lesions that have a clinical appearance of morphoeic, infiltrative or basosquamous
- lesions with poorly defined margins
- BCCs in patients who are immunosuppressed or have Gorlin’s syndrome
- BCCs located over important underlying anatomical structures (for example, major vessels or nerves) or where primary surgical closure may be difficult (for example, digits or front of shin).

Patients with superficial BCCs (not usually classified as high risk) should be appropriately referred in order that they are offered a full range of medical treatments, including photodynamic therapy.

Healthcare professionals managing superficial BCC in the community should have experience and knowledge of this condition.

Patients with clinically suspected or histologically confirmed high-risk BCCs should continue to be referred to approved specialists as recommended in ‘Improving outcomes for people with skin tumours including melanoma’ (NICE guidance on cancer services). 32

**Training and education**

All healthcare professionals dealing with skin lesions in the community should have access to specialist training in the diagnosis and management of skin lesions.

All healthcare professionals wishing to excise skin lesions in the community should be fully accredited to do so and undergo continuous professional development in the diagnosis and management of skin lesions to maintain their accreditation status.

**Quality assurance**

All skin lesion samples (excision, incision, punch biopsy and curettage) should be sent for histological examination as recommended in the NICE ‘Referral guidelines for suspected

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cancer. Where multiple lesions exist, they should be sent in separate specimen pots with individual referral forms.

Histology request and reporting forms, and the electronic recording of these data items, should be improved to capture the minimum dataset requirements (National Cancer Intelligence Network dataset project [in development] and the Royal College of Pathology dataset).

Healthcare professionals in the community sending skin lesion samples for histological assessment should have a mechanism in place to ensure that they receive histology results and should take appropriate action.

Healthcare professionals dealing with low-risk BCCs in the community should maintain a log book or spreadsheet of the suspected and actual skin cancer lesions they have managed.

All healthcare professionals performing skin surgery in the community should provide quarterly feedback to their primary care trusts (PCTs) on histology reported in the minimum dataset.

As required by the ‘Manual for cancer services 2008: skin measures’ there should be an audit of all BCCs excised by healthcare professionals in the community. The PCT should make these audit results available to the multidisciplinary team (MDT) on a quarterly basis and it should be included in the cancer network annual audit (cancer standards 08-6A-103J).

All healthcare professionals dealing with low-risk BCCs in the community should attend an educational meeting (organised by the Cancer Network Site Specific Group) where the annual BCC network results are presented along with a breakdown of individual healthcare professional data. This meeting should also include one CPD session (a total of 4 hours) on the diagnosis and management of low-risk BCCs. These meetings should be run at least twice a year and healthcare professionals should attend on at least one occasion.

The MDT should facilitate the development of a patient reported outcome measure (PROM) for the treatment of BCCs.

34 Available from the National Cancer Intelligence Network (NCIN): http://www.nacin.org.uk/index.shtml
Clinical governance

PCTs commissioning community dermatology services that include skin cancer should ensure that:

- Clinical governance arrangements are in place for all healthcare professionals providing these services (including private providers contracted to treat NHS patients) and they are accredited to perform skin lesion excisions.

- All healthcare professionals providing these services work 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.

Healthcare professionals dealing with skin lesions in the community should obtain informed consent before any treatment is undertaken\textsuperscript{37,38,39}.

This updated guidance and other national clinical guidelines should be used in the development of local protocols and guidelines at the cancer network level.

PCTs should ensure that all primary care healthcare professionals excising skin lesions are appropriately accredited.

Quality standards against which performance can be managed/monitored should be reflected in the national minimum dataset.

Commissioning

Commissioners should undertake a full needs assessment of low-risk BCC for their specific population and this should:

- include projections of the likely increase in the number of cases over the next two decades

- consider local issues such as population demographics, access to services and patient preferences.

Commissioners should use the commissioning cycle\textsuperscript{40} and follow the process outlined in the NHS primary care contracting guidance\textsuperscript{41}.

The commissioning process should plan for a significant increase in the number of patients with low-risk BCC, especially in an older population.


\textsuperscript{38} General Medical Council (GMC) guidance on informed consent. Available at: http://www.gmc-uk.org/static/documents/content/Consent_2008.pdf

\textsuperscript{39} Welsh Assembly Government Guidance on informed consent. Available at: www.wales.nhs.uk/consent


Commissioners should ensure that the management of low-risk BCCs by healthcare professionals in the community is subject to the quality standards and requirements outlined in this guidance.

All providers of community cancer services for low-risk BCC should demonstrate that they are competent in the diagnosis and management of skin lesions, including skin cancer surgery (SS1 and SS2 competencies). This should be assessed by direct observation of procedural skills (DOPS).

Commissioners should consider innovative approaches to the diagnosis of low-risk BCCs so that patients are not inconvenienced with unnecessary travel/access arrangements.

Commissioners should consider quality of care and value for money in commissioning services for low-risk BCCs.

Provided quality standards can be ensured, commissioners should commission services from different providers. The options are:

- Group 3 community cancer GPwSIs.
- Outreach specialist services provided by secondary care (including consultants, staff grade and associate specialist [SAS] doctors, specialist nurses and new model practitioners).
- A new GP expert in skin lesions (a framework should be developed based on SS1/SS2 that will enable commissioners to commission skin services and low-risk BCCs from suitably trained individuals).
- GPs already performing minor surgery within the Directed Enhanced Services (DES) (minor surgery) arrangements under General Medical Services (GMS) or Personal Medical Services (PMS). Such GPs may undertake low-risk BCC surgery if the following additional criteria are met:
  - GPs should satisfy their contracting PCT that they are competent in the diagnosis of BCCs and carry out the appropriate surgical procedures; this should be reviewed annually as part of the contracting arrangements for the DES.
  - GPs already excising BCCs should provide evidence that they have been excising low-risk BCCs appropriately with adequate skin margins. If the GP cannot provide such evidence, they should undergo a direct observation of procedural skills (DOPS).


GPs wishing to start providing this service should undergo a DOPS to demonstrate competency.

GPs should keep a log book or spreadsheet of all suspected low-risk BCCs to be excised.

All skin specimens removed should be sent to histology for analysis.

GPs should provide information about the site of excision and provisional diagnosis on the histology request form.

Practices should have a robust process to ensure that patients are informed of the final diagnosis, and whether any further treatment or follow-up is required.

GPs should provide quarterly feedback to their PCT on the histology reported in the minimum dataset. This should include details of all proven BCCs clinically diagnosed before surgery. GPs should also provide details of any type of skin cancer removed in their practice, as it is acknowledged that GPs will occasionally excise a skin cancer unknowingly.

GPs should attend an educational meeting (organised by the Skin Cancer Network Site Specific Group) where the annual BCC network results are presented, including a breakdown of individual GP performance. This meeting should also include one CPD session (a total of 4 hours) on the diagnosis and management of low-risk BCCs. These meetings should be run at least twice a year and GPs should attend on at least one occasion.

Models of care

PCTs should ensure that services procured/commissioned (by practice-based commissioning) for low-risk BCCs for their population adhere to national standards.

Data collection

Improved quality of data collection for BCC should be implemented by cancer peer review following the publication of the skin cancer minimum dataset now in development.

BCCs should be comprehensively registered by cancer registries to allow national and sub-national epidemiology and health service epidemiological studies to take place.

Communication

All healthcare professionals managing BCCs in the community should be responsible for the provision of information, advice and support for patients and their carers.

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Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

- Research on the epidemiology and health service epidemiology of BCCs should be increased.
- Further research should be undertaken on predictive factors in recurrence and other outcome measures.

Linking evidence to recommendations

The GDG reviewed a number of types of evidence in the process of assessing the fitness for purpose of the existing NICE guidance on skin cancer services\(^{48}\) pertaining to the identification, referral and management of low-risk BCC. This included:

- an overview of the epidemiology of BCC and its health service epidemiology
- a summary of methods for defining high- and low-risk BCC, including the clinical definitions included in the ‘Manual for cancer services: skin measures’\(^{49}\)
- preliminary data from the 2009 skin cancer services peer review process, presented by the National Cancer Action Team
- undergraduate and postgraduate training requirements for GPs in skin lesion recognition and management
- an evidence review undertaken to examine the question ‘Do outcomes differ when the excisional surgery of a suspicious lesion is performed by a GP compared with a specialist in secondary care?’.


The management of low-risk basal cell carcinomas in the community:
NICE guidance on cancer services update DRAFT (November 2009)
Evidence summary

[References for this evidence review are listed at the end of this section]

The evidence base for this topic consists of one randomised controlled trial (RCT), non-randomised observational studies (both prospective and retrospective), meeting abstracts presenting audit data, some audit data from specific health services and published correspondence. Almost half the evidence was generated from within the UK, with the other half generated from Australia and one paper published from New Zealand. Applicability of the Australian evidence is limited in the UK setting.

In order to accurately evaluate the outcomes from excisional surgery of a suspicious skin lesion performed by a GP compared with a specialist in secondary care, the ideal study would require the randomisation of patients to either of these settings and then assessment of the outcomes. The evidence body is limited in this sense, with only one study attempting to evaluate this question in this way (George et al., 2008). The remaining evidence comes from observational studies, mainly retrospective series, which involve high levels of bias with respect to data collection processes or patient/lesion selection criteria. Furthermore, this evidence did not consistently describe if the GP groups included were GPs with a special interest or not, therefore making it difficult to draw conclusions about the performance of GPs with a special interest or GPs (with no specialised training).

Overall, 11 studies (Carter et al., 2009; Dabrera 2007; De La Roche et al., 2008; George et al., 2008; Goulding et al., 2009; Khalid et al., 2009; Macbeth et al., 2009; Murchie et al., 2008; Neal et al., 2008; Su et al., 2007; Youl et al., 2007) with varying levels of methodological bias compared dermatologists with GPs or other clinical specialists. Eight of these studies indicated that margin clearance or complete excision is more adequately achieved by ('hospital' or 'specialist') dermatologists than GPs (Carter et al., 2009; Dabrera 2007; De La Roche et al., 2008; Goulding et al., 2009; Khalid et al., 2009; Macbeth et al., 2009; Murchie et al., 2008; Neal et al., 2008).

Three of the 11 studies reported the following:

- The equivalence study by George et al., (2008) compared three outcomes of minor surgery, including the excision of suspected skin cancers, and was conducted in primary care or at a hospital in the South of England. Statistically, hospital doctors scored higher marks than GPs in surgical quality (odds ratio [OR] = 1.64, 95%: 0.997–2.69%) but, as this was an equivalence study, the authors found the clinical significance of this result difficult to interpret. GPs failed to recognise a malignant lesion about one third of the time but were good at recognising benign lesions. Hospital doctors achieved more adequate excisions than GPs but the difference was not significant and, with such a low patient number, firm conclusions should not be drawn from this result. Patients were more satisfied with treatment in primary care and found it less inconvenient than attending hospital.

- Su et al., (2007) reported the incidence of incomplete excision at a tertiary referral public hospital. There was no significant difference in the percentage of incomplete
excision between consultants, registrars and the clinical assistant, but the low numbers of cases performed by consultants may have contributed to this result.

- Youl et al., (2007) compared the ability of GPs or hospital doctors to correctly
recognise malignant skin lesions. Hospital doctors were statistically superior in the
detection of BCCs and malignant melanomas but not squamous cell carcinomas.
GPs and hospital doctors were of equal ability in the detection of benign skin lesions.

Importantly, the evidence body lacked sufficient evidence of difference between GPs and
dermatologists in terms of long-term patient outcomes. Recurrence is one key outcome and
was addressed by only one study in this update (Wylie et al. 2009). Wylie et al. (2009)
reported a study that compared guideline recommendations and actual current practice.
Fifty-three dermatologists were involved in an anonymous online questionnaire. When asked
to respond to a clinical case example, which asked for the likely excision margin (1 mm to
> 4 mm) for a primary well-defined nodular basal cell carcinoma measuring 1 cm on the mid-
forehead, 33% suggested they would excise with a margin of 2 mm or less and only 32%
gave 4 mm or greater as their response. Similar wide variations in practice were found with
examples for high-/low-risk squamous cell carcinoma and also for initial primary melanoma
excision. Grade of operator and frequency of surgery were linked with the use of smaller
margins. The largest margins (more closely following recommended guidelines) came from
British Society of Dermatology Surgery members, although not exclusively. Overall it was
concluded that, in terms of providing adequate clearance and reducing recurrence rates, the
results indicated marked discrepancies.

In conclusion, the retrospective studies, although flawed, do indicate a consistent trend of
current practices and outcomes in favour of specialist care in this setting. The controlled
study by George et al., (2008) provides an important framework for further research to be
conducted and, along with more well-conducted studies using reliable audit data, the
outcomes of excisional surgery will be more adequately reported.

[The full evidence review is presented as a separate document that accompanies this update]
References for evidence summary


Appendices

Appendix 1.0: People and organisations involved in production of the guidance

1.1 Members of the Guideline Development Group (GDG)
1.2 Organisations invited to comment on guidance development
1.3 Individuals carrying out literature reviews and complementary work
1.4 Members of the Guideline Review Panel
Appendix 1.1: Members of the Guideline Development Group (GDG)

GDG Chair

Dr Julia Verne  Deputy Regional Director of Public Health and South West Public Health Observatory Director

Group members

Mrs Fiona Bonas  North West London Cancer Network Director

Dr Timothy Cunliffe  GPwSI in Dermatology and Skin Surgery, Middlesborough Specialist Skin Service

Dr Bruce Eden  GP Advisor to Greater Midlands Cancer Network

Dr Antony Feltbower  GP, Coventry

Ms Gillian Godsell  Skin Cancer Clinical Nurse Specialist, Nottingham University Hospital NHS Trust

Dr Stephen Keohane  Consultant Dermatologist, Portsmouth Hospital

Dr David Marshall  GP, Reading

Mr Barry Powell  Consultant Plastic Surgeon, St George's Hospital, London

Dr Julia Schofield  Principal Lecturer, University of Hertfordshire, Consultant Dermatologist, United Lincolnshire Hospital NHS Trust

Mrs Sylvia Toresen  Patient/carer member

Mrs Pippa Tostevin  Patient/carer member
Declarations of interest

GDG members were asked to declare any possible conflicts of interest that could interfere with their work on the guideline.

<table>
<thead>
<tr>
<th>GDG member</th>
<th>Interest declared</th>
<th>Type of interest</th>
<th>Decision taken</th>
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<tr>
<td>Julia Schofield</td>
<td>Received an honorarium from Leo Pharm Lecture to give a lecture on GPwSI accreditation and community cancer services</td>
<td>Personal pecuniary specific</td>
<td>Declare and must withdraw from discussions on topics that focus on GPwSI accreditation until Jan 2010. Chairperson’s action taken that JS can be asked specific technical questions about GPwSI accreditation.</td>
</tr>
<tr>
<td></td>
<td>Received an honorarium from Schering Plough to give a lecture on commissioning dermatology services</td>
<td>Personal pecuniary non-specific</td>
<td>Declare can participate in discussions as the meeting was not specific to skin cancer.</td>
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### Appendix 1.2: Organisations invited to comment on guidance development

The following stakeholders registered with NICE and were invited to comment on the draft version of this guidance:

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<thead>
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<th>Organisation</th>
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<tr>
<td>Association of British Insurers (ABI)</td>
<td>County Durham PCT</td>
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<tr>
<td>Associazione Infermieristica per lo Studio delle Lesioni Cutanee (AISLeC)</td>
<td>Criminal Justice Women’s Strategy Unit</td>
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<td>Antimicrobial Resistance and Healthcare Associated Infection</td>
<td>Department of Health</td>
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<td>Association of Chartered Physiotherapists in Oncology and Palliative Care</td>
<td>Dudley Group of Hospitals NHS Trust</td>
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<td>Association for Clinical Biochemistry</td>
<td>Gloucestershire Hospitals NHS Trust</td>
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<td>Kent County Council Children and Families Directorate</td>
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<td>British Nuclear Medicine Society</td>
<td>Liverpool PCT Provider Services</td>
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<td>ConvaTec</td>
<td>National Patient Safety Agency</td>
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### Appendix 1.3: Individuals carrying out literature reviews and complementary work

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<thead>
<tr>
<th>Role</th>
<th>Name</th>
<th>Affiliation</th>
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<tbody>
<tr>
<td>Overall Coordinators</td>
<td>Dr John Graham</td>
<td>Director, National Collaborating Centre for Cancer, Cardiff</td>
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<td></td>
<td>Dr Andrew Champion</td>
<td>Centre Manager, National Collaborating Centre for Cancer, Cardiff</td>
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<tr>
<td>Project Manager</td>
<td>Lianne Black</td>
<td>National Collaborating Centre for Cancer, Cardiff</td>
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<td>Senior Researcher</td>
<td>Angela Melder</td>
<td>National Collaborating Centre for Cancer, Cardiff</td>
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<tr>
<td>Researcher</td>
<td>Karen Francis</td>
<td>National Collaborating Centre for Cancer, Cardiff</td>
</tr>
<tr>
<td>Information Specialist</td>
<td>Stephanie Arnold</td>
<td>National Collaborating Centre for Cancer, Cardiff</td>
</tr>
<tr>
<td>Health Economist</td>
<td>Sarah Willis</td>
<td>London School of Hygiene and Tropical Medicine</td>
</tr>
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Appendix 1.4: Members of the Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The members of the Guideline Review Panel are:

**Dr John Hyslop – Chair**
Consultant Radiologist, Royal Cornwall Hospital NHS Trust

**Dr Ash Paul**
Deputy Medical Director, Health Commission Wales

**Professor Liam Smeeth**
Professor of Clinical Epidemiology, London School of Hygiene and Tropical Medicine

**Mr Peter Gosling**
Lay member

**Mr Johnathan Hopper**
Medical Director (Northern Europe), ConvaTec Ltd