NATIONAL INSTITUTE FOR HEALTH AND   
CARE EXCELLENCE

Quality standards

Briefing paper: skin cancer

**Quality Standards Advisory Committee meeting**: 9 May 2023

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1. Introduction

This briefing paper presents a structured overview of potential quality improvement areas for skin cancer. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

Recommendations selected from the key development source are included to help the committee in considering potential statements and measures.

* 1. Development source

The key development sources referenced in this briefing paper are:

* [Melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (2015, last updated 2022) NICE guideline NG14.
* [Suspected cancer: recognition and referral](https://www.nice.org.uk/guidance/ng12) (2015, last updated 2021) NICE guideline NG12.

* [British Association of Dermatologists guideline for the management of adults with basal cell carcinoma 2021](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/) (2021) British Association of Dermatologists.
* [British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/) (2020) British Association of Dermatologists.
* [Sunlight exposure: risks and benefits](https://www.nice.org.uk/guidance/ng34) (2016) NICE guideline NG34.

[Improving outcomes for people with skin tumours including melanoma](https://www.nice.org.uk/guidance/csg8) (2006, last updated 2010) NICE cancer service guideline 8.

1. Overview
   1. Focus of quality standard

This quality standard will cover preventing, assessing, diagnosis and managing skin cancer (non-melanoma and melanoma) in children, young people and adults. It will update and replace the existing [NICE quality standard on skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130).

* 1. Definition

Skin cancer includes basal cell carcinoma (BCC), squamous cell carcinoma (SCC), melanoma and other rare types. Basal cell carcinoma, squamous cell carcinoma and melanoma are responsible for more than 95% of all skin cancers. There are a number of factors associated with development of skin cancer including age, genetics and exposure to risk factors such as UV light.

[Cancer Research UK’s cancer statistics for the UK](https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk) [online, accessed 24 April 2023] reports that 86% of melanoma skin cancer in the UK is preventable.

* 1. Incidence and prevalence

Skin cancer is the most common cause of cancer in England ([Implementing a timed skin cancer diagnostic pathway](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/), NHS England 2022). [Cancer Research UK’s cancer statistics for the UK](https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk) [online, accessed 24 April 2023] reports that in the UK every year (2016 to 2018) there are around:

* 16,700 new melanoma skin cancer cases
* 156,000 new non-melanoma skin cancer cases

Incidence rates for melanoma skin cancer in the UK are highest in people aged 85 to 89 and more than a quarter of all new melanoma skin cancer cases are diagnosed in people aged 75 and over. Since the early 1990’s, melanoma skin cancer incidence rates have more than doubled in the UK. [Cancer Research UK’s cancer statistics for the UK](https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk) [online, accessed 24 April 2023] reports that incidence rates for non-melanoma skin cancer (NMSC) are highest in people aged over 90 in the UK and almost half of all new NMSC cases are diagnosed in people aged 75 and over (2016 to 2018). It also reports that non-melanoma skin cancer rates have increased more than two and a half times since the 1990s.

[Cancer Research UK’s cancer statistics for the UK](https://www.cancerresearchuk.org/health-professional/cancer-statistics-for-the-uk) [online, accessed 24 April 2023] shows that there are around 2,300 deaths from melanoma in the UK each year (2017 to 2019) and 918 deaths from NMSC each year (2018 to 2019).87% of people survive melanoma for 10 or more years (2013 to 2017, England).

Skin cancer can have physical and psychosocial impacts. Tumours most often occur on skin that has been regularly exposed to the sun such as the head, face, neck and hands, and tumours may lead to physical damage, disfiguration and can be associated with symptoms such as itchiness and bleeding. The disease and treatment may cause distress and anxiety ([State of the Nation: Non-melanoma skin cancer,](https://www.melanomauk.org.uk/news/state-of-the-nation-report-non-melanoma-skin-cancer) Sanofi Genzyme 2021)

* 1. Current service delivery and management

People with skin cancer may present to general practice with suspicious skin lesions People with a suspicious pigmented skin lesion that may be a high-risk BCC, SCC or melanoma should be referred to a doctor trained in the specialist diagnosis of skin cancer. People with a suspected melanoma should be referred using a suspected cancer pathway for an appointment within 2 weeks. A suspected cancer pathway referral (2 weeks) should be considered for people with SCC. All healthcare professionals who treat people with skin cancers should be members of a multidisciplinary team – either local hospital skin cancer multidisciplinary teams within a cancer unit or a specialist skin cancer multidisciplinary team within a cancer centre.

Melanoma can be managed by surgical excision and there are a number of options for adjuvant systemic anticancer treatments dependent on the stage and characteristics of the malignancy.

People with suspected BCC should have a routine referral considered, unless there is particular concern that delay may have a significant impact, for example dependent on lesion site or size. The majority of BCC can be managed in an out-patient day-case setting or in a community or primary care setting, by GPs with an extended role (GPwER) in dermatology or GPs with a specialist interest (GPwSI) in dermatology. There are a range of different clinical presentations and histological variants of BCC which will influence the management of the condition. Management includes:

* observation rather than immediate treatment
* surgical excision
* curettage and cautery or electrodessication
* cryotherapy or cryosurgery
* topical treatment
* photodynamic therapy
* Mohs micrographic surgery

radiotherapy.

* 1. Resource impact

For melanoma, and other types of cancer, more targeted treatments are being made available and people are living longer and needing more follow up scans. In addition, melanoma has the fastest growing number of cases of all types of cancer. In the last 10 years, statistics for the UK show the incidence of melanoma has increased by 32% and is continuing to rise ([Cancer Research UK - melanoma incidence](https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/melanoma-skin-cancer/incidence#heading-Two)).

Experts on the committee for [NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14) identified that in general, there are demand pressures in radiology and ultrasound services. This applies to scanning for all cancers, and non-cancer indications.

Most of the recommendations in [NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14) and referred to in this briefing paper reinforce best practice and do not need any additional resources to implement. However, some of the guideline areas and recommendations may represent a change to current local practice. Where a change is required to current practice, this may require additional resources to implement, which may be significant at a local level. There are some benefits from changes to practice which may help offset any additional costs. The areas suggested by stakeholders which may require additional resources and result in additional costs are discussed in the relevant sections below.

1. Summary of suggestions
   1. Responses

In total 8 registered stakeholders responded to the 2-week engagement exercise.

* 6 stakeholders suggested areas.
* 2 stakeholders had no comments.
* 8 specialist committee members suggested areas.

NHS England’s National Clinical Director for Cancer suggested areas.

The responses have been summarised in table 1 for further consideration by the committee.

Table 1 Summary of suggested quality improvement areas

| Area for improvement | Stakeholders |
| --- | --- |
| **Skin cancer prevention**   * awareness campaigns and targeted populations * nicotinamide to prevent NMSC | * BAD, SCM * SCM |
| **Diagnosis of skin cancer**   * examination of lesions * early diagnosis and referral * testing for diagnosis and staging | * BAD, BAOMS, NCD, SCM * BAD, BAOMS, NCD, NDRS, SCM * NDRS, RCPath, SCM |
| **Management of skin cancer**   * management of BCC in primary care and in the community * multidisciplinary team involvement * access to a clinical nurse specialist | * BAD, IND, RCGP, SCM * NDRS, SCM * BAD, BAOMS, SCM |
| **Treatment of skin cancer**   * access to therapy * radiotherapy for BCC and SCC * vitamin D | * NCD, SCM * NDRS * SCM |
| **Follow-up after melanoma**   * surveillance * access to services following discharge | * NCD, SCM * SCM |
| **Additional areas**   * national campaigns for skin cancer prevention * regulation of sunbeds * update to NICE guidance for children and young people with cancer | * BAD, SCKIN * BAD * SCM |

Abbreviations:

* BAD, British Association of Dermatologists
* BAOMS, British Association of Oral and Maxillofacial Surgeons
* IND, Individual
* NCD, National Clinical Director for Cancer
* NDRS, National Disease Registration Service
* RCGP, Royal College of General Practitioners
* RCPath, Royal College of Pathologists
* SCM, Specialist Committee Member

SKCIN, National Skin Cancer Charity

Full details of all the suggestions provided are given in appendix 2 for information.

1. Suggested improvement areas

Section 4 presents a summary of the suggested improvement areas, with provisional recommendations that may support statement development and information on current UK practice.

* 1. Skin cancer prevention

### Awareness campaigns and targeted populations

Stakeholders commented on the current quality statement on local health promotion activities and suggested that the statement should focus on clearer messaging on the prevalence of skin cancer in certain populations and provide evidence of local activities. They suggested that a targeted approach to at risk groups is needed as recommended in [NICE’s guideline on sunlight exposure: risks and benefits](https://www.nice.org.uk/guidance/ng34). SCMs suggested people with darker skin and those who are heavily tattooed as other examples of populations to be targeted in awareness campaigns. Stakeholders noted inconsistent messaging on minimum SPF of sunscreen and suggested this as an area for quality improvement.

#### Selected recommendations

[NICE’s guideline on sunlight exposure: risks and benefits](https://www.nice.org.uk/guidance/ng34) (NG34):

1.1.1 All public health activities related to over‑ or underexposure to sunlight should focus on:

* Groups of people who should take extra care to avoid skin damage and skin cancer, including:
  + children (particularly babies) and young people
  + people who tend to burn rather than tan
  + people with lighter skin, fair or red hair, blue or green eyes, or who have lots of freckles
  + people with many moles
  + people who are immunosuppressed (that is, they have less resistance to skin problems as a result of a disease or use of particular drugs)
  + people with a personal or family history of skin cancer (even if their natural skin colour is darker than that of the family member who had cancer).
* Groups who spend a lot of time in the sun and so are at increased risk of skin cancer, such as
  + outdoor workers
  + those with outdoor hobbies, for example, sailing or golf
* Groups with high, but intermittent, exposure to sunlight and who are therefore at increased risk of skin cancer. This includes people who sunbathe or take holidays in sunny countries.

Groups who have little or no exposure to the sun for cultural reasons or because they are housebound or otherwise confined indoors for long periods. For example, people who are frail or in institutions, or people who work indoors all day. These people are at increased risk of low vitamin D status (for more information see NICE's guideline on vitamin D: supplement use in specific population groups).

1.1.3 Communicate consistent, balanced messages about the risks and benefits of sunlight exposure and the groups at risk (for the latter, see recommendation 1.1.1). Include:

* environmental, biological and behavioural factors
* how to minimise the risks and maximise the benefits of sunlight exposure
* the strength of sunlight at different times of day
* advice for children and young people
* advice according to people's skin type
* approaches to protecting skin (clothing, shade and sunscreen)
* checking for possible signs of skin cancer

clarifying common misconceptions about sunlight exposure.

See supporting information for practitioners for more details.

1.1.8 Develop, deliver and sustain national and local media campaigns to raise awareness of the risks and benefits of sunlight exposure.

1.1.9 Campaign messages should:

* Aim to make people aware of the need to think about their daily exposure to sunlight.
* Target at‑risk groups (see recommendation 1.1.1) and be consistent (see supporting information for practitioners).
* Address common misconceptions about keeping safe in the sun and the risks and benefits of sunlight exposure.
* Present a balanced picture of the risks and benefits, explaining how to enjoy the sun safely.
* Emphasise how the risks and benefits will vary depending on the individual.

Relate to leisure activities and holidays as well as daily life.

1.1.13 Integrate and coordinate campaign messages with existing national and local health promotion programmes or services to keep costs as low as possible. (Examples of initiatives they could be integrated with include Sure Start, Healthier families and community pharmacy public health services.)

[NICE’s guideline on sunlight exposure: risks and benefits](https://www.nice.org.uk/guidance/ng34) (NG34) supporting information for practitioners, approaches to protecting skin:

* Sunscreen should:
  + Meet minimum standards for UVA protection (the label should have the letters 'UVA' in a circle logo). Preferably, the label should state that it provides good UVA protection (for example, at least '4‑star UVA protection').
  + Provide at least sun protection factor (SPF)30 to protect against UVB.
* Because most people do not apply enough sunscreen it is probably helpful to make them aware that:
  + The amount of sunscreen needed for the body of an average adult to achieve the stated SPF is around 35 ml or 6 to 8 teaspoons of lotion.
  + If sunscreen is applied too thinly, the amount of protection it gives is reduced.
  + Using SPF30 sunscreen or higher may partially overcome problems with inadequate application. But it does not necessarily mean people can spend more time in the sun without the risk of burning.
  + Sunscreen needs to be reapplied liberally, frequently and according to the manufacturer's instructions. This includes straight after being in water (even if it is 'water‑resistant') and after towel drying, sweating or when it may have rubbed off.
  + If someone plans to be out in the sun long enough to risk burning, sunscreen needs to be applied twice to exposed areas of skin: half an hour before, and again around the time they go out in the sun. This includes the face, neck and ears (and head if someone has thinning or no hair), but a wide‑brimmed hat is better.
  + Water‑resistant sunscreen is needed if sweating or contact with water is likely.

#### Current quality statements

[NICE’s quality standard for skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130):

Statement 1 Local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns.

#### Current UK practice

No published studies on current practice were highlighted for the area of local health promotion; this area is based on stakeholder’s knowledge and experience.

The Sanofi Genzyme report [State of the Nation: non-melanoma skin cancer](https://www.melanomauk.org.uk/news/state-of-the-nation-report-non-melanoma-skin-cancer) surveyed 3,638 adults across the UK and asked what they knew about NMSC. 38% of adults surveyed did not know what the risk factors for NMSC are and 23% were able to correctly identify the four most common signs of NMSC.

A [survey of healthcare professionals](https://onlinelibrary.wiley.com/doi/10.1111/phpp.12674) in 2018 asked about giving advice on sunscreen usage to their patients (Tan et al. 2021). There were 165 responses to an online questionnaire and showed that 57% of respondents very rarely discussed sun protection with patients although some did discuss this in cases of skin cancer or sun damage or with those who have a higher than average risk of skin cancer. The SPF recommended varied but 62% of respondents most commonly recommended sunscreen with at least SPF 30.

### Nicotinamide to prevent NMSC

SCMs suggested the use of nicotinamide to prevent NMSC in people with a previous diagnosis of NMSC is an area for quality improvement.

#### Selected recommendations

No relevant recommendations identified.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

### Resource impact

Experts from the committee from [NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14) suggested there were no significant additional resource impacts anticipated in this area.

### Issues for consideration

**For discussion:**

* Is current quality statement 1 still a priority for quality improvement?
* Should we add detail to the current statement to reflect suggestions on improving advice on SPF?
* Could we focus on a specific audience or setting, for example people with darker skin or tattoos?
* Who would implement an awareness campaign and what is the expected impact of this?
* Can we develop a specific, measurable statement on use of nicotinamide and is this a priority area for quality improvement?

**For decision:**

* Should these areas be prioritised for inclusion in the quality standard?
  1. Diagnosis of skin cancer

### Examination of lesions

Stakeholders and SCMs commented on a number of aspects of examination. They highlighted the 7-point checklist that should be used by GPs. They noted that a full examination of the skin and lymph nodes is needed when people with suspected skin cancer are referred. Stakeholders also noted the current quality statement on dermoscopy and suggested that this remains an area for quality improvement. The NCD and SCMs suggested that the use of teledermatology and artificial intelligence could support quality improvement in this area, by triage, diagnosis, monitoring and assessment of lesions using static digital images (macroscopic or dermoscopic) that can be viewed by a member of the skin cancer multidisciplinary team.

#### Selected recommendations

[NICE’s guideline on suspected cancer: recognition and referral](https://www.nice.org.uk/guidance/ng12) (NG12):

1.7.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted 7‑point checklist score of 3 or more.

Weighted 7-point checklist

Major features of the lesions (scoring 2 points each):

* change in size
* irregular shape

irregular colour.

Minor features of the lesions (scoring 1 point each):

* largest diameter 7 mm or more
* inflammation
* oozing

change in sensation.

[NICE’s guideline on melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.3.1 Assess all pigmented skin lesions that are either referred for assessment or identified during follow-up in secondary or tertiary care, using dermoscopy carried out by healthcare professionals trained in this technique.

1.3.2 Do not routinely use confocal microscopy or computer assisted diagnostic tools to assess pigmented skin lesions.

#### Current quality statements

[NICE’s quality standard for skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130):

Statement 4 People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy.

#### Current UK practice

A [survey of dermoscopy use in UK primary care by GPs with a specialist interest in dermatology](https://onlinelibrary.wiley.com/doi/10.1111/jdv.15614) (Jones et al 2019) showed that 96.8% of respondents with access to a dermatoscope used it regularly when reviewing pigmented skin lesions. Its use was more common among GPs who had worked longer in primary care and had experience of secondary care dermatology. 91.0% had undertaken training in dermoscopy, although this was variable in length and modality. This survey also reported that 70.4% of respondents did not use teledermatology as part of the 2 week wait referral pathway for suspicious pigmented skin lesions. 205 responses from an online survey of members of the Primary Care Dermatology Society were analysed.

A further small study of [dermoscopy use in UK primary care amongst GPs without a specialist interest in dermatology](https://onlinelibrary.wiley.com/doi/abs/10.1111/jdv.15781) (Fee et al 2019) resulted in 85 responses from GPs working in 66 practices in the region. 68% of practices had dermatoscopes available and they were used by at least 1 GP in 62% of practices. Of the 322 GPs working regularly in the responding practices, dermoscopy was used by 17% of them. Responses to an online survey also reported [the use of dermoscopy amongst dermatology trainees in the UK](https://www.bjmp.org/content/use-dermoscopy-amongst-dermatology-trainees-united-kingdom) (Reid et al 2018). There was a 25% response rate from 238 trainees surveyed. 92% of respondents used dermoscopy more than once daily. 85% always use dermoscopy when assessing pigmented lesions. A [qualitative study with GPs on dermoscopy use in primary care](https://bmcprimcare.biomedcentral.com/articles/10.1186/s12875-022-01653-7) surveyed those who were established dermoscopy users, GPs who had recently adopted dermoscopy and those who did not use dermoscopy (Fee et al 2022) and reported that training was considered to be essential for the effective use of dermoscopy in practice alongside on-going support from others who use it. Other barriers identified included experience and access to a dermatoscope. These are small surveys and may not be representative across England and the UK.

The British Association of Oral and Maxillofacial Surgeons (BAOMS) reported on non-melanoma skin cancers in their [quality outcomes in oral and maxillofacial surgery report (2021 to 2022)](https://www.baoms.org.uk/professionals/qoms_reports.aspx) and noted that dermoscopy was underutilised with 30% of BCC cases and 33% of SCC using it in diagnosis.

The [Getting it Right First Time Programme National Specialty Report for Dermatology](https://gettingitrightfirsttime.co.uk/girft-reports/) (2021) reported wide variation in access to teledermatology:

* 30% of trusts said that their local teledermatology services were adequately and safely integrated with their services
* 52% of trusts said that their local teledermatology services were not adequately and safely integrated with their services

18% of the 117 departments who responded had no local teledermatology service at all.

### Early diagnosis and referral

Stakeholders noted the current quality statement on referral using the suspected cancer pathway with an appointment within 2 weeks and commented that this should be updated to include all suspected skin cancers not limited to melanoma and reflect the faster diagnosis standard. Stakeholders noted commitments in the NHS Long Term Plan to provide earlier and faster diagnosis and provided details of the best practice timed pathway for diagnosis of skin cancer. There was also concern about patients who have to see their GP more than once before being referred for suspected melanoma. Stakeholders noted that implementation of the faster diagnostic pathway would require support by digital triage systems and so integration of data systems to aid referral is an area for quality improvement.

#### Selected recommendations

[NICE’s guideline on suspected cancer: recognition and referral](https://www.nice.org.uk/guidance/ng12) (NG12):

1.7.1 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted 7‑point checklist score of 3 or more.

1.7.2 Refer people using a suspected cancer pathway referral (for an appointment within 2 weeks) if dermoscopy suggests melanoma of the skin.

1.7.3 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for melanoma in people with a pigmented or non‑pigmented skin lesion that suggests nodular melanoma.

1.7.4 Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of squamous cell carcinoma.

1.7.6 Only consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with a skin lesion that raises the suspicion of a basal cell carcinoma if there is particular concern that a delay may have a significant impact, because of factors such as lesion site or size.

[British Association of Dermatologists guidelines for the management of adults with Basal Cell Carcinoma 2021](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/):

R2 Refer to a local skin multidisciplinary team (LSMDT) or a specialized skin cancer multidisciplinary team (SSMDT) member all adults with high-risk BCC, and all adults with low-risk BCC in the absence of an accredited General Practitioner with Enhanced Role (GPwER) or if the primary care facility is not suitable for surgery. See Table 3 for levels of community skin cancer services.

#### Current quality statements:

[NICE’s quality standard for skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130):

Statement 3 People with suspected malignant melanoma are referred using a suspected cancer pathway for an appointment within 2 weeks.

#### Current UK practice

[NHS England’s report on waiting times for suspected and diagnosed cancer patients](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/cwt-annual-reports/cancer-waiting-times-annual-report-2020-21/) showed that in 2020 to 2021:

* 89.9% of patients with suspected skin cancer were seen within 14 days. The operational standard is that 93% of all patients should be seen within 14 days.

94.0% of patients with skin cancer were treated within 31 days. The operational standard for wait for first treatment is 96%.

This data is for patients with malignant melanoma, Merckel cell carcinoma and SCC. First treatment does not include surgical biopsy or sentinel node biopsy. The [NHS England guidance for local health and care systems on implementing a timed skin cancer diagnostic pathway](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/) (2022) reported that in 2018 the variation between cancer alliances between time from referral to treatment from skin cancers (excluding BCC, soft tissue sarcoma and lymphoma) was 51 to 77.5 median days.

### Testing for diagnosis and staging

Pathology review of lesions and tumours, genetic testing and imaging of melanoma were suggested by stakeholders as areas for quality improvement. Stakeholders note the upscaling of genomic testing, and the challenging nature of skin lesions has made dermatopathology highly specialised and suggest expert dermatopathology review specifically as an area for quality improvement. They also noted large variation in use of genetic testing and the availability and use of the National Test Directory for Cancer. An SCM commented on the current quality statement 7 and suggested that BRAF testing is universally carried out but that this should be kept as a priority if this is in doubt.

SCMs also commented on the use of sentinel lymph node biopsy (SLNB) and imaging for staging, and incisional biopsy prior to formal excisional biopsy.

#### Selected recommendations

[NICE’s guideline on melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.3.7 If targeted systemic therapy is a treatment option, offer genetic testing using:

* a secondary melanoma tissue sample if there is adequate cellularity or

a primary melanoma tissue sample if a secondary sample is not available or is of inadequate cellularity.

1.3.10 Carry out BRAF analysis of melanoma tissue samples from people with stage IIC to IV primary melanoma.

1.3.11 Local skin multidisciplinary teams should arrange BRAF analysis of melanoma tissue samples and state the preferred tissue block for analysis.

1.3.14 Offer BRAF analysis of melanoma tissue samples to people with melanoma if they are potential candidates for any ongoing clinical trials that require knowledge of genetic status.

1.4.3 Consider SLNB for people who have melanoma with a Breslow thickness of 0.8 mm to 1.0 mm and at least one of the following features

* ulceration
* lymphovascular invasion

a mitotic index of 2 or more.

1.4.4 Consider SLNB for people who have melanoma with a Breslow thickness greater than 1.0 mm.

1.4.7 Offer staging with whole-body and brain CE-CT to people with stage IIC to IV melanoma.

1.4.9 Offer staging with whole body and brain MRI, instead of CE-CT, to:

* children and young adults (from birth to 24 years) with stage IIB to IV melanoma

women with stage IIB to IV melanoma who are pregnant.

[NICE’s guidance on cancer services: improving outcomes for people with skin tumours including melanoma (2006)](https://www.nice.org.uk/guidance/csg8) (CSG8):

Section 4, page 88 All cancer networks should have easy access to appropriate immunophenotypic, molecular biological and cytogenetic facilities. Some of the latter are very specialised pathology services and may not be provided by pathology laboratories within the LSMDT or SSMDT.

No recommendations identified for incisional and excisional biopsy.

#### Current quality statements

[NICE’s quality standard for skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130):

Statement 7 People with stage IIC to IV primary melanoma are offered BRAF testing of the tumour.

#### Current UK practice

The [Getting it Right First Time Programme National Specialty Report for Dermatology](https://gettingitrightfirsttime.co.uk/girft-reports/) reported variation in access to and use of histopathologists trained in skin cancer:

* 75% of trusts said skin cancer trained histopathologists report on skin cancers
* 11% of trusts said that skin cancers were reported by histopathologists not trained in skin cancer

14% of trusts were unsure.

Stakeholders highlighted results from a survey of fellows of the Royal College of Pathologists in 2021 that more than 50% of fellows have not accessed the National Genomic Test Directory for Cancer and two thirds have had to take on new work generated by genomic testing. More than 1 in 3 members indicate that they do not perform genetic tests on all samples that meet national eligibility criteria.

No published studies on current practice were highlighted for full skin assessment, genetic testing and sentinel lymph node biopsy. These areas are based on stakeholder’s knowledge and experience.

### Resource impact

Where BRAF analysis of melanoma tissue samples from people with stage IIA or IIB primary melanoma can be implemented (NG14, recommendation 1.3.9), there will be some extra resource needed within pathology departments to prepare the samples. This would enable treatment to be started sooner at an earlier stage of the melanoma.

For people who have melanoma with a Breslow thickness of 0.8 mm to 1.0 mm and at least one of the features given above, implementing NG14 recommendation 1.4.3 could reduce the number of sentinel lymph node biopsies (SLNB) by targeting them specifically to those with risk factors for a positive SLNB.

### Issues for consideration

**For discussion:**

* What is the priority area for quality improvement?
* Are current quality statements 3, 4 and 7 still priorities for quality improvement?
* Should we add detail to the supporting information for current statements 3 or 4 to reflect suggestions on use of teledermatology?
* The quality statement on sentinel lymph node biopsy was removed from the QS as part of the alignment with the updated NICE guideline on melanoma. Does this remain a priority for quality improvement and if so, what is the key action that will lead to improvement?

**For decision:**

Should this area be prioritised for inclusion in the quality standard?

* 1. Management of skin cancer

### Management of BCC in primary care and in the community

Stakeholders and SCMs commented on the management of low-risk basal cell carcinoma by GPs with extended roles (GPwER) in dermatology and suggested that accreditation and audit of services, including incomplete excision rate remains an area for quality improvement. They noted detail from NICE and British Association of Dermatologists guidance on low-risk BCC that could be added to or updated for the current quality statement, such as adding emphasis on new BCCs at low-risk sites and updating the terms used in the statement. They also highlighted the [GPwER framework for accreditation in dermatology](https://www.bad.org.uk/education-training/gps/become-a-gpwer-in-dermatology/).

#### Selected recommendations

[NICE’s guidance on cancer services: the management of low-risk basal cell carcinomas in the community (2010)](https://www.nice.org.uk/guidance/csg8) (CSG8) pages 25 to 32.

No recommendations identified for GPwER role in management of melanoma, SCC and high-risk BCC.

#### Current quality statements

[NICE’s quality standard for skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130):

Statement 2 GPs who manage low‑risk basal cell carcinoma maintain and audit records of their caseload.

#### Current UK practice

An [audit of the safety of community-based minor surgery performed by GPs](https://bjgp.org/content/66/646/e323.long) in the UK was completed in 2016 (Botting et al 2016). This was based on self-reported audit data from the following settings using a pre-defined dataset:

* GPs who carried out minor surgery in their practice funded as enhanced services (ESGPs)
* GPs with a Specialist Interest in dermatology (GPwSI)

GPs working under acute trust governance (model 2 practitioners).

A total of 6138 procedures were conducted, 2289 by ESGPs, 2331 by GPwSI and 1045 by model 2 GPs. 473 procedures were unclassified. The authors note that the range of conditions being operated on, and the numbers of pigmented lesions seem at odds with NICE guidance but conclude that GPs who worked within a managed framework performed better.

A [retrospective observational study of histological reports of BCC excisions from primary care in 2 district general hospitals in the south of England](https://bmjopen.bmj.com/content/8/11/e023299) (Cole et al 2018) found that 32% of BCC were high-risk subtypes. 17 out of 64 high-risk BCCs were excised by GPs who were accredited to do so. A total of 100 consecutive cases of lesion excisions confirmed as BCC were analysed from each hospital.

No published studies on current practice were highlighted for accreditation and audit of GPs who manage BCC; this area is based on stakeholder’s knowledge and experience.

### Multidisciplinary team involvement

Stakeholders and SCMs highlighted discussion by multidisciplinary teams for skin cancer cases and particularly people with melanoma and brain metastases that might be suitable for surgery or stereotactic radiotherapy or oligometastatic stage IV melanoma as an area for quality improvement. SCMs also noted that all regional tumour groups and cancer alliances should have a defined tumour group lead and comprehensive guidance available.

#### Selected recommendations

[NICE’s guideline on melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.8.1 Refer the care of people who appear to have oligometastatic melanoma to the specialist skin cancer multidisciplinary team for recommendations about staging and management.

1.8.2 Consider surgery or other ablative treatments to prevent or control symptoms of oligometastatic stage IV melanoma in consultation with other site specific multidisciplinary teams.

1.8.5 Refer people with melanoma and brain metastases that might be suitable for surgery or stereotactic radiotherapy to the neuro-oncology multidisciplinary team for a recommendation about treatment.

[British Association of Dermatologists guidelines for the management of adults with Basal Cell Carcinoma 2021](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/):

R2 Refer to a local skin multidisciplinary team (LSMDT) or a specialized skin cancer multidisciplinary team (SSMDT) member all adults with high-risk BCC, and all adults with low-risk BCC in the absence of an accredited General Practitioner with Enhanced Role (GPwER) or if the primary care facility is not suitable for surgery. See Table 3 for levels of community skin cancer services.

R22 Following discussion at an MDT, offer further standard surgical re-excision to adults with excised high-risk BCC with involved histological margin unless there is a contraindication (see also R4, R5, R7–21, Θ1, Θ2 and Θ3).

[British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/)

R11 Review the histology of people with cSCC with one or more involved or clear-but-close margins (< 1 mm) at an appropriate skin MDT (Figure 1).

R15 Discuss at an SSMDT people with cSCC with symptomatic perineural invasion and/or radiological evidence of perineural invasion. If discussed at a skin MDT, skull base or head and neck MDT opinion may be required. Aggressive surgical excision of the involved nerve should be the first step, where technically possible, followed by consideration of adjuvant radiotherapy.

R17 Discuss people with histologically proven cSCC being considered for radiotherapy at an MDT (LSMDT or SSMDT) with a clinical oncologist present.

[NICE’s guidance on cancer services: improving outcomes for people with skin tumours including melanoma (2006)](https://www.nice.org.uk/guidance/csg8) (CSG8):

Section 3, page 49 Arrangements for skin cancer teams. Patients should be referred for review from LSMDT to SSMDT according to the complexity of their disease (see Table 4). There should be flexibility in these arrangements to allow for local circumstances, including the management, by other specialist cancer MDTs, of patients with skin cancers of either specific types or specific anatomical location. Where this occurs, the cases need only be included in the discussion at one MDT but data on all skin cancers should be brought together in a single audit. For some rare skin cancers and sites, such as vulval melanoma, it may be appropriate that more than one MDT is involved in the treatment decisions.

Section 3, page 50 Review at an MDT meeting is only necessary for those patients to whose management it may make a difference. This may be when there are treatment choices, when management is challenging and would benefit from the input of several professionals, or when the diagnosis is difficult. The cases for LSMDT review are listed in Table 2.

Section 3, page 55 Patients with invasive skin cancer associated with a greater risk or rarity should be managed by SSMDTs.

#### Current UK practice

An [evaluation of the composition, quoracy and cost of specialist skin cancer multidisciplinary teams in the UK](https://linkinghub.elsevier.com/retrieve/pii/S1748-6815(21)00271-0) (Ali et al 2021) showed that 26% were quorate by membership and 69% were quorate by meeting frequency. The main reason for membership non-compliance was lack of clinical oncology presence. There was large variation in cost per patients and geographical variation in quoracy or cost between the countries of the UK. There was an 89% response rate from the 65 NHS Trusts.

No published studies on current practice were highlighted for MDT involvement and management of oligometastatic stage 4 melanoma; this area is based on stakeholder’s knowledge and experience.

### Access to a clinical nurse specialist

Stakeholders and SCMs highlighted that the current quality statement on access to a clinical nurse specialist remains a priority for quality improvement. They noted that nurses should be core members of the multidisciplinary team.

#### Selected recommendations

[NICE’s guideline on melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.1.4 Ensure that each local skin cancer multidisciplinary team and specialist skin cancer multidisciplinary team has:

* at least 1 skin cancer clinical nurse specialist to provide people with information and support

access to psychological support services for people with melanoma.

[British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/)

R40 Offer access to a key worker to people with cSCC, ideally a clinical nurse specialist, as part of an ongoing treatment prevention package. Provide information on the diagnosis and management of cSCC.

[NICE’s guidance on cancer services: improving outcomes for people with skin tumours including melanoma (2006)](https://www.nice.org.uk/guidance/csg8) (CSG8):

Section 3, page 53 Core membership of the local hospital skin cancer multidisciplinary team (LSMDT); Skin cancer clinical nurse specialists (CNS) (as defined by the Manual of Cancer Services). Patient advocacy and provision of information and support for patients and carers are crucial aspects of this role. The CNS will play a key role in communication between the patients and the different specialties involved in management and must have a high level of communication skills. She or he should be able to provide practical support such as advice postoperatively. The CNS will also have an important role in the identification of patients’ psychosocial needs and will advise on appropriate referral. The CNS may, if suitably trained, carry out a range of related service activities such as minor surgery, skin cancer surveillance and follow-up clinics in parallel with an appropriately trained doctor.

#### Current quality statements

[NICE’s quality standard for skin cancer](https://www.nice.org.uk/guidance/qs130) (QS130):

Statement 5 People with malignant melanoma or squamous cell carcinoma have access to a skin cancer clinical nurse specialist.

#### Current UK practice

The [Melanoma Focus and British Association of Skin Cancer Nurse Specialists skin cancer nurse specialist nurse census 2021](https://melanomafocus.org/for-professionals/educational-resources/) surveyed all secondary care trusts, Melanoma Focus members and British Association of Skin Cancer Nurses members requesting information on CNS posts in existence on 21 June 2021. They received responses representing 98 trusts in the UK. 92% of hospital trusts had at least 1 CNS and 56% of those without were planning to create a post. The report suggests a ratio of 68 new patients to CNS, and data collected suggests an average of 83 patient contacts per week with “significant variations across trusts and regions.”

[The National Cancer Patient Experience Survey 2021](https://www.ncpes.co.uk/current-results/) reported that 82.2% of patients with melanoma responded to say they had a CNS as a main contact to support them through their treatment (Q17). This can be compared to 81.5% of all patients with cancer.

[The Melanoma Focus Report Melanoma on the Rise: the increasing need for investment in specialist nurses](https://melanomafocus.org/for-professionals/educational-resources/skin-cancer-nurse-specialists-campaign/) reported that 14 patients (17%) who responded to a patient survey had not had access to the support of a skin cancer CNS and some patients had never met their CNS or reported that they were unable to give them the time they needed. Nurses also describe how increasing workload means that many people do not receive proactive support and may receive contact details of their CNS but not the holistic and personalised support that they would like to give This was a snapshot patient survey, conducted online between 8 March and 8 April 2022 and completed by 82 melanoma skin cancer patients across the UK and results from a focus group of 4 skin cancer CNS held in April 2022 and input from a further 7 CNS..

### Resource impact

No significant change in practice in management of BCC in general practice and in the community was identified by experts from the committee.

Although clinical experts suggested access to a skin cancer clinical nurse specialist (CNS) is current practice, they also suggested psychosocial support ([NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14), recommendation 1.9.2) is currently undertaken by the cancer nurse specialists who are trained to provide this support. The demands on the CNS are likely to increase with the recommendation to offer all patients this support. This may require additional CNS hours/additional staff and additional patient visits.

### Issues for consideration

**For discussion:**

* What is the priority for improvement? Are the current quality statements 2 and 5 still a priority for quality improvement?
* Could we add detail to the current quality statement 2 to reflect current guidance and information?
* What is the key action in the management of BCC that will lead to improvement, and can we develop a specific and measurable statement in this area?
* What is the priority for quality improvement around MDT management of skin cancer? Could we focus on a specific audience or setting?

**For decision:**

Should this area be prioritised for inclusion in the quality standard?

* 1. Treatment of skin cancer

### Access to therapy

SCMs and NCD commented on the new guidance for NICE approved adjuvant systemic therapies for people with resected stage IIB/C and stage III melanoma and suggested access to these treatments and implementation of [NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14) is an area to be included in the quality standard. SCMs also suggested provision of immunotherapy is an area for quality improvement but noted caveats with the recommendations for use that may make this a difficult area to measure. They also noted that patients may have to travel significant distances to access new treatments for skin cancer and they suggested that provision of adjuvant and palliative systemic treatments within cancer centres geographically closest to home is an area for quality improvement. Treatment at a regional specialist centre was noted a priority for in-transit melanoma. Stakeholders also commented on the need to audit data on pathway timings, for example time from primary excision to secondary surgery and oncology treatment.

#### Selected recommendations

[NICE’s technology appraisal guidance on dabrafenib with trametinib for adjuvant treatment of resected BRAF V600 mutation-positive melanoma](https://www.nice.org.uk/guidance/ta544) (TA544)

[NICE’s technology appraisal guidance on pembrolizumab for adjuvant treatment of completely resected stage 3 melanoma](https://www.nice.org.uk/guidance/ta766) (TA766)

[NICE’s technology appraisal guidance on nivolumab for adjuvant treatment of completely resected melanoma with lymph node involvement or metastatic disease](https://www.nice.org.uk/guidance/ta684) (TA684)

[NICE’s technology appraisal guidance on pembrolizumab for adjuvant treatment of resected stage 2B or 2C melanoma](https://www.nice.org.uk/guidance/ta837) (TA837)

[NICE’s guideline on melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.7.1 Discuss management of in-transit metastases, including surgery or treatment in a regional specialist centre, with the specialist skin cancer multidisciplinary team.

1.8.8 Offer nivolumab plus ipilimumab to people with untreated stage IV or unresectable stage III melanoma if suitable for them based on the factors in recommendation 1.8.6.

#### Current UK practice

[NCRAS and Cancer Research UK cancer statistics](https://www.cancerdata.nhs.uk/treatments) for treatment combinations shows the numbers of patients with melanoma at different stages and the treatment the tumours received. Data from 2019 includes 3567 tumours diagnosed at stages 2 and 3, 87% of stage 2 tumours had resection only, 9% had both resection and chemotherapy. This can be compared to data from 2017 for 3850 tumours diagnosed at stage 2 and 3 that showed 90% of tumours at stage 2 that had resection only and 5% that had resection and chemotherapy. Data from 2019 showed 35% of tumours at stage 3 had resection only, 56% had tumour resection and chemotherapy. Comparable data from 2017 showed 76% resection only and 14% had resection and chemotherapy. The data does not indicate specifics of the treatment or subdivision of stage.

No published studies on current practice were highlighted for local treatment (geographic); this area is based on stakeholder’s knowledge and experience.

### Radiotherapy for BCC and SCC

Stakeholders commented on treatment with radiotherapy for BCC or SCC and SCMs also noted that provision of these treatments in centres geographically close to home is an area for quality improvement.

#### Selected recommendations

[British Association of Dermatologists guidelines for the management of adults with Basal Cell Carcinoma 2021](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/):

R15 Offer radiotherapy as a treatment option to adults (suggested age ≥ 60 years) with low-risk and high-risk BCC who are unsuitable for or decline Mohs micrographic surgery or standard surgical excision and who express a preference for radiotherapy, and in whom the lesion is:

* a nodular BCC
* an infiltrative subtype of BCC, provided a sufficient planning margin is used

an excised BCC with involved margins

[British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020](https://www.bad.org.uk/guidelines-and-standards/clinical-guidelines/):

R18 Offer primary radiotherapy

* to selected people with cSCC as a treatment option following appropriate discussion at the appropriate skin MDT and/or with a clinical or radiation oncologist, factoring in patient preference, and

to people with cSCC when surgery is not feasible or would be challenging or likely to result in an unacceptable functional or aesthetic outcome.

R19 Consider adjuvant radiotherapy in people with cSCC

* if pathological excision margins are clear but close (< 1 mm) following discussion at an appropriate skin MDT, where a clinical oncologist is present, and

with completely excised T3 tumours, where there are multiple high-risk factors, including those > 6 mm in thickness (depth) and invasion beyond subcutaneous fat.

R20 Offer adjuvant radiotherapy to people with incompletely excised cSCC, where further surgery is not possible (or is not chosen by the patient) and in those at high risk of local recurrence

* in the case of perineural invasion (multifocal, named nerve and/or diameter of nerve > 0·1 mm, below the dermis),
* in recurrent disease, and

in those who are immunocompromised (see R21).

R34 Offer adjuvant radiotherapy following therapeutic regional lymphadenectomy to people with cSCC with high-risk pathology (e.g. two or more nodes, large nodes and extracapsular extension), defined by UICC8 as ≥ pN1.

No recommendations identified for treatment at local centres.

#### Current UK practice

[NCRAS and Cancer Research UK treatment data](https://www.cancerdata.nhs.uk/treatments) (experimental data) for treatment combinations shows a total of 92,557 BCC diagnosed in 2019. 69% of tumours had resection only, 1% had radiotherapy only and 0.7% had tumour resection and radiotherapy. 28% had other care. The data does not record the proportion of high-risk BCC in the statistics and is experimental so is likely to undercount surgical tumour resections.

The data shows 34,226 SCC diagnosed in 2019. 81% of tumours had resection only. 1% of tumours had radiotherapy only and 3.5 % had tumour resection and radiotherapy. The data is experimental so is likely to undercount surgical tumour resection.

No published studies on current practice were highlighted for local treatment (geographic); this area is based on stakeholder’s knowledge and experience.

### Vitamin D

SCMs suggested that vitamin D supplementation after a diagnosis of melanoma is an area for quality improvement.

#### Selected recommendations

[NICE’s guideline on melanoma: assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.2.1 Measure vitamin D levels at diagnosis in secondary care in all people with melanoma.

1.2.2 Give people whose vitamin D levels are thought to be suboptimal advice on vitamin D supplementation and monitoring in line with local policies and NICE's guideline on vitamin D.

#### Current UK practice

No published studies on current practice were highlighted for this suggested area for quality improvement; this area is based on stakeholder’s knowledge and experience.

### Resource impact

No significant resource impact is anticipated because the costs associated with systemic anticancer therapy (SACT) drugs are funded by specialised commissioning.

In addition, the newer SACT treatments for melanoma have been in use in the NHS for other indications for some time, therefore services for managing adverse effects, monitoring and follow up are well established. It is anticipated where newer treatments for melanoma displace previous therapies, there is no significant additional resource impact.

### Issues for consideration

**For discussion:**

* What is the priority for improvement? Access to therapy, systemic anticancer therapy, radiotherapy or vitamin D treatment?
* What is the specific priority area for quality improvement, and can we develop a specific, measurable statement on radiotherapy for BCC and SCC?
* Could we focus on a specific audience or setting for some of these suggested areas? Note stakeholder comments on people with in-transit melanoma.

**For decision:**

Should this area be prioritised for inclusion in the quality standard?

* 1. Follow-up after skin cancer

### Surveillance

The NCD and SCMs commented on the variation in access to ultrasound for lymph node surveillance. They also noted the NICE recommendations for an increased number of surveillance scans for people with melanomas and highlights this as a major issue for trusts. They suggested that development of ultrasound services to implement the new recommendations, including access to ultrasound and expertise in this technique is an area for quality improvement.

#### Selected recommendations

[NICE’s guideline on melanoma; assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.9.12 For people having both CE-CT and ultrasound scans, alternate between the 2 types of scan.

1.9.15 Offer follow-up for 1 year to people who have had stage IA melanoma, and for 5 years to people who have had stages IB to IV melanoma, using the table on follow-up after stages I to IV melanoma.

Section 1.9. table for follow-up after stages I to IV

#### Current UK practice

No published studies on current practice were highlighted for this area of quality improvement; this area is based on stakeholder’s knowledge and experience.

### Access to services following discharge

SCMs noted that people should be informed on how to re-access services once they have completed their treatment. They also highlighted little evidence or guidance on how to support patients post treatment and suggested survivorship following metastatic melanoma or SCC as an area for quality improvement.

#### Selected recommendations

[NICE’s guideline on melanoma; assessment and management](https://www.nice.org.uk/guidance/ng14) (NG14):

1.9.1 Ensure that people who have completed treatment for melanoma have been given direct contact details for specialist skin cancer services that can provide advice about problems or concerns related to their melanoma.

1.9.2 Offer psychosocial support to the person and their family or carers at all follow-up appointments.

**Current UK practice**

No published studies on current practice were highlighted for this area of quality improvement; this area is based on stakeholder’s knowledge and experience.

### Resource impact

Planning routine follow up (from [NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14), recommendation 1.9.15). Experts suggest the recommendations on follow up at each stage of melanoma may have resource implications. Resource constraints identified were trained radiologists, radiographers, and scanners. The guideline recommends services to consider using ultrasound scans as part of surveillance during follow up from stages IB to stage III. Clinical experts suggest this is likely to have resource implications due to the capacity of ultrasound services.

There may be resource benefits from implementing the guideline which may help mitigate some of the resource impacts above:

* reduce variation in the use of imaging during staging, with an increase in the use of CE-CT and reducing the use of PET-CT scans (recommendations 1.9.13 and 1.9.15)
* reduce the number of clinic visits for people with stages IIB to IIC melanoma (reduced from 4 visits to 2 visits in year 3; recommendation 1.9.15)
* reduce the use of less cost-effective imaging at stage III melanoma to allow timely identification of recurrences (recommendations 1.9.5 and 1.9.15)

lead to better health outcomes and care experience.

### Issues for consideration

**For discussion:**

* What is the priority for quality improvement?
* What is the key action that will lead to improvement?

**For decision:**

Should this area be prioritised for inclusion in the quality standard?

* 1. Additional areas

### Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However, they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or need further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the Advisory Committee meeting.

Table 2 Summary of information available for additional areas

| Suggested area for improvement | Within remit of NICE QS | In scope | Guideline recs | Relevant  existing QS |
| --- | --- | --- | --- | --- |
| National campaigns for skin cancer prevention | No | No | Yes | No |
| Regulation of sun beds | No | No | No | No |
| Update to NICE guidance for children and young people with cancer | No | No | NA | NA |

### National campaigns for skin cancer prevention

Stakeholders noted the existing quality statement on local authority health promotion activities and highlighted a lack of national campaigns for skin cancer. This area has not been progressed because quality standards focus on areas for quality improvement that can be addressed by local commissioners. National awareness campaigns are outside the scope of quality standards.

### Regulation of sun beds

Stakeholders commented that the use of sun beds needs to regulated. This suggestion has not been progressed because legislation is not within the remit of NICE quality standards.

### Update to NICE guidance for children and young people with cancer

SCMs noted the revised specifications for cancer services for children, teenagers and young adults with cancer and suggested that the NICE guidance be updated to include these findings. This area has not been progressed because additional guidance is outside of the remit of quality standards. Suggestions for additional guidance will be passed on to the NICE guideline surveillance team.

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# Appendix 1: Suggestions from registered stakeholders

| ID | Stakeholder | Suggested key area for quality improvement | Why is this a key area for quality improvement? | Supporting information |
| --- | --- | --- | --- | --- |
| 01 | British Association of Dermatologists | **General:** Other areas | The quality standard covers preventing, assessing, diagnosing and managing skin cancer, therefore any changes that are made should maintain through any update the generic overview that represents malignant and non-melanoma, otherwise it would become very confusing and lose applicability to all skin cancer pathways. Some of the existing quality standards emphasise what already exists as a standard. the quality standard should follow the skin cancer pathway of care recognised by patients and clinicians so this can be measured. |  |
| 02 | British Association of Plastic Reconstructive and Aesthetic Surgeons | **General:** We have consulted members and there was no need identified for any specific changes. |  |  |
| 03 | NCD | General: The NHS Cancer Programme is working to deliver the NHS Long Term Plan’s ambition to diagnosis 75% of cancers at stage 1 and 2 by 2028. Part of the way we are delivering this is by streamlining and improving diagnostic pathways and making the best use of our resources to rapidly diagnose or rule out cancer.  Referrals and treatments for skin cancer on the urgent cancer pathway have almost doubled since 2015. Skin cancer is now the second most common suspected cancer referred on cancer pathways in England with 509,668 referrals in 2019/20. Early diagnosis of skin cancers is important as prompt treatment improves chances of survival.  The Faster Diagnosis Standard (FDS) is fundamental to achieving the Long Term Plan ambitions for cancer and aims for patients to have cancer diagnosed or ruled out within a maximum of 28 days from referral. Delivery of the FDS is underpinned by best practice timed pathways that support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, and improve people’s experience of care. For skin cancer, new technology, in particular teledermatology, plays a key role in supporting systems to achieve the FDS.  There is a significant opportunity for NICE’s new Quality Standard on skin cancer to promote meeting the FDS and implementing the safe and effective use of teledermatology services to support NHSE’s earlier diagnosis strategy. Below we have set these priority areas in more detail and also outline other updates to the Quality Standard that would help to reduce variation in skin cancer treatment and experience of care. |  |  |
| 04 | Royal College of Nursing | **General:** Thank you for the opportunity to contribute to the above consultation, we received no member comments this time. |  |  |
| 05 | SCM4 | **General:** I agree with the standards that have been set, for melanoma. I think the priorities are early detection and diagnosis which are covered by statement 1, 3, and 4. I am less familiar with BCC re: statement 2, and can’t comment. CNS specialist are essential for patient experience, education, support and co-ordination between treating team and within teams and I think is useful also. I feel that statement 7 is universally carried out in the country, but if there is any doubt it should be kept as a standard. |  |  |
| 06 | British Association of Dermatologists | **Skin cancer prevention: awareness campaigns and targeted populations:** Key area for quality improvement 1  “Local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns.”  “Local health promotion activities, with messages consistent with any national campaigns, should minimise public confusion and increase the likelihood of behaviour change”. | Current campaigns run in the lead up to summer cause an influx of benign lumps and bumps and lesions from the worried well on already over-stretched dermatology departments. The reasons for patients presenting late needs to be targeted to age specific groups, deprivation areas and how these groups access services.  Clearer messages are needed on the prevalence of skin cancer in certain populations and geographical influences to help inform the public. A targeted approach to the groups outlined in the NICE guidance (PH32) is needed.  Public health messaging in the UK regarding the recommended minimum SPF of sunscreen remains inconsistent. While some health organisations recommend a minimum of SPF 15, an increasing number now recommend SPF 30 as a minimum, including the NHS, the British Association of Dermatologists (BAD), the British Skin Foundation (BSF), and various skin cancer charities such as Melanoma Focus and Skcin. While SPF 15 was previously considered to offer sufficient protection the evidence now suggests that the SPF 30 should be the new minimum SPF recommended in all public health messaging around sun protection.  The use of sunbeds needs to be regulated and prevented for use by under-18s.There are links to an increase in melanoma rates. | NICE campaigns ([NICE Skin cancer prevention PH32](https://www.nice.org.uk/guidance/ph32) ) are directed at the public in general and risk factors for skin cancer without target populations profiles and prevalence etc. which should also align to prevention in high-risk populations.  In summary, the evidence suggests that sunscreens with an SPF 15 provide insufficient protection in real world scenarios due to a combination of how sunscreen is applied, people’s behaviour and differences between laboratory testing and the real world. More information, including the evidence base for this, can be found [here](http://badmainstage.wpengine.com/wp-content/uploads/2023/03/The-evidence-base-for-SPF-30-in-UK-public-health-messaging-2023.pdf).  Sunbeds Act 2010. <https://www.legislation.gov.uk/ukpga/2010/20/introduction> |
| 07 | SCM5 | **Skin cancer prevention: awareness campaigns and targeted populations:** Key area for quality improvement 1:  Local and national preventative measures and promotional activities | As with all cancers prevention and early recognition and thus treatment at an earlier stage of disease is the single most likely strategy to reduce the incidence and improve long term outcomes within skin cancer | As per NICE current Quality Statement 1 (QS130);  Monitoring Skin cancer incidence and stage at diagnosis via NHS National Cancer Registry  Sunlight exposure: risks and benefits. NICE guideline NG34 (2016), recommendations 1.1.3 and 1.1.13 |
| 08 | SCM7 | **Skin cancer prevention: awareness campaigns and targeted populations:** Key area for quality improvement 1  Melanoma in people with darker/pigmented skin  Promote self-awareness and recognition of suspected skin cancer/melanoma in people with darker skins with targeted campaigns and advertising and personal skin checks.  NICE to give more initial information in respect of people with darker skin other than commenting to the effect that it is more often diagnosed at a later stage than people with a paler skin. This highlights a need for equal opportunity for people with darker skin. | Although skin cancer is more rare in people with darker skin people this may be due to the fact that skin cancer may be at a later stage in the disease when it is diagnosed. People with pigmented skin may refer themselves to the Doctor at a later stage than a person whose skin is non-pigmented because the lesions may blend in with darker skin.  Melanoma on pigmented skin most often occurs on areas that get little sun exposure such as palms of hands, soles of feet under the nail and the nail areas | NICE  Melanoma: assessment and management  Context Guidance  NG14  Andrew Alexis MD,MPH, Dept of Dermatology Mount Sinai St Lukes and Mount Sinai West, New York City  skincancer.org |
| 09 | SCM7 | **Skin cancer prevention: awareness campaigns and targeted populations:** Key area for quality improvement 5  Skin cancer Quality standard (QS130)  Published 21 September 2016  Last updated 27 July 2022  To include in National campaigns people who are heavily tattooed to be extra vigilant in observing their skin and know the signs to identifying possible skin cancer | With the ever-growing popularity of tattoos comes the need to understand the implications for skin health, which can range from minor irritation to the potentially life-threatening masking of melanoma  People need to be mindful of any moles or lesions that exist or develop within tattoos. A tattoo can mask these lesions. This could potentially delay a diagnosis of skin cancer. People considering getting a tattoo should avoid getting it over moles since that may make it more difficult to detect any changes.  For people choosing to become a tattoo artist to have access to recommendation to apply for a tattoo apprenticeship.  Tattooists to be made aware of courses to identify moles and skin lesions which could potentially be cancer | Helen Quinn Health Journalist  Nursing Standard 38,2,51-54. doi:10.7748/ns.38.2.51.s15  Jennifer DeFazio, dermatologist, MSK Skin Cancer Center Hauppauge USA Wednesday3 August 2022 mskcc.org/news/can-tattoos-hide-skin-cancer  Indeed Career advice, Editorial Team, Updated 19 January 2023  Pioneering training scheme in Bristol educating tattoo artists to recognise moles and growths on their clients skin that could be potential melanomas  Cancer research UK 2016  nb searching for tattoos and skin cancer there was very little UK evidence available other than ‘could tattoos cause skin cancer?’  Information was readily available from Australia, USA, Finland and Brazil |
| 10 | SCM8 | **Skin cancer prevention: awareness campaigns and targeted populations:** Health promotion | This should remain but improvements need to be made and evidence provided on local activities.  Advice regarding sunbed use. |  |
| 11 | SCM6 | **Skin cancer prevention: nicotinamide to prevent NMSC:** Reducing the rates of NMSC with Nicotinamide. | Since 2015 evidence suggests that Vitamin B3, taken as Nicotinamide 500 mg BD, reduces the rates of new NMSC by 23%. Reducing the rates of NMSC will lead to less mortality from SCC, less morbidity in terms of BCC, and significantly reduced health costs.  Nicotinamide cannot be prescribed on the NHS, and there is no evidence as to how often specialists recommend the use of nicotinamide for patients with previous diagnoses of NMSC. | Nicotinamide for photoprotection and skin cancer chemoprevention: A review of efficacy and safety.  Victoria A. Snaidr, Diona L. Damian, Gary M. Halliday  First published: 30 January 2019 https://doi.org/10.1111/exd.13819Citations: 45  Oral Nicotinamide Prevents Common Skin Cancers in High-Risk Patients, Reduces Costs.  Am Health Drug Benefits. 2015 Aug; 8(Spec Issue): 13–14. |
| 12 | British Association of Dermatologists | **Diagnosis of skin cancer: examination of lesions:** Key area for quality improvement 4  “People with pigmented skin lesions undergoing a specialist assessment in the community or secondary care have the lesions examined using dermoscopy and images (macroscopic and dermascopic) taken for their record. | People should be referred for an assessment and diagnosed by a specialist under a 2-week wait service. The 7-point checklist should be used by the GP to help determine the appropriate referral pathway. While the 7-point checklist should be used by GPs to help determine whether the patient needs to be referred, it should be noted that the 7-point checklist will not pick up on nodular melanoma because they do not always reach the threshold. Nodular melanomas represent the highest medico-legal cases due to delays in referrals and misdiagnoses. GPs should be encouraged to seek Advice and Guidance where there is diagnostic uncertainty. All Advice and Guidance requests can be converted to a 2WW referral by the skin cancer consultant, avoiding delays in care.  All GPs should use a dermatoscope to take a picture of the patient’s skin lesion(s) when referring the patient under a 2-week wait. This should also include a macroscopic image and appropriate labelling of the image(s) along with clinical history of the patient.  GPs do not have to be trained in the skin assessment and examination of the patient's lesion using the dermatoscope as this would require a high level of diagnostic training. | 7-point checklist: NICE CKS, Melanoma- <https://cks.nice.org.uk/topics/melanoma/diagnosis/assessment/>  Cancer 2ww guidance. <https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt> |
| 13 | British Association of Oral and Maxillofacial Surgeons | **Diagnosis of skin cancer: examination of lesions:** Use of dermoscopy by specialists for all pigmented lesions (as also recommended by recent BAOMS QOMS Report) |  | BAOMS QOMS report  <https://www.baoms.org.uk/_userfiles/pages/files/professionals/qoms/qoms_report_20212022_2023_01_23.pdf> |
| 14 | NCD | **Diagnosis of skin cancer: examination of lesions:** Teledermatology.  Recommendation: We recommend adding a Quality Statement related to the safe and effective use of teledermatology services, making reference to the  guidance for innovating the suspected skin cancer two week wait pathway.  A quality statement on teledermatology should reference the requirements for a  virtual teledermatology two week wait pathway as follows:  High quality macroscopic and dermoscopic images as these are the  ‘reasonable diagnostics’ needed to exclude cancer;  Triage should be carried out by a member of the skin cancer MDT  A triage outcome that permits the specialist clinician to request to see the  patient face to face if required; and  The facility to communicate directly with the patient and their GP. | The COVID-19 pandemic has driven rapid innovation and increased uptake in the use of teledermatology (the use of static digital images to triage, diagnose, monitor or assess skin conditions without the patient being physically present) and remote consultations across the majority of dermatology departments in the UK.  3.2 Teledermatology offers significant potential to ensure patients receive timely care in the most appropriate setting, reduce non-relevant referrals to secondary care and increase capacity for those patients who need face-to-face appointments. Taking advantage of available technologies can improve productivity while providing the same level of access to high quality care, diagnostics and treatments. It also plays a key role in systems’ abilities to deliver the FDS.  3.3 To harness this new technology, NHS England has published two week wait teledermatology pathway guidance that can replace previously required face-to face interaction. Supporting systems to implement, optimise and mobilise teledermatology models can help them safely manage new patient demand and the existing backlog while continuing restore face-to-face services.  3.4 Developing effective teledermatology models, without duplicating activity and increasing burden, requires specialist resources, including high quality image taking services and efficient and effective supporting technology and workforce. It also requires teledermatology to be incorporated into mainstream delivery of patient care using the NHS e-Referral service (e-RS), modification of which would enable more effective triage to appropriate management options. |  |
| 15 | NCD | **Diagnosis of skin cancer: examination of lesions:** Artificial intelligence (AI).  Recommendation: As AI continues to be developed and evaluated, it should be integrated into referral systems where it is safe and effective to do so and where there is clinical trial data to support it. To enable AI to develop safely, any trial needs to involve an accredited clinician, who also attends a skin MDT, to provide a second reading of images. Until such a time when the safety and effectiveness of AI is assured, emphasis should be on developing safe and effective teledermatology systems to optimise AI readiness. | Safe and effective AI technologies – such as software and apps that are used to contribute to diagnostic processes – have immense potential to support early diagnosis of skin cancer by recognising and classifying benign lesions. The COVID-19 pandemic has contributed to driving forward developments in this area. In the future, AI has the potential to inform clinical diagnosis and investigation choice and implement management plans.  4.2 Despite rapid advancements in this field, there is a lack of high quality studies that have examined the effectiveness of AI interventions in the skin cancer population.1,2 Studies using AI algorithms to support skin cancer diagnoses do not always reflect clinical practice, and some of the technologies face limitations by excluding certain skin tones or by only focusing on a limited number of skin cancers which risks missing rare but serious diseases.  4.3 There is still much to be done to ensure AI technologies address unmet clinical needs and that their adoption is regulated and governed appropriately and ethically. However, this rapidly advancing field means AI is an area that needs to be closely monitored and systems need to be prepared for the introduction of AI and machine learning. To achieve this, AI systems will need to be underpinned by effective high quality teledermatology services.  1 Takiddin A, et al. Artificial Intelligence for Skin Cancer Detection: Scoping Review. Journal of Medical Internet Research. 2021 Nov 24;23(11):e22934.  2 Jones OT, et al. Artificial intelligence and machine learning algorithms for early detection of skin cancer in community and primary care settings: a systematic review. Lancet Digital Health. 2022 Jun;4(6):e466-e476. |  |
| 16 | SCM1 | **Diagnosis of skin cancer: examination of lesions:** Keep QIC – on dermoscopy |  |  |
| 17 | SCM2 | **Diagnosis of skin cancer: examination of lesions:** Key area for quality improvement 1  Full skin examination at clinic appointments.  Section 1.9.11 | The recent melanoma NICE guidance recommends full skin examination of the skin and regional lymph-nodes at clinic appointments.  Patients inform me that they do not have a full skin examination when they see the oncologist and often not when the see a dermatologist. Some units are now undertaking telephone reviews of melanoma patients so are not having full skin examinations | Experience with patients.  Stage 1 patients are now having fewer follow up appointments so it is important that they have the full skin examinations and are instructed on how to check their skin. It should not make a difference where they are seen and by whom. |
| 18 | SCM5 | **Diagnosis of skin cancer: examination of lesions:** Teledermatology incorporating Dermoscopy | As per original NICE Quality statement 4, Dermoscopy is an important part of the diagnosis pathway for skin cancer patients but it’s incorporation with Teledermatology via the 2 week pathway from GP to secondary care during the Covid 19 Pandemic has shown it’s benefit in improving rates of appropriate referral and early assessment, feeding into the NHS England faster diagnosis pathway to improve skin cancer patient experiences and outcomes | As per NICE current Quality Statement 4 (QS130);  Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2021), recommendations 1.7.1 and 1.7.2  Dermoscopy referenced in;  Melanoma: assessment and management (2015, last updated 2022) NICE guideline NG14.  British Association of Dermatologists guideline for the management of adults with basal cell carcinoma 2021 (2021) British Association of Dermatologists.  British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020 (2020) British Association of Dermatologists. |
| 19 | SCM6 | **Diagnosis of skin cancer: examination of lesions:** Earlier diagnosis of melanoma | The most important factor in melanoma survival is early diagnosis.  Current evidence suggests that more than 45 percent of melanomas were an incidental finding on full skin examination by a specialist.  In the UK it is not routine/agreed practice to do a full skin examination in **relevant patients** referred as a 2WW, with no evidence reporting how often such practice is carried out. | Melanoma Screening by Means of Complete Skin Exams for All Patients in a Dermatology Practice Reduces the Thickness of Primary Melanomas at Diagnosis.  The Journal of Clinical and Aesthetic Dermatology [J Clin Aesthet Dermatol.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4142816/) 2014 Aug; 7(8): 18–22. |
| 20 | SCM7 | **Diagnosis of skin cancer: examination of lesions:** Key area for quality improvement 2  AI in identifying skin cancer  As AI technology becomes more evolved and accepted in the UK, medical staff to be kept updated with this training in identifying skin cancer. AI to be set to recognise significant differences between pigmented and non-pigmented skin when more current published evidence on technology becomes available and identified | A1 is increasingly being used in medicine to diagnose skin cancer more effectively  Research by Oxford University academics found the images and data available for training to identify skin cancer are insufficient to be accurate in identifying skin cancer in black people | NICE - Digital technologies for the detection of melanoma  Medtech innovation briefing  01 November 2022  University of Oxford  Dr Wen  Datasets used to train AI to detect skin cancer lack information on darker skin often incomplete  10 November 2021 |
| 21 | British Association of Dermatologists | **Diagnosis of skin cancer: early diagnosis and referral:** Key area for quality improvement 3  Quality statement:  “People with suspected malignant melanoma are referred using a suspected cancer pathway for an appointment within 2 weeks.”  People who have skin lesions, such as damaged or injured patches of skin or new, large, changing or unusual looking moles, and whose GP thinks it is a type of skin cancer called malignant melanoma, are referred for an appointment to see a specialist within 2 weeks. | There are more skin cancers that represent a threat to life than melanoma and melanoma may not be suspected when it should be. The statement needs to encompass the purpose of the 2-week wait referral which is for all suspected skin cancers. This includes high risk site lesions including BCCs requiring urgent review, SCCs and melanoma and rarer skin cancers. This meets the requirements of the NICE skin cancer referral guidelines 2015.  ‘Melanoma’ is the correct clinical description used by the NHS an in other NICE guidance. Please remove the word ‘malignant’ from melanoma.  “Any GP who thinks a patient has a suspected skin cancer (BCCs, SCC, malignant melanoma) should be referred for an appointment to see a specialist within 2 weeks. Data shows patients with SCCs are more at risk of not being diagnosed quickly and coming to harm than for melanoma patients”  The NICE IOG details 6 levels of care; SCCs and Melanoma’s are seen within level 3 and 4 care under the LSMDT.  All SCCs and melanoma are seen under 2-week wait/FDS rules. | NICE Melanoma, assessment and management <https://www.nice.org.uk/guidance/ng14>  BCC-  BAD clinical guideline for BCCs (updated 2021) <https://academic.oup.com/bjd/article/185/5/899/6599942?login=false>  SCC-  BAD clinical guideline for SCC (updated 2021) <https://academic.oup.com/bjd/article/184/3/401/6702204?login=false>  Referral guidelines:  NICE CKS- [Melanoma](https://cks.nice.org.uk/topics/melanoma/), [skin cancers- recognition and referral](https://cks.nice.org.uk/topics/skin-cancers-recognition-referral/management/referral-for-suspected-skin-cancer/)  BAD- [Melanoma](https://www.bad.org.uk/referrals/melanoma/), [SCC](https://www.bad.org.uk/referrals/squamous-cell-carcinoma/), [BCC](https://www.bad.org.uk/referrals/basal-cell-carcinoma/)  NHS E [Cancer waiting time guidance](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/cancerwaitingtimescwt)  The BAD holds PHE data for referred numbers for diagnosis in 2-week wait. For 2017-19 we have a confirmed proportion of malignant melanoma, SCCs, BCCs, |
| 22 | British Association of Oral and Maxillofacial Surgeons | **Diagnosis of skin cancer: early diagnosis and referral:** Referral of all suspected MM or SCC on a 2 week pathway |  |  |
| 23 | National disease registration service | **Diagnosis of skin cancer: early diagnosis and referral:** Time to be seen from referral |  |  |
| 24 | National disease registration service | **Diagnosis of skin cancer: early diagnosis and referral:** Also note you have an error in your document regarding referral pathways which suggests that only some sccs should be referred along the 2ww pathway when it should say all SCC should be referred along the 2ww pathway. |  |  |
| 25 | NCD | **Diagnosis of skin cancer: early diagnosis and referral:** Best Practice Time Pathway for Skin Cancer.  Recommendation: We recommend replacing Quality Statement #3 with an updated quality statement on meeting the FDS and implementing the BPTP guidance and to consider a suspected cancer pathway referral (for an appointment within 2 weeks) for people with suspected melanoma, squamous cell carcinoma, and rare skin cancers.  2.5 The NHS guidance also provides an audit tool that can be used to undertake a baseline audit of services being delivered and assess whether sufficient capacity is in place to routinely deliver.  2.6 The BPTP and FDS will need to be supported by digital triage systems that facilitate referrals. A separate quality statement may be needed to reflect the need to ensure e-RS is integrated with other data systems to enable accurate audit and ensure appropriate management of FDS patients. | The NHS Long Term Plan commits to providing earlier and faster diagnosis for patients through the introduction of the FDS. Since 2018, expert clinical task and finish groups have developed best practice timed pathways (BPTPs) to help meet the FDS. They do so by identifying specific clinical events and tests for patients referred with certain symptoms. NHS England recently (October 2022) published guidance for local health and care systems on implementing a timed skin cancer diagnostic pathway. The guidance was developed by a multidisciplinary consensus group with clinical leaders from local and specialist services across England, expert advice from cancer alliances, NHS England, National Outpatient Transformation Programme  (NOTP), Getting it Right First Time (GIRFT), the British Association of Dermatologists, and patient and public partners. The guidance sets out how the diagnosis of squamous cell carcinoma (SCC), malignant melanoma and rare skin cancers can be achieved within 28 days in the urgent suspected skin cancer referral pathway. It provides the opportunity to 3 review and streamline pathways using new and innovative approaches to optimise suspected skin cancer referrals and ensure timely diagnosis and management. If implemented, it is expected to reduce the variation currently seen across England in skin cancer diagnoses. |  |
| 26 | SCM1 | **Diagnosis of skin cancer: early diagnosis and referral:** % of patients who see their GP more than once for a lesion that subsequently turns out to be a melanoma | Early diagnosis of melanoma is essential to improving outcomes of patients with melanoma. However frequently patients will see their GP several times, reassured before eventually being referred in |  |
| 27 | National disease registration service | **Diagnosis of skin cancer: testing for diagnosis and staging:** Proportion stage III and IV melanomas tested for BRAF status and undergone imaging |  |  |
| 28 | Royal College of Pathologists | **Diagnosis of skin cancer: testing for diagnosis and staging:** Key area for quality improvement 2  for both NG14 & Cancer Service guideline 8:  Expert regional & central dermatopathology review for:  Atypical and intermediate melanocytic lesions (can be defined from WHO 5th edition  Adnexal tumours | Melanocytic lesions are the most frequent cause of and account to over half of most expert referral practice in dermatopathology in England.  They are the no. 1 source of litigation in the USA in cellular pathology (followed by breast cancer and prostate) since many are very challenging histologically and clinically.  The huge upscaling of genomics and ancillary testing available has made this field highly specialised and the WHO 5th edition of Skin Tumours includes much more molecular testing for diagnosis and this produces wide variation nationally in expertise – from expert dermatopathologists in SSMDTs to general pathologists reporting skin  2. Impact of expert pathology review in skin adnexal carcinoma diagnosis: Analysis of 2573 patients from the French CARADERM network – a regional and central model of pathology review  Diagnostic change in 21.7% (503 cases) -similar as French lymphoma group  Clinical impact on management 8.6%  Change of malignant v benign designation 5%  Sweat gland carcinomas most prone to diagnostic change on expert review | <https://tumourclassification.iarc.who.int/welcome/>  <https://www.virtualpathology.leeds.ac.uk/eqa/specialist/skin/melanoma_club.php>  Impact of expert pathology review in skin adnexal carcinoma diagnosis: Analysis of 2573 patients from the French CARADERM network. Eur J Cancer. 2022 Mar;163:211-221. Battistella M et al.  Recent Advances on Immunohistochemistry and Molecular Biology for the Diagnosis of Adnexal Sweat Gland Tumors. Macagno N, Sohier P, Kervarrec T, Pissaloux D, Jullie ML, Cribier B, Battistella M. Cancers (Basel). 2022 Jan 18;14(3):476. |
| 29 | Royal College of Pathologists | **Diagnosis of skin cancer: testing for diagnosis and staging:** Key area for quality improvement 1: for both NG14 & Cancer Service guideline 8:  Genomic and ancillary testing for skin cancers including melanoma, with major involvement of dermatopathologists in the annual update with respect of skin cancers in the National Test Directory for Cancers. | The National Test Directory for Cancer has been available since 2018 with annual updates – see link in supporting information  For dermatopathology (and other subspecialties of cellular pathology) this should enable widespread genomic and ancillary testing of cancers and diagnostically challenging and intermediate lesions eg atypical spitzoid tumour – known now as spitz melanocytoma in the recently published beta version of the WHO 5th edition Tumours of the Skin, IARC 2023; full publication later in 2023, which needs to be used for correct nomenclature in updated NICE guidelines.  There has been a huge expansion of available genomic and ancillary tests in the 4th and now especially 5th edition of the WHO classification  Although the testing has been a dramatic improvement for both diagnostics and therapy for skin cancers including melanoma, there are several major problems creating large variation in use and rollout of the tests between NHS Trusts especially as the Genomic Medicine Service which runs it evolved from clinical genetics for rare and inherited disease where cellular pathologists are generally not involved, and the Test Directory for Cancer has been bolted on with minimal involvement of the cellular pathologists/dermatopathologists who are pivotal in cancer work – they produce the studies and write the classifications of tumours the Test Directory is based on, require the tests in some cases to make the diagnosis, and order most of the tests reflexly rather than wait for MDT or oncologist requests (which was not anticipated by the Genomic Medicine Service), with none in any senior roles;  for dermatopathology (and each subspecialty) the Test Directory for Cancer should be updated after scrutiny by a National Dermatopathology Genomics and Ancillary Test Evaluation Group which could be set up by the RCPath Dermatopathology and Molecular Pathology Committees together with the British Society for Dermatopathology of the British Association of Dermatologists. At present there is no significant involvement of any dermatopathology specialists for this specialist area of work.  In addition, immunohistochemistry (such as for BRAF V600E for melanoma) and infectious diseases (eg HPV genotyping) must be included under the National Test Directory for Cancer – at present they are not which is the opposite of “get it right first time” and causes huge logistical problems as one biopsy eg from spitz melanocytoma (formerly atypical spitzoid tumour) can be sent to 3 different laboratories for different tests and then results come back from these 3 sources for an MDT, clinician or dermatopathologist to assess.  This is because cellular pathology laboratories receive and process the biopsy and make the diagnosis of eg melanoma then have to package up the sample to the Genomic Lab Hubs which do not have the facility to do immunohistochemistry and no pathologists working there (apart from 1 PA each for the 7 GLH Pathology leads who are not based in the GLHs anyway).  This has led to significant costs to cellular pathology laboratories in rolling out the tests – see supplementary information  Variable knowledge amongst cellular pathologists of the availability and use of the National Test Directory for Cancer as it sits outwith the employing NHS Trusts and is centrally funded and not run by any cellular pathologists – this has created a postcode lottery for patients  Huge unfunded cost implications to NHS Trusts – see Gloucestershire example in supplementary information | <https://www.england.nhs.uk/genomics/the-national-genomic-test-directory/>  <https://tumourclassification.iarc.who.int/welcome/>  3a. From RCPath survey of Fellows 2021:  Two thirds of RCPath Fellows have had to take on the extra work generated by genomic testing pro bono  >50% have not received sufficient training for this workload growth nor ever accessed the National Genomic Test Directory for Cancer.  >1 in 3 of our members indicate that they do not perform genetic tests on all samples that meet national eligibility criteria.  Almost 75% of pathology departments require additional resource (staff, space, infrastructure) for the extra genomic work.  Of those that have received additional resource this has been from disparate sources leading to inequalities in service provision for patients.  3b. Following modelling of costs excerpt from a letter Feb 2021 Chair of West Of England NHSI Pathology Network (& Chief Executive of Gloucestershire Hospitals NHS Foundation Trust) wrote to Pathology Lead at Public Health England  “Discussions with the GLH indicate that all parties are in agreement that sample preparation work should be carried out in local Trust Pathology Departments… an additional annual recurring cost of around £200,000 in our Trust, with no apparent funding source..”  Since the Trust serves 650 000 population this is approx. £20 million per annum for England. |
| 30 | SCM1 | **Diagnosis of skin cancer: testing for diagnosis and staging:** % of stage IIB & C patients offered SNB | New NICE recommendations on adjuvant systemic immunotherapy for stage IIB & C melanoma patients has resulted in some centres are not offering this group of patients SNBx. (If +ve patients will be stage IIIB&C, so offered adjuvant tx, if -ve will remain stage IIB&C so now can be offered adjuvant tx). This is contrary to the trial and could negatively impact on patients. |  |
| 31 | SCM1 | **Diagnosis of skin cancer: testing for diagnosis and staging:** % of melanomas which have an incisional biopsy prior to their formal excisional biopsy | The indications for incisional biopsy of a suspected melanoma are limited. Incisional biopsy does not remove the melanoma and can have an adverse impact on subsequent management. |  |
| 32 | SCM3 | **Diagnosis of skin cancer: testing for diagnosis and staging:** Staging with sentinel lymph node biopsy | Melanoma: assessment and management  NICE guideline [NG14]Published: 29 July 2015 Last updated: 27 July 2022  1.4 Staging with sentinel lymph node biopsy |  |
| 33 | SCM4 | **Diagnosis of skin cancer: testing for diagnosis and staging:** I think other guidelines one of these statements could be considered to the SLN guidance that has been removed. |  |  |
| 34 | SCM4 | **Diagnosis of skin cancer: testing for diagnosis and staging:** 1.4.7 Offer staging with whole-body and brain CE-CT to people with stage IIC to IV melanoma. [2022] |  |  |
| 35 | British Association of Dermatologists | **Management of skin cancer: management of BCC in primary care and in the community:** Key area for quality improvement 2  “GPs who manage low‑risk basal cell carcinoma maintain and audit records of their caseload.” | GPs who provide a minor surgical service which includes treating low risk BCCs, or GPwERs providing community skin cancer services must be accredited for their respective levels of practice and revalidation. They will also need to be named as extended members of their local hospital skin MDT and attend 4 times a year and submit a yearly audit on their BCCs. | GPwER curriculum : <https://cdn.bad.org.uk/uploads/2022/02/29200009/GPwER-dermatology-framework-2019.pdf>  The rationale and content needs to reflect NICE IOG contents for managing Model 1 low risk BCCs and the descriptors for a low risk BCCs with emphasis on new BCCs in low-risk sites (non- recurrent).  Please update the terms used in this statement, from the NICE 2010 update to the IOG and the BAD BCCs clinical guideline  [Improving outcomes for people with skin tumours including melanoma. The management of low-risk basal cell carcinomas in the community. NICE cancer service guideline CSG8](https://www.nice.org.uk/guidance/csg8) (2006, updated 2010), section on models of care  BAD clinical guideline for BCCs (updated 2021) <https://academic.oup.com/bjd/article/185/5/899/6599942?login=false> |
| 36 | Royal College of General Practitioners | **Management of skin cancer: management of BCC in primary care and in the community:** Auditing surgical services in primary care | Statement 2 in the current Quality Standard states GPs managing low risk skin cancers will maintain and audit their caseload. The RCGP developed and delivered a Community Based Surgery Audit (CBSA) nationally, which demonstrated not only that GPs can deliver minor surgery in a safe and timely manner, but that those that do, perform better in a managed framework.  Unfortunately, this type of work for GPs does not receive funding from NHSE, however it could be a useful resource to the health system.  As there are only 6 current quality statements in the NICE Quality Standards and one of them is audit of community skin cancer surgery, we would suggest that this could be a useful resource for practices to carry out this work and would urge it to be included in the update to support GPs and their patients. | The CBSA was evaluated and published in this paper: <https://pubmed.ncbi.nlm.nih.gov/26965026/#affiliation-4> |
| 37 | SCM5 | **Management of skin cancer: management of BCC in primary care and in the community:** Key area for quality improvement 3:  GP managing low risk BCC | BCC management in community as recommended in NICE guidance on improving outcomes for people with skin tumours including melanoma 2010 update has had variable uptake throughout the UK for various reasons, increasing patient inconvenience to not be managed locally and consuming valuable secondary/tertiary care resource | As per NICE current Quality Statement 2 (QS130);  Improving outcomes for people with skin tumours including melanoma. The management of low-risk basal cell carcinomas in the community. NICE cancer service guideline CSG8 (2006, updated 2010), section on models of care |
| 38 | SCM6 | **Management of skin cancer: management of BCC in primary care and in the community:** Incomplete excision rates of Basal Cell Carcinoma on the Head & Neck | Basal cell carcinomas are very common. Late and/or incomplete diagnosis leads to high levels of morbidity, especially on the head and neck.  Historically, incomplete BCC excision rates have been reported as being around 5%; however incomplete excisions are likely to be under reported and a recent systematic review has highlighted that rates are double what were previously reported.  There is likely to be significant variation in the reporting, auditing, and reflection on BCC incomplete excision rates between individuals and also within skin cancer multi-disciplinary teams. | Incomplete surgical excision of keratinocyte skin cancers: a  systematic review and meta-analysis  Incomplete surgical excision of keratinocyte skin cancers: a systematic review and meta-analysis. British Journal of Dermatology October 2020. [10.1111/bjd.19660](http://dx.doi.org/10.1111/bjd.19660) |
| 39 | National disease registration service | **Management of skin cancer: multidisciplinary team involvement:** Proportion discussed at MDT for melanoma, SCC, BCC and rare skin cancers |  |  |
| 40 | SCM3 | **Management of skin cancer: multidisciplinary team involvement:** Management of oligometastatic stage IV melanoma | Melanoma: assessment and management  NICE guideline [NG14] Published: 29 July 2015 Last updated: 27 July 2022  1.8 Managing stage IV and unresectable stage III melanoma  Management of oligometastatic stage IV melanoma  1.8.1 Refer the care of people who appear to have oligometastatic melanoma to the specialist skin cancer multidisciplinary team for recommendations about staging and management. [2015]  1.8.2 Consider surgery or other ablative treatments to prevent or control symptoms of oligometastatic stage IV melanoma in consultation with other site specific multidisciplinary teams. [2015, amended 2022] |  |
| 41 | SCM4 | **Management of skin cancer: multidisciplinary team involvement:** 1.8.5 Refer people with melanoma and brain metastases that might be suitable for surgery or stereotactic radiotherapy to the neuro-oncology multidisciplinary team for a recommendation about treatment. [2015, amended 2022] |  |  |
| 42 | SCM8 | **Management of skin cancer: multidisciplinary team involvement:** All regional tumour groups/Alliances have a website with a defined tumour group lead and comprehensive guidelines, adapted from NICE and other sources to local practice. | Not current practice. Publicising local guidelines so best practice can be shared across the country. |  |
| 43 | British Association of Dermatologists | **Management of skin cancer: access to a clinical nurse specialist:** Key area for quality improvement 5  “People with malignant melanoma or squamous cell carcinoma have access to a skin cancer clinical nurse specialist.” | These nurses are required to be core members of the LSMDT/SSMDT. The patients' cases will be review by the MDT and case allocated to the CNS with the patients' consultant to support the discussion. | Manual for Cancer Services Skin Measures 1.2 (2014)- 14-2J-101; 14-2J-2014 which remain in place for cancer organisational governance.  NICE IOG – CNS |
| 44 | British Association of Oral and Maxillofacial Surgeons | **Management of skin cancer: access to a clinical nurse specialist:** Care of all skin cancer patients by Skin CNS |  |  |
| 45 | SCM3 | **Management of skin cancer: access to a clinical nurse specialist:** People with malignant melanoma or squamous cell carcinoma have access to a skin cancer clinical nurse specialist. | Ideally CNS support should be available at the time of consultation for each patient with a new diagnosis of advanced SCC and Melanoma | Quality statement 5: Skin cancer clinical nurse specialist (previous NICE QSA)  Melanoma: assessment and management  NICE guideline [NG14]Published: 29 July 2015 Last updated: 27 July 2022  Ensure that each local skin cancer multidisciplinary team and specialist skin cancer multidisciplinary team has:  at least 1 skin cancer clinical nurse specialist to provide people with information and support  access to psychological support services for people with melanoma. **[2015]**  1.1.5Ensure that healthcare professionals can support people with melanoma by attending training and being competent in:  communicating complex and sensitive information clearly  tailoring information and support to the person's individual needs and circumstances. **[2015]** |
| 46 | SCM5 | **Management of skin cancer: access to a clinical nurse specialist:** Key area for quality improvement 2:  Skin cancer clinical nurse specialist provision | Provision of access to Skin Cancer CNS is reported as variable throughout the UK as evidenced by patient surveys, both national and local. The benefit of access to a Skin Cancer CNS has been highlighted in many patient satisfaction survey both locally and nationally. | Monitor vis COSD data and national cancer patient experience survey.  Melanoma: assessment and management. NICE guideline NG14 (2015, updated 2022), recommendation 1.1.4  Improving outcomes for people with skin tumours including melanoma. NICE cancer service guideline CSG8 (2006, updated 2010), section on organisation of skin cancer services |
| 47 | National disease registration service | **Treatment of skin cancer: Access to therapy:** Time to definitive treatment |  |  |
| 48 | NCD | **Treatment of skin cancer: access to therapy:** Systemic Anti-Cancer Therapy and radiological surveillance of stage 2a Melanomas.  Recommendation: We would recommend including a quality statement on implementing NG14 and on ensuring patients with resected Stage 2B/C and Stage 3 Melanoma have access to NICE approved adjuvant systemic therapies. | NICE guidance for systemic anti-cancer therapies and for radiological surveillance of stage 2a melanomas have changed considerably since the last Quality Standard on skin cancer was written. New guidance on adjuvant treatments will have major implications for oncology services as more anti-cancer drugs are now recommended for skin cancer. The updated NICE guideline NG14 on assessment and management of melanoma now recommends an increased number of surveillance scans for stage 2a melanomas, which has become a major issue for a considerable number of trusts. Including a quality statement on these two areas would help to highlight the changes in this area, and prioritising them would help to reduce variation in practice and improve survival.  3 As per NICE technology appraisal guidance TA837, TA766, TA684 and TA544. |  |
| 49 | SCM1 | **Treatment of skin cancer: access to therapy:** % Stage IIIA patients offered adjuvant systemic treatment | NICE recommended adjuvant treatment for stage IIIA patients, although the risk benefit for this group is in equipoise. |  |
| 50 | SCM3 | **Treatment of skin cancer: access to therapy:** Regional therapies: treatment of in-transit melanoma | Melanoma: assessment and management  NICE guideline [NG14]Published: 29 July 2015 Last updated: 27 July 2022  1.7 Treating in-transit metastases in stages III and IV melanoma |  |
| 51 | SCM4 | **Treatment of skin cancer: access to therapy:** The recommendation to use ipi nivo 1L if there are not contra-indications is an important statement (1.8.8) is likely to have influenced practise with more oncologists offering combination immunotherapy hopefully in the country, however I think given all the caveats it would be very difficult to audit, and for this reason I haven’t included it in my top tow. |  |  |
| 52 | SCM5 | **Treatment of skin cancer: access to therapy:** Key area for quality improvement 5:  Provision of adjuvant and palliative systemic treatments and radiotherapy treatments within cancer centres geographically closest to a patient’s home | The significant increase in the available adjuvant and palliative systemic treatments for all skin cancers and the guideline recommendations for adjuvant and primary radiotherapy in non-melanomatous cancers over the last decade has led to more patients being treated but these treatments are often only offered in centres with a Skin Cancer SMDT and patients often may have to travel significant distances, repeatedly to assess these treatments. This has been noted in patient satisfaction surveys both locally and nationally as an issue for multiple reasons including physical, psychological and financial. | RT data base and SACT data base can be utilised to monitor distance travelled by patients (home address to cancer centre)  NICE's guidance on improving outcomes for people with skin tumours including melanoma 2006 – Section regarding patient centred care |
| 53 | SCM8 | **Diagnosis of skin cancer: access to therapy:** Standardise pathway timings from primary excision, to secondary surgery and tertiary oncology treatment. | This data isn’t available.  Publish national data and/audit on pathway timings in skin cancer specially melanoma. |  |
| 54 | National disease registration service | **Treatment of skin cancer: radiotherapy for BCC and SCC:** Proportion BCC or SCC treated with radiotherapy |  |  |
| 55 | SCM7 | **Treatment of skin cancer: vitamin D:** Key area for quality improvement 4  Melanoma assessment and management  Vitamin D  NG14 1.2  1.21 (2015) | Research shows low Vitamin D levels may also help promote the growth of melanoma cells. Avoiding low Vitamin D levels after a melanoma diagnosis with supplementation is recommended | Hardie et al 2020 in Melanoma focus.org Vitamin D and melanoma |
| 56 | SCM3 | **Follow-up after melanoma: surveillance:** Lymph node surveillance with ultrasound | The DeCOG-SLT and MSLT-II studies demonstrated that ultrasound surveillance post positive sentinel node as opposed to nodal basin dissection was oncologically safe, and reduced morbidity.  However, the access to ultrasound and the expertise is lacking.  Development of ultrasound services in the NHS is required to implement the recommendations in the recently updated NICE guidance, and to enable the safe de-escalation of surgery for sentinel node positive stage III melanoma. | Melanoma: assessment and management  NICE guideline [NG14]Published: 29 July 2015 Last updated: 27 July 2022  1.9 Follow-up after treatment for melanoma  1.9.12 For people having both CE-CT and ultrasound scans, alternate between the 2 types of scan. **[2022]**  **See table**  **Follow-up after stages I to IV melanoma** |
| 57 | SCM2 | **Follow-up after melanoma: access to services following discharge**: Key area for quality improvement 2  Key Section 1.9.1 | Pts should be informed on how to re-access services once they have completed their treatment. | The cancer patient survey showed that patients are not being given direct contact details for specialist cancer services on discharge. |
| 58 | SCM8 | **Follow-up after melanoma: access to services following discharge**: Survivorship following immunotherapy for metastatic melanoma/scc. | Little evidence or guidance exists on how we can better support patients post t/m. |  |
| 59 | SKCIN- National skin cancer charity | **Additional areas:** Quality standard 1  Local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns. | Sadly, there are no PHE/HEE/NHS national campaigns exist for the public on skin cancer. The disease area of skin cancer is poorly represented as a prevention health campaign.  The latest CRUK campaign was in 2014  The latest data for skin cancer highlights that skin cancer will now affect 1in 4 males and 1 in 5 females. Skin cancer is now the UKs most common cancer. Due to previously the cancer registries only capturing data on melanoma the focus has been on those statistics rather the bigger picture of all skin cancers.  These new concerning figures from 2021 highlight that more needs to be done to tackle this public health concern.  90% of all skin cancers are preventable as they are largely due to over exposure to uv/sun so now more than ever a Govt supported national public health campaign is essential. Millions is being spent treating skin cancer patients for something that preventable and presents a burden for the NHS.  Skin cancer is not included in the PHE strategy document for 2020-2025.  [PHE Strategy 2020 to 2025 - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/phe-strategy-2020-to-2025)  Skcin has wrote the Health Minister to request that skin cancer education be included in PHE strategy document  Our feedback from patients and primary care highlights is there is huge gap in education on the topic and the profile of skin cancer very low. With skin cancer cases rising the evidence is clear that more needs to be undertaken in this area to help raise awareness with the public  Educational intervention strategies and campaigns are key to combatting the current rising statistics, but these need to be supported by Government bodies and key stakeholders and this health promotion activity listed as mandatory for commissioners and Health boards.  Skcin is the only UK charity dedicated solely to the purpose of raising awareness of all skin cancers, not just melanoma, promoting early detection and sun safety and has been for over 17 years and we well experienced in public health messaging. Huge strides have been made in the past 10 years but much more need to undertake in view of the rising statistics  Skcin over the years have helped 1000s of members of the public detect a skin cancer from our information in booklets/web site via our educational programmes that reaching over a million people with skin cancer sun safety advice  The quality standard needs to become part of wider strategy to tackle skin in the UK | [An updated report on the incidence and epidemiological trends of keratinocyte cancers in the United Kingdom 2013–2018 - Kwiatkowska - 2021 - Skin Health and Disease - Wiley Online Library](https://onlinelibrary.wiley.com/doi/full/10.1002/ski2.61)  Campaigns for skin cancer need to be supported a national level by regional PH and health boards. This sadly never happens Campaigns need to be consistent and robust and have longevity and tailored for the audience where possible. They need to be supported all year round not just the Summer and education provided on the 5 prevention strategies. The 5S of Sun Safety  [Use the Five S's of Sun Safety to help prevent skin cancer (skcin.org)](https://www.skcin.org/sunSafetyAndPrevention/theFiveSsOfSunSafety.htm)  Early detection is paramount with skin cancer and the sooner its detected and diagnosed the better the prognosis. Therefore, the public encouraged to undertake monthly skin checks is key for the public messaging.  The charity Skcin are solely dedicated to educational intervention working with the public and at risk and influential audiences.  It needs to be understood that one off ad hoc campaign or not effective. Campaigns need to be delivered annually and form part of a public health plan  Skcin have initiated many campaigns over the years and now their social media is a dedicated channel of educational information for the public. [Sun Safety and skin cancer prevention campaigns (skcin.org)](https://www.skcin.org/ourWork/otherPreviousCampaigns.htm)  In May every year Skcin run a national skin cancer awareness month where they deliver a social media campaign and engage with the press and media to raise the profile of skin cancer. They provide free toolbox of resources to those that wish to support our messaging.  [(18) SKCIN | Facebook](https://www.facebook.com/profile/100064871525019/search/?q=skin%20cancer%20awareness%20month)  The charity Skcin is a key source of information for public and patients via their comprehensive web site. In addition to an impressive social media channel with strong following where 98% of posts are of an educational nature  [(16) SKCIN | Nottingham | Facebook](https://www.facebook.com/SkcinCharity)  [(18) SKCIN | Facebook](https://www.facebook.com/profile/100064871525019/search/?q=skin%20cancer%20awareness%20)  Skcin also have other tools for the public to help educate themselves. Educational intervention is the key focus of Skcin’s work, and they understand this is one of the ways we can combat the rising statistics.  [SkcinBooklet2022.pdf](https://www.skcin.org/downloads/SkcinBooklet2022.pdf)  [Skcin shop - Skin cancer and melanoma UK awareness resources – SKCINSHOP](https://shop.skcin.org/)  Skcin supply 100s of hospitals/GP practices with their resources and now in effort to be digital and save money they also offer a FREE App for the public. (the App does not use AI nor is it medical device)  [Skcin App](https://app.skcin.org/)  Skcin are working with the NHS in effort to see the App featured in the NHS digital playbooks.  It already features on the BDNG British Dermatology Nursing Groups web site.  [App directory – BDNG](https://bdng.org.uk/app-directory/)  The App is great resource for engaging the public to take charge of their own skin health.  Skcin also offer digital screen monitors for GP practices.  All year round the charity in huge demand for resources. Skcin are happy to collaborate with stakeholders to help amplify our messaging. NICE would be appropriate for signposting/recommending services.  In addition, behaviour change, is key as research suggests that even if the public have the knowledge, they are not always willing to change behaviours. For this reason Skcin have for 10 years been running their Sun Safe schools and Sun Safe Nursery programmes  [www.sunsafenurseries.co.uk](http://www.sunsafenurseries.co.uk)  [www.sunsafeschools.co.uk](http://www.sunsafeschools.co.uk)  [Sun Safe Schools - FREE national accreditation programme - YouTube](https://www.youtube.com/watch?v=Ur1dBX820SI)  These free programmes are available to all relevant settings. Skcin have over 6000 schools engaged with the programmes and 1000s of reviews for schools and parents supporting the work. The aim of this work is embed the seeds of sun safety for the next generation evoke behaviour change and help mitigate the burden of skin cancer to the NHS  Skcin has also lobbied the Dept of Education for 6 years to see sun safe teaching included in the national PHSE curriculum and delighted this was made mandatory in 2020 so health boards should be signposting the programme in their localities.  As part of their wider work to engage communities in 2019 .Skcin developed an online training in bid to train hairdressers and beauticians into the early recognition of suspicious legions. Masced ( melanoma and skin cancer early detection course) [www.masced](http://www.masced). we are proud to share has now trained over 10,000 professionals in the sector with 100s and early detections stories and case studies.  Skcin are now working with Industry stakeholders to see such training included in the national curriculum. Our local communities can be powerful forces in helping with skin surveillance and signposting to the appropriate services. |
| 60 | SCM7 | **Additional areas:** Key area for quality improvement 3  NICE-Healthcare services for children and young adults with cancer to be updated to include new findings | NICE CSG7 Cancer service guideline  24 August 2005  Reviewed July 2014 no action | In 2019 NHS England Specialised Commissioning consulted on revised service specifications for cancer services for children, teenagers and young adults with cancer. Professor Sir Mike Richards was commissioned by NHS England to provide an independent view of the appropriateness of these services. All his recommendations were approved when the report was presented to the NHS England Board in 2020. |