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Quality standards

Consultation summary report: skin cancer (update)

Quality Standards Advisory Committee post-consultation meeting: 12 September 2023

1. Introduction

The draft quality standard for skin cancer (update) was made available on the NICE website for a 4-week public consultation period between 13 July and 10 August 2023. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 12 organisations, which included service providers, national organisations, professional bodies and others. Some key stakeholders did not respond at consultation.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in the appendix.

1. Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Is data for the proposed quality measures collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement-specific questions:

4. For draft quality statement 2: The rationale, audience descriptors and definitions include reference to the use of teledermatology as an option to support a suspected cancer referral. Is this widely used and is it acceptable to be included in these sections?

5. For draft quality statement 3: Would examination by dermoscopy be coded in patient records?

6. For draft quality statement 4: Should the statement include support from a clinical nurse specialist for all people with melanoma and squamous cell carcinoma, or are there some people who would not be assigned a clinical nurse specialist?

7. For draft quality statement 4: Should the quality measures include specific times during the care pathway that a person with skin cancer would receive support from a clinical nurse specialist? If so, when would this be?

8. For draft quality statement 5: What are the outcomes associated with this quality statement and can these be measured using routinely collected data?

9. For draft quality statement 6: What is the priority area for quality improvement; the staging scan or the type of scan (such as CE-CT and MRI)?

10. What are the challenges to implementing the NICE guidance underpinning this quality standard? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives).

1. General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

* Some support for the content of the quality standard and the key areas reflected.
* There should be consideration of extending the scope of the quality standard to include other non-melanoma skin cancers that are covered by the source guidance and routinely collected data. A lack of standardised definitions and comprehensive guidance for non-melanoma skin cancers creates inconsistencies in patient experience and outcomes and could impact on uptake of the quality statements.
* References to skin specialists should make clear that this can be any specialist who is trained and part of a skin multidisciplinary team.
* Statements should make reference to reasonable adjustments, communication needs and healthcare passports for people with a learning disability or autistic people.
* Other measures to consider using in the quality standard are:
  + measurement of the number of SNLB
  + stage at presentation
  + mortality
  + survival
  + percentage of diagnostic biopsies
  + number of follow up appointments
  + 2-week wait conversion rates
  + percentage of basal cell carcinomas referred along the 2-week wait pathway.

### Consultation comments on data collection

* Data is collected locally at diagnosis and updated as the care pathway changes. Local data feeds into national data sets.
* Some nationally collected data does not include non-melanoma skin cancer.

### Consultation comments on resource impact

* Statements are already delivered as part of the cancer organisation structure for skin cancer services but there is a need for better quality surveillance outcomes.
* There is a variation in service standards across England and investment is needed to level up.
* Skin cancer services are overwhelmed with benign lesions and unable to deliver to the 2-week target.
* There should be acknowledgement of insufficient primary care education in dermatology and lack of resources in secondary care.

1. Summary of consultation feedback by draft statement
   1. Draft statement 1

Integrated care boards work with local partners to implement strategies to prevent skin cancer and raise awareness of the risks of sunlight exposure in at-risk groups. **[new 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

Statement

Concerns about the statement

* It does not distinguish primary and secondary prevention.
* It needs more specific information for people with darker skin.
* The statement should be more specific about actions. Stakeholders noted that early detection of skin cancer is key, and this should be included in the quality statement.
* It should include cancers caused by sunbeds and artificial UV.
* Charities should be included in the statement as a key stakeholder for local partners. Local health promotion teams should connect with skin cancer multidisciplinary teams.
* It would be useful if the statement included commissioner funding for promotional material.

Measures

* The outcome measure is insensitive. The first diagnosis in nearly all melanoma is at stage 1 or 2 and measurement of diagnosis at stage 1 would be more clinically important. They also noted the time lag between process and outcome for this quality statement.
* The statement should measure outcomes in non-melanoma skin cancer as well as melanoma.

Audience descriptors

* The audience descriptors should reference sun safety and early detection.
* Charities can support commissioners and pharmacists in the offer of surveillance training.

Definitions

* There should be a separate definition on checking skin for signs of skin cancer.
* They should include UV radiation.

### Issues for consideration

#### For discussion:

* The statement refers to sunlight exposure. Should this be changed to reflect other risks such as UV radiation? Note the underpinning source guidance is on sunlight exposure and the definition of at-risk groups include people frequently exposed to UV rays.
* How can we strengthen the statement and supporting information to ensure clarity on primary and secondary prevention and the actions required?

#### For decision:

* Do we need to amend the wording of the quality statement to reflect stakeholder comments?
* Should the statement also include people with darker skin as an at-risk group?
* Should the measures also include non-melanoma skin cancer?
* Should this quality statement remain in the quality standard?
  1. Draft statement 2

People with suspected melanoma or squamous cell carcinoma are referred using a suspected cancer pathway referral for an assessment within 2 weeks. [**2016, updated 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

Statement

Support for the statement

* There was agreement for the inclusion of squamous cell carcinoma melanoma in the 2WW pathway to improve monitoring and alleviate the strain on specialist skin cancer services.

Concerns about the statement

* Rare skin cancers and high-risk basal cell carcinoma have not been included in the quality statement.

Measures

* The 2-week wait pathway also applies to lesions that are undiagnosed but may be malignant. The denominator should be the number of confirmed melanomas, cutaneous squamous cell carcinomas and undiagnosed skin cancers.
* The achievement of the outcome measures will be skewed due to limited numbers of specialists and overwhelming referrals. They should be reviewed to reflect the challenges of limited resource, for example, amend to time from assessment to diagnosis or rule out and time from assessment to first definitive treatment.

Audience descriptors

* The reference to the size of lesion should be removed as this is subjective. The description is not in line with the 2-week referral guidance wording.

### Consultation question 4

The rationale, audience descriptors and definitions include reference to the use of teledermatology as an option to support a suspected cancer referral. Is this widely used and is it acceptable to be included in these sections?

Stakeholders made the following comments in relation to consultation question 4:

* Teledermatology is widely in use especially within the 2-week-wait pathway for suspected cancer. Stakeholders highlighted the specific guidance on this in the 2-week wait pathway and also signposted to other relevant resources.
* A review of best practice and standardisation around teledermatology is needed as a variety of suppliers are in use.

### Issues for consideration

#### For discussion:

* The focus on suspected melanoma and suspected squamous cell carcinoma rather than including other types on non-melanoma skin cancer.
* Are amendments needed to the outcome measures?
* The impact of the upcoming changes to the 2-week wait pathway measures.

#### For decision:

* Should the statement remain focussed on suspected melanoma and suspected squamous cell carcinoma?
* Should the reference to teledermatology remain in the supporting information of the quality statement?
* Should this quality statement remain in the quality standard?
  1. Draft statement 3

People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy. **[2016]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

Statement

Support for the statement

* The use of dermoscopy in primary care is increasing and stakeholder comments highlighted the use of teledermoscopy in general practice.

Concerns about the statement

* The statement should include non-pigmented lesions.
* Should also include magnification as many plastic surgeons would use loupe magnification for examination of lesions.
* Dermoscopic and macroscopic photographs should be taken and added to the patient record and this should be included in the quality statement.

Outcomes

* The same limitations as noted in statement 1 were highlighted for measuring stage 1 and stage 2 diagnoses as an outcome.

Definitions

* GPs with extended roles/specialist interest in dermatology and plastic surgeons would carry out a specialist assessment. The definition of specialist assessment should be amended.

### Consultation question 5

Would examination by dermoscopy be coded in patient records?

Stakeholders made the following comments in relation to consultation question 5:

* Dermoscopy would be coded as part of the face to face assessment on a 2-week wait pathway or when dermatoscopic and macroscopic images are taken by a hospital photography department. Dermoscopy would also be used across other departments.
* Coding dermoscopy would be useful for data collection and research purposes.

### Issues for consideration

#### For discussion:

* Is dermoscopy routinely coded?
* Are non-pigmented lesions assessed by dermoscopy? Should they be? Note the underpinning recommendation is for pigmented lesions only.
* Should the definition of specialist assessment include GPs with extended roles and plastic surgeons?

#### For decision:

* Do we need to amend the statement wording to reflect stakeholder comments?
* Should this quality statement remain in the quality standard?
  1. Draft statement 4

People with melanoma or squamous cell carcinoma are supported by a skin cancer clinical nurse specialist. **[2016, updated 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

Support for the statement.

* Stakeholders agreed with the statement.
* Clinical nurse specialists are important for the patient through the treatment journey.

Concerns about the statement

* It is important to distinguish between the different skin cancer nurse specialist roles.
* The NCRAS COSD data on specialist nurse involvement is likely to be incomplete.

Measures

* Patient reported outcome measures should be collected at a local level.

### Consultation question 6

Should the statement include support from a clinical nurse specialist for all people with melanoma and squamous cell carcinoma, or are there some people who would not be assigned a clinical nurse specialist?

Stakeholders made the following comments in relation to consultation question 6:

* The role is not required for all skin cancer patients and additional resources would be needed to support all people with squamous cell carcinoma.
* Ideally both people with melanoma and people with SCC would be supported by a clinical nurse specialist.

### Consultation question 7

Should the quality measures include specific times during the care pathway that a person with skin cancer would receive support from a clinical nurse specialist? If so, when would this be?

Stakeholders made the following comments in relation to consultation question 7:

* Clinical nurse specialists provide support from time of diagnosis until discharge. They provide support for people with a range of skin cancers, including those requiring continued management and follow-up and those requiring treatment external to the department.
* There are key points on the patient pathway where support is critical, including the diagnosis, treatment option stage, relapse or progression and transfer to surveillance or survivorship.
* It would be useful to define the role of a clinical nurse specialist to help with continued recruitment and ensure stability for departments. Resourcing and workforce planning is a challenge.

### Issues for consideration

#### For discussion:

* Who would be offered support from a clinical nurse specialist? Are all people with squamous cell carcinoma offered support?
* Does the statement need to distinguish between the different roles for clinical nurse specialists?
* Are there key points in the care pathway that the measures should focus on?

#### For decision:

* Should the statement include all people with squamous cell carcinoma?
* Should the measures focus on specific points in the care pathway?
* Should this quality statement remain in the quality standard?
  1. Draft statement 5

People with stage IIC to IV primary melanoma have BRAF analysis of the tumour. **[2016, updated 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 5:

Statement

Support for the statement

* Turnaround time for BRAF mutation status could help with achievement of the 31-day treatment standard.

Concerns about the statement

* NICE has recommendations for BRAF testing for people with other stages of melanoma.
* The use of targeted gene expression tests for BRAF analysis should be explored.

Measures

* NCRAS data lacks immunohistochemistry results. All BRAF results are recorded in locally held databases and patient electronic records.

### Consultation question 8

What are the outcomes associated with this quality statement and can these be measured using routinely collected data?

There were no comments from stakeholders in relation to consultation question 8:

### Issues for consideration

#### For discussion:

* Is it acceptable to include people with stage IIB melanoma considering the NICE recommendation for this population?
* Will the lack of nationally collected data for immunohistochemistry analysis impact on the measures and quality statement?

#### For decision:

* Should the statement measure BRAF testing in people with stage IIB melanoma?
* Should this quality standard remain in the quality standard?
  1. Draft statement 6

Adults 25 and over with stage IIC to IV melanoma, and under 25s and pregnant women with stage IIB to IV melanoma, have a staging scan. **[new 2023]**

### Consultation comments

Stakeholders made the following comments in relation to draft statement 6:

Concerns about the statement

* People with stage IIB melanoma should be included as treatment options are the same as stage IIC. Omission may lead to unintended inequality.

### Consultation question 9

What is the priority area for quality improvement; the staging scan or the type of scan (such as CE-CT and MRI)?

Stakeholders made the following comments in relation to consultation question 9:

* The staging scan is the priority area for quality improvement. An accurate staging scan is needed for effective treatment and appropriate referral.

### Issues for consideration

#### For discussion:

* Do we focus on the correct population in the draft statement? Should the statement extend to all people with stage IIB melanoma or instead focus on people with stage IIC to IV melanoma?
* Does the statement need to include the type of imaging?

#### For decision:

* Do we need to amend the statement wording to reflect stakeholder comments?
* Should this quality statement remain in the quality standard?

1. Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

### Sentinel lymph node biopsy

Areas relating to sentinel node biopsy was suggested by stakeholders at consultation, including the use of gene expression testing to determine eligibility. This suggestion has not been progressed as the area was discussed but not prioritised by the QSAC at the first committee meeting.

### Survivorship

Areas relating to survivorship including recognition and management of the physical and psychological effects of treatment were suggested by stakeholders at consultation. This suggestion has not been progressed as the area was discussed but not prioritised by the QSAC at the first committee meeting.

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# Appendix: Quality standard consultation comments table – registered stakeholders

| ID | Stakeholder | Section | Comments |
| --- | --- | --- | --- |
| 1 | British Association of Dermatologists (endorsed by RCP) | General | The guidance covers ‘non melanoma’ skin cancers which includes rare skin cancers such as merkel cell cancer, but these are not included. These patients should also be supported by a skin cancer clinical nurse specialist (CNS) and should be managed along urgent pathways.  NICE may not want to extend the scope to include rare skin cancers, but this needs to be highlighted and the terminology of non-melanoma skin cancer should be changed to keratinocyte skin cancers for clarification. |
| 2 | British Association of Plastic Reconstructive and Aesthetic Surgeons | General | -wherever it the document refers to a "skin specialist" this should specify that "this can be any specialist who is trained and is part of a skin mdm." |
| 3 | British Association of Plastic Reconstructive and Aesthetic Surgeons | General | Regarding GP audit, comment should be given on what to do with the data collected, in order to identify outliers. Could there be a recommendation for an annual or 6/12ly compulsory local review meeting? |
| 4 | British Association of Skin Cancer Specialist Nurses | General | Given the increased incidences of melanoma particular emphasis should be given to local health promotion activities to prevent skin cancers and facilitate early diagnosis thus leading to better outcomes.  Local health promotion teams should connect with skin cancer multidisciplinary teams to enhance outcomes.  The rapid introduction of new treatment modalities in the adjuvant and metastatic settings coupled with the rise in incidences of melanoma specific consideration needs to be given to survivorship. The latter should include recognition and management of the short and long-term physical and psychological effects of treatments/experiences. |
| 5 | NHSE Learning disability and Autism programme | General | - We strongly suggest reference to making reasonable adjustments: This is a legal requirement as stated in the Equality Act 2010 and is important to help you make the right diagnostic and treatment decisions for an individual. You can ask the person and their carer or family member what reasonable adjustments should be made. Adjustments aim to remove barriers, do things in a different way, or to provide something additional to enable a person to receive the assessment and treatment they need. Possible examples include; allocating a clinician by gender, taking blood samples by thumb prick rather than needle, providing a quiet space to see the patient away from excess noise and activity. |
| 6 | NHSE Learning disability and Autism programme | General | - We recommend including reference to the importance of Communication: Communicate with and try to understand the person you are caring for. Check with the person themselves, their family member or carer or their hospital or communication passport for the best way to achieve this. Use simple, clear language, avoiding medical terms and ‘jargon’ wherever possible. Some people may be non-verbal and unable to tell you how they feel. Pictures may be a useful way of communicating with some people, but not all. |
| 7 | NHSE Learning disability and Autism programme | General | - A person with a learning disability and some autistic people may not be able to articulate their response to pain in the expected way: for example, they may say that they have a pain in their stomach when the pain is not there; may say the pain is less acute than you would anticipate; or not say they are in pain when they are. Some may feel pain in a different way or respond to it differently: for example, by displaying challenging behaviour; laughing or crying; trying to hurt themselves; or equally may become withdrawn or quiet. People who use a wheelchair may have chronic pain. Understanding what is ‘normal’ for that person by talking to |
| 8 | NHSE Learning disability and Autism programme | General | - Be aware of diagnostic overshadowing: This occurs when the symptoms of physical ill health are mistakenly either attributed to a mental health or behavioural problem or considered inherent to the person’s learning disability or autism diagnosis. People with a learning disability or autism have the same illnesses as everyone else, but the way they respond to or communicate their symptoms may be different and not obvious. Their presentation with COVID-19 may be different from that for people without a learning disability or autism. |
| 9 | NHSE Learning disability and Autism programme | General | - Pay attention to healthcare passports: Some people with a learning disability and some autistic people may have a healthcare passport giving information about the person and their health needs, preferred method of communication and other preferences. Ask the person or their accompanying carer if they have one of these. |
| 10 | Norfolk and Norwich University Hospital/NDRS | General | cSCC rates in particular are increasing at a rapid rate over the last decade (GDO)  cSCC mortality rates have increased by 40% over the last decade  NDRS GDO report includes national incidence, survival and routes to diagnosis for all skin tumours. |
| 11 | Norfolk and Norwich University Hospital/NDRS | General | Also consider: What proportion of patients with melanoma who meet the criteria receive Sentinel lymph node biopsy, stage at presentation, mortality and survival would also be useful quality standards. Also % diagnostic biopsies and no. follow up appointments, 2WW conversion rates, % BCCs referred along the 2WW pathway. |
| 12 | Sanofi | General | Nationally agreed definitions are needed  Some of the draft quality statements refer to SCC skin cancers. Particularly, the statements highlight where SCCs require different clinical management. However, there can be variations in the definitions used for different NMSCs, potentially creating variation between services in how the quality statements are applied.  The definitions used for high-risk or advanced (locally advanced or metastatic) BCCs and SCCs vary between both locally adopted and national/European guidelines. Guidance differs on the distinguishing features/risk factors of skin lesions and the sub-groups that skin cancers should be grouped within. The British Association of Dermatologists and the European Association of Dermato-Oncology have set their own definitions of advanced and/or high-risk NMSC skin cancers, however there is a lack of UK consensus or agreed NICE definition for advanced NMSC within guidelines or Quality Standards i, ii. ,  In Sanofi led market research carried out last year with healthcare professionals involved in the treatment of skin cancer, a lack of consensus regarding definitions was highlighted as delaying diagnosis and having a negative impact on NMSC patient management iii.  Nationally agreed definitions across NMSC, especially for advanced disease, are required to provide greater clarity to clinicians and commissioners. This is also a principal requirement for setting and delivering many of the draft quality statements. But the Quality Standards cannot do this alone.  A comprehensive NICE guideline specific to NMSC, as the single source of best practice, must be developed to establish precise, nationally agreed definitions and management, across NMSCs, which also encompasses patients with advanced disease. These should provide an update to existing NICE guidelines where NMSC is discussed, to reflect current changes in practice. Subsequently, the Quality Standards should reflect this guidance, ensuring nationally agreed definitions align with all statements.  i Keohane SG, et al, 2020, British Association of Dermatologists guidelines for the management of people with cutaneous squamous cell carcinoma 2020. Available at: https://onlinelibrary.wiley.com/doi/full/10.1111/bjd.19621 (Accessed August 2023)  ii Stratigos, A, et al, 2020, European interdisciplinary guideline on invasive squamous cell carcinoma of the skin: Part 1. epidemiology, diagnostics and prevention. Available at: https://eado.org/medias/Content/Files/stratigos2020.cSCC.pdf (Accessed August 2023)  iii Sanofi Data on File |
| 13 | SKCIN | General | There need to be a standard definition for skin cancer definitions. Some of the draft quality statements refer to SCC skin cancers. Particularly, the statements highlight where SCCs require different clinical management. However, there can be variations in the definitions used for different NMSCs, potentially creating variation between services in how the quality statements are applied.  The definitions used for BCCs and SCCs, and their severity level, vary between both locally adopted and national guidelines. Guidance differs on the distinguishing features of skin lesions and the sub-groups that skin cancers should be grouped within. Melanoma and SCC are highlighted for referral and not severe BCCs ie BCC that present in difficult to treat areas for surgery purposes. The severity of case should be considered for all types of skin cancers.  Nationally agreed definitions across NMSC are required to provide greater clarity to clinicians and commissioners. This is also a principal requirement for setting and delivering many of the draft quality statements. But the Quality Standards cannot do this alone.  We know from feedback from patients the referral pathway differs greatly across England, and this impacts patient outcomes. |
| 14 | British Association of Dermatologists (endorsed by RCP) | Question 1 | Yes. |
| 15 | British Association of Skin Cancer Specialist Nurses | Question 1 | The quality standards reflect the key areas for quality improvement |
| 16 | Department of Health NI | Question 1 | Guidance should include the potential to utilise the skilled workforce in primary care who currently provide assessment and treatment for patients with routine skin conditions including eczema, psoriasis, acne and pigmented lesions.  Primary Care Elective Services were established in Northern Ireland in 2018. GPs with Enhanced Skills (GPES) provide assessment and treatment for a range of routine conditions within a primary care setting. This includes assessment and treatment across dermatology pathways.  GPES providing primary care elective dermatology services in a primary care setting are accredited in lesion identification including the use of dermoscopy for assessment of pigmented lesions. This has enabled a shift in activity from secondary to primary care where GPES can assess and treat a range of dermatology conditions. Furthermore, GPES are skilled and accredited to undertake minor skin excisions including the management of low risk basal cell carcinomas. Whilst capacity and a skilled workforce is available within secondary care to assess and treat low risk basal cell carcinomas funding to support the development of this service model is unavailable leaving patients languishing on secondary care waiting lists for treatment that could potentially be provided within a primary care setting.  NICE should look to expand both guidance and quality standards to incorporate the potential alternative models available across primary care settings for the assessment, treatment and management of skin cancer. |
| 17 | Sanofi | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Sanofi believes that the draft updates to the Skin Cancer Quality Standard do not go far enough on establishing improvement areas for non-melanoma skin cancer (NMSC). Whilst we welcome inclusion of squamous cell carcinoma (SCC) in Statements 2 and 4, Sanofi believes that further critical improvements in SCC and for other types of NMSC such as basal cell carcinoma (BCC) should be included.  There is a particular need to establish quality standards that relate to all types of NMSC given that at present, there is no up-to-date comprehensive national clinical guideline for NMSC iv, v. Multiple guidelines exist that support the referral, management and treatment of NMSC; Sanofi understands that clinicians across England and Wales are currently using at least seven different guidelines.  The lack of single national guideline may be contributing to disparities in quality of care across regions, varying clinical definitions of NMSC, and referrals can be inappropriate, delayed, or both. This is creating inconsistencies in patient experiences and outcomes. Notably, it also impacts time to diagnosis through lacking clarity on referral pathways. Timely diagnosis of NMSC and appropriate patient referral are vital for effective management and the best possible patient outcomes: late diagnosis can lead to tumours spreading and becoming more advanced.  This is a particular issue for advanced SCC. Whilst the 2006 NICE guideline outlines referral pathways for SCC, as a whole the guideline does not contain clear pathways for advanced SCC vi. This is a significant issue given the high risk of SCCs and the challenges in treating them vii.  In market research conducted by Sanofi in 2022, 97% of 190 clinicians (oncologists, dermatologists and surgeons) responding to the survey said that NICE should publish a specific national guideline on the referral and management of NMSC patients. 94% believed a national guideline would ensure high-quality care, consistent management and improved access to innovative therapies viii.  In the absence of comprehensive national guidance, a Skin Cancer Quality Standard that adequately represents the needs of NMSC patients, in particular those with high-risk disease, is fundamental to ensuring optimal and consistent care.  iv NICE, Improving outcomes for people with skin tumours including melanoma (update), May 2010. https://www.nice.org.uk/guidance/csg8/resources/improving-outcomes-for-people-withskintumours-including-melanoma-2010-partial-update-pdf-773380189 (Accessed August 2023)  v NICE, Improving Outcomes for People with Skin Tumours including Melanoma, February 2006. Available at: https://www.nice.org.uk/guidance/csg8/evidence/2006-guidelineimprovingoutcomes-for-people-with-skin-tumours-including-melanomarecommendations-and-evidence-pdf-2191950685 (Accessed August 2023)  vi NICE, Improving outcomes for people with skin tumours including melanoma, February 2006. https://www.nice.org.uk/guidance/csg8/evidence/2006-guideline-improving-outcomes-for-people-with-skin-tumours-including-melanoma-recommendations-and-evidence-pdf-2191950685 (Accessed August 2023)  vii Skin Cancer Foundation. Advanced Squamous Cell Carcinoma Treatment. Available at: https://www.skincancer.org/skin-cancer-information/squamous-cell-carcinoma/advanced-scc/ (Accessed August 2023)  viii Sanofi Data on File 2022 |
| 18 | SKCIN | Question 1 | Does this draft quality standard accurately reflect the key areas for quality improvement?  Skcin believes that the draft updates to the Skin Cancer Quality Standard fall short on establishing improvement areas for non-melanoma skin cancer (NMSC). Whilst we are pleased to see inclusion of squamous cell carcinoma (SCC) in Statements 2 and 4, we feel that further critical improvements in SCC and for other types of NMSC such as basal cell carcinoma (BCC) should be included.  There is a particular need to establish quality standards that relate to all types of NMSC given that at present, there is no up-to-date comprehensive national clinical guideline for NMSC. With skin cancer incidences rising the problem is highlighted. Skcin witness feedback from patients experiencing inconsistency in care across the England.  Varying clinical definitions of NMSC, and referrals we have found can be inappropriate. This is creating inconsistencies in patient experiences and outcomes. It also impacts time to diagnosis through lacking clarity on referral pathways. A timely diagnosis of NMSC and appropriate patient referral are vital for effective management and the best possible patient outcomes: late diagnosis can lead to tumours spreading and becoming more advanced.  The Skin Cancer Quality Standard does not adequately represents the needs of NMSC patients, in majority of cases nmsc is not life threatening, but there are patients with high-risk disease or severe cases or difficult to treat surgically that are neglected in the referral process and this needs to be addressed/considered |
| 19 | British Association of Dermatologists (endorsed by RCP) | Question 2 | All trusts collect high-risk lesion site data, and some cases will be discussed at the skin multidisciplinary team (MDT). All pathology data presently is being reviewed by Public Health England (PHE) to identify more accurate prevalence in the English populations.  Data is collected locally at diagnosis and updated as the care pathway changes. |
| 20 | British Association of Skin Cancer Specialist Nurses | Question 2 | All locally collected data feeds into national data sets. |
| 21 | Department of Health NI | Question 2 | Data is available on the use of dermoscopy for patients referred via the dermatology photo triage pathway. This currently includes those referred via the 2 week wait suspect cancer red flag pathway and as from mid-August 2023 will include those referred with a suspected basal cell carcinoma.  Information on the use of dermoscopy or inclusion of dermoscopy image can be extracted from the monthly data collated as part of the regional monitoring of pathway usage and uptake. |
| 22 | Sanofi | Question 2 | Is data for the proposed quality measures collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected*.*  *Data collection for NMSC is needed at both local and national level*  Despite the scale of the NMSC in the UK, accurate and reliable data collection on prevalence, routes to diagnosis, time to treatment and patient experience is lacking ix. For example, in England, the Cancer Patient Experience Survey and the National Cancer Analysis and Registration Service do not include NMSC cases x, xi  Poor data collection impacts on clinicians’ ability to organise services and deliver optimal patient care. Importantly, it also restricts the Quality Standards ability to assess improvements to NMSC management in England.  The current quality statements that refer to NMSC, acknowledge that there is no routine data available to assess delivery of care in line with the statements. Lacking and inconsistent data collection on NMSC has not been addressed, and as such this problem will persist for the updated Quality Standard. The absence of consistent and reliable data means the quality statements that refer to NMSC will be limited in their ability to optimise care for NMSC patients.  The updated Quality Standard should acknowledge and call for more and better-quality data collection for NMSCs nationally and locally. Whilst this is addressed, each quality statement should clearly outline what local data sources should be used for monitoring progress and ask that they are routinely collected if not done so already. The Quality Standards should also support efforts to consolidate local data on NMSC to enable the assessment and improvement of services.  ix National Cancer Registration and Analysis Service, Non-melanoma skin cancer in England, Scotland, Northern Ireland and Ireland.  Available at: http://www.ncin.org.uk/publications/data\_briefings/non\_melanoma\_skin\_cancer\_in\_england\_scotland\_northern\_ireland\_and\_ireland (Accessed August 2023)  x National Cancer Intelligence Network, National Cancer Registration and Analysis Service (NCRAS), Available at: http://www.ncin.org.uk/publications/reports/ [Accessed June 2023]  xi Cancer Patient Experience Survey, National Level Data Tables, 2021. Available at: https://www.ncpes.co.uk/2021-national-results/  [Accessed July 2023] |
| 23 | SKCIN | Question 2 | Is data for the proposed quality measures collected locally? Please include in your answer any data sources that can be used or reasons why data cannot be collected.  Data collection for NMSC is needed at both local and national level  Despite the rising cases of the NMSC in the UK, accurate and reliable data collection on prevalence, referral process, time to treatment and patient outcome is lacking and has been for many years. Now more than ever we need to have a solution for improved data collection, the absence of such data will mean the quality standards will be limited in their ability to optimise patient care.  Poor data collection impacts on clinicians’ ability to organise services and deliver the best patient care. In addition, no data ultimately means there is little or no measure in place to measure effectively the quality standards. We make call for improved data collection of NMSC in the UK, to help better manage services and patient care. The true burden of the disease of nmsc is also not fully known and consistently underestimated and services will continue not meet demand. Over 50% of NHS trusts are not meeting their 18 week referral for NMSC referrals |
| 24 | Biocartis | Question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?  Biocartis suggest that local pathology centres can provide accurate and timely BRAF results for all melanoma tissue samples from people with stage IIC to IV primary melanoma with minimal impact on resources by utilising automated targeted BRAF mutation tests such as the Biocartis IdyllaTM BRAF Mutation Test. |
| 25 | British Association of Dermatologists (endorsed by RCP) | Question 3 | The quality standards are already being delivered as part of the cancer organisation structure for skin cancer services and were implemented from the recommendations from the NICE skin cancer IOG 2006, the Manual for Cancer Services – Skin Measures (2008-2014), the NICE cancer referral guidelines and BAD clinical guidelines for skin cancer. There is a need for better quality surveillance outcomes for cancer services from NHS England and collaboratively with cancer alliances |
| 26 | Department of Health NI | Question 3 | Given the ongoing pressures across the HSC resources are required to support realisation of the standards and measures outlined in the guidance. This includes resources allocated to primary, secondary and community care.  Recurrent funding to sustain the primary care elective model is required to support this guidance and quality standard as this model enables the assessment and treatment of patients with routine dermatology conditions in primary care reducing demand on secondary care services.  Funding would also be required to upskill the existing primary care workforce in the management of low risk basal cell carcinomas. Enhancing the existing workforce would enable the redirection of traditionally secondary care referrals to primary care GPs with Enhanced Skills (GPES) reducing the pressure on secondary care dermatology services.  Training in the use of dermoscopy and funding for the procurement of dermoscopy equipment would be required to ensure all patients presenting with a suspected pigmented lesion could be examined with dermatascope and associated images to be captured and transferred to secondary care to support the e-triage and assessment process.  Clinical teams should be encouraged to use standardised report when undertaking dermoscopy examination, this would be a useful template to share with those completing training in the use of dermatascope in clinical practice.  The standardised report should include:   1. Relevant clinical information about the patient E.g. age, history of the lesion, personal and family history of skin cancer and the presence of atypical naevi (recommended). 2. Clinical description of the lesion Location, symmetry, borders, colour, size, elevation (recommended). 3. The two-step method List dermoscopic criteria that differentiate melanocytic from non-melanocytic tumours (I consider this optional). 4. Dermoscopic description Use the standardised terms listed in the Dermoscopy Consensus Report published in 2003, or terminology of modified pattern analysis, and define any new term used. 5. Algorithm used Name which algorithm was used to differente between benign and malignant melanocytic tumours (optional). 6. Imaging equipment and magnification State the brand name and manufacturer of the device (optional). 7. Images Include clinical and dermoscopic views of the tumour (optional). 8. Diagnosis State the diagnosis or differential diagnosis (recommended). 9. Suggested management Management of the lesion may include follow-up, biopsy or excision (recommended).   Comments for the pathologist It may be useful to orientate the lesion to guide appropriate sectioning of the specimen when it is excised (optional). |
| 27 | SKCIN | Question 3 | Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.  A review of national services and best practice is needed to level up services across England. The huge variance across England in service standards, we know this from our patient community and published reports. Without investment services will fail. |
| 28 | British Association of Dermatologists (endorsed by RCP) | Statement 1, rationale | This draft quality standard does not distinguish between primary and secondary prevention. The latter needs a clear, simple, memorable and powerful message that enables people to readily identify lesions that might be skin cancer- this message needs to be targeted. There needs to be a clear pathway to diagnosis for the policy to have a memorable impact. |
| 29 | British Association of Dermatologists (endorsed by RCP) | Statement 1, measures | The proportion of stage 1 and 2 melanomas as a fraction of the total is not a plausible outcome measure. Firstly, there will be a long time-lag between making changes that might affect incidence and any such change occurring. Secondly, it is insensitive. There are many other reasons why such a variable might either increase or decrease, both locally and nationally. How will NICE distinguish these with evidence? It is important to recognise that the first diagnosis in nearly all melanomas is either stage 1 or 2. |
| 30 | British Association of Plastic Reconstructive and Aesthetic Surgeons | Statement 1 | Would be useful for a statement about commissioner funding for promotion activity |
| 31 | British Association of Skin Cancer Specialist Nurses | Statement 1 | Strategies should also focus on raising public awareness of skin cancer signs and symptoms. Evidence should be provided of robust educational campaigns across local populations, including educational establishments, GP practices to include in NHS Health Check, community events, etc. |
| 32 | Norfolk and Norwich University Hospital/NDRS | Statement 1 | Stage 1 vs stage II is also important given the difference seen in survival and this is where the greatest impact could be made in terms of prevention campaigns. Stage I MM 5 year net survival is around 99% compared to stage II is around 85% (NDRS Get data out 2023) only a few hundred patients each year present at stage III or IV compared around 10,000 stage I and 4000 stage II and so identifying the proportion who present at stage I not just stage I or II will be more clinically important than stage I+II vs III+IV. |
| 33 | Sanofi | Statement 1 | Integrated care boards work with local partners to implement strategies to prevent skin cancer and raise awareness of the risks of sunlight exposure in at-risk groups. [new 2023]  Strategies to raise awareness of skin cancer and sun safety measures are important for preventing cases of skin cancer and we welcome a focus on this within the quality standard.  However, the draft statement only seeks to measure progress against this by looking at the proportion of melanoma patients diagnosed at stage 1 or 2. The comparable statement in the current Quality Standard refers to the diagnosis of both melanoma and NMSC.  In 2019, Sanofi conducted market research with the public on NMSC. We found that public awareness and knowledge of NMSC is low xvi.  o 69% of 3600 respondents did not recognise NMSC as a form of skin cancer  o 38% did not know what the risk factors of NMSC are  o 66% of UK adults think that the government could do more to raise awareness and help prevent skin cancer  o 40% of UK adults were not confident about identifying the signs of the disease, and when presented with the four most common symptoms (a scab or sore that won’t heal, a scaly or crusty patch of skin, a flesh-coloured bump that grows, or a volcano like growth), just 23% were able to correctly identify them.  It is important that the measurement of statement 1 is updated to include NMSC, as it is clear there is still significant progress to be made on public understanding and awareness of this type of skin cancer.  xvi Sanofi Data on File 2019 |
| 34 | SKCIN | Statement 1 | The statement states to work with local partners and does not mention charities. Skcin work locally and nationally, and we also work with cancer alliances. The suggested wording should be key stakeholders. There are only 3 major skin cancer charities, Skcin, Melanoma UK and Melanoma Focus.  The statement covers two aspects prevention and risks and does not mention early detection or sun safety advice specifically. The definition at the end of the document is more specific and does include skin checking and mentions approaches to protecting the skin, but to include this under this definition is misleading and confusing.  Early detection is key with skin cancer for improved patient outcomes and this aspect can be highlighted through the promotion of monthly skin checking, which is a key element of our public messaging. Finally, the words sunlight exposure is not specific, skin cancer can be caused by sunbeds and artificial UV. Throughout the whole document risks of sunlight exposure is used.  The quality statement suggestion would therefore be:  Integrated care boards work with key partners and charities to implement strategies to prevent skin cancer, raise awareness of the risks of over exposure to uv, promote sun safety and early detection in at risk groups.  The rational section does not include “working with charities.  In addition, pharmacists have been highlighted, most pharmacists have little or no experience/expertise to offer on this topic of skin cancer. Skcin also work with pharmacies and healthcare teams to provide skin cancer surveillance training. The key stakeholders, such as pharmacists can be useful for amplifying campaigns. Skcin have developed pharmacy training module for pharmacists as they could be key and important groups to work with to help with this aspect of health promotion and intervention, particularly in relation early detection of skin cancer.  Charities offer significant expertise and well as robust solutions for commissioners which is being overlooked in the guidance.  In the draft statement, the measure of impact of the work and actions by integrated care boards, only seeks to measure progress against this by looking at the proportion of melanoma patients diagnosed at stage 1 or 2. The comparable statement in the current Quality Standard refers to the diagnosis of both melanoma and NMSC. Therefore, measures for both should be in place for quality standard 1.  Under: What the quality statements means to different people. The guidance seems to reiterate risk of sunlight and raising awareness of skin cancer and seems to omit and make reference to sun safety or early detection. These are key elements and need to be included separately. This was highlighted above.  Suggested inclusions in RED below  Service providers (such as local authorities) ensure that they work with integrated care boards to address local needs for improving skin cancer awareness in at-risk groups, identified by a joint strategic needs assessment. **They should ensure training is provided to public health practitioners and health care professionals covers the risks of over exposure to uv and the importance of conveying consistent, tailored messages relating to sun safety and the need for skin checking.**  Public health practitioners and healthcare professionals (such as members of the local cancer alliance, local skin cancer multidisciplinary team and community pharmacists) support local health promotion activities that focus on raising awareness of skin cancer and **the risks of over exposure to uv in at-risk groups, sun safety and early detection.** They deliver consistent, tailored messages to those at-risk groups.  Definitions of terms used in this quality statement.  Raise awareness of the risks of sunlight exposure  Communication of consistent, balanced messages about sunlight exposure, including risks from excessive exposure. This should 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 at-risk groups, including children and young people, and according to people’s skin type  approaches to protecting skin  checking for possible signs of skin cancer – this should have separate definition and this not feature “under raise awareness of risks of sunlight  clarifying common misconceptions about sunlight exposure **and uv radiation from sunbeds**  Public health practitioners and healthcare professionals (such as members of the local cancer alliance, local skin cancer multidisciplinary team and community pharmacists) support local health promotion activities that focus on raising awareness of skin cancer and the **risks of over exposure to uv, sun safety and early detection with at risk and influential groups**. They deliver consistent, tailored messages to those at-risk groups. |
| 35 | British Association of Dermatologists (endorsed by RCP) | Statement 2 | The 2 week wait pathway also applies to lesions which are undiagnosed but may be malignant (as per the 2006 NICE IOG- Improving outcomes for people with skin tumours including melanoma). Some of the most serious skin cancers present in this way. This part of the pathway requires much greater publicity. |
| 36 | British Association of Dermatologists (endorsed by RCP) | Statement 2 | The denominator should be ‘the number of confirmed primary melanomas, cutaneous squamous cell carcinomas, and undiagnosed skin cancers’.  Process is not really a substitute for outcome. There may have been very long delays due to misdiagnosis followed by a late referral. |
| 37 | British Association of Dermatologists (endorsed by RCP) | Statement 2, audience descriptors | This statement appears very non-specific and will not help allay the increasing proportion of non-cancerous 2WW referrals and is not in line with 2WW referral guidance wording. Where A&G services are provided with a 2–5 day turnaround and the ability for consultants to upgrade to a 2WW, these A&G services should be the recommended referral route unless there is high suspicion of melanoma or SCC. |
| 38 | British Association of Skin Cancer Specialist Nurses | Statement 2 | In agreement |
| 39 | Department of Health NI | Statement 2 | The 2-week suspect cancer pathway has been fully endorsed and implemented across NI however the ongoing pressures across the health service means many people are not seen within the 2-week target.  The Dermatology Photo Triage Pathway provides an e-Referral solution which can easily and securely capture and transfer images, of the right quality, from Primary Care to Secondary Care, and facilitate dermatology photo triage clinical decision-making, with images for patients with a suspected skin cancer. This pathway runs alongside the traditional red flag suspect cancer referral pathway.  The pathway enables GPs to provide images “of a suspicious skin lesion” alongside the clinical information on a dermatology referral for e-Triage to all dermatology teams in all five Trusts across Northern Ireland. All images are captured using the locally designed “SMARTDerm” App which works with the existing clinical systems (CCG and NIECR) and includes notification of the outcome of e-Triage back to the referring GP.  The Dermatology Photo Triage e-Referral pathway for suspected cancer was fully implemented in all 319 GP Practices across NI in July 2022 following the successful pilot originally launched in 2020. There have been over 6000 referrals managed via the pathway since December 2021 with 94% uptake by Primary Care. Almost all referrals are triaged within 72 hours of being received by the Dermatology team.  As part of the regional expansion the suspect cancer photo triage e-Referral pathway was adopted and successfully implemented on the Action Cancer Big Bus model as of January 2023 enabling people to access the service at one of the Big Bus locations.  Work has also commenced on the expansion of the pathway to referrals for a suspected basal cell carcinomas (BCC)and the Photo Triage team through Primary Care leadership has revised the current NI cancer referral guidance to advise that all referrals for suspected BCC will be prioritised as “urgent”. Whilst this steps outside existing NICE NG12 guidance this is in line with current practice especially given the ongoing pressures on HSC services following the COVID pandemic. The revised guidance has been approved and endorsed by the Regional Dermatology teams, SPPG and NIGPC.  GPs are advised to refer patients with a ?BCC through the dermatology photo triage pathway attaching 3 images (standard, macro and dermosocopy) to the referral to support the e-Triage by the Consultant Dermatologist in secondary care.  The pathway enables the consultant to make an informed decision at the point of triage as to the management plan for each referral, enabling patients to be managed in the right place at the right time. |
| 40 | Norfolk and Norwich University Hospital/NDRS | Statement 2 | Aggressive rare skin cancers such as merkel cell carcinomas and also high risk BCCs have not been mentioned in the report |
| 41 | Primary Care Dermatology Society | Statement 2 | Skin cancer services are overwhelmed with benign lesions and inability to deliver the 2 week target in many areas. Firstly, education in Primary Care is paramount to refer appropriate lesions on a 2 week pathway and other pathways need development where urgent skin cancer is not suspected. Secondly in response to audit measures:  “Time between referral and assessment for people with suspected melanoma or squamous cell carcinoma” will be skewed due to limited specialists to assess vs. overwhelming lesion referral (when we know from data the vast majority of lesions referred are benign).  Secondly, ‘Time from referral for specialist assessment of suspected melanoma or squamous cell carcinoma to diagnosis or rule out’ should be amended, in view of delays from referral to assessment and missing 14d targets, to ‘Time from specialist assessment of suspected melanoma or squamous cell carcinoma to diagnosis or rule out’ as a more accurate measure. Likewise the next statement, ‘Time from referral for specialist assessment of suspected melanoma or squamous cell carcinoma to first definitive treatment’ should be amended to time from assessment to allow the challenging resources in areas especially where there is a paucity of skin cancer diagnosticians.  There needs to be an acknowledgement of insufficient Primary Care education in skin lesions, stemming from lack of education in medical schools, through to lack of Dermatology training in GP training schemes when GPs are expected that 25% of their consultations will be about skin, and lack of secondary care resources with insufficient number of Dermatologists and specialists such as skin cancer nurse specialists and GPwERs, to fulfil 2 week targets and not affect general Dermatology services.  Finally, in ‘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 cancer called melanoma or squamous cell carcinoma are referred for an assessment of their lesion by a specialist within 2 weeks’ the word large should be removed as urgent skin cancer can be ‘small’ and large is a subjective term. Sub -6mm melanomas and SCCs do exist and having an arbitrary size cut-off encourages over-referral when a rule is used as a black-or-white reason to refer. |
| 42 | Sanofi | Statement 2 | People with suspected melanoma or squamous cell carcinoma are referred using a suspected cancer pathway referral for an assessment within 2 weeks. [2016, updated 2023]  We are supportive of the amendment to Statement 2 to include SCC alongside melanoma.  This will enable national bodies to effectively monitor and assess the referrals through the pathway and prevent over-crowded specialist skin cancer services. |
| 43 | SKCIN | Statement 2 | People with suspected melanoma or squamous cell carcinoma are referred using a suspected cancer pathway referral for an assessment within 2 weeks. [2016, updated 2023]  We are supportive of the amendment to Statement 2 to include SCC alongside melanoma. |
| 44 | British Association of Dermatologists (endorsed by RCP) | Question 4 | Yes, teledermatology is widely in use. The 2 week wait (2ww) pathway includes specific guidance on teledermatology and guidance on the virtual management of patient using appropriate dermoscopy and macroscopic images. The patient can be diagnosed virtually by a consultant dermatologist or a member of their team, based on the appropriate receipt of clinical history and the above images. Some regions have community photography hubs for skin lesions with options for skin lesion Advice and Guidance (A&G) services, 18ww review or 2ww review. The virtual management of patients does not reduce overall time to assess the patient under 2ww rules. |
| 45 | Sanofi | Question 4 | For draft quality statement 2: The rationale, audience descriptors and definitions include reference to the use of teledermatology as an option to support a suspected cancer referral. Is this widely used and is it acceptable to be included in these sections?  There is broad consensus that teledermatology has and will be a positive for patient care, most notably through increasing capacity for patients who need face-to-face appointments xii.  By triaging cases virtually, teledermatology frees up clinicians’ capacity to focus on more complex and advanced cases xiii. Digital tools also streamline care by shortening waiting times, providing more flexibility in appointments for patients and ensuring equitable access to care xiv.  Cardiff and Vale University Health Board had a mandatory teledermatology route in place prior to the pandemic. Results from an evaluation questionnaire sent to GPs and dermatologists in this area clearly showed appreciation for the service, with the removal of unnecessary appointments, a fast-track route for urgent referrals and opportunities for GP’s professional development through their involvement in the consultant’s feedback xv.  Central to the successful use of teledermatology is the presence of guidance and sharing of best practice. The Quality Statement should embed the role of teledermatology in the pathway and signpost to learning platforms, such as the dermatology digital playbook, and British Association of Dermatology (BAD) resources.  xii British Association of Dermatologists (BAD), Teledermatology. Available at: https://www.bad.org.uk/clinical-services/teledermatology/ (Accessed August 2023)  xiii British Association of Dermatologists (BAD), Teledermatology. Available at: https://www.bad.org.uk/clinical-services/teledermatology/ (Accessed August 2023)  xiv Jones, K, et al, Teledermatology to reduce face-to-face appointments in general practice during the COVID-19 pandemic: a quality improvement project. BMJ Open Quality. 2020;11:e001789. doi: 10.1136/bmjoq-2021-001789  xv Poolworaluk, N, et al. Teledermatology for all? A service evaluation of mandatory teledermatology in Cardiff and Vale 2016-17. Future Health. 2020;J;7(Suppl 1):s14. doi: 10.7861/fhj.7.1.s14. PMID: 32455261; PMCID: PMC7241175. |
| 46 | SKCIN | Question 4 | For draft quality statement 2: The rationale, audience descriptors and definitions include reference to the use of teledermatology as an option to support a suspected cancer referral. Is this widely used and is it acceptable to be included in these sections?  A review is needed of the various model of care used national to establish a best practice. During Covid many Trusts were forced to adopt and introduce teledermatology both by private and inhouse suppliers and this should be considered more widely.  The use of dermoscopy in primary care and increasing the numbers trained in it may be very beneficial. As more GP surgeries utilise the practitioners that have additional diplomas/a special interest – being able to offer this may provide a benefit to patients as magnification to a trained clinical eye should make missed skin cancer numbers lower. Moreover, it is a non-invasive approach. This will directly reduce the number of referrals to specialists and therefore, biopsies. Dermoscopy may also be taught to family members of frail patients who may not be able to self-examine. This is likely to encourage lesion monitoring. In terms of training, at SKCIN – MASCED PRO training has been a success worldwide due to easy, virtual accessibility.  Teledermatology needs to become accessible to all service providers otherwise discrepancies will appear. Software will have to become standardised and enable users to take pictures in correct lighting and formal. It is also important to recognise teledermatology does exist and if an existing programme were to be used – is that a direct referral to a Dermatologist (and thus saving time) or to detector powered by AI. Implementing a change like this will make medicine more accessible – especially in parts of the country that are more rural or in those who are less able to travel to outpatient appointments.  Skcin are aware of many Trusts that have implemented both private and in house teledermatology services and these need national review and best practice standardised |
| 47 | British Association of Dermatologists (endorsed by RCP) | Statement 3, measures | To reflect the 2ww referral pathway and the use of photography, and patients should have photos taken of their skin lesions for their patient record. The statement should read: “People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy. Macroscopic and dermoscopic photographic images should be taken and added to the patient record.”  The same limitations apply as already described in Statement 1(see comment 18 below). This is not a plausible measure. |
| 48 | British Association of Plastic Reconstructive and Aesthetic Surgeons | Statement 3 | Dermoscopy (or magnification) should be used for all suspected skin cancers not just pigmented lesions. Differentiating between SCC and BCC or even non-pigmented melanoma is incredibly helpful for prioritisation of surgery |
| 49 | British Association of Plastic Reconstructive and Aesthetic Surgeons | Statement 3 | Should read ‘or magnification’ as many plastic surgeons use loupe magnification for examination of such lesions. |
| 50 | British Association of Plastic Reconstructive and Aesthetic Surgeons | Statement 3 | The statement: ”An assessment carried out by a doctor trained in the diagnosis of skin malignancy, normally a dermatologist, who is a member of either a local hospital skin cancer multidisciplinary team or a specialist skin cancer multidisciplinary team.” should have dermatologist or Plastic Surgeon. |
| 51 | British Association of Skin Cancer Specialist Nurses | Statement 3 | In agreement |
| 52 | Department of Health NI | Statement 3 | Referral from Primary to Secondary Care- Yes, the Photo Triage Pathway protocol stipulates the inclusion of a dermoscopy image. Referrals made via the pathway are referred using the Photo Triage protocol which forms part of the patient record.  A CCG referral destination has been established on the Primary Care clinical system complete with a minimum dataset which is completed by the GP at the time of referral. This destination is aligned to the secondary care Dermatology Speciality on the NI Electronic Care Record system.  This referral destination provides unique coding of referrals made via the pathway and enables the tracking of referrals from primary to secondary care. These referrals are captured centrally by the Photo Triage Programme Team and quarterly reports are provided to the Trusts, GPs and the Programme Board to detail uptake to the pathway at a Practice and Trust level, total referrals and associated outcomes following eTriage in secondary care.  The pathway requires GPs to take 3 photos at the point of assessment- standard, macro and dermoscopy along with indicating the site of the lesion on the medical stickman included. (as per BAD guidance)  As part of the monitoring the programme team undertake analysis of the referrals made via the pathway to track those referrals which do not include all images and information required. Further training is then provided to both primary and secondary care on the use of the pathway and the need to include all images required, including dermoscopy image.  Regional letter templates have been implemented across all Trusts for the outcomes of the pathway which form the feedback on the referrals to the referring GP.  In terms of general GP assessment for dermatology conditions, there is no requirement nor mechanism for the GP to record examination with a dermoscope unless this is stipulated within the clinical information provided in the referral. |
| 53 | Norfolk and Norwich University Hospital/NDRS | Statement 3 | Why not dermoscopy also non pigmented lesions? |
| 54 | Primary Care Dermatology Society | Statement 3 | Page 15 ‘An assessment carried out by a doctor trained in the diagnosis of skin malignancy, normally a dermatologist, who is a member of either a local hospital skin cancer multidisciplinary team or a specialist skin cancer multidisciplinary team’. There are parts of the country where there is not access to a Dermatologist and in many areas GPs with specialist skills (GPs with extended role / GPs with specialist interest in Dermatology) are part of specialist assessment. This comment should be expanded as: An assessment carried out by a doctor trained in the diagnosis of skin malignancy, such as a dermatologist or a GP with extended role (in Dermatology), who is a member of either a local hospital skin cancer multidisciplinary team or a specialist skin cancer multidisciplinary team’ |
| 55 | SKCIN | Statement 3 | People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy. [2016]  This is most definitely required. |
| 56 | British Association of Dermatologists (endorsed by RCP) | Question 5 | All patients being reviewed under 2ww should have dermoscopy coded at their face to face 2ww appointment. Hospital teams using their photography department to provide the dermoscopic and macroscopic images for patients referred under 2ww, should also endeavour to code the use of dermoscopy as part of this process. This provides a quality indicator for a service to ensure all patients where possible will be suitable for having a dermoscopy image of a suspected skin lesion. |
| 57 | British Association of Skin Cancer Specialist Nurses | Question 5 | In general, the use of dermoscopy is coded in patient records. It is important to point out that dermoscopy may be utilised across dermatology, surgery and oncology during planned or ad hoc skin surveillance. |
| 58 | SKCIN | Question 5 | For draft quality statement 3: Would examination by dermoscopy be coded in patient records?  This would be useful, but definitive. In order for standardisation, it would need to be coded in notes and patient records. However, dermoscopy is subjective, and how and what the HCP/Clinician extracts from an image. A code will help document the findings. It can then also be used for data collection and research purposes. For further development, a code may help with a national scoring system that will aid practitioners to refer correctly. |
| 59 | British Association of Dermatologists (endorsed by RCP) | Statement 4 | A more realistic statement would be: “People with melanoma or high and very high-risk squamous cell carcinomas requiring MDT review are supported by a skin cancer clinical nurse specialist throughout the course of their treatment pathway.”  Some skin cancer services provide holistic needs assessments to all patients with SCC but in practical terms this can be challenging given the strains on the nursing workforce and indeed the risk of low-risk SCC returning is very low (reflected in the SCC guidelines by a single follow up in these patients). All patients with low-risk SCCs are of course given contact details for nursing support but a holistic needs assessment may not be necessary. The above is more practical and reflective of the risks and guidance. |
| 60 | British Association of Skin Cancer Specialist Nurses | Statement 4 | In agreement. BASCSN highlights the importance of distinguishing between the different skin cancer nurse specialist roles which come under the domains of dermatology, surgery and oncology. For example, an Oncology Skin Cancer CNS will care for patients undergoing oncological treatment and have a background and training, specifically in oncology. |
| 61 | Department of Health NI | Statement 4 | Are patients given a choice as to whether they want to have a CNS assigned to them?  Are patients provided with detail as to what the CNS will do to support them?  Is there defined criteria as to what can interventions/support will be provided by a CNS according to the patient management plan?  Is primary care advised that a CNS has been allocated to a patient or the patient has been reviewed by a CNS?  Can the patient opt to have follow up or support from their GP rather than a CNS and resources aligned to GP for this support? |
| 62 | Norfolk and Norwich University Hospital/NDRS | Statement 4 | NCRAS COSD data on specialist nurse involvement is likely to be incomplete – perhaps check this |
| 63 | Primary Care Dermatology Society | Statement 4 | Differentiation needs to be made between melanoma and melanoma in situ, and squamous cell carcinoma that requires follow-up care, versus well-differentiated SCC, low-risk, that does not require further follow-up, as per recent guidelines (NICE melanoma and BAD SCC guidelines). |
| 64 | Sanofi | Statement 4 | People with melanoma or squamous cell carcinoma are supported by a skin cancer clinical nurse specialist. [2016, updated 2023]  Sanofi welcomes that the draft statement includes SCC patients as requiring support from a cancer clinical nurse specialist. |
| 65 | SKCIN | Statement 4 | People with melanoma or squamous cell carcinoma are supported by a skin cancer clinical nurse specialist. [2016, updated 2023]  Skcin welcomes that the draft statement includes SCC patients as requiring support from a cancer clinical nurse specialist. Our patient community needs this support. |
| 66 | British Association of Dermatologists (endorsed by RCP) | Question 6 | There is a requirement for all skin MDTs to have one skin cancer nurse with back-up. These are trained individuals who require a skillset which includes breaking the bad news to patients and a very supportive role to deal with the varying degrees of severity in skin cancer patients. Ideally not a role for an untrained clinical individual to focus on this area. The CNS role is not required for all skin cancer patients.  Additional resources would be needed to support patients with SCCs. Current resources can only support complex and metastatic SCCs. All melanoma patients are allocated a Skin CNS. |
| 67 | SKCIN | Question 6 | For draft quality statement 4: Should the statement include support from a clinical nurse specialist for all people with melanoma and squamous cell carcinoma, or are there some people who would not be assigned a clinical nurse specialist?  Ideally all both patients should have access to CNS. Support from a Skin Cancer CNS is important for patients throughout their treatment journey. |
| 68 | British Association of Dermatologists (endorsed by RCP) | Question 7 | Yes, it would be beneficial to help define the role and help with the continued recruitment into these roles to ensure ongoing stability for departments. The CNS role is to support patients with a range of skin cancers, including those requiring continued management and follow-up and those receiving radiotherapy and chemotherapy treatment external to the department. Patients receive support from a CNS from diagnosis until discharge. |
| 69 | British Association of Skin Cancer Specialist Nurses | Question 7 | All patients with a diagnosis of melanoma or squamous cell carcinoma should have a named key worker and access to a Clinical Nurse Specialist. Patients should have access to a CNS throughout their treatment trajectory and during surveillance. Specific ‘crucial’ times for CNS input include initial diagnosis, treatment decision making and treatment initiation, relapse/progression and transfer to surveillance/survivorship. The CNS and/or Cancer support worker carry out a holistic health needs assessment (HNA) at key points during a patient’s journey and address any unmet needs, signpost and/or refer to supporting services.  The nursing team also undertakes an end of treatment review (EOT) which is sent to the patient and GP with the aim of providing information on potential treatment toxicities, short and long-term consequences of treatment, signs and symptoms of recurrence and any actions that need to be taken. This document is available to share with other health care professionals and services.  It is also important to recognise that nurse roles are broadening to include nurse consultants and advanced clinical practitioners in line accordance with Health Education England. Advanced Clinical Practitioners and Nurse Consultants are highly experienced |
| 70 | British Association of Skin Cancer Specialist Nurses | Question 7 | CNS outcomes should include enhancing quality of life for patients with a diagnosis of melanoma or SCC and enhancing recovery post-treatment. Improving patient experience throughout treatment, follow-up and survivorship. The National Cancer Patient Survey collects data on patients’ experience of cancer care and treatment. In addition, patient reported outcome measures should be collected at a local level. |
| 71 | Department of Health NI | Question 7 | Same as above |
| 72 | Norfolk and Norwich University Hospital/NDRS | Question 7 | Specialist nurse involvement should be from time of diagnosis, this is when their input is most useful |
| 73 | Sanofi | Question 7 | For draft quality statement 4: Should the quality measures include specific times during the care pathway that a person with skin cancer would receive support from a clinical nurse specialist? If so, when would this be?  Support from a Skin Cancer CNS is important for patients throughout their treatment journey. There are points in the pathway where access to a clinical nurse specialist is especially critical. At minimum, patients should be given access to a CNS at key moments in their pathway. |
| 74 | SKCIN | Question 7 | For draft quality statement 4: Should the quality measures include specific times during the care pathway that a person with skin cancer would receive support from a clinical nurse specialist? If so, when would this be?  At keys points in the pathway where access to a clinical nurse specialist is especially critical ie diagnosis or treatment option stage. Melanoma Focus have a patient support line managed by trained nurses and they too are campaigning for more skin cancer nurses nationally. Resourcing/workforce planning is challenge in many areas of the NHS |
| 75 | Biocartis | Statement 5 | The draft quality statement 5 states it is required that BRAF analysis should be carried out on melanoma tissue samples from people with stage IIC to IV primary melanoma. Early determination of BRAF status helps to optimise the use of targeted treatments and may speed up decisions about treatment for relapsed melanoma. Also, referring to the skin cancer briefing paper statement that 94.0% of patients with skin cancer were treated within 31 days when the required operational standard for wait for first treatment is 96%. An improvement is required and one of the areas causing delays is genetic testing and the turnaround time for reporting BRAF mutation status. Referring also to the skin cancer briefing paper section 4.2 which states that stakeholders note a large variation in the use of genetic testing and the availability and use of the National Test Directory for Cancer. Biocartis suggest investigating recommending the use of targeted BRAF mutation tests, such as the IdyllaTM BRAF Mutation Test (www.Biocartis.com), at local pathology centres as this would take the pressure off the GLH’s, significantly reduce turnaround time and time to treatment and ensure all patients receive timely test results. Section 4, page 88 of the skin cancer briefing paper states 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. The IdyllaTM system requires no specialist staff or laboratory to provide a molecular result and would ensure easy access for all hospitals to timely BRAF results. Stakeholders highlighted results from a survey of fellows of the Royal College of Pathologists in 2021 that more than 50% of fellows had not accessed the National Genomic Test Directory for Cancer and two thirds had to take on new work generated by genomic testing. More than 1 in 3 members indicated that they did not perform genetic tests on all samples that met national eligibility criteria. No published studies on current practice were highlighted for full skin assessment, genetic testing. These areas are based on stakeholder’s knowledge and experience. There are a number of NHS England hospitals using the IdyllaTM BRAF mutation test who could be contacted for their opinions on the system and to share their experiences. The IdyllaTM BRAF mutation test requires minimal input from pathologists and Biomedical scientists and would enable more trusts to meet the national testing requirements. In the briefing paper discussion on resource impact where BRAF analysis of melanoma tissue samples from people with stage IIA or IIB primary melanoma was discussed (NG14, recommendation 1.3.9), it was noted there would be some extra resource needed within pathology departments to prepare the samples for BRAF testing and to enable treatment to be started sooner and at an earlier stage of the melanoma. Use of the fully automated IdyllaTM system would require minimal, if any, additional resources for the local pathology department whilst enabling a more timely treatment initiation for all patients. Biocartis suggest that the use of targeted gene tests for BRAF testing at local pathology centres will be assessed during this consultation. Biocartis suggest that the use of targeted gene expression tests at local pathology centres is for improved time to treatment is a key area for quality improvement. |
| 76 | British Association of Plastic Reconstructive and Aesthetic Surgeons | Statement 5 | This only mentions IC and upwards. In last year’s NICE guidance stage IA &B have consider BRAF and this guidance should follow suit. |
| 77 | British Association of Skin Cancer Specialist Nurses | Statement 5 | In agreement |
| 78 | Department of Health NI | Statement 5 | For secondary care |
| 79 | Merck Sharp & Dohme (UK) Ltd | Statement 5 | Stage IIB melanoma is also considered at high risk of recurrence and this should be reflected throughout the document. Resected Stage IIB patients may be eligible for adjuvant treatment to reduce this risk, in line with NICE TA837. To ensure consistent messaging around the recurrence risks between TA837 and the quality standard, and enable appropriate and fast treatments to be administered more rapidly if the melanoma recurs, it seems reasonable to also conduct BRAF testing of stage IIB tumours, assuming that this does not have a substantial impact on NHS resources. |
| 80 | Norfolk and Norwich University Hospital/NDRS | Statement 5 | NCRAS molecular genetics data data lacks immunohistochemistry results which some centres perform instead of molecular genetics to assess BRAF status. |
| 81 | Biocartis | Question 8 | Referring to Question 8 For draft quality statement 5: What are the outcomes associated with this quality statement and can these be measured using routinely collected data? The draft quality statement 5 states it is required that BRAF analysis should be carried out on melanoma tissue samples from people with stage IIC to IV primary melanoma. Early determination of BRAF status helps to optimise the use of targeted treatments and may speed up decisions about treatment for relapsed melanoma. Biocartis suggest that not all available data has been collected regards methods of determining BRAF mutation status. Targeted gene mutation tests (e.g. Biocartis IdyllaTM BRAF Mutation Test, www.biocartis.com) are available that can be used at local pathology departments providing accurate and timely results to speed up treatment decisions. The Biocartis IdyllaTM system is currently used by a number of UK Hospital Pathology departments for BRAF V600 testing. Immunohistochemistry is considered as the first test to choose for BRAF V600E testing [NICE’s guideline on melanoma, evidence review A: genetic testing for melanoma, and recommendations [1.3.10, 1.3.11 and 1.3.12], Biocartis suggest this should be reviewed based on new technologies available for genetic testing of all actionable and prevalent BRAF V600 mutations including BRAF V600E2/D/K/R/M. Testing with the IdyllaTM BRAF Mutation Test enables detection of all actionable BRAF mutations, V600E/E2/D/K/R/M. The IdyllaTM BRAF Mutation test can provide a rapid fully automated result within 90 minutes with only 2 minutes hands on time and requiring a minimal skill level for use. A large number of publications are available demonstrating a high concordance for this test compared to routine methods and demonstrating that local and decentralised testing can improve patient outcome. Publications including: Finall et al. Improving care of melanoma patients through efficient, integrated cellular-molecular pathology workflows using tissue samples with low tumour nuclear content. J Clin Path. 2022 Apr; Nkosi et al. Utility of Select Gene Mutation Detection in Tumors by the IdyllaTM Rapid Multiplex PCR Platform in Comparison to Next-Generation Sequencing. Genes (Basel). Apr 2022; Melchior et al. Multi-center evaluation of the novel fully-automated PCR-based IdyllaTM™ BRAF Mutation Test on formalin-fixed paraffin-embedded tissue of malignant melanoma. Exp Mol Pathol. 2015 Dec; 99(3): 485-491. 148; Barel F et al. Evaluation of a Rapid, Fully Automated Platform for Detection of BRAF and NRAS Mutations in Melanoma. Acta Derm Venereol. 2018 Jan 12; 98(1): 44-49. Use of a rapid, targeted mutation detection test enables Service providers to ensure that systems are in place to provide BRAF analysis of the tumour for all patients with stage IIC to IV primary melanoma. Healthcare professionals can arrange BRAF analysis of the tumour for people with stage IIC to IV primary melanoma and state the preferred tissue block for analysis and complete the analysis on site with no need to transport the block, enabling all patients to receive BRAF testing. Local testing for BRAF mutations can help to speed up treatment decisions. Biocartis suggest that the use of targeted gene expression tests at local pathology centres is for improved time to treatment is a key area for quality improvement. |
| 82 | British Association of Dermatologists (endorsed by RCP) | Question 8 | BRAF analysis is an important factor in deciding systemic therapies so early analysis will not delay any potential systemic treatment. This data should be captured by COSD. The Cancer Outcomes and Services Dataset (COSD) specifies the items to be submitted electronically by service providers to the National Cancer Registration and Analysis Service (NCRAS) on a monthly basis, for all incidents of cancer. That data is not currently collected. Data can be collected for the genomics, but immunohistology data will be hard to gather.  Any BRAF or melanoma tissue samples from people diagnosed at a local level will be referred on to the SSMDT. The patient will be referred on to the SSMDT for further treatment once their case has been discussed. BRAF testing for melanoma is a specialised service, as per the NHS national genomic test directory for cancer.  All BRAF results are recorded in locally held patient database and in patient electronic records. |
| 83 | British Association of Skin Cancer Specialist Nurses | Statement 6 | In agreement |
| 84 | Merck Sharp & Dohme (UK) Ltd | Statement 6 | As stated in response to Statement 5, MSD are unclear why the management of stage IIB melanoma in terms of imaging differs to that for stage IIC given the active treatment options are the same. Please also clarify why the imaging schedule for patients 25 and over is for stage IIC and above while for under 25s (and pregnant women) imaging is also offered for stage IIB melanoma.  We are concerned this age dichotomy may lead to unintended differences in the levels of care for early-stage disease based on age which contrasts NICE’s commitments to issue recommendations that do not result in potential unintended inequalities. We therefore ask NICE to provide more information around the evidence that was used to substantiate the original recommendations around the level of imaging by melanoma disease sub-stage. |
| 85 | British Association of Dermatologists (endorsed by RCP) | Question 9 | The priority area is the staging scan rather than the type of scan. |
| 86 | British Association of Skin Cancer Specialist Nurses | Question 9 | Priority area for quality improvement should include the staging scan |
| 87 | SKCIN | Question 9 | For draft quality statement 6: What is the priority area for quality improvement; the staging scan or the type of scan (such as CE-CT and MRI)?  Accurate staging is needed for effective treatment and appropriate referral. The type of scan should depend on the disease stage as a cancer that is detected early may not require one. A study showed that PET scans in SLNB positive patients can be nonconclusive or negative. However, this does change with those who have higher stages of melanoma.  The priority area for quality improvement should lie in the staging scan. The detection of lymph node involvement is a direct prognostic factor and has a higher sensitivity. |
| 88 | Biocartis | Additional areas | Referring to the skin cancer briefing paper section 1.4.3 which states that Sentinel Lymph Node Biopsy SLNB should be considered 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. It is noted that over 80% of SLNB are negative, especially in a population with a Breslow thickness of 0.8mm to 1.0mm. Biocartis suggest that the use of gene expression tests should be considered by the consultation for the reduction of unnecessary SLNB surgeries. The use of gene expression tests has been proven to reduce the need for SLNB surgeries with many resulting advantages in cost, patient care and patient outcome. One such gene expression test is the Biocartis Merlin test (www.biocartis.com) distributed in partnership with Skyline DX. Use of the Biocartis Merlin test would significantly reduce the number of patients eligible for SLNB and we recommend that this gene expression test is further investigated. Implementation of the Biocartis Merlin test would significantly reduce the number of SLNB surgeries, the patient impact of unnecessary surgery, the costs associated with the SLNB and the workload of pathology departments. The Biocartis Merlin test is currently a manually performed qPCR test however, the test is soon to be launched on the IdyllaTM platform with the associated advantages then of a fully automated test requiring minimal hands on time and with a rapid turnaround for fast treatment decisions. There are a number of publications available on the use of the Biocartis Merlin test and a number of UK trusts are currently in the process of validating it: Validation of a clinicopathological and gene expression profile model to identify patients with cutaneous melanoma where sentinel lymph node biopsy is unnecessary. Johansson et al. 2021. European Journal of Surgical Oncology; Deselecting melanoma patients for sentinel lymph node biopsy during COVID-19: clinical utility of tumor molecular profiling. Meves & Eggermont 2020. Mayo Clin Proc Inn Qual Out; Using the Merlin Assay for reducing sentinel lymph node biopsy complications in melanoma: a retrospective cohort study. Hieken et al. 2022. International Journal of Dermatology. Biocartis suggest that the use of Gene expression tests for the reduction of unnecessary SLNB is a key area for quality improvement. |
| 89 | British Association of Dermatologists (endorsed by RCP) | Question 10 | There shouldn’t be challenges to implementing the guidance as long as each unit has a well-functioning SSMDT supported by the Dermatology department. Resistance to change, staffing and clinic resources may prove challenging for some departments. |
| 90 | Department of Health NI | Question 10 | Resources to support the shift of activity from secondary to primary care is essential. Whether this is a redeployment of funding from secondary care Trusts to primary care to support the transfer of patients or identification of new funding.  Enabling an agreed cohort of patients to be managed by skilled GPs in primary care delivers on real transformation and releases the pressure on secondary care services whilst enabling patients to be appropriately managed in a primary care setting.  NICE QS130 Low-risk basal cell carcinoma can sometimes be managed by GPs in the community, which can be more convenient for patients. Treatment in the community can also frequently be provided at a lower cost and free up capacity in hospitals. However, it is essential that this is balanced with ensuring that care offered in the community is as safe and effective as that in hospital. Maintaining and auditing records of their caseload can help in demonstrating competence.  Implementing the management of low risk BCCs in primary care by skilled GPs with enhanced skills would free up outpatient and surgical capacity within secondary care. This would enable improved management of patients requiring specialist assessment and treatment. Work is ongoing to implement this quality standard in Northern Ireland given the skilled primary care workforce available. Discussions are going with Secondary Care Trusts to enable Primary Care input to the skin cancer multi-disciplinary team.  If implemented this would not only implement this NICE quality standard but would also improve access to treatment for patients with a low risk basal cell carcinoma diagnosis.  Understanding the role of the CNS is essential to ensure that those patients who require CNS input receive this support.  Defining the CNS role and the input required aligned to a diagnosis should be a priority for health care providers.  Patient choice should be paramount when deciding CNS input and patients should be fully informed of what support is available from a CNS during and beyond their diagnosis. |
| 91 | SKCIN | Question 10 | What are the challenges to implementing the NICE guidance underpinning this quality standard? Please say why and for whom. Please include any suggestions that could help users overcome these challenges (for example, existing practical resources or national initiatives).  In relation to quality standard 1  Local communities have poor or no such dedicated resources for providing skin cancer prevention and early detection tools and assets to help develop local plans or initiatives/campaigns they rely on local authority and or Cancer Alliance who then in turn resort to charities with specialist knowledge to develop campaigns and initiatives. The campaigns and initiatives developed by Integrated care boards/local authority tend to be ad hoc aimed at mass audiences and lack a direct call to action or a specific goal. Skcin is inundated with requests nationally for community support. There needs to be a mechanism to signpost Commissioners and Integrated care boards to the solutions available.  Skcin’s national educational intervention programmes can capture data.  Skcin also provide educational interventions that can be measured by participation in our national accreditations. Skcin can collect national data that can be shared. Ie number of primary schools engaged in our free Sun Safe schools programme or number of workplaces engaged with our Sun Safe Workplace programme or number of HCP enrolled in our melanoma and skin cancer early detection programme. Masced.www.masced.uk. The number of downloads on our Free App. Providing very useful data collection for Commissioners at Integrated care boards engage and participate with our accreditations at local and national level.  The ultimate measure of success should be lower incidences of skin cancer(nmsc/melanoma) but this may take some time to reflect in the figures, as skin cancer can occur at a significant time after exposure to uv even over many years’ time and this is why behavioural change over a period of time must be considered, as the effects of educational education will not be immediately evidenced.  Skcin’s Sun Safe schools accredited was reviewed as shared best practice on the NICE web site. But we can no longer locate this online. www.sunsafeschools.co.uk  Skcin call for clear commitment from all stakeholders to (The NHS, Public Health, Cancer Alliances, Health and Integrated care boards) to address this area of educational intervention for the next generation and the key at risk audiences and work collaboratively with Skcin. |

Note: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

## Registered stakeholders who submitted comments at consultation

* Biocartis
* British Association of Dermatologists (endorsed by Royal College of Physicians)
* British Association of Plastic Reconstructive and Aesthetic Surgeons
* British Association of Skin Cancer Specialist Nurses
* Department of Health NI – Strategic Planning and Performance Group, Directorate of Primary Care, Primary Care Elective and Photo Triage Programme Team
* Merck Sharp & Dohme (UK) Ltd
* NHSE Learning disability and Autism programme
* Norfolk and Norwich University Hospital/National Disease registration Service (NDRS)
* Primary Care Dermatology Society
* Sanofi
* Skcin