NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Skin cancer (update)

NICE quality standard

Draft for consultation

21 September 2016

13 July 2023

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| **This quality standard covers** preventing, assessing, diagnosing and managing skin cancer (melanoma and non-melanoma). It describes high-quality care in priority areas for improvement.  This quality standard will update and replace the existing quality standard on [skin cancer](https://www.nice.org.uk/guidance/qs130) (published September 2016). The topic was identified for update following the annual review of quality standards. The review identified:   * changes in the priority areas for improvement * updated guidance on melanoma.   For more information see [update information](http://www.nice.org.uk/guidance/qsXXX/chapter/Update-information).  This is the draft quality standard for consultation (from 13 July to 10 August 2023). The final quality standard is expected to publish in December 2023. |

# Quality statements

[Statement 1](#_Quality_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]**

[Statement 2](#_Quality_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]**

[Statement 3](#_Quality_statement_3:) People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy. **[2016]**

[Statement 4](#_Quality_statement_4:) People with melanoma or squamous cell carcinoma are supported by a skin cancer clinical nurse specialist. **[2016, updated 2023]**

[Statement](#_Quality_statement_5:) 5 People with stage IIC to IV primary melanoma have BRAF analysis of the tumour. **[2016, updated 2023]**

[Statement 6](#_Quality_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]**

In 2023 this quality standard was updated and statements prioritised in 2016 were updated (2016, updated 2023) or replaced (new 2023). For more information, see [update information](#_Update_information_2).

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| Questions for consultationQuestions about the quality standard **Question 1** Does this draft quality standard accurately reflect the key areas for quality improvement?  **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.  **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. Questions about the individual quality statements **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?  **Question 5** For draft quality statement 3:Would examination by dermoscopy be coded in patient records?  **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?  **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?  **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?  **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)? Implementing NICE guidelines **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). |

# Quality statement 1: Local health promotion activities

## Quality statement

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]**

## Rationale

Skin cancer is the most common form of cancer and, even though most types are preventable, its incidence is increasing. People can recognise changes to their skin in early stages of the disease, but some are still seeking help too late. Commissioners should adopt a consistent multiagency approach, working with partners such as local authorities, members of their cancer alliance or equivalent local partnerships, local skin cancer multidisciplinary teams and community pharmacies, to implement strategies to ensure consistent, relevant messages on the risks of sunlight exposure and increase the likelihood of behaviour change for people at increased risk of skin cancer.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Structure

a) Evidence that integrated care boards have an action plan that identifies key strategies to raise awareness of skin cancer and the risks of sunlight exposure in at-risk groups.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by integrated care boards, for example from an action plan.

b) Evidence of local campaigns to raise awareness of the risks of sunlight exposure in at-risk groups.

Data source: No routinely collected national data for this measure has been identified. Data can be collected by information recorded locally by integrated care boards and partners, for example from campaign materials such as posters, leaflets, skin-type charts, texts and social media messaging.

### Outcome

Proportion of melanoma diagnosed at stage 1 or 2.

Numerator – the number in the denominator diagnosed at stage 1 or 2.

Denominator – the number of melanomas diagnosed.

**Data source:** [NHS Digital's Cancer registration statistics, England](https://digital.nhs.uk/data-and-information/publications/statistical/cancer-registration-statistics) reports annual counts, age-specific and directly age-standardised rates of cancer incidence by ICD-10 codes including melanoma of the skin and stage at diagnosis.

## What the quality statement means for different audiences

**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 provided to public health practitioners and health care professionals covers the risks of sunlight exposure and the importance of conveying consistent, tailored messages.

**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 sunlight exposure in at-risk groups. They deliver consistent, tailored messages to those at-risk groups.

**Commissioners** ensure that they have a joint strategic needs assessment that includes skin cancer awareness in at-risk groups and working with partners such as local authorities and cancer alliances to address local needs. They identify local opportunities to raise awareness of the risks of sunlight exposure, such as identifying health, social care and other practitioners in contact with at-risk groups including in specific settings such as schools, workplaces, communal and leisure environments.

**People identified as at increased risk of skin cancer, or who should take extra care to avoid skin damage and skin cancer** are given advice about how to prevent skin cancer and how to recognise early signs, through health promotion activities from local services.

## Source guidance

[Community pharmacies: promoting health and wellbeing. NICE guideline NG102](https://www.nice.org.uk/guidance/ng102) (2018), recommendation 1.2.8

[Sunlight exposure: risks and benefits. NICE guideline NG34](https://www.nice.org.uk/guidance/ng34) (2016), recommendations 1.1.1, 1.1.14 and 1.1.15

## 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
* clarifying common misconceptions about sunlight exposure

[Adapted from [NICE’s guideline on sunlight exposure](https://www.nice.org.uk/guidance/ng34), recommendations 1.1.2 and 1.1.3]

### At-risk groups

* Groups of people who should take extra care to avoid skin damage and skin cancer, including:
  + children (particularly babies) and young people
  + people who tend to burn rather than tan
  + people with lighter skin, fair or red hair, blue or green eyes, or who have lots of freckles
  + people with many moles
  + people who are immunosuppressed (that is, they have less resistance to skin problems as a result of a disease or use of particular drugs)
  + people with a personal or family history of skin cancer (even if their natural skin colour is darker than that of the family member who had cancer).
* Groups who spend a lot of time in the sun and so are at increased risk of skin cancer, such as:
  + outdoor workers
  + those with outdoor hobbies, for example, sailing or golf.
* Groups with high, but intermittent, exposure to sunlight and who are therefore at increased risk of skin cancer. This includes people who sunbathe or take holidays in sunny countries.
* People frequently exposed to UV rays, including from a sunbed, before the age of 25.

[[NICE’s guideline on sunlight exposure](https://www.nice.org.uk/guidance/ng34), recommendation 1.1.1, [NHS website](https://www.nhs.uk/common-health-questions/lifestyle/are-sunbeds-safe/), accessed 30 June 2023, and expert opinion]

## Equality and diversity considerations

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

# Quality statement 2: Suspected cancer pathway referrals

## Quality statement

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]**

## Rationale

Timely referral to a specialist for assessment is important for a quick and accurate diagnosis of skin cancer. This may be referral for a face-to-face appointment or a virtual referral for assessment of images of the skin lesion. The specialist will usually be working as part of the local hospital skin cancer multidisciplinary team and can provide rapid diagnosis, treatment, management and follow‑up for most people with skin cancer.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of confirmed melanomas and squamous cell carcinomas that were referred using a suspected cancer pathway for an assessment within 2 weeks.

Numerator – the number in the denominator that were referred using a suspected cancer pathway for an assessment within 2 weeks.

Denominator – the number of confirmed melanomas and squamous cell carcinomas.

**Data source:** [The National Disease Registration Service (Get Data Out)](https://www.cancerdata.nhs.uk/routestodiagnosis) reports route to diagnosis for skin tumours including by GP referral, via a two-week wait pathway, emergency presentation or other outpatient appointment.

### Outcome

a) Time between referral and assessment for people with suspected melanoma or squamous cell carcinoma.

**Data source:**[NHS England's Cancer waiting times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) reports waiting times for people with suspected cancer including the 2-week wait for suspected skin cancer.

b) Time from referral for specialist assessment of suspected melanoma or squamous cell carcinoma to diagnosis or rule out.

**Data source:**[NHS England's Cancer waiting times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) reports waiting times for people with suspected cancer including the 28-day faster diagnosis standard for suspected skin cancer.

c) Time from referral for specialist assessment of suspected melanoma or squamous cell carcinoma to first definitive treatment.

**Data source:**[NHS England's Cancer waiting times](https://www.england.nhs.uk/statistics/statistical-work-areas/cancer-waiting-times/) reports waiting times for people with suspected cancer including the 31-day wait for first treatment for suspected skin cancer.

## What the quality statement means for different audiences

**Service providers** (such as GP practices, community hubs and secondary care services) ensure that systems are in place for people presenting with suspected melanoma or squamous cell carcinoma to be referred using a suspected cancer pathway for an assessment of their skin lesion within 2 weeks. If a virtual referral is used, services should have the necessary equipment and digital tools to take and transfer high-quality images of the skin lesion (see [NHS England’s A teledermatology roadmap: implementing safe and effective teledermatology triage pathways and processes](https://future.nhs.uk/canc/view?objectId=119935493)).

**Healthcare professionals** (such as GPs) ensure that they refer people with suspected melanoma or squamous cell carcinoma using a suspected cancer pathway for an assessment of their skin lesion within 2 weeks. In accordance with [[NHS England’s Faster diagnostic pathways: implementing a timed skin cancer diagnostic pathway, guidance for local health and care systems; 28-day best practice timed pathwa](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/)y](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/), referrals should include a locally agreed minimum dataset, and macroscopic and dermatoscopic images to an agreed standard and format if a virtual referral is used.

**Commissioners** ensure that services they commission refer people with suspected melanoma or squamous cell carcinoma using a suspected cancer pathway for an assessment of their skin lesion within 2 weeks. If virtual referral services are used locally, commissioners should ensure that services have the necessary equipment and digital tools required.

**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.

## Source guidance

[Suspected cancer: recognition and referral. NICE guideline NG12](https://www.nice.org.uk/guidance/ng12) (2015, updated 2021), recommendations 1.7.1, 1.7.2 and 1.7.4

[Improving outcomes for people with skin tumours including melanoma. NICE guideline CSG8](https://www.nice.org.uk/guidance/csg8) (2006), box 1, page 78

## Definitions of terms used in this quality statement

### Suspected cancer pathway referral

The skin lesion is assessed within the national target for cancer referrals. This was 2 weeks at the time of publication of the [NICE guideline on suspected cancer: recognition and referral](https://www.nice.org.uk/guidance/ng12). [NHS England’s Faster diagnostic pathways: implementing a timed skin cancer diagnostic pathway, guidance for local health and care systems; 28-day best practice timed pathway](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/) sets out how diagnosis of melanoma, squamous cell carcinoma and other rare skin cancers can be achieved within 28 days of a referral. [[NICE's guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12), terms used in this guideline]

### Assessment

Face-to-face clinical assessment or a virtual (teledermatology) referral by the local skin cancer team working within the multidisciplinary team. Face-to-face clinical assessment could take place in a standard skin cancer diagnosis clinic, one-stop skin cancer clinic, or community or hospital based ‘Spot’ clinic. An assessment following virtual (teledermatology) referral uses high-quality images including dermatoscopic images by a clinician experienced in teledermatology and teledermoscopy and supported by a systematic quality assurance process. [[NHS England’s Faster diagnostic pathways: implementing a timed skin cancer diagnostic pathway, guidance for local health and care systems; 28-day best practice timed pathway](https://www.england.nhs.uk/publication/rapid-cancer-diagnostic-and-assessment-pathways/)]

## Question for consultation

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?

# Quality statement 3: Dermoscopy

## Quality statement

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

## Rationale

Dermoscopy performed by suitably trained specialists is more sensitive and more specific in classifying skin lesions than clinical examination with the naked eye. It lessens the chance of missing a diagnosis of melanoma and reduces the number of unnecessary surgical procedures to remove benign lesions.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of pigmented skin lesions undergoing specialist assessment that are examined using dermoscopy.

Numerator – the number in the denominator examined using dermoscopy.

Denominator – the number of pigmented skin lesions undergoing specialist assessment.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

### Outcome

a) Pigmented skin lesions not selected for biopsy that are subsequently confirmed as melanoma.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of melanoma diagnosed at stage 1 or 2.

Numerator – the number in the denominator diagnosed at stage 1 or 2.

Denominator – the number of melanomas diagnosed.

**Data source:**[NHS Digital's Cancer registration statistics, England](https://digital.nhs.uk/data-and-information/publications/statistical/cancer-registration-statistics) reports annual counts, age-specific and directly age-standardised rates of cancer incidence by ICD-10 codes including melanoma of the skin and stage at diagnosis.

## What the quality statement means for different audiences

**Service providers** (such as local hospital multidisciplinary teams and specialist multidisciplinary teams) ensure that systems are in place for using dermoscopy during specialist assessment of pigmented skin lesions. Service providers should also ensure that those using dermoscopy have formal training.

**Healthcare professionals** (such as members of local hospital skin cancer multidisciplinary teams) undertaking specialist assessment of pigmented skin lesions ensure that they examine the lesions using dermoscopy. They should include formal training as part of their continuing professional development.

**Commissioners** ensure that the specialist services they commission have trained specialists who use dermoscopy to examine pigmented skin lesions.

**People with pigmented skin lesions (such as damaged or injured patches of skin or new, large, changing or unusual looking moles) that are being assessed by a specialist** have the lesions examined using a magnifying tool called a dermatoscope, which gives a more accurate view of the lesion.

## Source guidance

[Melanoma: assessment and management. NICE guideline NG14](https://www.nice.org.uk/guidance/ng14) (2015, updated 2022), recommendation 1.3.1

## Definitions of terms used in this quality statement

### Specialist assessment

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. [[NICE's guideline on improving outcomes for people with skin tumours including melanoma](https://www.nice.org.uk/guidance/csg8) (2006), key recommendations (page 8)]

**Dermoscopy**

Skin scoping or observing the skin directly using a special hand-held microscope, called a dermatoscope, usually performed on a mole or suspicious spot on living skin. Dermatoscopes can be adapted to allow a camera or smartphone to take static images of a skin lesion to assist in referral, assessment and triage of suspected skin cancer (teledermoscopy). [Adapted from [NICE’s guideline on improving outcomes for people with skin tumours including melanoma](https://www.nice.org.uk/guidance/csg8) (2006), glossary of terms; dermatoscope and dermatoscopy and expert opinion]

## Question for consultation

Would examination by dermoscopy be coded in patient records?

# Quality statement 4: Skin cancer clinical nurse specialist

## Quality statement

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

## Rationale

Skin cancer clinical nurse specialists can provide specialist guidance and support at all stages of care and treatment, including follow‑up. They can act as a source of information (including about local support groups) and provide psychological support.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

a) Proportion of people with melanoma or squamous cell carcinoma who are supported by a skin cancer clinical nurse specialist.

Numerator – the number in the denominator who are supported by a skin cancer clinical nurse specialist.

Denominator – the number of people with melanoma or squamous cell carcinoma.

**Data source:** The [National Cancer Patient Experience Survey](https://www.ncpes.co.uk/) reports the proportion of respondents with melanoma who had a specialist nurse as a main contact person within the team looking after them who would support them through treatment (Q17). No routinely collected national data for this measure has been identified for people with squamous cell carcinoma. Data can be collected from information recorded locally by provider organisations, for example from patient records.

b) Proportion of people with melanoma or squamous cell carcinoma who had a holistic needs assessment by a clinical nurse specialist.

Numerator – the number in the denominator who had a holistic needs assessment by a clinical nurse specialist.

Denominator – the number of people with melanoma or squamous cell carcinoma

**Data source:** [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset - Core](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd) records the offer and date of a holistic needs assessment, the point of the pathway where this was completed and who carried out the assessment, including whether this was a cancer nurse specialist (data item number CR7900, CR3140 and CR7910).

c) Proportion of people with melanoma or squamous cell carcinoma who had a personalised care and supportive planning assessment by a clinical nurse specialist.

Numerator – the number in the denominator who had a personalised care and supportive planning assessment by a clinical nurse specialist.

Denominator – the number of people with melanoma or squamous cell carcinoma

**Data source:** [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd) records the offer and date of a personalised care and supportive planning assessment, the point of the pathway where this was completed and who carried out the assessment, including whether this was a cancer nurse specialist (data item number CR8000, CR8010 and CR8030).

### Outcome

a) Quality of life among people with melanoma or squamous cell carcinoma.

**Data source:** The [Cancer Quality of Life survey](https://www.cancerdata.nhs.uk/cancerqol) reports quality of life reported by people with melanoma, including functional categories for quality of life (EORTC QLQ-C30), overall health (EQ-5D) and summary scores. No routinely collected national data for this measure has been identified for people with squamous cell carcinoma. Data can be collected from information recorded locally by provider organisations, for example from patient surveys.

b) Satisfaction with support received from skin cancer clinical nurse specialist, reported by people with melanoma or squamous cell carcinoma.

Numerator – the number in the denominator who were satisfied with the support received.

Denominator – the number of people with melanoma or squamous cell carcinoma supported by a clinical nurse specialist.

**Data source:**No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from patient satisfaction surveys. [The National Cancer Patient Experience Survey](https://www.ncpes.co.uk/) includes a number of questions and responses on satisfaction with cancer services by people with melanoma.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services or tertiary care services) ensure that local and specialist skin cancer multidisciplinary teams have a skin cancer clinical nurse specialist to support people with melanoma or squamous cell carcinoma under their care.

**Skin cancer nurse specialists** ensure that people with melanoma or squamous cell carcinoma are supported at diagnosis and all stages of treatment and follow-up. They provide advice and information and signpost to other relevant services, such as local support groups.

**Commissioners** ensure that there are enough skin cancer clinical nurse specialists to support all people with melanoma or squamous cell carcinoma.

**People with a type of skin cancer called melanoma or squamous cell carcinoma** have a skin cancer nurse specialist who can provide information, advice and support.

## Source guidance

[Melanoma: assessment and management. NICE guideline NG14](https://www.nice.org.uk/guidance/ng14) (2015, updated 2022), recommendation 1.1.4

[Improving outcomes for people with skin tumours including melanoma. NICE guideline CSG8](https://www.nice.org.uk/guidance/csg8) (2006), section 3 on organisation of skin cancer services

## Definitions of terms used in this quality statement

### Support

Skin cancer clinical nurse specialists provide information and patient advocacy to people with melanoma or squamous cell carcinoma from the time of diagnosis to treatment periods and during follow-up. They provide practical support, such as during the postoperative period, psychosocial support and advise on appropriate referral. They may perform risk factor assessment, holistic needs assessment and personalised care and support planning. They may also carry out skin cancer surveillance and follow-up clinics in parallel with an appropriately trained doctor. [Adapted from [NICE’s guideline on improving outcomes for people with skin tumours including melanoma](https://www.nice.org.uk/guidance/csg8) (2006), section 3; core membership of the local multidisciplinary team (LSMDT), page 53 and the [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd), data fields CR2050, CR7900 and CR8000]

## Equality and diversity considerations

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed. If a need for advocacy is identified, healthcare professionals should allow enough time for the advocate to help the person to prepare before any appointments or discussion and to ensure that they understand the outcome afterwards. People should be supported to use an advocate by healthcare professionals involved in their care, including a skin cancer clinical nurse specialist [Adapted from [NICE’s guideline on advocacy services for adults with health and social care needs](https://www.nice.org.uk/guidance/ng227), section 1.5].

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](https://www.england.nhs.uk/ourwork/accessibleinfo/) or the equivalent standards for the devolved nations.

## Questions for consultation

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?

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?

# Quality statement 5: Genetic testing

## Quality statement

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

## Rationale

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.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of people with stage IIC to IV primary melanoma who had BRAF analysis of the tumour.

Numerator – the number in the denominator who had BRAF analysis of the tumour.

Denominator – the number of people with stage IIC to IV primary melanoma.

**Data source:** [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd) records the gene or stratification biomarker analysed (including BRAF), date reported and reporting laboratory as part of the section on somatic testing for targeted therapy and personalised medicine (data item numbers CR6170, CR6190 and CR6200).

## What the quality statement means for different audiences

**Service providers** (such as secondary care services, tertiary care services and laboratory services) ensure that systems are in place to provide BRAF analysis of the tumour for people with stage IIC to IV primary melanoma.

**Healthcare professionals** (such as histopathologists, oncologists or members of a local skin cancer multidisciplinary team or specialist skin cancer multidisciplinary team) arrange BRAF analysis of the tumour for people with stage IIC to IV primary melanoma and state the preferred tissue block for analysis.

**Commissioners** ensure that they commission services that provide BRAF analysis of the tumour to people with stage IIC to IV primary melanoma.

**People with a type of skin cancer called stage IIC to IV primary melanoma** have genetic testing of their tumour to help find out whether a type of drug treatment called targeted therapy might be suitable for them. It can also help to speed up treatment decisions if the cancer occurs again.

## Source guidance

[Melanoma: assessment and management. NICE guideline NG14](https://www.nice.org.uk/guidance/ng14) (2015, updated 2022), recommendation 1.3.10

## Definitions of terms used in this quality statement

### BRAF analysis

Analysis of the BRAF gene in melanoma tissue samples from people with stage IIC to IV primary melanoma. Local skin cancer multidisciplinary teams should specify the preferred tissue block for analysis. Consider immunohistochemistry as the first test for BRAF V600E, if available. [[NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14), [evidence review A: genetic testing for melanoma](https://www.nice.org.uk/guidance/ng14/evidence), and recommendations 1.3.10, 1.3.11 and 1.3.12]

## Question for consultation

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

# Quality statement 6: Imaging

## Quality statement

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]**

## Rationale

Accurate staging, including the use of imaging, can help in determining clinical follow-up, informing choice of therapy and early detection of metastases. Whole-body contrast enhanced (CE)-CT or MRI and brain CE-CT or MRI should be considered as part of follow-up surveillance for people who have had stage IIB to IV melanoma and so the choice of imaging for staging should be consistent with this.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

a) Proportion of adults 25 and over with stage IIC to IV melanoma who have staging with whole-body CE-CT and brain CE-CT or MRI.

Numerator – the number in the denominator who have staging with whole-body CE-CT and brain CE-CT or MRI.

Denominator – the number of adults 25 and over with stage IIC to IV melanoma.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd) records cancer imaging modality, anatomical site and date of procedure as part of the section on imaging (data item numbers CR0320, CR0330 and CR0340).

b) Proportion of under 25s and pregnant women with stage IIB to IV melanoma, who have staging with whole-body and brain MRI.

Numerator – the number in the denominator who have staging with whole-body and brain MRI.

Denominator – the number of under 25s and pregnant women with stage IIB to IV melanoma.

**Data source:** No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd) records cancer imaging modality, anatomical site and date of procedure as part of the section on imaging (data item numbers CR0320, CR0330 and CR0340).

## What the quality statement means for different audiences

**Service providers** (such as secondary care services or tertiary care services) ensure that systems are in place for adults 25 and over with stage IIC to IV melanoma, and under 25s and pregnant women with stage IIB to IV melanoma to have staging confirmed by whole-body and brain CE-CT or MRI as appropriate for the stage of their cancer, their age and whether they are pregnant.

**Healthcare professionals** (such as dermatologists, clinical oncologists, medical oncologists, surgeons and radiologists) use suitable imaging techniques for confirmation of staging in adults 25 and over with stage IIC to IV melanoma, and under 25s and pregnant women with stage IIB to IV melanoma. Adults 25 and over with stage IIC to IV melanoma should have whole-body and brain CE-CT and under 25s and pregnant women with stage IIB to IV melanoma, should have whole-body and brain MRI. Brain MRI can be considered for adults 25 and over who are not pregnant if locally available and after discussion and agreement with the specialist skin cancer multidisciplinary team.

**Commissioners** ensure that they commission services in which adults 25 and over with stage IIC to IV melanoma, and under 25s and pregnant women with stage IIB to IV melanoma have staging confirmed by whole-body and brain CE-CT or MRI as appropriate for the stage of their cancer, their age and whether they are pregnant.

**Adults 25 and over with stage IIC to IV melanoma, and under 25s and pregnant women with stage IIB to IV melanoma** have a scan that can show how advanced their cancer is. This can help them to choose the right care for them and can help with follow-up after the cancer has been treated.

## Source guidance

[Melanoma: assessment and management. NICE guideline NG14](https://www.nice.org.uk/guidance/ng14) (2015, updated 2022), recommendations 1.4.7, 1.4.8 and 1.4.9

## Definitions of terms used in this quality statement

### Staging scan

Adults 25 and over with stage IIC to IV melanoma should have a whole-body and brain CE-CT. Brain MRI can be considered for adults 25 and over who are not pregnant after discussion and agreement with the specialist skin cancer multidisciplinary team. Under 25s and pregnant women with stage IIB to IV melanoma, should have whole-body and brain MRI. [[NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14), recommendations 1.4.7, 1.4.8 and 1.4.9]

## Question for consultation

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

# Update information

**July 2023:** This quality standard was updated and statements prioritised in 2016 were replaced. The topic was identified for update following the annual review of quality standards. The review identified:

* changes in the priority areas for improvement
* updated guidance on melanoma.

Statements are marked as:

* **[2016]** if the statement remains unchanged
* **[new 2023]** if the statement covers a new area for quality improvement
* **[2016, updated 2023]** if the statement covers an area for quality improvement included in the 2016 quality standard and has been updated.

# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards) is available from the NICE website.

See our [webpage on quality standards advisory committees](http://www.nice.org.uk/Get-Involved/Meetings-in-public/Quality-Standards-Advisory-Committee) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10172).

NICE has produced a quality standard service improvement template to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource impact products for the source guidance to help estimate local costs:

* [resource impact statement for NICE’s guideline on suspected cancer](https://www.nice.org.uk/guidance/ng12/resources)
* [resource impact summary report for NICE’s guideline on melanoma](https://www.nice.org.uk/guidance/ng14/resources).

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](https://www.nice.org.uk/guidance/indevelopment/gid-qs10172) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

ISBN:

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