BRITISH ASSOCIATION OF DERMATOLOGISTS
HEALTHY SKIN FOR ALL

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SERVICE GUIDANCE AND STANDARDS FOR SKIN CANCER

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Declarations of interest

All WPG members and Pilot sites were asked to declare any pecuniary or non-pecuniary conflict of interest, in line with the BAD conflict of interests policy. There were no declarations made from our WPG

Contents

Acknowledgements 3
Aims, purpose, and scope 6
Introduction 7
Cancer Organisational Infrastructure 10
Standard 1: Commissioning Skin Cancer Services 10
Standard 2: Skin Cancer MDTs 12
Skin Cancer Pathway 18
Standard 3: Referral and Patient Assessment 18
Standard 4: Patient Information and Consent 21
Standard 5: Clinical Management & Monitoring 25
Standard 6: Follow-up and Discharge Protocol 27
Standard 7: Governance and Audit 30
Standard 8: Staff, Training and Education 34
Standard 9: Equipment and Facilities 36
References and Evidence 38
Appendix 1: Skin Cancer Levels of Care 42
Appendix 2: Skin Measures Flowchart 43

Aims, purpose, and scope

Aims

Service guidance and standards (SGS) are developed primarily for commissioners of NHS services, service providers (NHS and private practice) and those regulatory bodies involved in the scrutiny of care.

The SGS aims:

- To produce evidence-based Service Standards for the provision of Skin Cancer services in the United Kingdom which align to NICE guideline processes;
- To ensure commissioners of NHS services procure services from appropriately accredited healthcare providers;
- To improve direct access to care for patients requiring treatments and vice versa, reducing unnecessary consultations and improving the overall cost of care;
- To quality assure Skin Cancer education and training standards within services;
- To quality assure patient outcomes by improving the clinical recording of decisions and audit reporting for Skin Cancer services.

Purpose

BAD Service Guidance and Standards for Skin Cancer are designed to provide a set of required Service Standards which underpin NICE IOG recommendations (2006 & 2010 update), existing cancer organisational infrastructures, skin cancer clinical guidelines and NICE quality standards. This document forms the basis of a quality assurance programme for all Skin Cancer services nationally. It sets out the essential criteria for the safe provision of care for all patients being treated in a Skin Cancer Service. Service Standards are aligned to existing frameworks for NHS clinical governance, CQC fundamental standards of care and their equivalent for the devolved nations, and the service and general conditions of the NHS standard contract for providers.

Scope

It is important for the Skin Cancer service guidance and accompanying standards to reflect the issues which can make a difference to patient experience. For this reason, this guidance follows the patient Skin Cancer care pathway from referral to discharge. As far as possible, standards are written from the service user perspective and reflect the service infrastructure required for patient safety.

We recognise that services are under increased pressure to demonstrate that they comply with urgent skin cancer referrals and the pathway management standards for patients requiring treatment (time clocks). For this reason, our guidance incorporates existing requirements and standards (recommendations) set out nationally for NHS services.

Introduction

BAD guidance and service standards for Skin Cancer have been produced in accordance with the core principles and methods set out by NICE. This process is informed by previous and existing published service guidance, national policies. These are reviewed by our WPG experts. Updates to the Skin Cancer service standards are normally scheduled to take place bi-yearly, or when key evidence is changed or updated. The standards should already be the basis for providing and evaluating the quality of a service and areas requiring improvement.

All decisions in the development of this guidance have been made by the WPG through a process of informal-consensus and agreement. The finalised standards have been scrutinised and approved by the BAD Officers prior to consultation with our stakeholders.

A formal consultation period (normally one month) also took place to allow for stakeholder registration and feedback on the Skin Cancer service guidance and standards. Comments received have been collected using a standard proforma recognised by NICE. Stakeholder feedback has been responded to by the WPG and any necessary changes to guidance actioned prior to its publication.

Service Standards Framework

As far as possible, standards are written from the service user perspective and reflect the service infrastructure required to reduce risk and harm. For this reason, this guidance follows the patient care pathway specific for Skin Cancer resources from referral to discharge.

Our standards are covered by the following topic headings:

STANDARD 1: Commissioning Skin Cancer Services
STANDARD 2: MDTs
STANDARD 3: Referral and Patient Assessment
STANDARD 4: Patient Information and Consent
STANDARD 5: Clinical Management and Monitoring
STANDARD 6: Follow-up and Discharge Protocol
STANDARD 7: Clinical Governance and Audit
STANDARD 8: Staffing and Education
STANDARD 9: Equipment and Facilities

Evidence/Minimum requirements

Each service standard has its own ‘rationale’ and ‘essential criteria’ section, which must be demonstrated with supporting documentary evidence. The evidence requirements are intended to be well-defined and easy to understand. They must be used to meet the standards specified within the guidance and used in the self-assessment audit. Some of the evidence requirements relate to existing national policy and guidelines, which underpin all services. All standards require a set number of anonymised patient cases to be used as core evidence.

Self-Assessment Audit

Each service standard has a series of audit questions used to demonstrate how essential criteria are being met by a department. The following flag status system is used to identify each essential criteria areas of risk and will be applied to the self-audit reported outcomes.

For Example:

	Essential Criteria	Comments	Status
100%	90% of all referrals will start treatment within six weeks of referral from dermatology outpatients	79% of patients started treatment within six weeks of referral	>100% Green Flag 70-100% Yellow Flag <70% Red Flag

- Red Flag [Action Required]: failure to meet these standards places undue clinical risk on patients, and/or may result in remedial action;
- Yellow Flag [Monitoring Required]: service standards that a service would be expected to meet;
- Green Flag [No Action Required]: meets service standard essential criteria

Please note where the 'Essential Criteria' outcome dictates clear boundaries for % 100 Green without any moderation, then the Status should be changed to indicate only Yes = Green and No = Red. The yellow flag is deleted.

Secondary care providers implementing the SGSSC have a grace period (12 months) to identify shortfalls in their service provision. This enables the multi-disciplinary team to review their local procedures and practices against the standards and, if necessary, implement the changes required. A summary of the results from the self-assessment audit should form the basis of a Gap analysis and business case for any identified areas of service improvement.

Participation in the self-assessment audit provides valuable assurance about dermatology services and provides important evidence about the safety, effectiveness and responsiveness of services.

It is particularly recommended that you involve your trainees. Many of the standards require audit evidence to demonstrate compliance and these can form the basis of quality improvement projects.

Registration

The registration form is available on the BAD website. It requires each department to provide contact details for the person responsible for co-ordinating the department's participation in the SGSSC audit. This should be the Skin Cancer lead(s), and they will be the person(s) responsible for liaising with the BAD's Transformation and Quality Improvement Unit (TQIU). Note that there can be more than one lead.

For departments in England, the CQC regards the BAD SGS as an approved source of information on the quality of dermatology secondary care services and the standards are mapped to their KLOEs.

Medicolegal implications of SGS

SGS are not intended to be construed or to serve as standards of clinical care. It is advised, however, that significant departures from the SGS should be fully documented by departments and raised on the risk register with their clinical governance team and board. All self-assessment audit reports for the SGS should be used for quality outcome reporting to Trust Boards, Integrated Care Boards, Health Boards and for CQC inspections (and their equivalent in the devolved nations).

SERVICE GUIDANCE AND STANDARDS

Cancer Organisational Infrastructure

Standard 1: Commissioning Skin Cancer Services

Standard Statement 1A – Commissioning Responsibilities	
Rationale In England, Integrated Commissioning Boards (ICBs) have the statutory responsibility for commissioning local cancer services, with NHSE responsible for commissioning some specialist cancer services. Cancer Alliances work to transform the diagnosis, care and treatment of cancer patients by working collaboratively with hospital trusts, ICBs and other health professionals. Cancer Alliances advise their ICB(s) on the commissioning of routine and specialised cancer services, including associated diagnostic services, to ensure that there is sufficient capacity to meet the needs of people with cancer or suspected cancer. They are responsible for monitoring operational performance and identifying, diagnosing and acting on areas of weakness. This includes leading local pathway re-design and other support to improve operational performance. In Scotland, three Regional Cancer Networks (NCA, SCAN, WOSCAN) and stakeholders have developed quality indicators for melanoma skin cancer (QPIs). In Northern Ireland, there is the Northern Ireland Cancer Network (NICaN). The NICaN works with Clinical Reference Groups, including a CRG for Melanoma and Complex Skin Cancer. In Wales, the Welsh Cancer Network oversees the Cancer Site groups, including Skin Cancer.	
Essential Criteria	
1A.1	Each responsible commissioner should ensure up to date skin cancer clinical guidelines published by the BAD and NICE are used by its skin cancer centres (specialised services) and skin cancer units (local services).
1A.2	The responsible commissioner of skin cancer services should ensure agreed patient pathways to supranetwork MDTs/services are in place for patients with nodular mycosis fungoides (stage 2B or over) and consideration for Total Skin Electron Beam therapy (TSEB) and patients with erythrodermic cutaneous T-cell lymphoma that are challenging to diagnose (stages 3 and 4) for treatment by photopheresis as well as access to clinical trials.
1A.3	The responsible commissioner of skin cancer services should ensure there is sufficient capacity within its trusts to provide review clinics for immunocompromised patients with skin cancer. Trust centres for organ transplants should also be required to run such a clinic to meet the ongoing needs for these cohorts of patients.
1A.4	The responsible commissioner and cancer alliance should ensure agreed patient pathways to SSMDTs are in place for patients with complex skin cancers requiring Mohs surgery. Reciprocal arrangements for local provision of Mohs services should be agreed with the SSMDT along with a needs assessment for local provision and agreed budgets for the service. Mohs surgeons providing local services should present audit outcomes to the SSMDT. All commissioned Mohs services should demonstrate they meet the Mohs service standards relevant to the specialty's practice.
1A.5	Commissioners should ensure local skin MDTs provide non-surgical options for treating patients with non-melanoma skin cancers (NMSC). This includes options for the use of radiotherapy and photodynamic therapy (PDT) as appropriate.

Examples of Suitable Evidence			
• Patient pathways documents			
• Published agreed skin cancer documents agreed by the cancer networks and cancer alliances respectively			
• Quality indicators for skin cancer published by cancer network and cancer alliance respectively			
Audit Outcomes of Patient Cases		**Status**	
1A.1	*100%* The responsible commissioner of skin cancer services has stipulated the use of BAD and NICE clinical guidelines in its commissioning of skin cancer services.	Yes **Green** No **Red**	
1A.3	*100%* The responsible commissioner has agreements in place with its local hospitals to provide specific review clinics for immunocompromised patients with skin cancer.	Yes **Green** No **Red**	
1A.3	*100%* The responsible commissioner has agreements in place with its specialised organ transplant centres to provide review clinics for these immunocompromised patients.	Yes **Green** No **Red**	
Audit Questionnaire		**YES**	**NO**
All	**Q1.** Does your responsible commissioner regularly review the operational performance of your local skin cancer pathways?		

Standard 2: Skin Cancer MDTs

Standard Statement 2A: Arrangements of MDTs		
Rationale		
The local skin cancer multidisciplinary team (LSMDT) operate within **cancer units** in District General Hospitals accepting GP referrals for their population. Specialist skin cancer multidisciplinary teams (SSMDT) operate in **cancer centres** in larger Teaching and Specialist Hospitals serving its local population of usually above 750,000 and also accept consultant referrals from out of area for specialist cancer. These teams can also serve as the LSMDT for the local population. Specialised melanoma multidisciplinary teams (MMDT) historically exist in some cancer centres taking all referrals for melanoma within their locality. The LSMDT/SSMDT consists of a core team of clinicians from different healthcare disciplines who contribute independently to the diagnostic and treatment decisions about a patient's care. MDT core members meet together at an arranged time to contribute virtually or face to face for patient cases requiring their input. There are 4 LSMDTs in Northern Ireland, of which the Belfast and South Eastern LSMDT also holds SSMDT meetings for the region.		
Essential Criteria		
2A.1	**Both LSMDT and SSMDT core members as a minimum; one of each to be quorate:**	
	• MDT chair plus clinical lead (dual or singular roles); • MDT co-ordinator/secretary • Two dermatologists • A cellular pathologist (histopathologist) • A surgeon trained in skin cancer	• A skin clinical nurse specialist • Links to a clinical oncologist, where treatment is available • Skin Cancer key worker (coordinating patient care); • Core member responsible for recruitment into clinical trials
	In addition, SSMDTs and MMDTs should have the following minimum core members and have one to be quorate:	
	• A plastic surgeon and; • A surgeon trained in Head and Neck surgery (both with a dedicated interest in skin cancer management and skin cancer training) • Clinical oncologist • Medical oncologist	• Cellular pathologist (histopathologists), with Specialist EQA • Clinical Radiologist
2A.2	***Both LSMDTs and SSMDTs should have the following extended members, who attend as and when is necessary for patient discussion and support:***	
	• Specialists in palliative care • Trained counsellors with experience in cancer • Psychologists • Cosmetic camouflage advisers	• Prosthetics and orthotics staff • Physiotherapists • Lymphoedema therapists • Liaison psychiatrists (SSMDT, MMDT) • Radiographers (SSMDT, MMDT)

	• Clinical geneticist/ genetics counsellor • Occupational therapists • GPwERs only for LSMDT (4x a year)	• Speech and language therapists (SSMDT, MMDT) • Surgeon with oculo-reconstructive experience
2A.3	Any dermatologist diagnosing skin cancer only should attend the MDT for any of their patient cases requiring **mandatory** discussion by the MDT, i.e. melanoma (see case discussion criteria 2C).	
2A.4	The national requirement is now for individual scheduled treatment planning MDT meetings to be quorate on 95% or more occasions. There is no longer a requirement for a minimum attendance by individual members. The detail of required roles and what constitutes a quorum is set out in 2A.1 above.	
2A.5	There should be an operational policy for a single named key worker for the patient's care with contact information provided. The responsibility for ensuring that the key worker is identified should be that of the CNS MDT member(s).	

Examples of Suitable Evidence
• Minutes from recent MDT meetings
• Operational Policy, Annual Report, Work Programme
• Service Profile

Audit Outcomes		**Status**
2A.1- 2A.2	*100%* The MDT has core membership and cover for its LSMDT/SSMDT/ MMDT attend meetings weekly, as relevant.	Yes **Green** No **Red**
2A.4	*95%* Individual scheduled treatment planning MDT meetings are quorate at least 95% of the time.	Yes **Green** No **Red**
2A.5	*100%* Each MDT session should be able to facilitate collaborative MDT assessments and to discuss appropriate patient treatment outcomes with the patient.	Yes **Green** No **Red**

Standard Statement 2B: MDT Characteristics	
Rationale Successful MDT working requires facilitative leadership, equality between members, encouragement of constructive challenge, and common access to information. MDTs need to have a clear role and purpose, be well led and organised, have sufficient diversity of professions and disciplines, and be supported by an enabling infrastructure. Teams do not have to be co-located in the same premises to work successfully but opportunities to engage in person, alongside virtual meetings, help to build relationships between members. The characteristics of an effective MDT provides a framework from which to facilitate teams to work optimally.	
Essential Criteria	
2B.1	The MDT chair (any core member of the MDT) is responsible for the organisation and the running of the MDT meetings and will: • Agree the agenda with the MDT co-ordinator to prioritise cases for discussion. • Ensure patient discussion and resulting treatment/care plan recommendations are recorded in the patient record and that the actions are fed back to the responsible clinician to act on post-meeting. Mechanisms for feedback to the patient, GP and clinical team should be in place. • Ensure eligibility for relevant clinical trial recruitment is considered along with relevant demographic and clinical data recorded.
2B.2	MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to and attend MDT meetings. MDT commitment requires 1-2 hours per meeting for the discussion of skin cancer cases. This should be in addition to the consultant's skin cancer workload.
2B.3	MDT chair has dedicated time included in their job plans (minimum of 1 PA) but flexible according to the number of cases they are required to review. This is in addition to the PAs for the MDT meeting itself.
2B.4	Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as they see fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.
2B.5	Every effort should be made to ensure that a nominated clinician who has knowledge of the patient discussed at MDT is present at the meeting.
2B.6	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.
2B.7	MDT clinical leads and managerial leads (tumour site management team) for skin cancer should be accountable for Cancer Waiting Times (CWT) delivery, management of the PTL (including data quality and completeness), and breaches.
2B.8	MDT meetings are held during core hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.
Examples of Suitable Evidence	
• A register of attendance	
• Minutes of MDT meetings	

Audit Outcomes		Status
2B.2	*100%* Each clinical core member should have sessions specified in the job plan for the care of patients with skin cancer and attendance at MDT meetings.	Yes **Green** No **Red**
2B.4-2B.5	*100%* Nominated clinicians who have direct knowledge of the patient to be discussed should be present at the MDT case discussion.	Yes **Green** No **Red**

Standard Statement 2C: MDT Mandatory Case Discussions

Rationale

The MDT meeting is about considering the patient as a whole, including their views, preferences and circumstances wherever possible. An MDT makes recommendations rather than decisions using the information available to the MDT at the meeting. The responsibility for placing the patient on the MDT list and providing accurate information to the MDT lies with the patient's diagnosing clinician in all cases. Pathology lists should be downloaded and reviewed by the MDT chair to ensure cases are not missed.

The final decision on the way forward needs to be made by the patient in discussion with their clinician. Reasons for significant changes to MDT recommendations should be clearly documented in the patient records, relisted by the MDT and must take into account any relevant recommendations by NICE.

Essential Criteria		
2C.1	There is a locally agreed cut-off time for inclusion of skin cancer cases on the MDT list and high-priority cases on the agenda. Team members abide by these deadlines. There should be flexibility for cases to be added at the last minute due to clinical urgency.	
2C.2	Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda should allow for some members to leave if all cases requiring their input have been discussed.	
2C.3	Skin cancer cases on the agenda should have the following patient information collated and summarised prior to the MDT meeting wherever possible. • diagnostic information (pathology and radiology), • clinical information (including co-morbidities, frailty, psychosocial and specialist palliative care needs) and • patient history, clinical photographs, views and preferences where known.	
2C.4	Skin cancer cases on the MDT list (**not** requiring discussion) should be listed with the following information (Cancer Outcomes and Services Dataset (COSD)).	
	Cases **not** for discussion: • In situ melanoma/lentigo maligna • Newly presenting high-risk site BCCs and SCC with clear histological margins, unless for clinical trial	Information for cases not listed: • Diagnosis date (specify method of diagnosis); • Stage (specify investigations);

	• High-grade dysplastic naevi	• Histopathological and/or cytological diagnosis; • Relevant co-morbidities; • Patient preference (if known) and/or any special circumstances have been taken into consideration; • Any additional tumour-specific tests needed to inform diagnosis; • MDTM recommendation and treatment pathway.
2C.5	LSDMT **mandatory** patient cases (level 4) for discussion:	
	• Recurrent and/or incomplete excisions for high risk BCCs • Recurrent and/or incomplete excisions for SCCs (without metastasis) • Melanoma up to stage IB (new, single primary, non-metastatic, not for approved trial entry) (depending on suitability for SLNB)	• Patients requiring radiotherapy (if clinical oncologist is at LSMDT) • Melanocytic lesions of uncertain but potential malignant nature • Patients indicated for adjuvant radiotherapy-histology clearance <1mm;
2C.6	SSMDT **mandatory** cases (level 5-6) for patients with:	
	• Melanoma stage IIA or higher[1] • Melanoma stage I or higher who are eligible for clinical trials • Metastatic melanoma, BCC or SCC • Immunocompromised patients or those with a genetic predisposition to skin cancer • Consider SLNB for melanoma IB (Breslow thickness 0.8-1mm and above, ulceration, lymphovascular invasion or a miotic index of 2 or more). • Cases listed for Mohs surgery (including SCCs and rare tumours) with discussion on complex or priority cases only.	• Difficult, borderline or malignant cutaneous adnexal tumours • Merkel cell carcinoma • Atypical giant congenital naevi • High-risk squamous cell carcinomas that pose management difficulty • Primary cutaneous sarcoma (also Sarcoma MDT where available) • Cutaneous lymphoma (also Lymphoma MDT where available) • Patients eligible for clinical trials if such discussion is mandated by trial synopsis • All very high-risk SCCs
2C.7	The MDT should agree and record individual patient treatment plans on a digital platform and in the patient's electronic record. The record should include: • the identity of patients discussed • the multidisciplinary treatment planning options (i.e. to which modality(s) of treatment - surgery, radiotherapy, systemic anticancer treatment, immunotherapy or supportive care or combinations of the same, that are to be referred for consideration); • confirmation that the holistic needs have been taken into account.	

[1] Where appropriate, review acquired genomic data to determine therapeutic choice (BRAF V600E).

	In Northern Ireland, the Northern Ireland Electronic Care Record (NIECR) facilitates the sharing of patient data within the region. This will be replaced by Encompass, a single digital care record, by 2025.
2C.8	There should be an operational policy in which all new patients specified as level 4, 5 and 6 care should be reviewed by the MDT for discussion of their initial treatment plan. The policy should specify that the results of patient holistic needs should be taken into account in the decision making. Any significant changes to the MDT recommendations and the reasons for this should be fed back to the MDT.

Examples of Suitable Evidence

- MDT policy document

Audit Outcomes		Status
2C.4	*100%* A regular audit is undertaken of the MDT list of cases not discussed in relation to the appropriateness of their treatment outcome.	Yes **Green** No **Red**
2C.7	*100%* The MDT should agree and record individual patient treatment plans.	Yes **Green** No **Red**
2C.8	*100%* An operational policy whereby all new patients specified as level 4, 5 and 6 care should be reviewed by the multidisciplinary team for discussion of their initial treatment plan. There should be a written procedure governing how to deal with referrals which need a treatment planning decision before the next scheduled meeting.	Yes **Green** No **Red**

Skin Cancer Pathway

Standard 3: Referral and Patient Assessment

Standard Statement 3A –Referral Criteria for Skin Cancer
Rationale All UK patients (adults and children) with a suspicious skin lesion, or a lesion in a high-risk site, or where the diagnosis is uncertain, must be referred urgently to their local skin MDT (LSMDT). This includes BCC, SCC or a suspected melanoma in line with the NICE suspected cancer referral guidance (NG12). Patients referred for urgent skin cancers will not normally be given a choice of services to ensure that they are seen within the maximum waiting times and are counted once for local cancer planning purposes. In England, patients of all ages must receive a definitive diagnosis within 28 days of their referral under the Faster Diagnosis Standard (FDS). Patients can be seen virtually where their GP includes dermoscopic/macroscopic images with the referral. Alternatively, patients may have an appointment for their photographic images to be taken by the hospital medical illustration team or in a community diagnostic centre (CDC), or by a trained HCA who is a member of the skin MDT. These images and the patient's clinical history are uploaded to the patient's referral record to be reviewed by the patient's dermatology consultant. A virtual clinical diagnosis and management decision can be made without a diagnostic biopsy. The diagnosis and management can be communicated over the phone, letter or email for patients with NMSC (discharge to primary care or booking for surgical appointment). Patients with diagnosed malignant neoplasms should be seen in a face-to-face appointment to receive their diagnosis, unless indicated otherwise. They may have an excision procedure on the same day or be booked for surgery within 31 days. In Scotland all suspicious pigmented lesions, potential squamous cell carcinomas and high risk basal cell carcinomas should be referred to secondary care 'urgent suspicious of cancer' (USC). Scottish government cancer waiting times targets detail that all melanomas referred USC should be treated within 62 days of GP referral. Patients with diagnosed melanomas should be treated within 31 days. There should be Advice and Guidance services set up locally for pre-cancerous, benign lesions and BCC to reduce unwarranted urgent referrals. There should be clear clinical criteria for using this service and where appropriate, providing clinical images.

Essential Criteria	
3A.1	Patients with suspicious lesions or who have atypical naevus syndrome should be referred for assessment by a consultant dermatologist or member of their team within the required time standard (FDS for England).
3A.2	Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.
3A.3	Maximum two-month (62-day) wait to first treatment from urgent GP referral.
3A.4	Offer patients, and their families, with evidence of genetic predisposition a referral to the Clinical Genomics Services or a specialist dermatology service.
3A.5	Patients with high grade anogenital intra-epithelial neoplasia (including anogenital Bowen's disease) should be referred to a relevant specialist centre, and this may include referral to a urologist, gynaecologist or coloproctologist, depending upon local expertise.

3A.6	It is accepted that individual patients being referred for urgent referral for skin cancer will not normally be given a choice of services as they must be seen and diagnosed within the maximum waiting time of four weeks in England (NHS Constitution). The provision of local and specialist MDTs can only be maintained if: i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations are counted once for planning purposes and investing in cancer resources.
3A.7	Any patient with suspected metastatic disease (new or recurrent) which requires SSMDT management should be referred immediately within standard cancer timeclocks for starting treatment (i.e. 31 or 62 days). Where a patient is referred for SSMDT review, even if for discussion only, the referring hospital/ LSMDT is responsible for the inter-provider transfer for urgent suspected skin cancer.

Examples of Suitable Evidence
• A referral form and/or letter is in each patient's medical record.
• A copy of the current agreed referral and access policy with timescales for review.
• A link to the department's website which includes information on Skin Cancer services and referral.
• Case mix of patients referred into the service over a 12-24 month period with waiting times, including the diagnosis.
• Case mix of referral to and from LSMDT and SSMDT.
• Standard of Care (SoC) agreed and approved by the Trust Medical Director for the MDT.

Audit Outcomes of Patient Cases		**Status**
3A.1	*75%* Faster Diagnosis Standard: a diagnosis, of cancer or not cancer, within 28 days of referral.	75% **Green** 60-74% **Yellow** <60% **Red**
3A.2	*96%* Maximum one-month (31-day) wait from decision to treat for all skin cancer patients in England.	96% **Green** 70-95% **Yellow** <70% **Red**
3A.2	*100%* Maximum one-month (31-day) wait from decision to treat for melanoma patients in Scotland	100% **Green** 70-99% **Yellow** <70% **Red**
3A.3	*85%* Maximum two-month (62-day) wait to first treatment from urgent suspicion of cancer (USC) GP referral or consultant upgrade.	>85% **Green** 70-84% **Yellow** <70% **Red**
3A.2	*98%* In Northern Ireland, at least 98% of patients diagnosed with cancer should begin their first definitive treatment within 31 days of the decision to treat.	98% **Green** 70-98% **Yellow** <70% **Red**
3A.3	*95%* In Northern Ireland, patients should begin their first treatment for cancer within 62 days following an urgent GP referral for suspected cancer.	95% **Green** 70-94% **Yellow** <70% **Red**
3A.3	*75%* In Wales, the target is 62 days for a patient to be treated for cancer from first suspicion of cancer.	75% **Green** 60-74% **Yellow** <60% **Red**
	100% All patients presenting with skin cancer who are immunocompromised, have a genetic predisposition, present with a	Yes **Green** No **Red**

	metastatic SCC, or have multiple recurrent high-risk BCCs, are referred to the SSMDT.	
3A.4	*100%* All patients, and their families, with evidence of genetic predisposition should be offered referral for genomic testing to the Clinical Genomics Services or a specialist dermatology service. Patients with familial MM, Gorlin's syndrome or XP should be reviewed by SSMDTs and be managed by dermatologists and surgeons who have expertise in these conditions.	Yes **Green** No **Red**
	100% Patients with atypical naevus syndrome have access to total body photography taken for self-surveillance purposes.	Yes **Green** No **Red**
3A.5	*100%* All patients with high grade anogenital intra-epithelial neoplasia (including anogenital Bowen's disease) are referred to the relevant specialist centre.	Yes **Green** No **Red**

Standard 4: Patient Information and Consent

Standard Statement 4A: Provision of Written Patient Information	
Rationale Patients should be given written information specific for their skin cancer (if diagnosis known) and treatment modality, at their consultation appointment, whether they are seen in clinic or virtually. All patient information should be available in an accessible variety of formats and languages as appropriate for the patients using the service, including those with Special Educational Needs and Disabilities (SEND) and/or those with language difficulties. This should be available on the department's webpage along with contact details for the skin cancer service. Additional information on alternative treatments discussed by the consultant with the patient should also be provided (if appropriate). The skin cancer MDT should also provide patients with information, including patient support groups and available support services.	
Essential Criteria	
4A.1	All patients/carers must be offered Patient Information Leaflets (PILs), if available, that cover their skin cancer diagnosis (if known) and treatment options, prior to commencing treatment.
4A.2	The MDT provides written material for patients and carers which includes: • information specific to that MDT about local provision of the services offering the treatment for that cancer site; • information about patient involvement groups and patient self-help groups; • information about the services offering psychological, social and spiritual/cultural support, if available; • information specific to the MDT about the disease and its treatment options (including names and functions/roles of the team treating them); • information about services available to support the effects of living with cancer and dealing with its emotional effects. • Information about the purpose of the MDT and its membership.
4A.3	All patients should have equal access to NHS services and materials to inform on their care. To help ensure equality of access, departments may need to adjust their messages, modify their tone and present information in alternative formats (see NHS Brand Guidelines for communicating with patients).
4A.4	All patient information including skin cancer PILs must be kept up-to-date and reviewed on a yearly basis or when contact details change.
4A.5	Patient information leaflets should be provided in plain English and presented in accordance with NHS brand Guidance (see 4A.2). Skin cancer PILS should be available in a variety of formats and languages (including translation using Google) as appropriate for those patients accessing the service.
4A.6	Children and adults with special educational needs and/or disabilities (SEND), the neuro-diverse, and those with language difficulties should have their Skin Cancer treatment pathway suitably adapted to ensure the dignity and safety of the patient at all times.

	In Scotland, teenagers and young adults have care supported by a cancer nurse specialist.

Examples of Suitable Evidence
• Published leaflets and website information
• Patient notes to show that relevant patient information resources have been provided.
• A copy of the PIL or the website address of the Skin Cancer service describing the service.

Audit Outcomes - Review of 50 Patient Cases		**Status**
4A.1	*100%* Review of notes indicates that all patients have received a PIL prior to commencing treatment (where available).	>90% **Green** 70-90% **Yellow** <70% **Red**

Audit Questionnaire		**YES**	**NO**
4A.2	**Q1**. Does the Skin MDT provide written material for patients and carers on the specifics about the MDT, its membership roles, treatments and support services for patients with cancer?		
4A.3	**Q3.** Is there information available on the trust's/hospital's website regarding the Skin Cancer service for patients?		
4A.4	**Q4.** Are PILs and websites kept up-to-date and reviewed on a yearly basis or when contact details change?		

Standard Statement 4B –Obtaining Validated Consent for Surgery

Rationale

All patients (adults and children) undergoing treatment for skin cancer are required to give informed consent in two stages. The first stage of consent is obtained after providing the patient with information on their skin cancer and options for treatment (surgical and non-surgical). They should be given the contact details of the CNS should they have any further questions. Consent should be taken by a clinician who is competent in the procedure or treatment the patient is undergoing, and this should be recorded in the patient's notes.

Where patients are being virtually triaged straight to surgery, they will need to be offered the opportunity of a face-to-face appointment and be sent the same information as above for first stage consent to be valid (see 4A). Patients should receive sufficient information to prepare them for surgery, including pre and post-operative advice (see example: BAD Pre and Post-Operative template as a guide for skin cancer services). This should be sent with the appointment letter ahead of surgery for the patient to confirm their preferred treatment option and appointment.

The second stage of consent is obtained at the time of a patient's treatment appointment by the clinician carrying out the procedure.

If surgery is offered on the same day, there needs to be a cooling off period, allowing the patient to assimilate the information and ask any questions. This will vary on a case-by-case basis but should allow the patient time to consider their options, read any information that has been provided and allow sufficient time for any questions to be answered. If the patient decides to go ahead with their surgical procedure, then second stage consent is taken by the treating surgeon, or competent nurse surgeon.

For those patients who cannot give written informed consent, local Trust guidelines on consent in this situation must be followed.

Essential Criteria	
4B.1	There must be a record of formal written informed patient consent in the patient's medical notes prior to and at the time of treatment.
4B.2	Consent forms should state whether tissue can be used for anonymous teaching, education and quality control or as part of an ethically approved research study (tick box option).

Examples of Suitable Evidence

- Written confirmation of consent prior to the treatment for skin cancer which is held in the patient record.
- Patient information leaflets on skin cancer and available treatment information provided to the patient.
- Standard Operating Procedures for skin surgery.

Audit Outcomes - Review of 50 Patient Cases		**Status**
4B.1	*100%* There is documented two stage consent obtained by the consultant and treating surgeon in the patient notes. This should include the information covered in the discussion with the patient covered by 4B1.	>95% **Green** 70-95% **Yellow** <70% **Red**

Audit Questionnaire		**YES**	**NO**
4B.1	**Q1.** Does the service have a pre and post-operative surgical guidance to give patients ahead of surgery?		
	Q2. Does the department's consent forms include the option for tissue to be used for anonymous teaching or research?		

	Q3. Is there a named healthcare professional available for the patient to contact with any questions regarding the procedure?		
	Q4. Does the department's Standard Operating Procedure for skin surgery include a cooling off period for patients being offered same day surgery?		

Standard 5: Clinical Management & Monitoring

Standard Statement 5A: Recording Skin Cancer Procedures

Rationale

Safe and efficient patient care relies on high quality data. By taking responsibility for their clinical data, clinicians can improve its quality and help drive up standards of care. Accurate recording of clinical investigations /procedures is required for service planning and investment. Suboptimal recording of skin cancer treatments leads to income losses which impact on the maintenance and development of services, staff, equipment and viability of the department.

Skin cancer diagnosis and treatment pathways should be reported as Hospital Episode Statistics (HES) to NHS England. In Scotland, cancer waiting times data for the 62 day and 31 day wait is submitted by all health boards quarterly with melanoma quality performance indicators submitted annually.

Essential Criteria

5A.1	**Coding Outpatient Surgical Procedures in England:** Outpatient: - new appointment face to face or virtual consultation WF01B First Attendance face to face or virtual consultation- any dermoscopy used or provided with referral should have the code S605 recorded (NICE quality indicator). WF01A Follow Up Attendance(s) plus surgical procedure for e.g. Biopsy of lesion of skin of head or neck – S151 plus body specific site Z code Patients offered same day surgery should be recorded as a follow-up attendance. **Admitted Care Day case surgery** Record - Primary Diagnosis (ICD10) code plus with any existing co-morbidities which affect the patient's treatment. Record the Primary Procedures plus additional procedures and their body sites codes, where relevant.
5A.2	Agreed protocols in place for recording the skin cancer treatments with the Hospitals coding team.
5A.3	Regular review skin cancer activity data (at least monthly) by the skin cancer unit to ensure accuracy of clinical information before charges are made to NHS England.
5A.4	Histopathology skin cancer cases submitted by the department should be reported, confirmed and authorised within seven to ten calendar days of the procedure (in England).

Examples of Suitable Evidence

- Audit data should be provided to demonstrate appropriate provision. This could include data for on the day cancellations, unplanned overnight admission, unplanned return or readmission to day surgery unit or hospital, and patient experience.

Audit Outcomes - Review of 50 Patient Cases		Status
5A.1	*100%* Patient records are available (paper or electronic) in 100% of cases.	>90% **Green** 70-90% **Yellow** <70% **Red**
5A.4	*80%* of skin cancer cases must be reported by pathology within seven calendar days of receipt and 90% within ten calendar days (in England).	>80% **Green** 60-80% **Yellow**

		<60% **Red**	
Audit Questionnaire		**YES**	**NO**
	Q1. Has the department undertaken an audit of its skin cancer surgical procedures over the last 12 months?		
5A.1	**Q2**. Does the skin cancer unit have outpatient income forms for recording skin cancer procedures?		
5A.3	**Q3.** Does the skin cancer unit regularly review its activity data?		

Standard 6: Follow-up and Discharge Protocol

Standard Statement 6A- Follow Up Management and Discharge

Rationale

The NICE IOG made recommendations on follow-up care. Patients referred for specialised cancer treatment (SSMDT) may need to continue receiving follow up care from the specialised service, but it is expected the majority will be able to receive follow up locally (LSMDT). Some patients may be suitable for patient-initiated follow-up (PIFU).

Some patients at risk of developing multiple lesions over time may need longer-term follow-up. For those who are immunocompromised or who have a genetic predisposition to the development of skin cancers (e.g. Gorlin's syndrome, xeroderma pigmentosum), lifelong surveillance is needed.

In skin cancers with a low risk of mortality or recurrence (e.g. low-risk BCCs or SCC), follow-up is not cost effective. The majority of these patients will be suitable candidates for primary care monitoring and self-surveillance. Clinicians should be aware that, because of their psychological or physical conditions, not all patients will be able to perform skin self-examination.

Essential Criteria	
6A.1	The patient, their GP and the referring Consultant are notified within 10 working days following completion of Skin Cancer treatment and informed of any follow-up arrangements and given relevant information.
6A.2	Melanoma: • Stage 0: one follow-up appointment within a year for education then discharge. • Stage IA: consider 2 clinic appointments, with discharge at the end of year 1. • Stage IB 6-monthly for 1 year then yearly for next 4 years then discharge +/- imaging according to guideline at the end of year 5. • Stage IIA: 6-monthly for 2 years then offer yearly appointments for next 3 years then discharge. • IIB and IIC: 3-monthly for 2 years, then 6-monthly for one year, then yearly to year 5 then discharge. Imaging according to guidelines. • Stage IIIA to IIIC not currently having adjuvant therapy: 3-monthly for 3 years then 6-monthly to year 5 then discharge. Imaging according to guidelines. • Stage IIIA to IIIC, IIID and resected IV having adjuvant therapy and stage III and IV unresected melanoma: Offer personalised follow-up as guided by SSMDT.
6A.3	cSCC: • Low-risk: offer, where appropriate, a single post-treatment appointment and discharge. • High-risk: follow-up 4-monthly for 12 months, then 6-monthy intervals for 12 months. Discharge at 2 years. • Very high-risk: follow-up 4-monthly for 24 months, then 6-monthly intervals for 12 months. Discharge at 3 years. • Metastatic: follow-up 3-monthly for 24 months, then 6-monthy for a further 36 months, with potential longer-term review dependent on patient factors.

	• Refer all adults with excised high-risk cSCC with a close histological margin (< 1 mm) for MDT discussion of management options.
6A.4	BCC: • Single BCC, usually discharge post operatively with a standard letter detailing histology and any further advice e.g. self-surveillance. • Ensure that patients with multiple BCCs who are discharged are aware of future risks and have appropriate information to re-access services, such as through Advice and Guidance and PIFU. • Refer all adults with excised high-risk BCC with a close histological margin (< 1 mm) for MDT discussion of management options.
6A.5	Actinic keratoses: • Agree local primary care guidelines so referral usually only if topical treatment unsuccessful. • In secondary care, aim to treat most on their first appointment and discharge. • Offer information on skin self-surveillance / cancer risk. • In patients at high risk of cancer, consider PIFU post-treatment. Follow-up if very high risk (e.g. if immunosuppressed).
6A.6	For SCC in situ, consider PIFU post-treatment if patient is at high risk of cancer. Follow-up if very high risk (e.g. if immunosuppressed).
6A.7	MDT protocols should be in place to determine when skin cancer cases should be re-discussed at MDT, e.g. if new evidence has been found.
6A.8	Short-term follow-up (less than 6 months) is important for: • patient education, especially regarding sun protection measures and early recognition of new and recurrent lesions • provision of help, and rehabilitation for patients suffering from complications and side-effects of treatment, e.g. scars, lymphoedema • provision of psychological and emotional support to patient, carer and family • the evaluation of surgical outcome through audit.

Examples of Suitable Evidence
• Discharge protocols
• GP letter in patient notes, with patient copied into letters where appropriate
• Hospitals to communicate clearly and promptly with GPs following outpatient clinic attendance, where there is information which the GP needs quickly in order to manage patient's care (certainly no later than 14 days after the appointment)

Audit Outcomes - Review of 50 Patient Cases		**Status**
6A.1	*100%* The patient, their GP and referring Consultant are notified within 10 working days following completion of Skin Cancer treatment and informed of any follow-up arrangements and given relevant information.	>90% **Green** 70-90% **Yellow** <70% **Red**

6A.3-6A.4	*100%* of adults with excised high risk BCCs and SCCs with close histological margins are referred to the MDT for discussion of their management options.	>90% **Green** 70-90% **Yellow** <70% **Red**

Audit Questionnaire		**YES**	**NO**
6A.2	**Q1**. Does the department apply the follow-up appointment requirements for each stage of melanoma covered under 6A.2?		
6A.7	**Q2.** Are MDT protocols in place to decide when to re-discuss cases at MDT?		
6A.8	**Q3.** Does the department provide short-term follow up (less than 6 months) for patient education on lesion monitoring, help and rehabilitation of patients suffering complications of treatment, provision of psychological support and evaluation of suitable outcomes?		

Standard 7: Governance and Audit

Standard Statement 7A – Organisational Cancer Management

Rationale

Cancer is an organisation-wide service, involving most specialties and diagnostic services. It requires distinctive structures within each organisation and recognised staffing for skin cancer services. This reflects the complexities of care involved in treating these patients.

It is vitally important that the remits and level of authority of the core cancer management team and individuals within the team are:

- clear and communicated across the organisation;
- accountability for cancer delivery is clearly identified;
- board level support for the structure is articulated;
- sufficient time resource is made available for individuals to enact their roles; and
- there is a clear governance framework in place
- monitoring cancer waiting times and recording cancer outcome data

In Scotland, skin cancer waiting times data is submitted quarterly by each health board. Melanoma quality performance indicator data is reviewed regionally and then submitted nationally for discussion prior to sign off by the three Managed Clinical Network leads (see Rationale 1A).

In Northern Ireland, cancer waiting times are reported to the Department of Health, which is recorded on the Cancer Patient Pathway System (CaPPS).

In England, 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.

Essential Criteria

7A.1	Cancer Waiting Times (CWT) guidance provides a set of rules to ensure that data are recorded in a way which allows cancer waiting times to be transparently reported and monitor the timely delivery of services to patients by local and national organisations. CWT also measures the NHS' performance against the NHS Constitution standards as well as a number of other metrics.
7A.2	Responsibility for Cancer Waiting Times (CWT) should be well integrated within operational delivery structures for providers of cancer services. It should be clearly explained and understood who is responsible for which elements of the delivery the CWT standards.
7A.3	The executive lead for cancer should reinforce the lines of responsibility and ownership to ensure accountability for cancer waits delivery sits with those in a position to deliver i.e. ultimate responsibility will sit within the specialty, rather than within the remit of support structures such as the core cancer team, service improvement, etc.
7A.4	The cancer lead clinician/ executive lead should meet at regular intervals bi-annually with the tumour site management team to review skin tumour level performance, good practice and agree remedial or improvement actions as appropriate. Outside of this meeting structure, there should be clear lines of escalation in place.

Examples of Suitable Evidence

- Cancer Waiting Times data for the past year

Audit Outcomes		Status
7A.1	*100%* The organisation's Operational Delivery structures outline who is responsible for the delivery of Cancer Waiting Times	Yes **Green** No **Red**
7A.3	*100%* The Skin Cancer lead meets with the tumour site management team regularly (bi-annually) to discuss performance and remedial actions.	Yes **Green** No **Red**
7A.1	*100%* Skin cancer data is reviewed at least annually and is used for audit purposes by the department to inform ICBs, commissioners, cancer alliances and clinical networks etc	Yes **Green** No **Red**
7A.1	*100%* There are clear lines of accountability for cancer delivery for skin cancer within the organisation.	Yes **Green** No **Red**

Standard Statement 7B – Clinical Governance	
Rationale	
Providers must ensure robust clinical governance processes and systems are in place to demonstrate a safe, high-quality service that shares good practice, evidence of learning and strives for continuous quality improvement. Reports of adverse incidents should be made available, so that any problems with equipment, staff or procedures can be identified before they cause adverse events or interruption to the service. Skin Cancer services must have in place Standard Operating Procedures (SOPs) for skin lesion surgeries and biopsies. This must include adherence to the WHO Safer Surgery guidance. Services should also adhere to the National Safety Standards for Invasive Procedures (NatSSIPs) and local policies where they are in place. Services must use robust Incident Reporting Systems to report potential harm, serious incidents and Never Events that occur during skin surgery, as per the Serious Incident Framework (for services in England). For Scottish and Northern Irish services, incidents should be reported through DATIX as Severe Adverse Events. Patient safety incidents in NHS Wales are managed by Putting Things Right. Skin cancer services need to ensure that they adopt the use of photography to record both lesion images and site marking for patients requiring skin surgery.	
Essential Criteria	
7B.1	All staff are involved in some form of clinical governance activity at least twice per year, including a governance meeting which covers the topics of: • Clinical incidents; • Health and safety; • Audit and guidelines.
7B.2	There is a system in place to allow reporting of critical incidents and other untoward incidents and near misses within a positive, supportive, no blame culture, which includes demonstrated learning.
7B.3	There is a system in place to facilitate learning and quality improvement with response to feedback and complaints from patients and carers.
7B.4	Regular meetings between all members of the multidisciplinary skin cancer team to discuss matters pertaining to clinical governance and audit.
7B.5	All adverse events should be noted at the clinical governance and audit meetings.
7B.6	The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself against similar MDTs making use of national tools like TEAM-QI to address team effectiveness with a quality improvement programme.
7B.7	Health boards in Scotland are required to record QPIs for melanoma, which cover referral and treatment.
Examples of Suitable Evidence	
• Examples of suitable audits/programmes to demonstrate compliance with this standard.	
• Example of how a complaint has been dealt with and learned from. Confirmation from staff that actions taken in response to patient feedback are disseminated regularly.	

• Minutes of morbidity and mortality reviews and risk register should be seen including agenda, attendance and evidence of actions taken. Copies of an incident reporting form and information provided on induction should be seen.		
• Understanding of and engagement with the current national reporting systems (NaPSIR) should be confirmed.		
• Verbal confirmation should be given from all staff groups that they are aware of the reporting mechanisms in place and that the department communicates learning on a regular basis.		
• Organisation SOP for Skin Cancer surgery.		
• LocSSIP policy in place under the ICB (where available)		
Audit Outcomes		**Status**
7B.1	*100%* Record of clinical governance meetings over the previous year – there must be evidence of a Skin Cancer Unit Governance meeting (or of another clinical governance activity) at least once every six months.	Yes **Green** No **Red**
7B.2	*100%* There is a system in place to allow reporting of critical incidents and other untoward incidents and near misses within a positive, supportive, no blame culture, which includes demonstrated learning.	Yes **Green** No **Red**
7B.3	*100%* There is a system in place to facilitate learning and quality improvement with response to feedback and complaints from patients and carers.	Yes **Green** No **Red**
7B.4	*100%* Regular meetings between all members of the multidisciplinary skin cancer team to discuss matters pertaining to clinical governance and audit.	Yes **Green** No **Red**
7B.5	*100%* Evidence from Clinical Governance/Audit meeting minutes that all adverse events have been discussed at the meeting and the outcome recorded on the adverse event form and if appropriate on a Trust Incident Form.	Yes **Green** No **Red**
7B.6	*100%* The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself making use of tools such as TEAM-QI.	Yes **Green** No **Red**
7B.7	*100%* The skin MDT reviews a sample of patient data quarterly, covering both patients on predetermined Standards of Care, and those referred for discussion at the MDT.	Yes **Green** No **Red**
Audit Questionnaire		**YES** **NO**
	Q1. Does the department review protocols and procedures against current best practice or national guidelines and update if necessary?	

Standard 8: Staff, Training and Education

Standard Statement 8A – Qualified Professional Staff

Rationale

All Dermatology Consultants are trained to diagnose and manage skin cancer. Some consultants will specialise in skin cancer surgery while others will only diagnose the patient and refer on for surgery. Mohs surgeons will need to complete post-CCT/ fellowship training relevant for their specialty. Specialty doctors and locum consultants (not on the specialist register) seeing skin cancer patients will need to demonstrate that they meet the skin cancer competencies in the dermatology training curriculum.

GPs in Extended Roles (GPwERs) working as group 2 or 3 practitioners undertake skin cancer surgery for low-risk BCCs within a Model 1 service must be trained in the skin surgery competencies of the BAD and RCGP GPwER dermatology framework. GPwERs must be signed off through the National Accreditation Programme by a consultant dermatologist. This includes those GPs who were previously accredited in line with the 2007/2011 Department of Health Guidelines prior to 2018 as GPs with Specialist Interests (GPwSIs).

Model 2 practitioners can carry out more complex surgical procedures in the community under the governance and direction of their skin MDT and require more extensive surgical training in a range of skin cancer lesions including melanoma.

Skin cancer Nurse Specialists and skin cancer surgical nurses should be trained appropriately using the BDNG skin cancer curriculum.

Those who are directly involved in treating patients should receive specific training in advanced communication skills and breaking bad news.

Essential Criteria	
8A.1	All clinicians diagnosing skin cancer need to be trained in the use of the dermatoscope to review and diagnose skin cancer lesions, and where appropriate how to take a clear image using a dermatoscope.
8A.2	All members of clinical staff must have up-to-date Cardiopulmonary Resuscitation Skills and know the location of their nearest resuscitation trolley, in line with the Trust's resuscitation policy. It is also essential they are familiar with its operation and the procedure for calling the local emergency resuscitation team.
8A.3	The skin cancer service should employ at least one registered Cancer Nurse Specialists (at least Band 7) with at least two years of experience in dermatology. They should be part of the LSMDT and/or SSMDT. At least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month;
8A.4	Education should be provided for all members of the primary care team who see and refer patients with suspected skin cancer that are working in the ICB region.
8A.5	All staff should maintain an up-to-date development portfolio in relation to skin cancer related work and be supported in this regard to attend relevant training courses and update meetings every year for their appraisal and revalidation.

8A.6	MDT members recognise the need for continued learning in their respective professional roles and are supported in gaining the necessary knowledge and skills for continued learning. Support is available for members to take up relevant CPD opportunities.
8A.7	The histopathologists engaged in skin cancer diagnosis should participate in the national specialist dermatopathology external quality assurance (EQA) scheme and demonstrate evidence of continuing professional development (CPD) relevant to skin cancer.
8A.8	All surgeons offering reconstructive surgery following skin cancer excision should have specific training in this area and be able to show evidence of relevant CPD.

Examples of Suitable Evidence

- A written copy of the Annual Operating Plan should be provided. Verbal confirmation from staff that the plan has been developed collectively and is an active working document.
- A detailed review of staffing requirements every six months. This would normally be supported by evidence such as risk registers and be referenced within the trust/board annual plans.
- There is documented and verbal evidence that the appropriate recruitment methods are routinely implemented for consultant and SAS dermatology staff.
- Examples of appraisal process. Verbal confirmation from department lead appraiser and consultants.

Audit Outcomes		Status
8A.1	*100%* All clinicians in the department diagnosing skin cancer are trained in the use of dermatoscope to review and diagnose skin cancer.	Yes **Green** No **Red**
8A.3	*100%* The service should have at least one skin cancer CNS with at least 2 years training in dermatology who should be a member of the LSMDT/SSMDT.	Yes **Green** No **Red**
8A.5	*100%* All staff should maintain an up-to-date development portfolio and be supported in this regard via training courses and updates every year for their appraisal and revalidation.	Yes **Green** No **Red**
8A.8	*100%* Evidence of CPD undertaken by MDT members, including surgeons offering reconstructive surgery.	Yes **Green** No **Red**

Standard 9: Equipment and Facilities

Standard Statement 9A - Safety and Compliance
Rationale All services require adequate facilities, which are compliant with the Department of Health building notes. This includes up to date risk assessments for the any clinical space used for carrying out skin surgery. Consultation rooms are essential for examination of patients, virtually or physically. Surgical procedure rooms should be co-located to the consultation room when providing same day surgery to patients. MDT rooms must be suitable with regards to confidentiality and equipment, including facilities for videoconferencing.

Essential Criteria	
9A.1	The procedure room should be a dedicated facility (not doubling up as a wound dressing room or an outpatient clinic room). The operating room must be of an adequate size to accommodate the couch with space around for free movement of staff. Double doors are required for wheelchair and trolley access if needed.
9A.2	There should be a waiting area near the operating room for use by patients before and after surgery. This should be of a sufficient size to accommodate accompanying relatives and carers
9A.3	A skin surgery unit should have a reclining chair, couch or bed that can be adjusted in height and position with some support (arms or cot-sides) for infirm or less co-operative patients.
9A.4	Effective haemostasis is essential and is best provided with either a hyfrecator or a radiosurgical unit with both unipolar and bipolar modes. Hot-point cauterisation is no longer generally used as it is difficult to ensure sterility.
9A.5	An extractor should be available to remove the smoke plume produced by electrosurgical devices and some lasers. This not only smells unpleasant but could carry infective particles and toxic substances contributing to indoor air pollution.
9A.6	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions. The room is environmentally appropriate in size and layout i.e. all team members have a seat and are able to see and hear each other and view all presented data (e.g. diagnostics) within and across hospital trusts. Facilities for projecting radiology images, specimens and case recommendations should be in place. There should also be appropriate provisions for video conferencing.
9A.7	Wall or ceiling-mounted suction equipment should be available in main operating rooms.
9A.8	The consultation room should have a detachable/ handheld mirror available for patients and doctors to check lesion sites ahead of surgery.
9A.9	Any histopathologists in England and Wales must work in laboratories that are accredited with Clinical Pathology Accreditation Ltd. This includes any Mohs laboratory.
9A.10	The facility for MMS will usually consist of two or more procedure rooms with all the necessary equipment for Mohs cases of all complexities and including access to appropriate surgical beds

	and recovery areas, electrosurgical equipment and surgical instruments for peri-ocular, aural and fingertip tumours. See the BAD Service Standards for MMS Services.

Examples of Suitable Evidence
• Documented Risk Assessment identifying risks, hazards and control measures.
• Documented plan to deal with any emergency.
• Records of inspections show that consulting/treatment rooms provide privacy etc.

Audit Outcomes		**Status**
9A.1- 9A.5	*100%* Evidence that the Skin Cancer unit's facilities are suitable with respect to design, layout and service users' rights to privacy and dignity.	Yes **Green** No **Red**
9A.2	*100%* There is a waiting room near the operating room for use by patients before and after surgery.	Yes **Green** No **Red**
9A.3	*100%* The skin cancer service has a reclining bed which is adjustable.	Yes **Green** No **Red**
9A.3-9A.5, 9A.7	*100%* Surgical rooms for surgery have the necessary equipment for skin cancer extractor and ventilation.	Yes **Green** No **Red**
9A.6	*100%* There is a dedicated MDT room in an appropriate location.	Yes **Green** No **Red**
9A.10	*100%* The facility for Mohs consists of two or more procedure rooms with all the necessary equipment for Mohs cases of all complexities including access to appropriate surgical beds.	Yes **Green** No **Red**

References and Evidence

Evidence searches were made using the following electronic databases from September until December 2023: Cochrane Library; PubMed; British Medical Journal (BMJ); British Journal of Dermatology (BJD); Royal Society of Medicine (RSM) Library.

Our selection criteria included the headings from our Service Guidance and Standard's core principles, on a generalist and clinical intervention level (e.g. general facilities versus clinical intervention-specific facilities). This provided us with a wider scope, due to the limited availability of service-based evidence.

Evidence Search: December 2023

	Standard								
	1	2	3	4	5	6	7	8	9
Care Quality Commission. The Fundamental Standards.	X	X	X	X	X	X	X	X	X
Care Quality Commission. Memorandum of understanding - Systems regulators for the four nations	X	X	X	X	X	X	X	X	X
Confidentiality: Good Practice in Handling Patient Information. General Medical Council. Updated 2018.	X	X	X	X	X	X	X	X	X
Confidentiality. NHS Code of Practice. 2003.	X	X	X	X	X	X	X		
Data Protection Act 2018.	X	X	X	X	X	X	X	X	X
Department of Health. Health Building Note 00-02: Sanitary Spaces.									X
Department of Health. Health Building Note 00-03: Clinical and Clinical Support Spaces.									X
Department of Health. Health Building Note 12: Out-patients Department.									X
Department of Health. The NHS Constitution for England (last updated 2015).	X	X	X	X	X	X	X	X	X
Equality Act 2010.	X	X	X	X	X	X	X	X	X
Essential Standards of Quality and Safety. Care Quality Commission. 2010.	X	X	X	X	X	X	X	X	X
Fitness to Practice Rules: Nursing and Midwifery Council. 2004.								X	
General Medical Council. Ethical Guidance, Decision Making and Consent. 2020	X	X	X	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 9: Person-Centred Care.	X	X	X	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 10: Dignity and Respect.				X	X	X			
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11: Need for Consent.				X					

Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 15: Premises and Equipment.									X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 17: Good Governance.	X	X	X	X	X	X	X	X	X
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18: Staffing.			X					X	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19: Fit and Proper Persons Employed.			X					X	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Duty of Candour.	X	X	X	X	X	X	X	X	
How to Write in Plain English. The Plain English Campaign.	X	X	X	X	X	X	X	X	X
National Health Service England. 2019/20 National Tariff Payment System.					X				
National Health Service Standards Contract 2020/21.	X	X	X	X	X	X	X	X	X
National Institute for Health and Care Excellence. Health and Social Care Directorate Quality Standards Process Guide. 2016	X	X	X	X	X	X	X	X	X
NICE guidelines on behaviour change: individual approaches and behaviour change: general approaches.					X				
NICE guidelines on medicines adherence and medicines optimisation.					X				
NICE guideline on transition from children's to adults' services for young people using health or social care services					X				
NICE guideline on patient experience in adult NHS services					X				
Nursing and Midwifery Council Registration.								X	
Principles for best practice in clinical audit. NICE. 2008.							X		
Patient's Global Assessment (classified as clear, nearly clear, mild, moderate, severe or very severe)			X						
The Professional Record Standards Body (PRSB) - PRSB Standards for the Structure and Content of Health and Care Records 2018		X	X	X			X		X
NHSX, The Records Management Code of Practice for Health and Social Care. 2021		X	X	X			X		X
Specialty Training Curriculum for Dermatology. 2010. Joint Royal Colleges of Physicians Training Board.								X	
Professional Guidance on the Safe and Secure Handling of Medicines. 2018. Royal Pharmaceutical Society.									X
NHS Discharge Protocol						X			

General Medical Council. Good practice in prescribing and managing medicines and devices					X				
Specialist Evidence									
Statistics, Office for National. Index of cancer survival for Clinical Commissioning Groups in England: adults diagnosed 2000 to 2015 and followed up to 2016. 2017.						X			
Independent Cancer Taskforce. Achieving world-class cancer outcomes: A strategy for England 2015 - 2020. 2015.					X	X	X		
NHS. The NHS Long Term Plan for Cancer					X	X	X		
NHS England. Cancer waiting times national time series Oct 2009 - Dec 2018 Provider-based with revisions. 2019.							X		
NHS England. RTT Overview Time Series Jul22. 2022			X						
NHS England. Referral-to-treatment waiting time statistics for consultant-led elective care: 2019/20 Annual Report. 2022.			X						
NHS. Clinically-led Review of NHS Access Standards - Progress Report, 2019			X						
NCAT, The Characteristics of an Effective Multidisciplinary Team (MDT) 2010		X	X						
The NHS Managers' Code of Conduct							X		
NICE. Improving outcomes for people with skin tumours including melanoma (update). 2010	X	X	X	X	X	X	X		
NICE. Skin cancer, Quality standard QS130. Published September 2016. Updated July 2022			X	X	X	X	X		
NHS. Delivering Cancer Waiting Times: A Good Practice Guide, 2015.							X		
NHS. Implementing a Timed Skin Cancer Diagnosis Pathway. V 2.2. 2022			X	X	X	X			
NHS. Manual for Cancer Services – Skin Measures Version 1.2	X	X	X	X	X	X	X	X	
NDRS, NHS Digital. Cancer Outcomes and Services Dataset (COSD) Pathology User Guide v4.1.1. 2021.		X	X		X		X		
RCPath, The role of the cellular pathologist in the cancer multidisciplinary team. 2022								X	
NHS England, National Guidance on System Quality Groups, January 2022	X								
Healthcare Improvement Scotland, Melanoma Quality Performance Indicators, January 2022 (v4.0)	X						X		
RCPath, Dataset for histopathological reporting of primary cutaneous basal cell carcinoma, 2019			X						

RCPath, Dataset for histopathological reporting of primary invasive cutaneous squamous cell carcinoma and regional lymph nodes, 2019			X						
RCPath, Dataset for histopathological reporting of primary cutaneous malignant melanoma and regional lymph nodes, 2019			X						
RCPath, Dataset for histopathological reporting of primary cutaneous adnexal carcinomas and regional lymph nodes, 2019			X						
NHS England, Streamlining Multi-Disciplinary Team Meetings, 2020		X	X						
RCR, Radiotherapy dose fractionation: fourth edition, 18 Skin Cancer, 2024					X				
RCR, The timely delivery of radical radiotherapy: guidelines for the management of unscheduled treatment interruptions. Fourth edition, 2019					X				
BAD, NHS England Reform of Cancer Multidisciplinary Team (MDT) Meetings: The Skin MDT Response Report, 2018		X							
BAD, A Guide to Job Planning for Dermatologists, 2022		X							
NICE, Melanoma: assessment and management. Updated 2022		X				X			
BAD, Guidelines for the management of adults with basal cell carcinoma 2021		X				X			
BAD, Guidelines for the management of people with cutaneous squamous cell carcinoma 2020		X				X			

Appendix 1: Skin Cancer Levels of Care

British Association of Dermatologists (bad.org.uk)

Care Level	Person or Team	Case Mix/ Procedure
1	Any general practitioner in the community	• Benign lesions • Actinic keratoses • Precancerous - SCC in situ/ Bowen's
2	Listed community skin cancer clinicians associated with a named MDT (LSMDT or SSMDT acting as 'local' LSMDT)	• Low risk BCC
3	LSMDT, hospital staff core team member (may be core member of SSMDT acting as 'local' LSMDT). Without mandatory individual case review by MD.	• High risk BCC • SCC } Other than categories below
4	LSMDT, hospital staff core team member(s), with mandatory individual case review by LSMDT (may be the SSMDT and its core members acting as 'local' LSMDT)	• High risk BCC • SCC } Recurrent or with +ve excision • Malignant Melanoma (MM) – new, single primary, adult, non-metastatic, not for approved trial entry, up to and including stage IIa (must fulfil all these criteria) • Radiotherapy if attendance by clinical oncologist at LSMDT • Lesion where diagnosis is uncertain but may be malignant • Incompatible clinical and histological findings
5	SSMDT hospital staff core team member(s) with mandatory individual case review by SSMDT. (May have been previously reviewed by LSMDT or rapidly referred without prior review) For some cases – only one agreed SSMDT, if more than 1 network Cases to be dealt with by only one agreed SSMDT per Network, if more than one in the Network: • Cutaneous lymphoma • Kaposi's sarcoma • Cutaneous sarcoma above superficial fascia (below fascia, refer to sarcoma MDT) *Note: There should be agreed working arrangements with site specialised MDTs required for sarcoma and mucosal malignant melanoma.*	• Selected BCCs and SCCs needing plastic/ reconstructive surgery by SSMDT core member (as per Network clinical guidelines) • Radiotherapy (as per Network clinical guidelines). If not discussed and treated by LSMDT clinical oncology core team member • Metastatic SCC on presentation or newly metastatic • MM – stage IIb or more, or <19 years or metastatic on presentation or newly metastatic or recurrent or for approved trial entry or +ve excision margins • Any cases for approved trial entry • Any cases for adjuvant therapy (as per Network clinical guidelines) • Histology opinion from SSMDT core pathology team member • Mohs surgery • Skin Cancer in Immunocompromised patients including organ transplant recipients • Skin Cancer in genetically predisposed patients including Gorlin's Syndrome
6	• Supranetwork team. Selected Networks only. Agreed with SCGs. • Clinician responsible for named facilities for photopheresis (very small number of patients). Agreed with SCGs	• T-cell cutaneous lymphoma: Total Body Surface Electron Beam Therapy • T-cell cutaneous lymphoma: Photopheresis

Appendix 2: Skin Measures Flowchart