National Institute for Health and Clinical Excellence

Skin cancer partial update
Guideline Consultation Comments Table
23 November – 21 December 2009

Type	Stakeholder	Order No	Document	Page No	Line No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
SH	Association of Surgeons in Primary Care	3.00	Update	4	31-32	"50% of GPs removing suspected BCCs do not submit them for histology" – Where is the evidence for this. Personal communication as evidence is unacceptable for this important manuscript.	Thank you for your comments. These data have been checked with the National Cancer Action Team.
SH	Association of Surgeons in Primary Care	3.01	Update	6	17-18	We don't believe that –" 24% of primary care workload is related to the diagnosis and management of skin conditions, including skin lesions"	Thank you for your comments – the figure is correct and the reference has been included.
SH	Association of Surgeons in Primary Care	3.02	Update	8	21 - 22	The review paper presented by Dr Roberts has not been itemised in the evidence and it appears to be central to the GDG definition of high risk BCCs. The conclusions appear to run counter to the BAD own guidance: British Association of dermatologists. British Journal of Dermatology 2008 159, pp 35-48	Thank you for your comments. We will reference the review by Dr Roberts which appears in the full evidence review that accompanies the guidance.
SH	Association of Surgeons in Primary Care	3.03	Update	9	19-20	Managing 'multiple' superficial BCCs ….. word 'multiple should be added	Thank you for your comments - we disagree.
SH	Association of Surgeons in Primary Care	3.04	Update	10	18	6 monthly or an annual feedback is more appropriate and practical than quarterly audit. (East Kent current practice)	Thank you for your comments. We agree that 6 monthly would be more appropriate and have revised the document.
SH	Association of Surgeons in Primary Care	3.05	Update	10	34	MDT's should have an educational role too.	Thank you for your comments. You are absolutely right, as specified in the peer review standards
SH	Association of Surgeons in Primary Care	3.06	Update	11	7-8	…..work to agreed local clinical protocols (based on uniform national protocols) for referrals……	Thank you for your comments.
SH	Association of Surgeons in Primary Care	3.07	Update	12	23-25	Whilst this review is not about Model 2 – there is a need for further clarification –between a	Thank you for your comments. The GP expert is a GPwSI and therefore sits within the GPwSI

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						GP expert and Model 2 practitioner.	framework under PCT clinical governance. The Model 2 practitioner is part of an acute Trust governance framework and acts as a surgical technician removing the full range of skin tumours provided they have been pre-diagnosed and the management plan agreed by a core member of the MDT. Some GPwSI's will also be working as Model 2 practitioners. We will clarify this in the final document.
SH	Association of Surgeons in Primary Care	3.08	Update	12	30-36	Feedback of annual review should take place 6 weeks to 2 months prior to commissioning / re commissioning –to ensure quality and safe delivery of service.	Thank you for your comments. We agree that 6 monthly would be more appropriate and have revised the document.
SH	Association of Surgeons in Primary Care	3.09	Update	13	10	6 monthly or an annual feedback to their PCT –not quarterly	Thank you for your comments. Yes we agree
SH	British Association of Dermatologists, The	8.00	Update	General		The draft GDG update on the management of low risk BCC in the community is complex and confusing regarding the proposed new models of care. It is unclear how the governance will ensure patient safety. The document does not appear to focus on patients. The introduction of the new 'GP Expert' practitioner with no guidance as to the recommended training and assessment of these individuals invites inappropriately trained GPs to manage BCCs. The first step in the appropriate management of skin cancer has to be correct diagnosis and no guidance is given on the training of these 'GP Experts' in diagnosis. Misdiagnosis will lead to mismanagement. This appears to be an invitation for untrained GPs to do surgery unsupervised and unlinked to secondary care or the local MDT. We feel strongly that any practitioner treating skin cancer should be a member of the local MDT, with an attendance requirement. This is	Thank you for your comments. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD. The high incidence of BCC necessitates a mixed model of care so we have attempted to introduce a mixed model of care with flexibility to ensure rapid access to best possible quality of care for these patients. The wording regarding clinical governance structures has been clarified in the guidance as will training and assessment for the new GP

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						to the benefit of the patient as the practitioner will establish links with the team members and gain better understanding of their local Cancer Network protocols and pathways. The definition of SS1 and SS2 GPSI surgeons is not clear in either the original IOG, the DH Dermatology GPSI guidance or the Quality Measures; this needs to be properly defined regarding training requirements, competencies and governance of each level. The DES (Directed Enhanced Service) GP surgeons offer patients a wide range of operations such as vasectomy, hernia repair etc. but have not specifically included skin cancer surgery. Skin cancer should not be included in the DES as these practitioners although skilled surgeons are not trained in the diagnosis and management of skin cancer. Referral to Model 2 practitioners via appropriate Peer Reviewed routes is a safer management pathway for patients. Although the remit of this GDG update is the management of low risk BCC in the community, it highlights the issue of the management of high risk BCC by good experienced GPSIs. The current guidance makes it difficult for these doctors to manage more complex BCCs which are within their capability. Some attention needs to be given to allow these experienced doctors, trained in cancer diagnosis and management, to manage more complex cases while maintaining links with secondary care and being member of the local MDT. Below are the individual comments returned by	expert. Correct diagnosis is very important and we have recommendations to improve training in undergraduate and post-graduate curricula to address this. The clinical governance structure for GP has been clarified. The definitions of GPwSI surgeons will be further clarified. We disagree as GP's should be able to remove low risk BCC under the DES agreement. Other skin cancers are covered by existing NICE guidance and therefore by implication excluded by DES. There appears to be a group of GPwSI's with a very great deal of experience and training operating in the community and the GDG have reviewed the levels of expertise of GP's and the appropriate type of work they will undertake.

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						our members following the publication and circulation of the Draft GDG update:	
SH	British Association of Dermatologists, The	8.01	Update	General		Throughout, it is insufficiently clear how this guidance sits with the IOG & to what extent the frameworks for training and accreditation are superseded	Thank you for your comments. This is an update of one section of the original NICE skin cancer IOG.
SH	British Association of Dermatologists, The	8.02	Update	General		• Potential confusion of referring GP as to exact demarcation of high (H zone) and low (intermediate) risk areas on the face. Patients inappropriately referred to a primary care service will then have an unnecessary delay before ultimately seeing the dermatological surgeon. • Lack of evidence that surgery performed by GPwSI is cosmetically equal to that performed by Dermatological surgeons. • General evidence that margins of surgery performed on 'like for like' lesions are poorer for GPwSIs than Dermatological surgeons. • Risk of SCCs on face being excised as 'BCCs'. A scenario that often occurs in my area. • Risk of badly planned flaps/grafts leading to future problems with narrowly excised facial lesions which then have to be widely excised by Plastic or Dermatological surgeons who are trained to constantly think of the next step. • Lack of continued experience of GPwSIs operating on facial areas as numbers of patients will be lower. Surgical expertise is built up not only by initial training but also by continued practice. More complex surgery is inevitably going to be better performed by individuals who are routinely operating in this area. • Lack of sterile operating environment in Primary care practice rooms with potential	Thank for your comments. We have taken them into consideration whist making revisions to the guidance.

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						increase in infection risk. • Lack of follow up structure in Primary care.	
SH	British Association of Dermatologists, The	8.03	Update	6	32	Patients surely want practitioners who treat them to be doing a sufficient number per annum to maintain skills. This number should be mentioned to avoid operators doing too few procedures.	Thank you for your comments. The GDG patient/carer representatives were very clear that they would want, regardless of age, to have the best possible results of curative removal and a good cosmetic result
SH	British Association of Dermatologists, The	8.04	Update	7	13	This terminology could include consultant dermatologists and so seems misleading	Thank you for your comments
SH	British Association of Dermatologists, The	8.05	Update	7	21-29	You refer to 3 key documents – yet there is no document dealing IN DETAIL with the non-dermatology GPwSI who wishes to perform surgery including cancer work.	Thank you for your comments. Reference 29 details this but we will clarify in the final guidance.
SH	British Association of Dermatologists, The	8.06	Update	8	11	The most striking omission is that no definition of low risk BCC is provided. This seems to be assumed that anything not high risk is low risk. A definition of low risk BCC should be included. E.g. well defined, primary, nodular BCC, no more than 10mm in diameter on the trunk and limbs	Thank you for your comments. In the light of stakeholder comments we have reviewed the definitions of high risk BCC to ensure these are as clear as possible. The remainder will be low risk but clinicians will need to take in account factors such as anatomical location even for low risk BCC, for example back of elderly hands or on shin where resection or cosmetic result may be difficult.
SH	British Association of Dermatologists, The	8.07	Update	8	11	The simple definition of low risk bcc is much more helpful, though histology is still mentioned at one point.	Thank you.
SH	British Association of Dermatologists, The	8.08	Update	8	27	'might' instead of 'would'	Thank you for your comment. We have amended the guidance.
SH	British Association of Dermatologists, The	8.09	Update	9	4	I think that morphoeic, infiltrative and micronodular BCCs should be specified as lesions that GPs should not attempt to excise if they have done a diagnostic biopsy or reexcise if they have done an incomplete excision.	Thank you for this helpful comment. We have revised the definition.
SH	British Association of Dermatologists, The	8.10	Update	9	4	This definition of high-risk BCC is very straightforward and less open to interpretation by unskilled GPs. All skilled surgeons will still be able to do complex ops if patients referred via MDT. Difficult for skilled cancer trained	Thank you for your comments. We know this is an issue and we have revised the definition accordingly.

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						GPSIs who would now be more restricted.	
SH	British Association of Dermatologists, The	8.11	Update	9	4	the definition of high risk seems reasonable, but there appears to be no flexibility in the text to loosen this definition for good accredited GPWSIs who are very experienced to progress and take on more difficult cases where the definition of high risk using the H zone might be more appropriate.	Thank you for your comments. We know this is an issue and we have revised the definition accordingly.
SH	British Association of Dermatologists, The	8.12	Update	9	4	The High-risk BCC definition is excellent and very helpful.	Thank you.
SH	British Association of Dermatologists, The	8.13	Update	9	4	I think I would also suggest that any patient who is under 30-40 should also be immediately referred to secondary care with a suspected bcc (regardless of any other factors).	Thank you for your comment. We have now included the following recommendation from the original Skin Cancer Improving Outcomes Guidance: 'All children and young people (aged 24 or below) with a suspected skin cancer including BCC should be referred to a member of the skin cancer multidisciplinary team (MDT) regardless of suspected lesion diagnosis, size or anatomical location'. The definition of children and young people from the Skin IOG and the Children and Young People's IOG is 'aged 24 or below'. While BCC is rare, melanoma is not that rare in children and young people and it is important to get the correct diagnosis.
SH	British Association of Dermatologists, The	8.14	Update	9	4	Definition of High Risk: First, I think that the neck should be included as it is difficult to operate on in some areas, so the term should be head and neck. However, I think that if the system were worked differently it would be as follows in the GP referral system: The lesion has to have a tick in ALL boxes to be referred to the primary care skin cancer	Thank you for your very helpful comments. We know this is an important an issue and we have revised the definition accordingly.

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<tr><td></td><td></td><td></td><td></td><td></td><td></td><td>service:

<table><tr><td>Tick if true</td><td></td></tr><tr><td></td><td>New primary tumour (not recurrence)</td></tr><tr><td></td><td>Not on the head or neck</td></tr><tr><td></td><td>Be less than 2cm across, unless it is very superficial</td></tr><tr><td></td><td>Be well defined</td></tr><tr><td></td><td>Be located away from important arteries or nerves</td></tr><tr><td></td><td>The patient must have normal immunity(not be immunosuppressed)</td></tr><tr><td></td><td></td></tr><tr><td></td><td>Refer to primary care skin cancer service if ALL are ticked</td></tr></table>
The reason I make this point is because it enables the GP to make a positive conscious process to refer to primary care rather than to make the decision one based on not picking out an exclusion. So secondary care is the default, but can be altered through doing the check list.</td><td></td></tr>
<tr><td>SH</td><td>British Association of Dermatologists, The</td><td>8.15</td><td>Update</td><td>9</td><td>5</td><td>Incompletely excised BCC needs to be added as a separate item.</td><td>Thank you for your comment. This has now been included.</td></tr>
<tr><td>SH</td><td>British Association of Dermatologists, The</td><td>8.16</td><td>Update</td><td>9</td><td>5</td><td>Also suggest the addition of "incompletely excised bcc" to the definition of high risk- these are difficult to excise and form one of the criteria nice suggested in 2/06 for referral for mohs surgery</td><td>Thank you for your comment. This has now been included.</td></tr>
<tr><td>SH</td><td>British Association of Dermatologists, The</td><td>8.17</td><td>Update</td><td>9</td><td>6</td><td>I would also like 'head' sites to include neck and not just scalp.</td><td>Thank you for your comment. We have revised the definitions to be far more precise.</td></tr>
<tr><td>SH</td><td>British Association of Dermatologists, The</td><td>8.18</td><td>Update</td><td>9</td><td>6</td><td>"face and scalp"- This definition will potentially exclude bccs on the ear and neck and these</td><td>Thank you for your comment. We have revised the definitions to be far more precise.</td></tr>
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						are still high risk sites difficult surgical sites esp ear bccs. I would suggest "head and neck"	
SH	British Association of Dermatologists, The	8.19	Update	9	7	BCCs greater than 2cm (can be treated as low risk provided the other criteria mentioned are addressed.) Why 2cm? Why not 2.2cm or 1.8cm?. Where is the evidence for 2cm being a safe cut off point? Size matters when it comes to BCC recurrence risk (irrespective of site). References: • Mohs FE. Chemosurgery. Microscopically controlled surgery for skin cancer. Springfield, Ill, Charles C Thomas Publisher 1978 • Sweet RD. The treatment of basal cell carcinoma by curettage. Brit J Dermatol 1963, 75:137-148. • Breuninger H; Schippert W; Black B; Rassner G The margin of safety and depth of excision in surgical treatment of basalioma. Use of 3-dimensional histologic study of 2,016 tumors Hautarzt; 1989 Nov; 40(11); P 693-700 The evidence is of course incomplete but the Mohs and Sweet data both show that the bigger the tumour the greater the risk of recurrence. The Breuninger data shows that there is a clinically important difference in subclinical tumour extent between 1cm and 2cm wide BCCs. I do not believe there is sufficient evidence to reassure a patient that a 2cm BCC – even one on the trunk- should be treated by a non expert. I would recommend reducing this size to 1cm.	Thank you for your comments. We are trying to produce clear and memorable guidance and that is why 2 cm and not 2.2 or 1.8 has been chosen. This decision was based on clinical consensus. The paper by Breuninger was retrieved and reviewed by the NCC-C. However it was not included in the evidence review as it did not match the criteria specified in the PICO.
SH	British Association of Dermatologists, The	8.20	Update	9	15	The issue of whether all sup BCCs should be referred needs to clarified; it is not clear in the text.	Thank you for your comments. We think this is clear and gives patients a choice of non surgical management.

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SH	British Association of Dermatologists, The	8.21	Update	9	19	Why the term healthcare professional – are they thinking of not using doctors? I would recommend sticking with the term doctor.	Thank you for your comments. We will check to what extent nurses are managing low risk BCC in the community
SH	British Association of Dermatologists, The	8.22	Update	9	27	Healthcare professionals dealing with skin lesions should be trained and experienced in their diagnosis and management – not just have access to training. Wording is vague and in theory could allow non-trained personnel to manage skin lesions.	Thank you for your comments. The issue of training does need to be more clearly defined and this has now been addressed in the guidance.
SH	British Association of Dermatologists, The	8.23	Update	9	27	Simply stating that all GPs must have access to training is very different to providing mandatory training. Any training and assessment must be carefully costed for.	Thank you for your comments. The issue of training does need to be more clearly defined and we are revising the recommendations to be more appropriate to the role of the GP. NICE will be developing a costing template for this update to assess whether it will have a significant financial impact on the NHS.
SH	British Association of Dermatologists, The	8.24	Update	9	30	There is no clear guidance on how to be an assessor of surgical competence - I would suggest a BSDS member/ BAPRAS member. It should be a core member of an LSMDT who undertakes at least one surgical list a week.	Thank you for your comment. We feel the revised recommendations are now adequate.
SH	British Association of Dermatologists, The	8.25	Update	9	32	There is no mention of MDT or minimum number of cases. Will the PCT or Peer Review teams be tasked with making sure practitioners meet minimum requirements	Thank you for your comments. The GDG have not specified a minimum number of cases and the recommendations relating to MDT have been revised. We have strengthened the clinical governance section.
SH	British Association of Dermatologists, The	8.26	Update	9	32	There is no mention of MDT or minimum number of cases. Will the PCT or Peer Review teams be tasked with making sure practitioners meet minimum requirements	Thank you for your comments. The GDG have not specified a minimum number of cases and the recommendations relating to MDT have been revised. We have strengthened the clinical governance section.
SH	British Association of Dermatologists, The	8.27	Update	10	1-36	Thus whole section is a very watered down version of the nice initial guidance. GPs excising bccs should attend MDTs. The addition of a new type of educational meeting will only serve to confuse the management of skin cancer –there are already 3 levels of existing MDT- and it is a backward quality	Thank you for your comments. After extensive discussion the GDG felt that audit and accreditation will be a more effective approach to ensuring quality of care than attendance at MDT meetings, however we fully recognise the importance of CPD. GPwSI's will still have a requirement to attend MDTs.

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						move that GP-excised BCCs do not need to be discussed at an MDT or even listed at an MDT	
SH	British Association of Dermatologists, The	8.28	Update	10	14	Log should be used to ensure operator reaches an acceptable minimum number of procedures on skin cancer per annum to maintain skills. Previous minimum number 40 seems reasonable – less than one per week.	Thank you for your comments. An absolute number has not been used but we have clearly specified the competency required.
SH	British Association of Dermatologists, The	8.29	Update	10	24	It is good that the audits should be presented to the MDT quarterly – this could be a good time for the community practitioner to attend the MDT – i.e. 4 per year.	Thank you for your comments. The audits will be 6 monthly and recommendations to attend an annual CPD session will remain.
SH	British Association of Dermatologists, The	8.30	Update	10	32	There is a burden on secondary care to provide two 4-hour sessions on CPD for community practitioners per year. However the community practitioner could join the NSSG meetings to present audit and provision of CPD for them could be included – duty shared between secondary care practitioners probably manageable.	Thank you for your comments. We envisage that the CPD session will be organised by the skin cancer NSSG.
SH	British Association of Dermatologists, The	8.31	Update	10	24	Happy with all community data to PCT and thereby MDT quarterly. This needs to be highlighted as something that must be looked at as part of peer review	Thank you for your comments. We hope that peer review will pick this up.
SH	British Association of Dermatologists, The	8.32	Update	10	27	No total numbers of BCC excisions per year are mentioned. This undermines our previous efforts over the last 2 years to establish quality standards in BCC management. There has to be a minimum number: ?20-40 at least. This was a key driver in establishing a small, highly experienced group of GP operators.	Thank you for your comments. An absolute number has not been used but we have clearly specified the competency required.
SH	British Association of Dermatologists, The	8.33	Update	10	32/32	Twice yearly meetings big time commitment for secondary care who already stretched with MDTs and the other meeting requirements for Peer Review etc	Thank you for your comments. This is a network responsibility but could be linked to national peer review standards.
SH	British Association of Dermatologists, The	8.35	Update	11	17	This sentence should make it clear that primary care accreditation includes training in diagnosis and surgery of skin lesions	This has been revised to make it clear that all healthcare professionals treating skin lesions in the community should have training in diagnosis

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							and surgery of skin lesions.
SH	British Association of Dermatologists, The	8.36	Update	11	4	Important	Thank you.
SH	British Association of Dermatologists, The	8.37	Update	11	17/18	Does this accreditation still include minimum number of cases?	Thank you for your comments. An absolute number has not been used but we have clearly specified the competency required.
SH	British Association of Dermatologists, The	8.38	Update	11	23	The PCTs in my area (Greater Manchester) are just not equipped to commission this complexity of services. In my view the area most in need of support is the PCT commissioning and accreditation process.	Thank you for your comments. PCTs do need support in commissioning and this document will help to clarify what they need to do.
SH	British Association of Dermatologists, The	8.39	Update	11	23-29	We have tried this and the amount of relevant data is limited for projection. Firstly, histological records that are available from hospital services only illustrate the ones that were treated surgically, and many may not be treated this way. Secondly, they do not illustrate the number patients that might be referred with lesions that give rise to concern but do not turn out to be skin cancer. So although it sounds good to do this kind of modeling, I don't think that it will give PCTs much of a true idea.	Thank you for your comments. There is some evidence of geographical variation of BCC demographics (age), and ethnicity will also play a role in the incidence of BCC. The PCT could get some data from local histopathology departments on the number of cases being processed. At present there is virtually no needs assessment being undertaken and therefore commissioning of services for skin cancer can be imprecise and may result in under funding of services. The more the data is used the more accurate it will become.
SH	British Association of Dermatologists, The	8.40	Update	11	23-32	It emphasizes the duty of the pct's to get their GPs in order and doing regular audit submission etc. However, I think it is really important that we in secondary care resist the suggestion that we 'shop' our GP colleagues and send copies of histology reports etc to the pct (as has just been suggested by the pct to our hospital!!). My favoured view regarding commissioning is that is should be consultant led right from the start.	Thank you for your comments. We will be recommending that audits are collated from histopathology and follow a system similar to cervical screening quality assurance that is well established and allows PCTs to identify problems with individual practitioners.
SH	British Association of Dermatologists, The	8.41	Update	12	8	Diagnostic skills should be assessed as well as surgical skills which are to be assessed by DOPS	Thank you for your comments. The intention of the guidance is that this will happen and this aspect is considered very important. Additionally practitioners will be expected to perform and present the results of an audit of clinical diagnosis versus histological diagnosis to

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							provide evidence of diagnostic competency.
SH	British Association of Dermatologists, The	8.43	Update	12	11	This sentence is vague. Should mention teledermatology or photography if that is what is intended.	Thank you for your comments. We will revise this sentence.
SH	British Association of Dermatologists, The	8.44	Update	12 13	17-36 1-20	The methods by which GPs can be accredited to work in primary care remain confusing. The guidance seems to imply that even for low risk BCC the same complicated methods of accreditation apply. Is this the intention? I'm sure it should be, but if this is the case I don't see really how this guidance simplifies the current situation.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	British Association of Dermatologists, The	8.45	Update	12	19	Model 1 stays the same - the old rules, requirements still valid?	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	British Association of Dermatologists, The	8.46	Update	12	19-36	Very happy with the first two bullet points which requires a GP to have a special interest and undertake SS1/2 and be accountable to the MDT, but I am very worried about the remaining bullet points referring to those GPs who are already performing minor surgery - some excellent and some dangerous. They only need to be accountable to the PCTs, and I would urge that just one route of service approval be given for all i.e. the same as the first two point and they should satisfy the local MDT and NOT the PCT.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD. The GDG are also strengthening the contractual

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							arrangement between the PCT and the GP providing the skin cancer service.
SH	British Association of Dermatologists, The	8.47	Update	12	20-22	Model 3 stays the same – but now incorporates Model 2 - or is this just grouped together for convenience? If they are not core members can they treat without scrutiny or must this be in a joint clinic setting? What does "new model 2" mean? For "old" model 2: • Does it still exist? Do they still function under the old rules, requirements? • Can they now see-and-treat low risk BCCs without it going via the MDT – the general surgical GP below apparently can? • Does the 40 BCC rule still apply – should this be looked at if they can treat anything sent by the MDT not only BCCs? Not a new question but as things are changing is this the time to visit this as well? • Following on from this – should they also have ACSTraining? They could in theory be treating MMs and SCCs in the community. They would have to break bad news initially and transfer to the secondary care thereafter.	Thank you for your comments. The document does not refer to Model 3. It indicates that Group 3 GPwSI's will continue to be able to provide community cancer services for low risk BCCs 'New' Model 2 practitioners is referencing the fact that this was a new role developed as part of the development of the peer review process. There are no plans to change this role as previously described in the peer review document but instead to strengthen and promote the development of this role where the clinician: • Performs only the surgical procedure (having demonstrated surgical competency) • Can excise any pre-diagnosed skin cancers including MMs and SCCs • Works within an acute Trust governance framework and is linked to an MDT • Breaking bad news will be done by the core member of the MDT that is making the diagnosis • The Model 2 practitioner works as a surgical technician only The 40 BCC rule is unlikely to apply, but this is documented in the dermatology and skin surgery GPwSI Guidance which will be reviewed and updated once this guidance is complete.
SH	British Association of Dermatologists, The	8.48	Update	12	23	What is the 'New GP expert in skin lesions'? Is this a GPSI in skin cancer? SS1 and SS2 have surgical skills but not diagnostic skills. Is it proposed to offer modular training in recognition and management of skin lesions to accredit this group?	Thank you for your comments. The new GP expert in skin lesions will be a GP with a special interest in skin lesions and the framework for training and assessment will be agreed as part of a review of the dermatology and skin surgery GPwSI document which will take place once the updated skin cancer guidance is published.

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							SS1 and SS2 competencies are appropriate when assessing surgical competency, other tools will be used to assess diagnostic skills such as mini-CEX. See 2007 DH dermatology and skin surgery guidance for current assessment tools. A review of this guidance will consider the assessment tools and competencies required for the GPwSI in skin lesions
SH	British Association of Dermatologists, The	8.49	Update	12	23	Where is the definition, and what is the remit of the "new GP expert" Is this a new model? Where does governance sit? How does this differ from GPs below (or is it the same just new to the service) and model 2 above? What is the definition/criteria/training and prowess expected of SS1/SS2? How is accreditation achieved?	Thank you for your comments. The new GP expert in skin lesions will be a GP with a special interest in skin lesions and the framework for training and assessment will be agreed as part of a review of the dermatology and skin surgery GPwSI document which will take place once the updated skin cancer guidance is published. SS1 and SS2 competencies are appropriate when assessing surgical competency, other tools will be used to assess diagnostic skills such as mini-CEX. See 2007 DH dermatology and skin surgery guidance for current assessment tools. A review of this guidance will consider the assessment tools and competencies required for the GPwSI in skin lesions GPwSI in skin lesions will provide diagnostic and surgery for skin lesions including low risk BCCs. The training and assessment will be agreed as part of the review of the dermatology and skin surgery GPwSI guidance.
SH	British Association of Dermatologists, The	8.50	Update	12	23	Dermatologists are skin experts, using the terminology proposed will confuse the public and ultimately undermine the dermatology profession when the public, in time, will no doubt perceive that these GPs are the skin experts!	Thank you for your comments. The new GP expert in skin lesions will be a GP with a special interest in skin lesions and the framework for training and assessment will be agreed as part of a review of the dermatology and skin surgery GPwSI document (DH 2007) which will take place once the updated skin cancer guidance is

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							published. Further details of this expert role are presented in the 'models of care' section and Appendix B of the guidance.
SH	British Association of Dermatologists, The	8.51	Update	12	23	Page 12 line 23 'new GP expert': we strongly object to the potential provision of this new provider; we can foresee this becoming labelled as a 'skin cancer expert'; this should only apply to accredited specialists or GPWSI who have undergone the appropriate training, accreditation, continued CPD, governance and liaison with the MDT; this term is very woolly and seems an unnecessary confusing addition ie keep to GPWSI, outreach specialists and accredited GPs who work with the local MDT. It is paramount that any individual who wishes to undertake skin cancer work is appropriately trained with appropriate CPD & governance measures as well as working in conjunction with the local MDT.	Thank you for your comments. The new GP skin lesion expert will be a GPwSI and will sit within the clearly defined frameworks that exist for GPwSI's and the commissioning of GPwSI services. The specific CPD and governance requirements will be identified as part of the review of the 2007 DH GPwSI guidance.
SH	British Association of Dermatologists, The	8.52	Update	12	26	The definition of GP performing minor surgery within the DES is quite thorough but does not mention minimum number of lesions (40) or attendance at MDT. The value of MDT needs to be stressed somewhere in this document – it is not just to discuss individual patients but is important in forming links and relating to colleagues in secondary care.	Thank you for your comments. An absolute number has not been used but we have clearly specified the competency required. The value of the MDT has been reinforced in the revised document.
SH	British Association of Dermatologists, The	8.53	Update	12	26	Simply saying GP need to be properly accredited is v weak the precise requirements need to be more specific- I note under commission it says GPs need to have competencies S1 and S2 but the document also then seems to indicate that anyone already doing excisions can simply keep a log and only new GPs need to demonstrate competency- all GPs excising BCCs should be competent in S1 and S2 and should undergo a DOPS and be signed off competent by the LSMDT lead	We agree and this is what we propose in the guidance.

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SH	British Association of Dermatologists, The	8.54	Update	12	26	Using GPs in our patch and their DES is a recipe for disaster as so few of them know what they are doing (as shown in my audit).	Hopefully this document will address your local issues.
SH	British Association of Dermatologists, The	8.55	Update	12 13	26-36 1-20	This part of the proposal contradicts the "Patient Perspective" of the same document pg 6 lines 26-32	We have looked carefully at this and disagree.
SH	British Association of Dermatologists, The	8.56	Update	12 13	26-36 1-20	This section contradicts and reverses the basis of the 2006 IOG regarding Clinicians working in the community Guidance on cancer services: IOG for people with skin tumours including melanoma Feb 2006 pgs 63+64 "All doctors and specialist nurses working in the community who knowingly treat skin cancer patients should be approved by, and be accountable to, the local LSMDT/ SSMDT skin cancer lead clinician. They should work closely together to agreed local clinical protocols for referral, treatment and follow-up. These should be coherent with network-wide clinical protocols and signed off by the network site-specific lead for skin cancer. Any doctor or specialist nurse who wishes to treat patients with skin cancer should have specialist training in skin cancer work, be a member of the LSMDT and undergo ongoing education (see section on 'Structure and clinical governance'). In the absence of a national body to determine the surgical training within the remit of skin cancer, this should be determined by the network site-specific group for skin cancer and be consistent with the NICE Referral guidelines for suspected cancer. All doctors participating in the MDT should have a letter of appointment from the MDT lead clinician. Ideally all doctors treating patients with skin cancer should have attended a recognised skin surgical course. They should	Thank you for you comments. This is an update to the NICE skin cancer IOG published in 2006.

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						also work at least one session per week as a clinical assistant, hospital practitioner, associate specialist or staff-grade doctor in the local hospital department. This should be in a parallel clinic with an appropriate hospital specialist, normally a dermatologist, who is a member of the LSMDT/SSMDT. This applies to GPwSIs as well, as specified in the joint recommendations by the DH, RCGP and BAD. This is considered essential to maintain skills and promote dialogue with the specialist."	
SH	British Association of Dermatologists, The	8.57	Update	12	35	A DOPS is not a substitute for a log book or list of previous operations and histology reports.	Thank you for your comments. Before being approved as competent to diagnose and manage low risk BCCs it is expected that a portfolio of evidence (including a review of clinical versus histological diagnosis) will be submitted and reviewed by those wishing to excise low risk BCCs. This is in addition to assessment of surgical competence and a review of excision margins/management plans for those already excising BCCs.
SH	British Association of Dermatologists, The	8.58	Update	12	26-36	This is very loose and low skill in comparison with the GPwSI service. The level of proof of competence should be much higher than one DOPS. There is no framework for them to "satisfy their PCT they can make the diagnosis" There is plenty of scope for collusion between the PCT and primary care. There is no statement of the need for a certain number to be done per year. I would suggest that the GP wishing to excise a low risk BCC registers the case prospectively on a web based database that brings the case to the attention of the MDT and hence makes it included in the MDT assessment. The active process of registering the case will make the GP think about the MDT as they register it and	Thank you for your comments. It is expected that competency in diagnosis and skin surgery for GPs excising low risk BCCs as part of the DES will be to the same level as the GPwSI. PCTs will have to be able to demonstrate that the required standards have been met and this will be assessed through peer review. We welcome the suggestion about logging BCCs so that an audit trail can be created.

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						there could be a checklist for them on the website as well as guidance. The histology will be automatically reviewed. Where GPs yield skin cancer histology without registering their cases, then there will be a case for asking them why and if it is frequent, some form of penalty – removal of all DES status?	
SH	British Association of Dermatologists, The	8.59	Update	12	30	These should be able to demonstrate dermatology training ie be GPSI	The guidance should ensure that the standards of competency will be the same whoever is managing the BCC.
SH	British Association of Dermatologists, The	8.60	Update	12	30-32	These should demonstrate by being a group 3 GPwSI	The guidance should ensure that the competency standards will be the same whoever manages the BCC.
SH	British Association of Dermatologists, The	8.61	Update	12	33-36	They should have to go back and obtain retrospective excision data	Thank you for your comments. Before being approved as competent to diagnose and manage low risk BCCs it is expected that a portfolio of evidence (including a review of clinical versus histological diagnosis) will be submitted and reviewed by those wishing to excise low risk BCCs. This is in addition to assessment of surgical competence and a review of excision margins/management plans for those already excising BCCs.
SH	British Association of Dermatologists, The	8.62	Update	12-13		It is very unclear from this update whether the 'levels' in the previous document remain and if so how these recommendations fit. No-one has issue with competent GPs doing a good job but it is difficult to see how these recommendations will ensure only those who practice consistently well can continue if there is potentially no need for:- minimum case numbers, that practitioners only have to do a single DOPS if they have no previous data to present, and that there seems to be no requirement implied for either GP 3 training or if this hasn't been completed and signed off no need for surgeons (previous level 2) to only treat pre-diagnosed lesions (be they BCC SCC	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD. GPs can perform surgery as contracted through the DES provided they have demonstrated competency and that they undergo regular

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						or Melanoma)	annual review of their clinical practice, in particular excision margins and appropriate management of low risk BCC.
SH	British Association of Dermatologists, The	8.63	Update	13	23	There does not appear to be any mention of how these various practitioners receive their referrals. Has the need for referral by MDT member gone? Do GPs now refer straight to SS1/2, or new expert GP, or GP DES surgeon – none of whom are trained in the diagnosis of skin lesions (including the referring GP) ?	Thank you for your comments. Referral pathways are unchanged and are now described visually in the guidance.
SH	British Association of Dermatologists, The	8.64	Update	13	23	The model of a 'surgeon in the community' such as Mr X X at x Medical Centre, X who sees patient referred direct by GPs for excision, does excisions of lesions including cancers and does not follow up any patients himself is inappropriate and poor patient care. Our local skin cancer MDT picks up the pieces in these cases.	Thank you for this information.
SH	British Association of Dermatologists, The	8.65	Update	13	1-2	Should have to demonstrate met group 3 (ie have dermatology training to ensure adequate diagnostic ability) or that will only treat pre-diagnosed lesions if level 2 practitioner	Thank you for your comments. We expect that the same skin surgery and diagnostic competency will be demonstrated for GPs excising low risk BCCs as part of the DES. We hope that some of these GPs will consider becoming accredited as GPwSIs in skin lesions.
SH	British Association of Dermatologists, The	8.65	Update	13	8	There should be specific guidance as to what these robust measures of notifying patients are. In our dept we have v precise robust histology databases with automated warnings when histology has not been reviewed after a certain time.	Thank you for your comments. This is useful and we hope that such systems will become universal in primary care as well
SH	British Association of Dermatologists, The	8.66	Update	13	15-20	Large time undertaking for MDT core members already stretched by MDTs. MDT for GPs seems to have been dropped *but no such reconciliation for secondary care practitioners in any tumour group*	Thank you for your comments.
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.00	Update	General		The committee should be commended on the draft document that has been produced to date. It is a thorough review with many good suggestions for developing the management of	Thank you for your clear suggestions The cost effectiveness of treating low risk BCC has not been evaluated in this guideline. This is

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						low-risk BCCs. in the community. It acknowledges that there is little evidence upon which to develop recommendations for the service, but attempts to provide a framework around which this new service should be focused We feel there are several areas which the proposals should be strenghtened and should be included or acknowledged as part of the core for this framework, not necessarily under these headings. Specifically these include i.Non-discriminatory status ii.Diagnostic skills / Training iii.Surgery iv.Financial implementation v.Clinical Governance vi.Evidence **i. Non-discriminatory Status** This document treats GpwSI differently to consultant working within a hospital environment. GPwSI will need to report their individual healthcare data quarterly to their PCT and annually to the Cancer Network Site Specific Group however this public individual reporting is not required of any other medical practitioner dealing with skin malignancies, although perhaps it should be. GPwSI are also required to maintain a log book of all procedures which will be good practice, but	primarily due to the lack of conclusive clinical data on health outcomes for patients. A de novo economic model would therefore be difficult to construct using quality adjusted life years (QALYs) as the outcome measure by which to judge cost-effectiveness. It is also difficult to accurately capture the difference in cost between surgery by a GPwSI or by a dermatologist in a hospital setting, given the wide variation in payment for GPwSIs across the country. The factors you have highlighted here are important and would impact cost-effectiveness of surgery compared to other treatment options (although transport costs that fall on patients would not be included in an analysis from an NHS perspective, given the imperative to only consider costs borne by the NHS or personal social services). We have addresses these points within the guidance.
				10 &13	17-35 & 3-20		

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						one which is only a requirement for all surgical trainees as part of their Annual Review of Surgical Performance (ARCP). For consultant surgeons a log book using a national database of procedure codes will form part of their evidence for revalidation, however again it is not standard practice for dermatologists. **ii.Diagnostic Skills / Training** The skills that have to be developed require only 3 options to be considered for each lesion - Observation, Excision, or Referral. Current evidence confirms that following appropriate training GPwSI are good at diagnosing benign skin lesions. The focus of training should be on accurate diagnosis of all skin lesions benign or malignant. GPwSI will be referred appropriate and inappropriate lesions for excision and they will need to be able to discriminate between the two. Compared to hospital consultants who deal with skin cancer regularly, GPwSI will be faced with fewer skin lesions and work in community skin cancer sessions where the ratio of skin cancer (SCC/melanoma) to benign/BCC lesions will be relatively lower. Therefore identifying suspicious lesions may be harder. So should all GPwSI be required to be trainied and use a dermatoscope? It is certainly a skill that will aid clinical diagnosis . If GPwSI have a special interest in managing skin malignancy they should want to attend educational sessions more than 4 hours per annum. I would suggest a minimum of 4 meetings per year which would be in addition to their reaccreditation process. The attendance at MDT meetings or outpatient sessions could be skewed to ensure that for	

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				13	35-36	the first 3 years attendance is higher during the learning curve period. This could be once a month for the first 6 months, then once every 2 months for the next 12 months, then every 3 months. This would allow the GPwSI to become part of the skin cancer team and develop the diagnostic skills quickly at the start. The number of GPwSI should be limited to start with, to ensure that those that are working are appropriately trained, that they get the volume of work required to give them the experience needed and to ensure that the governance processes in put in place work. Training should also include detailed knowledge of the various treatments available so that patients are offered the most suitable treatment for their condition. **iii.Surgery** GPwSI as part of their surgical training should be able to recognise the patients with high risk BCCs, discuss the potential operative morbidity of the procedure as well as the expected cosmetic outcome, define the appropriate margin for various skin lesions, excise the lesion in one piece and be able to manage simple complications. GPwSI should be required to review their patients once following surgery for the first year of their role. This will ensure that they can review the results of their surgery and any complications that may arise. This process of feedback is something that is encouraged with plastic surgery trainees in the weekly dressing	

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						clinics and something that all clinicians who work in the private sector undertake routinely. The secondary advantage is that you can deliver the pathology result to the patient. **iv.Financial Implementation** There has been little stated in these guidelines about how the financial costs will be met and what is the most cost effective service for treating this group of patients. It is assumed that excision in the community by a GPwSI is cheaper than excision in a hospital. However there are several factors which need to be considered: a. GPwSI have to send all specimens for histology, whereas a consultant clinician will be more confident of a benign clinical diagnosis and not require histology or not carry out the biopsy. b.There will be reduced transport costs for treatment in the community c.What are the cost implications of setting up community surgical units and maintaining them, compared to a rapid 'pop-in excision service' at a hospital. d.Experience improves speed. How many cases should be completed in a session to make it financially viable? **v.Clinical Governance** This is the most difficult part of the proposed changes. There are no details on how GPwSI	i.v – This is not the case for service guidance and it is outside our scope.

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						will be trained, monitored and accredited. Who will be clinically responsible for assessing their competence? Who will pay for these various levels of accreditation? Will GPwSI in effect become extended core members of the Local Skin MDT? There are many references to papers suggesting that GPs have a significantly higher incomplete excision rates compared to hospital consultants. One would expect this. There is however no discussion on the relevance of incompletely excised low risk BCCs. Does it matter? By definition these are low risk and therefore if they recur the consequences will be irrelevant. It will be similar to the same patient developing another BCC, which, when compared the general population, they will be at a greater risk of doing. The risk of a incompletely excised high and low risk BCC recurring has been shown to be 40%, in other words 60% don't recur. How important is it that GPwSI achieve a 100% complete excision rate? It should also be noted that BCCs treated non-surgically eg topical chemotherapy, currettage and diathermy, do not have histological confirmation of adequecy of excision. The importance is that we have a diagnosis of the lesion, that any high risk BCCs or malignant skin cancers are identified early and referred correctly.	
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.01	Update	8	11	Definition of low- and high- risk basal cell carcinoma	Thank you for your comments
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.02	Update	8	33	The risk of recurrence (incomplete excision) cannot change a low risk BCC into a high risk BCC. High risk is high risk because of its anatomical location and the potential	Thank you for your comments - we have altered the wording.

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						consequences of leaving the lesion / inadequately resecting it or the pathological features of the lesion itself.	
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.03	Update	9	1	A recurrent BCC (one that had been previously adequately excised) should be clearly identified from a persistent BCC (one that had been incompletely excised and has now recurred) as this reflects a factor of the biology of the original lesion.	Thank you for your comments we have altered the wording.
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.04	Update	9	3	Patients with more than ~ 5 BCCs previously excised should be reviewed by the local MDT. 5 is an arbitrary number but the principal identifies people who are at higher risk of other skin malignancy in general.	Thank you for your comments – the GDG discussed this but felt that an absolute number was not required.
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.05	Update	9	19	The healthcare professionals should also have knowledge of all the available treatment options including cryotherapy, topical chemotherapy, PDT etc. This would need to be discussed during their regular MDT and OPD attendance	Thank you for your comments. This is what we mean by a full range of medical treatments. This knowledge will be linked to training and attendance at an annual network update day
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.06	Update	9	26-32	This document is defining the national standard for management of low-risk BCCs and one of the aims should be to try to establish equity and uniformity of care throughout the UK. It should therefore be more specific in what is expected of specialist training. It does not define who is providing the training; the number of hours of CME required; any courses, in addition to (SS1 and SS2 competencies), to be completed eg dermoscopy; the number of lesions to be assessed and excised etc. These criteria have in part been established with the main IOG on skin cancer, with attendance, numbers of lymph node dissections etc	Thank you for your comments. The issue of training does need to be more clearly defined.
SH	British Association of Plastic Reconstructive and	92.07	Update	10	5	The histology request form should be a national standard possibly with a diagram	Thank you for your comments. We agree that histopathology request forms should be

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	Aesthetic Surgeons (BAPRAS)					clearly showing the high risk H-area. The potential confusion of the H-area I think it would be easier to define the 'low-risk' area as anywhere below the neck collar line.	standardised nationally although we will not be pushing for the H-area.
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.08	Update	11	2-21	Again there is no guidance on what is required of "accreditation", "quality standards", "appropriately accredited". There should be also a reference standard for "referral, treatment and follow-up" not in a dicatorial way but to try and develop equality of care over all cancer networks.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD. Most patients do not need following up.
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.09	Update	11	23	I think there is no point commissioners "undertaking a full needs assessment of low-risk BCC for their specific populations" at the moment. It has been accepted that there is no accurate data available at present, so why waste time looking for it. Instead the information that the GPwSI will have to present to their NSSG on a regular basis should be used as the foundation for answering this question. This data collected centrally. An assessment of annual numbers will also help with population planning and BCC incidence.	Thank you for your comments. There is some evidence of geographical variation of BCC demographics (age) and ethnicity will also play a role in the incidence of BCC, and the PCT could get some data from local pathology departments on cases being processed. At present there is virtually no needs assessment being undertaken and therefore commissioning of services for skin cancer is a very imprecise process and may result in under funding of services.
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.10	Update	12	11-15	Innovative ideas... a.The cost of establishing a fixed operating theatre/facility means that to cover a large area either patients have to come to it or several have to be built and maintained. Has it been looked at to develop a mobile theatre facility, which could either be booked by	Thank you for your very helpful comments which were discussed by the GDG. However these approaches will be determined by commissioners as they begin to set up these services.

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						individual practices when they have sufficient patients or more effectively it travels to fixed locations at different practices on a monthly schedule and patients local to this attend ... visa vie the mobile MRI and PET CT scanners. The facility could be restocked at base and different GPwSI could drive it each day. A hub and spoke arrangement. b.The cost of outreach services needs to be looked at, because an experienced individual able to remove 10+ lesions in a session will be more efficient than someone who occasionally removes lesions and as a result is slower. It is therefore essential that GPwSI complete a minimum number of sessions per month to maintain their surgical skills. c. If there was a national template each regional NNS could adapt this generic template for use locally.Consequently each NSSG would not have to develop their own clinical protocols, thereby saving time and money. By comparing protocols derived from an identical template comparison of services would also be easier.	
SH	British Association of Plastic Reconstructive and Aesthetic Surgeons (BAPRAS)	92.11	Update	11	17	There needs to be a GpwSI portfolio. There will be two groups of providers. Those GPs who currently remove lesions and wish to do so and those that want to start. This document needs to define clearly the standards required of anyone who wants to start providing this service. Those GPs already providing such a service need to show that they are compliant with the recommendations, but this could have a 6 month period of grace for them to acquire the evidence needed.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	British Medical Association	10.00	Update	Genera		We feel that where 'Health Care Professionals'	Thank you for your comments. We have ensured

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	(BMA)			I		are referred to in the document it should be made clear whether this refers to GPs, consultants or specialist nurses.	that Health Care Professionals is clearly defined in the final document.
SH	British Medical Association (BMA)	10.01	Update	9	27	We disagree with this statement. Their training should be appropriate to their role. GP skin surgeons need to be trained to GP skin surgeon standards.	The issue of training does need to be more clearly defined. We have amended the recommendations to be more appropriate to their role
SH	British Medical Association (BMA)	10.02	Update	9	30	We disagree with this statement. There is no definition of GP accreditation in this area. Once trained by a GP surgeon trainer, as long as the doctor keeps up to date and has regular appraisals, they do not require GP-accreditation in this area. There is no mechanism for this in the GMS contract, beyond the minor surgery DES. If GPs wish to perform minor surgery outside the DES then it falls within the standards of competencies that doctors set themselves as professionals, as with any other task. If an accreditation process was to be put in place this should not be controlled by local dermatologists. GPs would prefer the skills to be assessed by someone with overall minor surgical skills, preferably a GP but it could be a suitable surgeon balanced by someone with community involvement, otherwise we risk having to be assessed groups of different people.	Thank you for your comments. We have revised the guidance and changed 'accreditation' to 'specialist training'.
SH	British Medical Association (BMA)	10.03	Update	10	17	We do not believe that it would be appropriate for a doctor who removes a BCC inadvertently to have to attend a meeting organised by the local dermatologists. This would be an excessive burden. Annual Multidisciplinary team meetings are acceptable.	You have misread the document here, but we agree.
SH	British Medical Association (BMA)	10.04	Update	10	27	This will result in removal of low risk BCCs becoming limited to one or two GPs working on a high patient population through PBC	We do not envisage this limited model as you have described.

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						arrangements. Is this what is intended?	
SH	British Medical Association (BMA)	10.05	Update	12	23	There is a reference to 'GP experts in skin lesions'. There is no definition of a GP expert in skin lesions, and we do not feel that this should be defined.	Thank you for your comments. The new GP expert will be a GPwSI and will sit within the clearly defined frameworks that exist for GPwSIs and the commissioning of GPwSI services. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Central South Coast Cancer Network	16.00	Update	8	23	agree	Thank you.
SH	Central South Coast Cancer Network	16.01	Update	8	30	agree	Thank you.
SH	Central South Coast Cancer Network	16.02	Update	8	34-35	We have an experienced surgical GPwSI who knows his limitations on treating original 'low risk' facial sites, e.g. forehead, cheeks and chin. Reference, BJD 2009 correspondence, 161, pp187,.I know this does not include cosmetic result but this could be proven if necessary.	We are trying to produce guidance that is clear for everyone.
SH	ConvaTec	20.00				This organisation responded and said they had no comments to make	Thank you.
SH	County Durham PCT and Darlington PCT	22.00	Update	10	1 & 2	Where multiple lesions exist and are removed same time – each specimen is sent in different pots. Is it recommended that each specimen should also have individual histology request form or one request form can be used? If 2-3 specimens from one patient are sent at the same time, then histology reports on each specimen received on one report paper may be more practical for processing by all	We have revised the recommendation and deleted the word 'individual'.

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						concerned. Please clarify recommendation.	
SH	County Durham PCT and Darlington PCT	22.01	Update	General		4mm margins have been quoted throughout the document as ideal; success rates improve with wider excision (but never appear to reach 100%) This suggests that there may be different optimums to achieve a balance between recurrence risk and cosmetic outcome in high and low risk BCCs, and that there may be circumstances where 4mm is inappropriate. Does the committee have any comments, or is it perhaps worthy of specific research?	Thank you for your comments. This issue has been addressed under the definition of high and low risk BCC.
SH	County Durham PCT and Darlington PCT	22.02	Update	6	27	Is there any evidence for these precise statements? This looks like a medical quality assurance statement. Our perception is that the following statements (p7) list patient priorities	Thank you for your comments The GDG patient reps were very clear that they would want, regardless of age, to have the best possible results of curative removal and a good cosmetic result
SH	County Durham PCT and Darlington PCT	22.03	Update	9	34	Presumably this relates to specimens from possibly cancerous lesions as the guideline is not scoped to cover benign lesions - could this be clarified so it is not taken out of context? (it is not a rarity to take 20 identical benign lesions off at one sitting and this amount of histology/ paperwork seems unnecessary for non-cancerous lesions)	This relates to all skin samples.
SH	County Durham PCT and Darlington PCT	22.04	Update	10	14	We support the concept of a log, but how this differs from current computerised record keeping is unclear - well kept computer records should suffice	Thank you for your comments. The concept of 'failsafe' has been emphasised and is supported by the RCGP.
SH	County Durham PCT and Darlington PCT	22.05	Update	13	3	We support the concept of a log, but how this differs from current computerised record keeping is unclear - well kept computer records should suffice	Thank you for your comments. This is to ensure that this actually happens.
SH	County Durham PCT and Darlington PCT	22.06	Update	10	27	We support and encourage the idea of specific CPD but it is important that sessions are truly educational and wide ranging rather than a repetitive box-ticking exercise. Our current experience is that the latter has sometimes	We agree.

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						been the result of guideline implementation.	
SH	County Durham PCT and Darlington PCT	22.07	Update	12	6	The idea of DOPS is acceptable, but we are concerned as to how they will be practically managed and who will carry them out. Coordinating patient, GP surgeon and DOPS assessor will not be easy - or will these be performed on mannequins? We feel it is important to define this at the guideline stage to avoid inappropriate and variable implementation procedures	Thank you for your comments. Wherever possible it is hoped that assessments of competency will be carried out locally by suitably trained experts using the readily available standardised and validated documentation. DOPS assessments in a simulated environment are available and can be used as an alternative. The process is well established for dermatologists in training and other educational settings (such as for nurse surgery).
SH	Department of Health	24	Update	General		In our view, there are no problems with the reference to the minor surgery direct enhanced services (DES). It is for primary care trusts (PCTs) to decide which procedures they want to commission under this DES, either from their GP practices or from other local providers. We would query the sentence stating *"GPs should satisfy their contracting PCT that they are competent in the diagnosis of basal cell carcinomas (BCCs) and carry out the appropriate surgical procedures"*. Our view is that this is more about GPs being able to identify suspected BCCs, to avoid too many unnecessary excisions on patients, rather than being able to actually diagnose the condition (which can only be done in a laboratory). Could you please consider amending the text to *"competent in the identification of potential BCCs"*. The reference at footnote 46 appears to be out of date. Could you please consider re-wording this to read *"The Primary Medical Services (Directed Enhanced Services)(England) Directions 2008"*.	Thank you for your comments - we agree regarding DES. The issue here is that GP's should be able to differentiate between different types of skin cancer. The vast majority of GP's should not be operating on melanoma or SCC and most should not be operating on high risk BCCs. Thank you for correcting the reference.

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SH	Gloucestershire Hospitals NHS Trust	27.00	Update	9	15	Superficial BCC's are classified as low risks but have various non-surgical methods of treatment. My concern is this may be unduly treated surgically. It will clearly depend on diagnostic acumen followed by diagnostic biopsy plus discussion of all choices of treatment with patient	We agree and have made this clearer in the guidance under 'models of care'.
SH	Gloucestershire Hospitals NHS Trust	27.01	Update	9	6	As regards other low risk BCC's on trunk and limbs, these are classified as low risk but have various non-surgical methods of treatment. There is a choice of excision versus double or triple curettage.	Thank you for your comments. We have expanded the section on non surgical treatment.
SH	Leeds Teaching Hospital NHS Trust	86.00	Update	12	26	GP's who perform minor sugery within DES under GMS or PMS should not have quality standards set below those of community GPwSIs or a new GP expert in skin lesions.	They should only be removing low risk BCC and therefore do not need to have the same standards as GPwSI or the new GP expert.
SH	Leeds Teaching Hospital NHS Trust	86.01	Update	12	30	Demonstrating competence should be based on GpwSI accreditation, DOPs etc as per the accrediation documentation. Their previous quality measures eg complete excision rates need to be collected by the PCT/local MDT before approval of service.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Leeds Teaching Hospital NHS Trust	86.02	Update	12	33	GP's already excising BCC's should provide evidence of adequate margins **and** complete excision rates **and** diagnostic accuracy **and** they should undergo a DOP.	Thank you for your suggestion. It is expected that a portfolio of evidence including a review of clinical versus histological diagnosis will be submitted and reviewed by those wishing to excise low risk BCCs in addition to assessment of surgical competence and a review of excision margins.
PR	NETSCC	87.00	Update			1.1 Are there any important ways in which the work has not fulfilled the declared intentions of the NICE guideline (compared to its scope – attached)	Not applicable

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PR	NETSCC	87.03	Update			2.1 Please comment on the validity of the work i.e. the quality of the methods and their application (the methods should comply with NICE's Guidelines Manual available at http://www.nice.org.uk/page.aspx?o=guidelinesmanual).	Not applicable
PR	NETSCC	87.06	Update			2.2 Please comment on the health economics and/or statistical issues depending on your area of expertise.	Not applicable
PR	NETSCC	87.09	Update			3.1 How far are the recommendations based on the findings? Are they a) justified i.e. not overstated or understated given the evidence? b) Complete? i.e. are all the important aspects of the evidence reflected?	Not applicable.
PR	NETSCC	87.19	Update			4.1 Is the whole report readable and well presented? Please comment on the overall style and whether, for example, it is easy to understand how the recommendations have been reached from the evidence.	Not applicable
PR	NETSCC	87.23	Update			4.2 Please comment on whether the research recommendations, if included, are clear and justified.	Not applicable
PR	NETSCC	87.26	Update			Please make any additional comments you want the NICE Guideline Development Group to see, feel free to use as much or as little space as you wish.	Not applicable
PR	NETSCC (1)	87.01	Update	General		None	Thank you.
PR	NETSCC (1)	87.04	Update	General		The methods for the evidence review are correct – an meta-analysis appears not to be warranted in this case	Thank you.
PR	NETSCC (1)	87.07	Update	General		The review clearly needs the input of a qualified statistician; the interpretation of the MISTIC trial appears in places inconsistent with itself and with the excellent HTA report on the trial. There is the impression from the tone that opinion outweighs evidence and there needs to be a more measured interpretation of results.	We have re-written the evidence summary.

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PR	NETSCC (1)	87.08	Update	General		Reporting of results can be sloppy, e.g. on evidence review page 9, 44% v 70% success is given as OR 0.33, but 32 v 92% as 25.47 – the ORs need to both be <1 or both >1 not one either side.	We are only reporting what was in the abstract.
PR	NETSCC (1)	87.10	Update	15	28-38	The authors say that differences in this trial were not significant, and "because it was an equivalence trial" the clinical significance of results can not be assessed. This shows a fundamental lack of understanding of the issues surrounding equivalence trials, and the summary does not accurately reflect the summary in the HTA report on the MISTIC trial. There is clear evidence of the lack of statistical expertise in the panel.	We agree. The MISTIC trial (George et al 2008) was not summarised in full in our report (it was a very big HTA report and we drew out the most relevant parts to include in the evidence summary). In our report we state that "the authors found the clinical significance of this result difficult to interpret" see p 5, therefore we have tried to explain it as the authors had described it in their report. In order to fully quality assess this study again, we need to re-check for validity issues of the study design as equivalence trials tend to require more vigorous design issues than comparative studies. One important aspect of the study design is the power calculation and to be convinced that this study had enough participants in it so in order to detect true equivalence. Our feeling is that they didn't but we need to look at this study again.
PR	NETSCC (1)	87.11	Update	5	7	Rates are "much higher" in SW England, without any idea of confidence intervals. It is likely that the rate could be as little as 15% higher, and by choosing the region with the highest incidence, this could be seen as cherry picking. There is therefore insufficient evidence to support the conclusion – it would however be acceptable to say that the highest rate occurred in SW England.	We have checked this with the SWPHO and revised the guidance.
PR	NETSCC (1)	87.12	Update	5	25-27	Where is the evidence that unless attitudes change, rates must increase? While it appears logical, an evidence based guideline needs to either support this scientifically or remove as it currently appears to be mere editorialising.	The GDG felt that this statement was correct, based upon expert opinion.

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PR	NETSCC (1)	87.13	Update	6	27-32	There are no references for the patient perspective – where is this from? In particular, is the average patient really concerned that much about audit?	The GDG patient/carer representatives were very clear that they would want, regardless of age, to have the best possible results of curative removal and a good cosmetic result
PR	NETSCC (1)	87.14	Update	7	13	It was recognised that training was limited in 1998 and 2004 – what about more up to date evidence to justify the present tense?	The recently published document (2009) entitled Skin conditions: a health care needs assessment by Schofield et al reviews this further and concludes that there has been little change.
PR	NETSCC (1)	87.17	Update	General		Throughout, the report says there is a lack of evidence, but the recommendations appear to be rather too clear cut given the lack of quality evidence	The recommendations were based principally on GDG consensus and this is made clear in the Linking Evidence to Recommendations section.
PR	NETSCC (1)	87.20	Update	General		There are a lot of statements here that appear to be quite dogmatic, but lacking in evidence – why, given the results of the RCT is it quite clear that commissioners should commission from a wide variety of sources? (page 12)	The majority of recommendations were based on GDG consensus and their collective experience and expertise to identify good clinical practice. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
PR	NETSCC (1)	87.24	Update	14	4-7	The research questions addressed don't address the ultimate question of the best care model – evidence is currently limited as the reviewers admit, yet purely epidemiological and prognostic measures are all that is proposed. Why not a large RCT to answer the question of who should treat what kind of BCC? Predictive in line 6 is misused and should be prognostic – predictive implies an	Thank you for your comments. A large RCT which included high risk BCC would be unethical as it is well established that these should be managed by experts (theoretically an RCT of low risk BCC's could be conducted) We have amended the wording.

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						RCT and interaction between treatment and covariates.	
PR	NETSCC (1)	87.27	Update	General		My main comment is that a lot has been made here of very little. As someone who believes that competence outweighs convenience every time, the low weight given to the one RCT bothers me. There is a clear need for good quality evidence and this need should be made clearer – at present there is a lack of statistical understanding, and the report does not read like a scientifically motivated document, but rather an opinion piece.	The majority of recommendations were based on GDG consensus and their collective experience and expertise to identify good clinical practice.
PR	NETSCC (2)	87.02	Update	General		No omissions noted	Thank you.
PR	NETSCC (2)	87.05	Update	General		Guideline complied with Quality and Methodological guidelines	Thank you.
PR	NETSCC (2)	87.15	Update	General		All the critical aspects of evidence are appropriately presented	Thank you.
PR	NETSCC (2)	87.18	Update	General		The limitations of the evidence are clear however it would be appropriate to provide a key point summary	The 3 key studies are summarised in the Evidence Summary.
PR	NETSCC (2)	87.21	Update	General		A flow chart would improve the readability of the requirements for the different groups (EG: GP's Commissioners)	We agree – and these have now been included in the guidance.
PR	NETSCC (2)	87.22	Update	General		Key point boxes would also improve retention of key points	We agree – and we have now put the models of care into boxes.
PR	NETSCC (2)	87.25	Update	General		The research recommendations are clear	Thank you.
SH	NHS Improvement	44.00	Update	12	23	It is not made clear how this role will ad value to those already described in detail in the previous DH document on GP working and Dermatology. If such a role is to be developed then more clarity is needed defining the role and competencies required.	Currently a GPwSI in dermatology has to complete the full range of training in inflammatory skin disease and skin lesion diagnosis and management. This new role will enable GPs to be trained and accredited in skin lesion diagnosis and management (including skin surgery) only. The GPwSI will become expert in this particular area ONLY of dermatology. Since up to 50% of specialist referrals are for skin lesion diagnosis, we believe that this new role could help in ensuring timely

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							access to diagnosis of skin lesions provided a suitable training and accreditation framework is developed. The DH has agreed to fund a review of the 2007 dermatology and skin surgery guidance and the role and competencies will be clarified as part of this process.
SH	NHS Improvement	44.01	Update	12	26-36	Surprised that this has been approved by the experts in the GDG and the patient representatives as in essence this allows any GP to excise BCCs without the formal assessments required by the previous DH guidance. A single DOPS is completely inadequate.	It does not allow any GP to excise a BCC. We are focussing on the low-risk BCC. The DOPS is part of a process that also includes prospective audit, feedback, training and CPD.
SH	NHS Improvement	44.02	Update	1	13	Even worse, a new GP starting such a service may only need to undergo a single DOPS to demonstrate competency. Were all the experts and patient representatives asleep when this was agreed?	Single DOPS doesn't stand alone – it is in the context of single audit.
SH	North East Lincolnshire Care Trust Plus	48.00	Update	12	17	Particular focus of line 26	Thank you.
SH	North East Lincolnshire Care Trust Plus	48.01	Update	12	26	The DH guidance 074665, as well as outlining the accreditation requirements for GPs with a specialist interest for dermatology, also highlights the requirements for community skin cancer clinicians. These are not mentioned in this guidance. Would it be appropriate that, set within the governance arrangements outlined within the DH guidance, these clinicians could be commissioned by the PCTs. This would appear appropriate as their service arrangements would often be consistent with those historically delivered through Directed Enhanced Services. This approach would also support a consistency and perhaps make the governance arrangements more robust.	Thank you for your comments. Community skin cancer clinicians are referred to as Group 3 GPwSIs throughout this document (as per the DH guidance 074665). They are commissioned and accredited by PCTs. The plan is that GPs working through the DES that have demonstrated competency in the diagnosis of low risk BCCs and in skin surgery (via a DOPS assessment) will also be able to remove low risk BCCs (subject to an annual audit).
SH	North East Lincolnshire Care Trust Plus	48.02	Update	13	1	For new doctors, potentially as per the above comments, who wish to enter into the community skin cancer arrangements / enhances service arrangements, would their	Yes - Group 3 GPwSIs will need to be accredited according to the 2007 DH guidance.

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						training requirements be comparable to those as advocated within DH074665 for new community skin cancer clinicians?	
SH	North East Lincolnshire Care Trust Plus	48.03	Update	13	15	Would it be appropriate for the training requirements to be comparable to those for the community skin cancer clinicians?	We would expect standards of training and demonstration of competency to be the same whoever is managing low risk BCC.
SH	North East Lincolnshire Care Trust Plus	48.04	Update	11	34	Given the anticipated increased numbers of BCCs and given that they are frequently found on the face and scalp, would it be appropriate to consider some community skin cancer clinicians who have received or demonstrated an expertise in managing such cases to continue to provide this service, supported by appropriate governance arrangements? Within this arrangement, high risk BCCs, as per the current skin cancer guidance, would be managed in conjunction with the MDT.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD. We anticipate these models of care that would permit this.
SH	North East Lincolnshire Care Trust Plus	48.05	Update	10	21-25	Fully support a comprehensive audit of all BCCs excised in the community. Will there be a recommendation for a comparable audit to be undertaken within the specialist service to enable appropriate peer review?	The comprehensive audit of BCC is not limited to the community - it includes secondary and tertiary care as well.
SH	North East Lincolnshire Care Trust Plus	48.06	Update	11	17	Inevitably, if suspected BCCs are removed by, for example, community skin cancer clinicians in the community some, following histological assessment, will be shown to be squamous cell carcinomas. Providing they are then managed through the MDT as per the Improving Outcomes Guidance, this is acceptable. Inevitably, to some extent, with the exception of malignant melanomas, the management of skin lesions in the community will be 'excision to clarify the diagnosis by histology' rather than having an initial definitive diagnosis of a BCC. Perhaps this emphasis could be considered to be included within the guidance?	Thank you for your very helpful comments which have been considered during the revision of the guidance.
SH	North East Lincolnshire Care	48.07	Update	Genera		On behalf of N E Lincolnshire health	Thank you for your very helpful comments.

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	Trust Plus			I		community we welcome NICE's review of the management of low risk basal cell carcinomas in the community. We appreciate that the review is endeavouring to ensure historic good community practice can be incorporated into the updated service provision, supported by an appropriate governance framework. The governance framework should look at having a focus both of quality assurance of the service but also appropriate professional development and peer review. We welcome this opportunity of a rationalisation of the various accreditation arrangements that have been in place historically and since the introduction of the IOG, for example those developed through enhanced service / minor surgery arrangements, the GPwSI and the community skin cancer clinicians. Our approach to date as a health community has been to look to harness skills across primary and secondary care to appropriately deliver the Improving Outcomes Guidance. We would be more than happy to share our experience with the NICE Review Group given the significant community element.	
SH	North Trent Cancer Network	88.00	Update	9	6	"face and scalp"- This definition will potentially exclude bccs on the ear and neck and these are still high risk sites difficult surgical sites esp ear bccs. We would suggest "head and neck"	The definitions have been revised in the models of care section.
SH	North Trent Cancer Network	88.01	Update	9	14	Also suggest the addition of "incompletely excised bcc" to the definition of high risk- these are difficult to excise and form one of the criteria nice suggested in 2/06 for referral for mohs surgery	Thank you for your comments - the definition has been revised in the document.
SH	North Trent Cancer Network	88.02	Update	10		Thus whole section is a very watered down version of the nice initial guidance. GPs excising bccs should attend mdts. The addition	Thank you for your comments. After extensive discussion we think that audit and accreditation will be a more effective approach to ensuring

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						of a new type of educational meeting will only serve to confuse the management of skin cancer –there are already 3 levels of existing mdt- and it is a backward quality move that GP-excised bccs do not need to be discussed at an mdt or even listed at an mdt.	quality of care than attendance at MDT meetings. However we recognise the importance of CPD. GPwSI's still have a requirement to attend MDTs.
SH	North Trent Cancer Network	88.03	Update	12	26	Simply saying GP need to be properly accredited is v weak the precise requirements need to be more specific- I note under commission it says Gps need to have competencies S1 and S2 but the document also then seems to indicate that anyone already doing excisions can simply keep a log and only new GPs need to demonstrate competency- all GPs excising bccs should be competent in S1 and S2 and should undergo a DOPS and be signed off competent by the LSMDT lead	Thank you for your comments. We agree and this is what we propose. All practitioners will be expected to demonstrate competence, keep a log diary and undergo audit if they are to excise low risk BCCs in the community.
SH	North Trent Cancer Network	88.04	Update	10	32	Why ask for the NSSG to provide an educational meeting twice a year when originally this was to be organised locally? This was considered in our Network but thought to be too difficult whilst local teams can have more appropriate meetings and the GPwSI are more likely to attend	It will be up to the NSSG to decide. They could link with the peer review measure when organising such events
SH	North Trent Cancer Network	88.05	Update	12	23	"a new expert GP" means yet another additional level which isn't necessary	We disagree. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	North Trent Cancer Network	88.06	Update		8	There should be specific guidance as to what	Thank you for your comments. We hope that

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				13		these robust measures of notifying patients are. In some departments we have v precise robust histology databases with automated warnings when histo has not been reviewed after a certain time.	such systems will become universal in primary care as well
SH	North Trent Cancer Network	88.07	Update	General		Comment for the whole document: this is just making it more and more impossible for GPwSI to treat skin cancers under these new proposed guidelines.	We disagree. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	North Trent Cancer Network	88.08	Update	7	6	The BAD guidelines discuss the possibility that no treatment may be needed for frail, ill patients with low grade BCC on the trunk etc which are not symptomatic. This is not addressed in the document.	Thank you for your comments. We have now addressed this in the document.
SH	North Trent Cancer Network	88.09	Update	10	30	Half a day study leave every year to discuss diagnosis and management of low grade bcc seems out of proportion	We disagree. The whole GDG felt 4 hours CPD per year was appropriate for skin lesion recognition and the diagnosis and management of low-risk BCCs.
SH	Primary Care Dermatology Society	53.00	Evidence Review And Draft for consideration	General		The Primary Care Dermatology Society (PCDS) is grateful to be involved in this consultation and thanks NICE for the opportunity to contribute. The PCDS has consulted its membership asking for comments on the Draft IOG for skin cancer. We have had substantial response, including 25 detailed audits and many more brief audit results. We are deeply concerned that the Draft IOG as it stands will not allow the NHS to cope with the huge increase we see and expect for BCCs. Much of the guidance is good and fully	Thank you.

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						acceptable but there are areas which risk undoing some of the good work and successful innovations that the NHS reforms have produced.	
SH	Primary Care Dermatology Society	53.01	Evidence Review	General	90nwards	'The evidence base for this topic consists of one randomised controlled trial (RCT), non-3 randomised observational studies (both prospective and retrospective), meeting abstracts 4 presenting audit data, some audit data from specific health services and published 5 correspondence. Almost half the evidence was generated from within the UK, with the other 6 half generated from Australia and one paper published from New Zealand. Applicability of 7 the Australian evidence is limited in the UK setting. None of the audits sent in by the PCDS (albeit not peer reviewed were listed and therefore presumably not considered.	All these references were considered and clearly described in the full evidence report. Due to inconsistency in collection of audit data it was very difficult to make overall conclusions about current practices and outcomes.
SH	Primary Care Dermatology Society	53.02	Evidence Review	General		A list of audits some already provided others a result of the concern regarding the Draft Guidelines. Ron Higson North East last 300+ BCC excisions– 97% complete excision rate and this includes approximately 80% in "high risk" areas. Julian Peace Number of procedures performed for suspected cancer – 31 Breakdown of diagnoses 24 BCCs 1 SCC 2 Bowen's 1 Clear cell acanthoma 1 Spitz naevus 1 Trichoepithelioma 1 Stasis dermatitis (not mine - the boss asked me to excise this 'BCC'!)	We are at liberty to include audit or abstract data that comes in after the submission deadline. Essentially these data just add to the rather limited evidence body and doesn't really change the overall recommendations.

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						1 incomplete (collar of superficial around a nodular BCC)
						Therefore complete excision rate 97%
						
						Martyn Chambers and Simon De Vos
						Clinical Audit
						As part of the accreditation process to become a GP with a special interest (GPSI) in skin cancer, both doctors presented their audit data to the Local Skin Cancer Multi-disciplinary Team (MDT) in January 2009. The audit results were as follows:
						
						MC
						• Summary
						  ○ Data collected from 28/2/2008 to 22/1/2009 (11 month period)
						  ○ Total procedures: 122
						  ○ Excisions for suspected cancer: 56
						  ○ Excisions of BCCs: 41
						  ○ Incomplete BCC excisions: 1 (superficial component only)
						  ○ Incomplete excision rate for BCCs: 2.4%
						  ○ Incomplete excision rate for all suspected skin cancers: 1.8%
						• 114 procedures were performed in secondary care. 67 were excisions of which
						  ○ 33 BCCs (23 were head and neck tumours)
						  ○ 16 moles
						  ○ 3 melanomas
						  ○ 5 SCCs
						  ○ 7 wide local excisions for melanoma	

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						○ 3 other • In primary care, 8 BCCs were excised (4 head and neck) SDV • Summary ○ Data collected from 29/1/08 to 6/1/09 ○ Total procedures: 275 ○ Excisions for suspected cancer: 112 ○ Excisions of BCCs: 61 ○ Incomplete excisions: 1 Merkel cell (presented as cyst) ○ Incomplete excision rate for BCCs: 0% ○ Incomplete excision rate for all suspected skin cancers: 0.8% • Total excisions were as follows: ○ BCC – 61 (Head and neck: 45, Body: 16) ○ SCC – 8 (Head and Neck: 5, Body 3) ○ MM & MMIS – 13 ○ Merkel cell - 1 ○ Wide local excision – 29 • Total Shaves / Punches: ○ BCC – Shaves: 45, Punch Bx: 6 ○ SCC – Shaves: 3 (in Bowens x1, in AK x1) • Excisions of precancerous/dysplastic lesions ○ Dysplastic naevi: 15 ○ (Benign naevi: 18) ○ Spitz: 2	

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						○ AK: 6 + 1 Bowens ○ KA: 3 ○ (SK:6) Conclusions • We have demonstrated that properly trained GPs can safely perform skin cancer surgery of all types, particularly BCCs • The majority of our BCC excisions were for high-risk lesions under the current definition • Our incomplete excision rates were very low and comparable to consultants and experienced registrars within the Dermatology Department Discussion Our audit data has demonstrated that properly trained GPs can safely excise BCCs and other skin lesions in a hospital setting. Oxfordshire PCT is in the process of commissioning a community skin cancer clinic and MC and SDV will be the clinicians providing this service. In our opinion, there are several key areas where the NICE IOG for skin cancer makes such a service potentially unviable or extremely difficult to provide. Alison Buckly Stockport 43 excisions were performed for suspected BCCs Only 1 was 'incompletely excised' . This patient, a 75 year old lady, had a nodular BCC on her left forehead. She has opted to be monitored rather than further surgery. One year post op there is no evidence of recurrent BCC.	

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						38/43 were confirmed as BCCs on histology. The 5 not confirmed were: 1. Dermatofibroma 2. Seborrhoeic keratosis 3. Re-excision scar reported as incompletely excised BCC following GP excision -no evidence residual BCC. 4. Nodule within radiotherapy scar for BCC - scar tissue only 5. Nodule within birthmark -benign naevus Of lesions excised there was only 1 where the diagnosis of BCC was made histologically rather than pre-operatively. Brian Malcolm BARNSTAPLE MARCH 2008-MARCH 2009-08-09 INTRODUCTION: I provide an in house referral and treatment service for the patients of this practice with a list size of 15,700.The South West Peninsula has high levels of sun related skin cancers and as this short outcome study demonstates there is no shortage of material! Total Excision Procedures: 40 6 Malignant Melanomas 3 In-situ Melanomas 2 Squamous Cell Cancers 29 Basal Cell Cancers Excision was mainly directed towards head and neck BCC's or thicker BCCs/younger patients In addition a further 39 skin cancers were treated with other modalities Excision rates with histological clearance 100% Christy Chou Darlington Primary care Skin Surgery Audit 08/09	

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						>Total cases 1988 per year >Skin cancer cases 305 (15% work load) >Skin cancer work all local anaesthesia and direct closure Skin cancer incomplete excision rate 2% Emmy Babor I disagree that all head and neck BCCs are high risk. Of all my primary care minor ops >25% are BCCs and most of these are in head and neck. I do >60/year and audit margins. Teeside 3 GPwSIs 640 BCC in total - 76 % Head and neck - complete excision rates of over 98.5%	
SH	Primary Care Dermatology Society	53.03	Evidence Review	General		The studies below also inform the debate and are not listed. 1.Management of nonmelanoma skin cancer by 'expert GPs' (Can patients with nonmelanoma skin cancer be treated safely in primary care? A retrospective clinical audit. L.D. El-Dars, G.Davies and D.L. Roberts. British Journal of Dermatology 151 (Suppl.68), 21-62). The results of this paper showed comparable / favourable results compared with BCC (basal cell carcinoma) excision in secondary care. Rates of complete BCC excision in the community were 7.3% for BCC. Studies in secondary care shows incomplete excision rates between 4.7 % (Kumar P et al. Incidence of incomplete excision in surgically treated basal cell carcinoma: a retrospective clinical audit. Br J Plast Surg 2000; 53: 563-6) and 13.7% (Schreuder F, Powell BW. Incomplete excision of basal cell carcinomas:	Many thanks for providing us with these references. These papers will have to be retrieved and screened for relevance. 1 This paper was appraised and included in the evidence review that supported the 2006 guidance and would therefore not be included in the updated search. 2-4 The GPwSI papers were excluded from the search as they didn't match the criteria for inclusion in the clinical question (PICO – see methodology section in the guidance).

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						an audit. Clin Perform Qual Health Care 1999; 7:119-20) - High levels of patient satisfaction in the expert GP clinics 2.'B.Sibbald et al. Shifting care from hospitals to the community: a review of the evidence on quality and efficiency. J Health Serv Res Policy 2007; Volume 12 No 2 April' - No reduction in quality of care provided for patients by GPwSI. 3. Patient experience - Patient satisfaction surveys of GPwSI are generally reported as being high based on the following: - 2003 Action On Pilot Sites - 'Salisbury C, Noble A et al. Evaluation of a general practitioner with a special interest service for dermatology: randomised controlled trial BMJ 2005; 331: 144-1444' - Patients stated a preference for the care given by the GPSI service when compared to the hospital outpatient care - 2007 Care Closer to Home Report for Dermatology - 'B.Sibbald et al. Shifting care from hospitals to the community: a review of the evidence on quality and efficiency. J Health Serv Res Policy 2007; Volume 12 No 2 April'. 4.Waiting lists – These have generally been positive: - Several references to the same work regarding Action on Dermatology show reduced wait times for GPwSI clinics but little impact on overall wait times unless several GPwSIs in post - Salisbury et al BMJ 2005 33 1441-6 shows reduced waiting times	

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						- Rosen et al London 2005 show reduced waiting times - 2007 Care Closer to Home Pilot sites for Dermatology show reduced waiting times with positive effects on dermatology and plastic surgery - PCDS questionnaires of its own members (2003/2004 and 2007) show other GPwSI also show positive impacts on plastic surgery. -'B.Sibbald et al. Shifting care from hospitals to the community: a review of the evidence on quality and efficiency. J Health Serv Res Policy 2007; Volume 12 No 2 April' - Reduced waiting lists.	
SH	Primary Care Dermatology Society	53.04	Update	4,5 and 6		The PCDS agrees with the significant increase in BCCs and supports the view that there will be considerable stress placed on medical services to cope with this. It is therefore vital to establish a comprehensive and joined-up approach between primary, intermediate and secondary care.	We agree.
SH	Primary Care Dermatology Society	53.05	Update	7	5	Patient choice also includes the right to choose (informed) where and who performs any treatment. The guidelines do not allow for co-morbidities and situation to be taken into consideration nor the patient who refuses to go to hospital or other secondary care premises (a not uncommon response in elderly and rural patients!) Patient consent. The principles of the 2009 GMC guidance on consent stress patient choice. Therefore, we are still faced with the patient, elderly or not, who choses NOT to be referred to hospital but seeks treatment in primary care. Medicolegally, there is more weight to the consent laws then the NICE guidance. This has not been acknowledged by the NICE GDG. (Soon Lim, Beds)	Thank you for your comments. The question of being fully informed is important. Would the patient have access to the GP's personal audit results? The GDG patient/carer representatives were very clear that they would want, regardless of age, to have the best possible results of curative removal and a good cosmetic result Thank you for referring to the GMC guidance on consent. We need to consider those patients who choose not to be referred to hospital. We also need to consider consent for patients who want the best possible chance of a correct diagnosis and complete removal of their skin cancer and a good cosmetic result. Patients should have access to this sort of information on the performance of the clinician who is planning

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							to remove their lesion as well as on their training and experience
SH	Primary Care Dermatology Society	53.06	Update	7	29	Where established GPwSI organisations (not just "notable exceptions") have been assessed the Peer group process has found no cause for concerns. We fully acknowledge the rogue operators who ignore any guidance and condemn those who fail to send specimens for histology but it is unfair and limiting to lump all primary care operators in the same category.	Thank you for your comments.
SH	Primary Care Dermatology Society	53.07	Update	8	22	The PCDS supported these sensible guidelines for low risk BCC and regard them a fully workable for accredited GPwSIs.	Thank you for your comments.
SH	Primary Care Dermatology Society	53.08	Update	8	24-28	Definition of High risk to include all face and scalp BCCs is erroneous . The risk is the pateint's risk -so it depends on other factors as well as site and size . A 1cm lesion on the face with recommended 4mm margins would lead to extensive surgery, possibly not primary closure, and risk of poor cosmetic outcome if done by GPs this point I would strongly contend as there are some excellent primary care surgeons who would have no trouble with primary closure with an 18mm incision; some GPs are even expert at doing flaps, and have plastic surgery experience. (Clare Kendall)	Thank you for your comments. You have submitted conflicting comments on the definitions of high and low risk BCC. In one comment you say you support sensible guidelines for low risk BCC and say they all fully workable for accredited GPwSI, but these conflict with other comments you have given. For example (order no. 53.07. pg 8 line22).
SH	Primary Care Dermatology Society	53.09	Update	9	4-14	Line 6 is totally unacceptable to the PCDS since it goes back on the Dafydd Roberts definition and will prevent the aims of the NICE IOG which is to provide an efficient service to an increasing number of patients in a manner which is safe, convenient and effective. Since up to 80% of BCCs arise on the head and neck the Practice Based Commissioning movement and the care closer to home imperatives, the Choice Agenda and Action On will be obstructed. We cannot have	Thank you for your comments. Our main aim is to provide the best outcome for patients. We are not taking into account financial incentives for one group or another as this is not within our remit. We are attempting to produce guidance which is suitable for all practitioners. We are aware that there are a relatively small number of very highly skilled GPwSI's who are acting almost at consultant dermatologist level. We will be discussing ways to ensure that this group of very highly experienced primary care

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						a mechanism which is controlled by one group with a financial incentive in competition with another. The working together, which we all seek, (none more so than the PCDS) is not at present universally apparent. Please see last comment and suggestions. The remainder is agreed other than the proviso in 9 above.	professional can still play a significant roll in high risk basal cell carcinoma management. We reiterate that the best possible care for the majority of patients is the driving force behind the revision of this guidance. Furthermore the patient/carer representatives on the GDG were emphatic that for themselves or even for elderly relatives they would want BCC's on the face to be removed by clinicians with sufficient expertise to achieve not only the best chance of total excision but also the best cosmetic result. They were absolutely clear that age or other frailties did not diminish a patients desire to have either of these outcomes.
SH	Primary Care Dermatology Society	53.10	Update	9	15-17	Many respondents have pointed out that in their areas there is either no PDT available in secondary care (eg Bristol) or that the cost often precludes its use (e.g.Bedford) and that it is available in primary as well as intermediate GPwSI clinics in any case,.	This is true of most health service interventions.
SH	Primary Care Dermatology Society	53.11	Update	9	22-24	Fully supported.	Thank you.
SH	Primary Care Dermatology Society	53.12	Update	9	26	Training and accreditation have been highlighted as areas of difficulty since some secondary care units limit or decline to train or accredit either pleading work pressures or sometimes conflict of financial interest! The PCDS offers frequent educational meetings with skin cancer as a regular subject and indeed runs a series of practical training courses of both basic and advanced level which involves the use of flaps as well as simple closure techniques. These are taught by consultant dermatologists and plastic surgeons as well as experienced GPwSI surgeons.	Thank you for your comments. This guidance aims to improve outcomes for patients. Issues of conflict of financial interest need to be managed by the PCT in the light of this guidance. It is not pertinent to this guidance. This is an implementation issue.
SH	Primary Care Dermatology Society	53.13	Update	9/10	34and 1-25	Fully supported with the proviso that PCTs will have to develop the mechanisms for this since in many areas there is little awareness of skin	Thank you for your comments. PCT awareness does need to be increased.

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						cancer in PCT personnel.	
SH	Primary Care Dermatology Society	53.14	Update	10	27-32	Some respondents feel that such education should be flexibly provided and more self-directed, overseen by a Cancer Network Site Specific Grpup (CNSSG) e.g. PCDS educational meetings CME approved	Thank you for your comments. This guidance is intended to cover the majority of primary care practitioners.
SH	Primary Care Dermatology Society	53.15	Update	11	11	Agreed as long as Page 7 Line 5 comment is recognised.	Thank you.
SH	Primary Care Dermatology Society	53.16	Update	12	11	Care Closer to Home strategy document and many studies reporting patient satisfaction with GP/GPwSI treatment support the provision of Primary care management. It is vital that cost alone does not control the modality or place of treatment since the patient and their morbidity/convenience is important.	Thank you for your comments. The prime aim of the GDG is to improve the quality of care for patients. Cost is important but not the over-riding issue.
SH	Primary Care Dermatology Society	53.17	Update	12	20	Any extra delay or duplication required by the guidance for facial lesions will increase costs and prohibit "one stop shops" even if a mentor is agreeable it will take secondary care time and in the current climate that will no doubt incur an extra cost.	Thank you for your comments. NICE will be developing a costing template for this update to assess whether it will have a significant financial impact on the NHS.
SH	Primary Care Dermatology Society	53.18	Update	12	23	These will only be financially viable if there is independence from secondary care especially in areas where there is competition between providers when one provider is expected to agree to the service being performed by a competitor! This is a recipe for restraint of trade in some cases and may seriously affect the financial viability of established community services with high quality and expensive facilities and current excellent audits.	Thank you for your comments. This guidance is about clinical quality. It is for the commissioners to deal with local implementation issues.
SH	Primary Care Dermatology Society	53.19	Update	12 and 13	26-36 and 1-20	This reduction in requirements is generally acceptable and may increase skin cancer awareness. It is not a substitute for a fully skilled community GPwSI but has been welcomed by some DES GPs who generally perform non-cancer procedures. The PCDS has some concerns that this category risks a	Thank you for your comments. We hope that tightening up the DES process as described in the 'models of care' section in the guidance will address your concerns.

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						continuation of "occasional"cancer surgeons and should be confined to a GPs own practice patients. It may be a step towards full accreditation.	
SH	Primary Care Dermatology Society	53.20	Update	14	1-7	The PCDS wholeheartedly support these recommendations and would like to be involved in developing methods for this.	Thank you.
SH	Primary Care Dermatology Society	53.21	Update	14	20-22	This would be better phrased as a comparison of all types of operator and include nurses and trainees in secondary care as well as all specialities rather than a blanket primary versus secondary care comparison which to date have proved inadequate to capture the detail needed to make commissioning decisions.	This was the clinical question that was agreed at the start of the process. However it would have identified all types of specialist operator in secondary care.
SH	Primary Care Dermatology Society	53.22	Update	General		With reference to the significant controversy, as the PCDS sees the definition of a high versus low risk BCC, we would like to make the following suggestions: 1.The referral to diagnosis needs to include the option of a GPwSI for low risk BCCs = or <1cm on the head and neck excluding the H zone (i.e. around the ears, eyes, nose and mouth)` and the agreed special types and situations. That the GPwSI can be expected to diagnose and treat such lesions without recourse to a mentor or MDT. This will allow patient choice and follow the Dept of Health guidelines.and allow the continued development of a necessary service to cope with future demands and to maintain GP education and interest. MDT involvement and continued CME is entirely appropriate. 2.Level 2 practitioners as per the document and able to manage high and low risk skin cancers under secondary care governance and MDT. 3. Commissioners / employers / patients should be aware of standards of care	Thank you for your comments. The GDG has fully considered these comments during the revision of the guidance. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.

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						All individuals managing BCC (GPwSI and secondary care) should be expected to produce annual results showing as a minimum, complete excision rates and cosmetic outcomes . Thank you	
SH	Public Wales NHS Trust	40				This organisation responded and said they had no comments to make	Thank you.
SH	Royal College of General Practitioner	55.15	Update	11	9	• This has to be worded in such a way that the network site specific group cancer lead is not unduly weighted with power to reject candidates who have adequate training as this is a responsible position and in the wrong hands can damage the ability of clinicians who are safe to continue to practice.	Thank you for your comments. This is about local operational policies not individuals.
SH	Royal College of General Practitioners	55.00	Update	4	29-32	• Without reference to more than personal communication to the NCAT the audit stating "up to 50% of GPs removing suspected BCCs do not submit them for histology" is unsubstantiated, runs counter to the PCT monitoring requirements for minor surgery D.E.S and counter to evidence collated in Primary Care • Departure from NICE guidelines may happen amongst consultants as well as GPs.	Thank you for your comments. These data have been clarified with the National Cancer Action Team.
SH	Royal College of General Practitioners	55.01	Update	5	1-2	• "All excised skin lesions should be sent for histological examination". The impracticality of undertaking this for multiple skin tags or seborrhoeic keratosis means that the words *all* and *should* need to be followed by the word *usually*.	Thank you for your comments. This is what's recommended in the NICE guidance. We have strengthened the recommendations on sending skin lesions to histology in the guidance.
SH	Royal College of General Practitioners	55.02	Update	6	1	• BCCs are not treated as cancer in the NICE Urgent Cancer Referral Guidelines. • They extremely rarely cause death. • Their importance is their commonness and	Thank you for this useful information.

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						their increase in incidence in the future. These are arguments for ensuring as many are dealt with in General Practice, which deals with common conditions. However the logical conclusion that more should be done in General Practice is not reached in this document.	
SH	Royal College of General Practitioners	55.03	Update	7	25-29	• Again a personal communication has been referenced reflecting anecdotal evidence. • There is also mention of a detection of failure of compliance of cancer networks through peer review. This shouldn't be seen as a criticism of the non-compliers but should be an acknowledgment that many GPs are unhappy with the IOG.	Thank you for your comments – we have addressed this. We disagree. NCAT report poor compliance.
SH	Royal College of General Practitioners	55.04	Update	8	21-22	• The review paper presented by Dr Roberts has not been itemised in the evidence and it appears to be central to the GDG definition of high risk BCCs. • The conclusions appear to run counter to the BAD own guidance: (Ref: 2008 British Association of Dermatologists British Journal of Dermatology 2008 159, pp35–48)	Thank you for your comments. We will reference the review by Dr Roberts which appears in the full evidence review that accompanies the guidance.
SH	Royal College of General Practitioners	55.05	Update	8	25-27	• There is comment about the lack of wisdom of GPs removing 10mm lesions with a 4mm margin. • In general GPs only remove much smaller lesions where they are confident they can produce a satisfactory cosmetic result. • 10mm is a very large lesion by GP standards.	Thank you for your comments. We are trying to issue guidance which is clear for everyone.
SH	Royal College of General Practitioners	55.06	Update	9	3-17	• Our service sees approximately 140-150 BCC a year. • We really only treat the nodular forms and most are on the face as the superficial ones are treated successfully with imiquimod	Thank you for your comments. We are aware that there are some highly skilled GPwSI's who provide a large amount of skin cancer surgery to their local community and we are reviewing our recommendations to try to differentiate between

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						cream. • The nodular ones happen to be more common on the face and also it seems that most of these patients are older than 75 years old. • I have never had any scar marking issues and removed all lesions with adequate margins. • My inadequate margin rate is 1%. If this guidelines is adopted then my service will not be able to do these and I will be compelled to send this work to plastic surgeons which will obviously blow holes into budgets These definitions of high risk BCCs are suitable for GPs operating under a D.E.S contract but are unnecessarily restrictive for GPwSIs who meet the requirements for Community Skin Cancer Clinicians • These definitions of high risk BCCs are suitable for GPs operating under a D.E.S contract but are unnecessarily restrictive for GPwSIs who meet the requirements for Community Skin Cancer Clinicians • The recommendation for referral of clinical superficial BCCs to secondary care with the goal of "being offered the full range of medical treatments, including PDT" ringfences these low risk BCCs out of community care. • However, with limited resources in secondary care dermatology departments, it is considered to be good stewardship to offer treatments which have minimal need for follow up, therefore releasing clinical appointments for new cases or chronic cases without the option for a quick efficient	GP's without that sort of training and those who are highly experienced. It is important to note that the most expensive treatment option may be the most cost-effective treatment if it results in sufficiently better outcomes for patients. That is, if it provides the best value for money for the NHS.

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						completion of the episode of care. It is therefore considered by secondary care that surgery is still the best option for efficient management of finite dermatology department resources. • It is therefore my opinion, that the maintenance of the management of superficial BCCs in secondary care is argued on an unrealistic premise of a wider treatment option in secondary care. If the hospital departments are not going to offer PDT, then surely, the recommendation merely prevents the shift of surgery from secondary care into the community. • I am concerned that this recommendation limits the community based service by only allowing a small subsection of low risk BCCs to be managed in the community. It's going to be surgically excised in secondary care anyway.	
SH	Royal College of General Practitioners	55.07	Update	9	22-24	• Community Skin Cancer Clinicians should be able to continue to offer surgical treatment to facial and scalp BCCs that do not have high risk morphological characteristics (morphoeic, multinodular, sclerosing) and are within their skill mix.	Our main aim is to provide the best outcome for patients. We are not taking into account financial incentives for one group or another and this is not within our remit. We are attempting to produce guidance which is suitable for all practitioners. We are aware that there are a relatively small number of very highly skilled GPwSI's who are acting almost at consultant dermatologist level. The GDG have discussed ways to ensure that this group of very highly experienced primary care professionals can play a significant role in the management of high risk BCCs. We reiterate that the best possible care for the majority of patients is the driving force behind the revision of this guidance. Furthermore the patient/carer representatives on

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							the GDG were emphatic that for themselves or for elderly relatives they would want BCC's on the face to be removed by clinicians with sufficient expertise to achieve not only the best chance of total excision but also the best cosmetic result. They were absolutely clear that age or other frailties did not diminish a patients desire to have either of these outcomes.
SH	Royal College of General Practitioners	55.08	Update	9	30-32	• Please state who they will be accredited by as many GPs will need to know who they will have to get their accreditation from that do this work. • Again this will create more referrals to specialist services in the community	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Royal College of General Practitioners	55.09	Update	9-10	34-35, 1-2	• "All excised skin lesions should be sent for histological examination". The impracticality of undertaking this for multiple skin tags or seborrhoeic keratosis means that the words all and should need to be followed by the word usually.	Thank you for your comments – these recommendations have been revised.
SH	Royal College of General Practitioners	55.10	Update	10	10-12	• Histological results should be *Fail Safe*. • This means all samples sent to the laboratory are accompanied with a numerical check list. • Any sample not received by the laboratory is immediately notified to the operating GP. • All results are cross checked to ensure they have been seen and actioned.	Thank you for your comments - we have added 'failsafe'. Thank you for your very useful suggestions – the GDG have considered these during the revision of the guidance.
SH	Royal College of General Practitioners	55.11	Update	10	17-19	• The quarterly data-set should be a standard PCT contracting issue for the D.E.S.	We have included this in the proposed model of care.
SH	Royal College of General Practitioners	55.12	Update	10	21-25	• The submission of a BCC audit to the MDT should be on an annual basis not quarterly. This would follow the network audit cycle	We have compromised on 6 monthly to align with the bi annual CPD days.

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						and comply with: 'Improving Outcomes for People with Skin Tumours Including Melanoma '(P55 Table 3.)	
SH	Royal College of General Practitioners	55.13	Update	10	27-30	• It isn't clear throughout the document whether the suggestions deal with all GPs who may excise a BCC "unknowingly", GPwSI, GPs who have offered excision of skin lesions to others for many years or all these. • This is such an important matter that absolute clarity in the guidance should exist. Some points clearly should refer to all GPs but many expectations would only be at all reasonable for those who specialise in offering removal of skin lesions. • For example line 27 page 10 could apply to all GPs who might "unknowingly" remove a BCC or even a real skin cancer. The expectation of attendance at meetings would be unreasonable.	We have revised the document to make this clearer.
SH	Royal College of General Practitioners	55.14	Update	10	30-32	• CPD does not need to be specifically MDT delivered. • This limitation puts unacceptable pressures upon MDTs and limits the ability of GPs to obtain the education most suited to their needs, informed by their own PDP and agreed with their appraiser.	Thank you for your comments. This CPD is to be delivered by the cancer network. It does not preclude needs informed by PDP and agreed with appraisal.
SH	Royal College of General Practitioners	55.16	Update	12	6-9	• As the core to all safe surgery is diagnostic skills these should be assessed with the use of an AKT. • DOPs when used can be under simulated conditions as well as actual observed surgery. • The former allows more controlled and reproducible environments and follows educational assessment (nMRCGP).	Thank you for your comments. Whilst we accept that an AKT may be a good assessment tool, we do not believe that the multiple choice AKT used in the nMRCGP has enough dermatology component to demonstrate skin lesion diagnostic skills. We believe that a more robust assessment is required and should be developed following a period of appropriate training. The current RCGP curriculum relating to skin problems remains optional and it is still

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							possible for a new GP to not have had any postgraduate training or formal assessment in dermatology. There is good evidence that the DOPS assessment whether in day to day clinical practice or a simulated setting, is reliable for the assessment of practical skills.
SH	Royal College of General Practitioners	55.17	Update	12	26-36	• As above, AKT to test knowledge, DOPs to assess skills, one is incomplete without the other. • The proposals stray into the "excision of benign skin lesions" service that GPs offer. It is important that proposals that are intended to improve cancer services (BCCs are not cancers) don't unintentionally damage other services. • Nowadays, PCTs ensure that hospitals are not allowed to remove "cosmetic" lesions. This gives the patient the option of going privately if they are wealthy. If they are not wealthy then the patients' only option is to ask their GP to excise the lesion. The GP is allowed to remove such lesions, but if the proposals make life difficult for GPs who may occasionally unknowingly remove a small BCC, then there will be an increase in inequalities for patients based on access to private medicine • Please clarify who can do the DOPS-in my opinion an experienced GPWSI is as good as a plastic surgeon or dermatologist	We have considered your comments during whilst re-drafting the section on training and competencies.
SH	Royal College of General Practitioners	55.18	Update	13	1	• As above AKT and DOPs	Thank you.
SH	Royal College of General Practitioners	55.19	Update	13	10-11	• General practice, through the RCGP, has its own mechanism for standards, which are monitored through appraisal and revalidation. • The proposals seek to establish parallel mechanisms, which damage the integrity of the GP processes.	Thank you for your comments. The model for quality assurance mirrors that of cervical screening. These proposals do not intend to damage the integrity of any other process. They are patient focussed guidance with the sole intention of improving outcomes for patients. We have the responsibility for producing guidance

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						• For example why is it necessary for all GPs performing skin surgery to send the pct quarterly reports, when this work will be part of the GP's revalidation anyway? • Who at the PCT will have the skills to interpret the results? • When we look at the vastly more important conditions that GPs deal with, where there is no expectation of sending quarterly results to the PCT. • Real cancers are an example, but also ischaemic heart disease, strokes, suicides, acute abdominal emergencies, sudden deaths, asthma admissions, anaphylaxis and so on. These are the real killers of hundreds of thousands of people a year. • Clearly the proposal is unreasonable unless the intention is for all other sub-specialties of general practice to insist that GPs send their PCT information quarterly about incidences of their condition. Not only would this be totally impractical, it would also damage the current revalidation mechanism.	for improving quality of care for patients with low risk BCC and at present have no evidence that similar process are part of the GP revalidation process. Primary Care Trusts have a duty to monitor enhanced services that GPs have been contracted to provide under the new GMS contract (2004). Most of these enhanced services (numbers and quality) will be agreed between GPs and PCTs at the start of the financial year, and the activity then monitored quarterly so that under or over-performance can be adjusted mid year. Some enhanced services such as the minor surgery Directed Enhanced Service require more detailed information such as type of lesion removed, as some skin lesions should be treated under the Additional Services section of the GP contract, to prevent double payment. Further, most PCTs do not commission cosmetic surgery so such monitoring ensures that GPs are claiming appropriately. The NICE proposals for the management of low risk Basal Cell Carcinomas, if accepted, mean that only certain accredited GPs may treat such skin tumours, so some form of monitoring will be needed to ensure that only those accredited GPs are treating and claiming for the removal of low risk BCCs. These proposals therefore are not creating parallel mechanisms for checking standards but just expanding a mechanism that is already in place. GPs are paid £80+ for each minor surgical procedure undertaken under the DES, and PCTs have a statutory responsibility to ensure public money is spent correctly.

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							PCTS already monitor the quality of cervical samples taken in General Practice so have individuals who can interpret pathological reports. If needed, all PCTs have a number of clinicians such as medical directors, Professional Executive Committee members and primary care cancer leads who could be asked for help in interpretation if necessary. However, it is envisaged that GPs would just record that a low risk basal cell carcinoma has been removed. More details, such as excision margin, would be cross-checked with regular reports from the Histopathology Laboratory. Once the system is embedded and shown to be working as intended, monitoring intervals could be increased. Even if the quality standards for treating low risk basal cell carcinomas were eventually covered by appraisal and revalidation, PCTs would still need to monitor the enhanced services contracts for the reasons stated above. The driver for ensuring good PCT governance structures has been the very low primary care compliance with the Cancer Peer review measures There are specific PCT measures which most of the 30 Cancer Networks have struggled to meet. The panel will be aware that secondary cancer services have had a high level of scrutiny with an annual peer review of all tumour sites. This has lead to significant service improvement and development of cancer services. The aim is to have a similar process in primary care services. The argument that because other conditions do not have a similar peer review process and therefore the proposal is unreasonable is a weak one. Cancer services in secondary care have

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							always been subject to a myriad of targets, reviews and scrutiny and it seems reasonable that commissioned primary care services should have a similar process. In terms of the comment" who in the PCT will have the skill to interpret the results" this would we carried out with the assistance of the Cancer Network
SH	Royal College of General Practitioners	55.20	Update	13	15-20	• MDTs work best with a stable and identifiable group. GPwSIs undertaking skin cancer work will be well known to their MDTs, expected to present audit data annually and be involved in peer review. • Asking all GPs operating under the DES to submit BCC data is likely to overload these meetings and dilute their use. • It is GPwSIs who should be commissioned by their PCTs and on behalf of the MDT to look at the audits of D.E.S operating GPs. In this way cancerous and non cancerous surgery can be assessed (skin cancers other than low risk BCC surgery will have already been reported to the MDT) and advice given on improved outcomes and educational needs. • Much is made of comparing GPs with specialists, but there is no suggestion that dermatologists should be compared with plastic surgeons or general surgeons for example. • Furthermore there is no suggestion that specialists should have league tables, even though it is suggested that GPs should be openly compared at their annual sessions of education and audit. Everyone should be able to have equally informed choice.	Thank you for your interesting comments. Because of these concerns, the guidance suggests an annual meeting specifically to review BCC management. Current MDTs are of little relevance to those excising BCCs as they do not discuss BCC Whilst GPwSIs could perform a role in the teaching and assessment of GPs performing surgery through the DES we believe this responsibility should sit firmly with the local MDT and the skin cancer network. Evidence was presented and discussed comparing these groups and there is good published peer reviewed comparative evidence of the competency of dermatologists in the diagnosis and management of BCCs (see evidence review) All specialist teams are subject to robust processes of review and audit of clinical practice through the peer review process We believe that 4 hours of continuing professional development annually in this area is the minimum requirement to ensure that clinicians are up to date with new treatments. For example PDT and the medical management

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						• It is proposed that there should be an audit and education session annually which will last for 4 hours. • During this time GPs' results will be compared. Given that in my network, it is unlikely to involve more than a handful of GPs, the remaining time devoted to the "diagnosis and management of low risk BCCs" seems grossly disproportionate. Is there an annual corpus of new work on this topic, which could conceivably be stretched out to occupy 3 hours? • This teaching would be for competent GP surgeons who may have many years more experience than their teachers- this would certainly be the case in my network. • I believe the requirement for such extensive teaching comes from the first iteration of the IOG, where GPs surgeons were expected to operate on real skin cancers rather than just low-risk BCCs. • To maintain such extensive CPD for a much more minor role is unrealistic. It should be sufficient to show adequate audits and have a network whereby the new information on "diagnosis and management of low risk BCCs" could be circulated whenever any such information arises. • In general we should support adult learning for general practice. To remain generalists we have to maintain adequate expertise on thousands of subject areas. This is only possible if GPs can attend to areas of their personal educational need as defined in appraisal. To have areas of compulsory education, except in the case of genuinely	of BCC. There is regular new literature in this area. The audit process is likely to take quite a lot of this time if more BCCs are excised in the community via the DES and the new GPwSI in skin lesions. Additionally the group will be across a large enough group to facilitate networking and interprofessional learning.

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						universal new knowledge, makes such GP education difficult.	
SH	Royal College of General Practitioners	55.21	Update	15	12-13	• The evidence provided here is admitted to be weak in terms of suggesting that care in general practice is inferior to that of specialists. • The most suitable evidence, according to the summary, that of George, shows no statistical evidence in favour of adequacy of specialist excision, but evidence that patients were more satisfied with GP treatment and found GP treatment more convenient. • There is no comment on the evidence summary whether the latter two statements were statistically significant. If they were then this shows bias in presentation of the evidence by this report. • The report should then really have said that the evidence statistically was in favour of GP excision- no evidence of inferiority in excision adequacy and some evidence in favour of patient acceptability. • The other factor, which has not been noted, is that all the presented evidence, poor though it is, has appeared since the original IOG. • This means that the identical conclusions of the original IOG on discouraging GP surgery, were based on even flimsier evidence.	Full details are provided in the full evidence summary. The short summary is meant to present the brief findings of relevant studies. For the George study there are no statistical findings reported for the outcome 'patients were more satisfied with GP treatment and found GP treatment more convenient'. However statistics are reported for other outcomes from this study. We have no bias toward any professional group and NICE systematic reviewers maintain objectivity at all times.
SH	Royal College of General Practitioners	55.22	Update	16	22-26	• Unfortunately the study by George et al studied very few skin cancers with only 16 skin cancers in primary care and 20 in hospital care, these very small numbers suggest that no GPs actively undertaking skin cancer work were included. • Audits submitted by RCGP members show that activity of at least double that would be	The clinical question was: 'Do outcomes differ when the excisional surgery of a suspicious skin lesion is performed by a general practitioner compared with a specialist in secondary care?' We did not look for evidence that one professional group was better than another; we were looking for a difference. As per the clinical question. The PICO in the full evidence report

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						expected annually by any single GP undertaking such work. These audits furthermore show an incomplete excision rate of less than 1%. • The principle used for the evidence gathering by the group *is questionable*. They *appear to* have looked for evidence that one professional group does the job better than another, and appear to use this to stop one group doing the work with the other group benefiting by having the additional work. • Clearly there are some specialists who are good at skin excision and others who are not good, and equally amongst GPs. The essential discriminator should be that only the person able to perform the job competently, should be allowed to do it.	clearly outlines this.
SH	Royal College of General Practitioners	55.23	Update	6	26	• The patient perspective is crucial, but overall this document gives little weight to the patient's own decision nor does it take into account the patients physical and mental wellbeing. • A fully informed patient who is cared for by a GP who is skilled and willing to undertake surgery outside the BCC guidance should be able to ask for their care to be provided by that doctor. • In turn that doctor should have the support and help of their local specialist and MDT. • In addition it should be possible for the GP, who will know the patient best, to decide that in view of co-morbidities the patient will be best served by care closer to home and in these circumstances to be able to provide the treatment that they are skilled to provide without fear of recrimination from the local MDT. This would follow national guidance (*Our health our care our say: a new direction for community services*) as well as the BAD	Thank you for your comments. We disagree. The patient/carer members on the GDG have provided a great deal of input into developing this guidance and fully support its recommendations. The question of being fully informed is important. Would the patient have access to the GP's personal audit results? The GDG patient/carer representatives were very clear that they would want, regardless of age, to have the best possible results of curative removal and a good cosmetic result.

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						Guidelines for the management of BCC (*2008 British Association of Dermatologists • British Journal of Dermatology 2008 159, pp35–48*)	
SH	Royal College of Nursing	58.00	Update	General		The RCN welcomes this document. It is comprehensive.	Thank you.
SH	Royal College of Nursing	58.01	Update	11	23	Commissioners need to build in to SLA with Acute sector the role of supervision and education of GPs and GPwSI regarding the management of skin cancers and willingness to undertake the accreditation of skin cancer management by GPs/GPwSI and dermatology nurses in the community. Time available and cost needs to be factored in.	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Royal College of Nursing	58.02	Update	11	23	Acute sector needs to be aware of timing when arranging training for Multiple Disciplinary Teams and GPs/GPwSIs - (Mondays and Fridays are often very difficult in Primary Care.)	We agree.
SH	Royal College of Nursing	58.03	Update	9	26	It was not clear if the reaccreditation for skin cancer takes place annually or 3 yearly in line with the Department of Health outline for Guidance and competencies for the provision of services using GP with a special interest.	Thank you for your comments. These requirements have been more clearly defined in the guidance.
SH	Royal College of Nursing	58.04	Update	9	26	If patients are going to be diagnosed and treated by GPs - where does this fit into the 18 week pathway that acute and Community services e.g. Intermediate Dermatology Services have to comply with?	If patients are referred to an intermediate dermatology service or community dermatology service, the 18 week referral to treatment time has to be met. The 18 week target applies to all providers and all patients referred for a more specialist assessment.
SH	Royal College of Nursing	58.05	Update	General		Access to written information - IT accessible and must be handed out with discussion not just sent in the post.	We agree.

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SH	Royal College of Paediatrics and Child Health	60.00	Update	General		Although exceptionally rare, the College thinks that children with suspected basal cell carcinomas should be referred to secondary/tertiary care and not (as stated in this guidance) managed in primary care, in line with the NICE Improving outcomes with children and young people and cancer. This should ideally be in context of a Skin Specialist Multi-Disciplinary Team (SSMDT).	Thank you for your comments. We have made a more specific recommendation in the guidance that while BCC is rare in children and young people, melanoma is not that rare and it is important to get the correct diagnosis.
SH	Royal College of Pathologists	61.00	Update	9	3	Recommendations Age is not considered with regard to surgery in the community. We are increasingly seeing basal cell carcinomas on the face of teenagers (16-18 years) . It could be regarded as inappropriate for community clinicians to be excising low risk BCCs on the face in this young (or younger) age group (with the potential for cosmetic damage). The problem is compounded by benign trichepitheliomas In children and teenagers being excised in the community as apparent low risk nodular BCCs.	Thank you for your comments. Age cannot be considered as this would constitute discrimination. Clinicians need to take into account the physical condition of the patient not their chronological age. Thank you for your comments on children and teenagers. Please could you send us evidence of the increasing number of BCCs in teenagers? We have amended the definitions of high risk BCC to clearly include children and young people.
SH	Royal College of Pathologists	61.01	Update	9	3	Recommendations The guidelines do not cover the not uncommon eventuality of low risk BCCs excised in the community, on histology then showing involved peripheral or deep margins (so called incomplete excision) This places the BCC at high risk of recurrence and any wider	Thank you for these helpful comments. We have reviewed the recommendations again based on your comments to consider two group characteristics which define high risk BCC for clinical triage and histopathological findings, which may change the clinical prognosis grouping from low to high risk.

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						reexcision should be undertaken by specialists. Perhaps positive margins of both low and high risk BCCs should be added to the list of high risk BCCs!!	
SH	Royal College of Pathologists	61.02	Update	9	3	Recommendations The guidelines do not incorporate a firm statement of BCC risk status as defined by histopathology. This is essential to assist community physicians interpreting histopathology reports of diagnostic biopsies and the planned nature and location (community/secondary care) of excision. Low risk Growth pattern subtypes : superficial , nodular , fibroepithelial variant of Pinkus High risk Growth pattern subtypes: morphoeic , infiltrating , micronodular, basosquamous Histology features : perineural invasion , invasion below dermis Any BCC over 1mm in thickness should not be regarded as suitable for treatment by either topical or photodynamic modalities	Thank you for these helpful comments. We have reviewed the recommendations again based on your comments to consider two group characteristics which define high risk BCC for clinical triage and histopathological findings, which may change the clinical prognosis grouping from low to high risk.
SH	Royal College of Pathologists	61.03	Update	9	3	Recommendations The guidelines do not incorporate a firm statement that low risk clinical BCCs are of	Thank you for these helpful comments. We have reviewed the recommendations again based on your comments to consider two group characteristics which define high risk BCC for clinical triage and histopathological findings, which may change the clinical prognosis

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						superficial or nodular type.	grouping from low to high risk.
SH	Royal College of Pathologists	61.04	Update	9	22	This requires to also include the eventuality of clinically suspected low risk BCCs that transpire to be high risk BCCs on biopsy. At the moment there is a tendency for community physicians to continue with the excision, despite the histology report!	This is a recommendation from the NICE GP referral guidelines for suspected cancer.
SH	Royal College of Pathologists	61.05	Update	9	26	In general community physicians are sadly lacking in their ability to accurately interpret all types of skin cancer (and many other!) histopathology reports. This can / does have significant adverse effects on treatment or management. This aspect of education should be incorporated into all community skin cancer training and CPD. One local GP thought an invasive basal cell carcinoma was benign and a rodent ulcer was due to rats!! As basic as that!!	Thank you for 'rat' ifying these concerns. Clearly interpretation of pathology should be part of the CPD programme.
SH	Royal Pharmaceutical Society of Great Britain	66.00	Update	General		The RPSGB welcomes these guidelines	Thank you.
SH	Royal Pharmaceutical Society of Great Britain	66.01	Update	General		Community pharmacists, as part of the public health and self care components of their contractual framework, are required to provide information and advice and participation in campaigns on health matters such as prevention of cancers. E.g. protection of the skin from the sun. They also sell and advise on sun screening products. They are also trained, using the Centre for Pharmacy Postgraduate Education materials, to provide first line advice on cancers and refer as appropriate.	Thank you for your comments. We acknowledge the important pharmaceutical role in the prevention of skin cancer and in advising patients with suspected skin cancer to seek medical advice.
SH	Royal Pharmaceutical Society of Great Britain	66.02	Update	General		Hospitals now have consultant oncology pharmacists who provide specialist advice on areas such as skin cancer. There is also a special interest group, the British Oncology Pharmacists Association (BOPA) which	Thank you for your comments. We acknowledge the important pharmaceutical role in the prevention of skin cancer and in advising patients with suspected skin cancer to seek medical advice.

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						provides development support such pharnacists.	
SH	Skin Care Campaign	70.00	Update	9	6	Choosing just the face and neck is an arbitrary and un-patient centred approach – we suggest "BCCs on areas that could cause scarring that would cause the patient unnecessary anxiety or decreased self esteem"	The definition of high and low risk BCC has been revised and is now described for each model of care. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Skin Care Campaign	70.01	Update	10	34	We would like to see "should facilitate the development of a" changed to "must provide a"	Thank you for your comments this is not possible we can only use the word 'must' if there is a legal requirement to do so.
SH	Skin Care Campaign	70.02	Update	12	30	Unless what is required is specifically outlined then further confusion will occur – the updated guidelines must provide detail of what each GP needs to provide to the PCT as proof of competence in their diagnosis and treatment of BCCs	The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Skin Care Campaign	70.03	Update	13	6	To ensure effective histology "GPs must provide information about the site of excision and provisional diagnosis on the histology request form."	We agree.
SH	Skin Care Campaign	70.04	Update	13	35	To ensure patients are given the most appropriate information we suggest: "Each Cancer Network needs to agree a framework of information, advice and support	The cancer network will be involved in the implementation of these recommendations, including those in the original IOG which cover information provision and communication.

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						that healthcare professionals managing BCCs in the community can provide to all patients and their carers. To complement this the network needs to provide a pack of written resources that each patient can take away with them	
SH	Skin Care Campaign	70.05	Update	14	1	The guidelines should also include a recommendation that more research is carried out to prove the effectiveness of non-surgical treatments for BCCs.	Thank you for your comments. This is not within the scope of this update.
SH	Skin Care Campaign	70.06	Update	General and 9	15	There is not enough information within the guidelines about effective non-surgical treatments – for best outcomes for patients it would be helpful if the update provided guidelines on when and what can be provided as an alternative to surgery eg: PDT, aldara, cryotherapy	Thank you. We have now provided more detail regarding non surgical treatments in the document.
SH	Skin Care Campaign	70.07	Update	General		The update should also provide guidelines on when no intervention maybe the best treatment plan	Thank you for your comments. The guidance identifies appropriate practitioners who are trained in all treatments options, which includes no treatment.
SH	Skin Care Campaign	70.08	Update	9	6	Choosing just the face and neck is an arbitrary and un-patient centred approach – we suggest "BCCs on areas that could cause scarring that would cause the patient unnecessary anxiety or decreased self esteem"	The definition of high and low risk BCC has been revised and is now described for each model of care. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all practitioners to be accredited and to participate in audit and CPD.
SH	Skin Care Campaign	70.09	Update	10	34	We would like to see "should facilitate the development of a" changed to "must provide a"	Thank you for your comments this is not possible we can only use the word 'must' if there is a legal requirement to do so.

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SH	West Herts PCT & East and North Herts PCT	91.00	Update	General		The document already has existing sections on epidemiology (page 4) and burden of disease (page 6). The section of the document on commissioning (page 11) states that "the commissioning process should plan for a significant number of patients with low risk BCC, especially in an older population." Commissioners would welcome the sections on epidemiology and burden of disease being expanded (for instance to include a table) to show at different age groups (e.g. under 50 years, 50-79, 80 plus) for a reference population of say 100,000 how many new cases of BCC would be expected per year, and of those how many would be low risk BCC. Second and subsequent tables could show what the projections are for numbers of BCC / low risk BCC will be year on year for the next 5 -10 years given the suggested 3% year on year increase.	The epidemiology section can be strengthened to help guide commissioners.
SH	West Herts PCT & East and North Herts PCT	91.00	Update	10	15	Where it says "…lesions they have managed' should that say …."lesions they have excised".	We mean 'managed' as they may be managed medically.
SH	West Herts PCT & East and North Herts PCT	91.01	Update	10	17	If so (as above) it could then go onto say: "…. lesions they have excised AND should provide quarterly feedback to their PCTs etc….."	See above.
SH	West Herts PCT & East and North Herts PCT	91.02	Update	10	21	Cannot see any reference in the Manual for cancer services 2008: skin measures regarding "there should be an audit of BCCs excised by healthcare professionals in the	Thank you for your comments this is a recommendation from the original IOG (page 65) but was not turned into a peer review measure.

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						community". What it says (page 193) is that GPwSI should have their community skin cancer service included in their cancer network's skin cancer audit for peer review". How this will work in practice may differ between networks. One option could be for the MDT to be responsible for discussing all community diagnosed skin cancer cases (including those excised inappropriately, inadvertently or deliberately) and for the MDT to collate information on a regular basis (e.g. quarterly and annually) about those cases to be made available to a skin cancer network wide group.	It is not practical for MDT's to discuss all low risk BCC but they should be included in the 6 monthly audit where overall and individual practitioner performance is reviewed.
SH	West Herts PCT & East and North Herts PCT	91.03	Update	12	30	Please can you give examples of how "GPs should satisfy their contracting PCT that they are competent in the diagnosis of BCC and carry out the appropriate surgical procedures."	This will be addressed by audit and training requirements described in the 'models of care' section.
SH	West Kent PCT	83.00	Update	9	3	The recommendations in draft guidance inappropriately include all face and scalp BCCs, irrespective of BCC size (lines 4 - 6, page 9) The draft guidance states on the previous page, "…criteria … take into account ..... the skill and experience required by the healthcare professional to achieve a good cosmetic result" (line 32 – 35, page 8) Many GPs would not consider removing a 10mm diameter BCC on the face which, with perfect 4mm margins, would create an 18mm defect to close. This does not logically mean that all BCCs on the face and scalp should be	Thank you for your comments. We are aware that there are some highly skilled GPwSI's who provide a large proportion of skin cancer surgery in their community and we have reviewed our recommendations to try to and differentiate between GP's without that sort of training and those who are highly experienced. The guidance now describes three models of care for the treatment of patients with low-risk BCC in the community and makes specific recommendations in relation to the different groups of potential providers. Each model describes a new set of clinical criteria for triage and defines the appropriate criteria for training and accreditation. Underpinning the clinical governance arrangements are the need for all

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						therefore be deemed high risk. Most BCCs present much earlier and are often significantly smaller when seen by a GP e.g. between 2-7mm. Closure of such an excision, with adequate margins, for smaller BCCs is much simpler and well within the skill of many experienced GP minor surgeons. Smaller BCCs outside the classical high risk 'H' on the face can be quite safely removed by many GP surgeons with all the advantages this will offer patients. Smaller BCCs do not present significant surgical problems and removal in primary care should take into account the skill and experience of the practitioner involved (line 32 – 35, page 8). The original evidenced research which provided a sensible and understandable definition of high and low risk BCCs (as summarised in a review paper prepared by Dr Dafydd Roberts and presented to the meeting at NICE in April 2009 – at which I was in attendance) should stand. The proposed quarterly reports (line 17, page 10) should be used by commissioners to determine a health care professional's competence to continue removing BCC service. A blanket ban on all facial and scalp surgery will be both very inconvenient for many elderly patients and expensive for the NHS. I would strongly urge you to reconsider this part of what is otherwise a very good draft document. Thank you for your time and consideration.	practitioners to be accredited and to participate in audit and CPD.

Stakeholder where approached but didn't respond:
Association of British Insurers (ABI)
Association of Chartered Physiotherapists in Oncology and Palliative Care
Associazione Infermieristica per lo Studio delle Lesioni Cutanee (AISLeC)
AstraZeneca UK Ltd

BMJ
Brighton and Sussex University Hospitals Trust
British Association of Oral and Maxillofacial Surgeons
British National Formulary (BNF)
British Nuclear Medicine Society
British Society for Dermatopathology
Cambridge University Hospitals NHS Foundation Trust (Addenbrookes)
Care Quality Commission (CQC)
College of Occupational Therapists
Commission for Social Care Inspection
Connecting for Health
Cornwall & Isles of Scilly PCT
Criminal Justice Women's Strategy Unit
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Dudley Group of Hospitals NHS Trust
Gorlin Syndrome Group
Institute of Biomedical Science
Johnson & Johnson Medical
Juvenile Diabetes Research Foundation
KCC Children and Families Directorate
Liverpool PCT Provider Services
Luton & Dunstable Hospital NHS Foundation Trust
Macmillan Cancer Support
Medicines and Healthcare Products Regulatory Agency (MHRA)
Met Office
Ministry of Defence (MoD)
National Patient Safety Agency (NPSA)
National Treatment Agency for Substance Misuse
Newcastle Upon Tyne Hospitals NHS Foundation Trust
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Plus
NHS Quality Improvement Scotland
NHS Sheffield
North West London Cancer Network
Patients Council
PERIGON Healthcare Ltd
Plymouth PCT
Royal College of Anaesthetists
Royal College of General Practitioners Wales
Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians London
Royal College of Psychiatrists
Royal College of Radiologists

Royal College of Surgeons of England
Sandwell PCT
Scottish Intercollegiate Guidelines Network (SIGN)
Sheffield Children's NHS Foundation Trust
Skincheck Ltd.
Social Care Institute for Excellence (SCIE)
Society and College of Radiographers
Society of Chiropodists & Podiatrists
Teenage Cancer Trust, The
University College London Hospitals (UCLH) Acute Trust
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
Western Health and Social Care Trust
York NHS Foundation Trust