NICE National Institute for Health and Care Excellence

Appendix B1: Stakeholder consultation comments table

2019 surveillance of Melanoma: assessment and management (2015)

Consultation dates: 19 March to 1 April 2019

Do you agree with the proposal to update the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
Pierre Fabre Ltd	Yes	No comments provided	Thank you for your response. We note that you agree with the proposal to update this guideline.
North of England Dermatopathology Service (NEDS)	Yes	One reason for the update is stated to be the new 8th Edition of TNM (TNM8) and specifically AJCC8. The expert reviewers imply that they are not aware that as from January 1st 2018 that Public Health England and the Royal College of Pathologists, and more frequently the British Association of Dermatologists, updated to the international and WHO linked UICC8 and not the American AJCC8. Both are essentially similar but AJCC8 requires a licence fee for usage and is deficient for some types of nonmelanoma skin cancer.	Thank you very much for your comments. We note that you agree with the proposal to update this guideline. Thank you for highlighting the need for this guideline to consider the current staging used for melanoma. The existing version of this guideline refers to stages of melanoma from the American Joint Committee on Cancer's (AJCC) 7th edition. Topic expert feedback in this surveillance review emphasised that melanoma staging had changed since the publication of this guideline (with experts most frequently citing the introduction of the AJCC 8th edition) and that the guideline should be updated to

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		The NICE update must relate to UICC8 and not AJCC8. This is not a problem but NICE must be accurate!	reflect this. Topic experts have indicated that AJCC8 is currently widely used in clinical practice in this country, with some services (e.g. histology, pathology) also using UICC8. We acknowledge that it is important that the staging system referred to in the proposed guideline update reflects current practice. We will ensure guideline developers are aware of the changes in melanoma staging since the guideline so that these can be considered in the proposed update. It will be the role of topic experts on the guideline committee to discuss and agree the most appropriate melanoma staging system to be used as part of the proposed guideline update.
Melanoma Focus	Yes	In the short term the NICE Pathway Document *Assessing suspected or diagnosed melanoma* of 22 January 2019, which is not required in this process, should be removed from the NICE website. Our letter to the Pathway Team of 8 February 2019 refers.	Thank you for your comments. We note that you agree with the proposal to update this guideline. The introduction of the 8th edition of the AJCC staging system has potential to impact on multiple recommendations in the guideline and this has been one of the key factors influencing the decision to update the guideline. We plan to add text to both the staging node of the melanoma pathway and the overview and/or stages of melanoma landing page for this guideline to alert readers that the change in melanoma staging system will be considered as part of the planned guideline update. Since our surveillance has indicated that not all of the sections in this guideline should have been affected by the change in staging system, we consider that there is value in maintaining the availability of guideline and pathway content on the website. Topic experts and stakeholders at consultation have also highlighted the need for this guideline to consider the change in staging system but have not

			similarly requested that the pathway or guideline documents be withdrawn from the NICE website. We will continue to consult with registered stakeholders as part of the planned update.
Merck Sharp & Dohme Limited	yes – with corrections	We note that in the proposal to update the guideline, under section 1.7 Managing stage III melanoma; Systemic treatment for stage III disease; Impact statement; on page 37 that: "A topic expert commented that there was no heading for adjuvant treatment and systemics in the guideline and considered that inclusion of a patient decision aid in the guideline would be useful. Section 1.7 Managing stage III melanoma should be revised to allow cross referencing to the melanoma pathway describing NICE technology appraisals of systemic treatments for stage III melanoma." We are in favour of section 1.7 of NG14 to be updated to reflect the fact that there are now NICE recommended adjuvant treatments for this stage of the disease, and for the relevant parts of the melanoma pathway to be cross-referenced. However, we note that there is an error in the content of the published melanoma pathway describing NICE technology appraisals of systemic treatments for stage III melanoma that we would like to have corrected especially if/when this content is incorporated or cross-referenced in an updated NG14.	Thank you for your comments. We note that you agree with the proposal to update this guideline, with corrections. Thank you for highlighting that you consider there to be an error in the melanoma pathway content relating to NICE technology appraisals of systemic treatments for stage III melanoma. We note that you identify your raised error as being located under the 'therapies for unresectable or metastatic stage III melanoma' node of the pathway, under 'systemic immunotherapy', 'previously untreated advanced melanoma' and that nivolumab for adjuvant treatment is listed as an option following TA558. You state that TA558 only recommends nivolumab for adjuvant treatment of patients who have completely resected disease and therefore is not a NICE recommended option for patients with unresectable or metastatic stage III melanoma. We note that you wish to have the content of the 'therapies for unresectable or metastatic stage III melanoma' node to be corrected by removal of nivolumab for adjuvant treatment as an option and for this revised content to be reflected or cross-referenced in the update of NG14. We will refer this issue to the pathways team so that any necessary changes may be made according to their processes.

		Specifically, in the "Therapies for unresectable or metastatic stage III melanoma" node of the pathway, under the "Systemic immunotherapy", "Previously untreated advanced melanoma" section, nivolumab for adjuvant treatment is listed as an option based on TA558. However, TA558 only recommends nivolumab for adjuvant treatment of patients who have completely resected disease (i.e. without any evidence of remaining melanoma), and so is not a NICE recommended option for patients with "unresectable or metastatic stage III melanoma". We would therefore like to have the content of the "Therapies for unresectable or metastatic stage III melanoma" node of the melanoma pathway corrected, by removing nivolumab for adjuvant treatment as an option, and the corrected content to be reflected/cross-referenced in the updated version of NG14.	
British Dermatological Nursing Group (BDNG)	Yes	AJCC 8th edition drives the need for further update in particular with management of sentinel lymph node biopsy, adjuvant therapy and different stages of melanoma. New evidence on completion lymph node dissection should be considered to inform change of practice With the event of targeted and immunotherapy treatments we have now patients surviving Stage IV melanoma, survivorship and its implications has not been discussed anywhere in the guideline nor is it discussed in the CG138	Thank you for your comments. We note that you agree with the proposal to update this guideline. We agree that AJCC staging for melanoma has changed since the publication of the guideline and this impacts on its relevance to current clinical practice. We acknowledge that this revision has potential to impact on multiple recommendations in the guideline, including sentinel lymph node biopsy and management of different stages of melanoma. New evidence on completion lymphadenectomy was considered in this surveillance review (including 2 RCTs and additional

		With a view to holistic and increasingly more complex management of melanoma patients, the role of the skin cancer CNS is extremely important especially as they may deliver a significant part of the patient's care and should also deliver the "Recovery Package" Holistic Needs Assessment (HNA), End of Treatment Summary (EOT) and Health and Wellbeing Events (HWBE) The CNS plays a pivotal role in patient support especially with the advent of new adjuvant therapies, managing immunotherapy toxicities and survivorship as a result our roles are becoming more complex and specialised. Patients like/ would benefit from a personalised care plan that incorporates aspects of holistic assessment and treatment It is imperative at diagnosis stage to discuss the use of appropriate sun protection, taking into consideration vitamin D and skin surveillance	observational studies) and it was concluded that this evidence has potential to impact on recommendations on completion lymphadenectomy. Thank you for highlighting the issue of survivorship in melanoma and the fact that implications of survivorship are not discussed in this guideline or CG138. However, no evidence or intelligence was identified on survivorship in the surveillance review. We note your comment relating to the important role of the skin cancer clinical nurse specialist in care and support of people with melanoma. We propose to retain recommendations 1.1.1 to 1.1.5 on communication and support in this guideline. We also note your comment that appropriate sun protection should be discussed at diagnosis (also considering vitamin D and skin surveillance). This is already covered in recommendation 1.1.3.
British Association of Dermatologists (the BAD)	Yes	No comments provided	Thank you for your response. We note that you agree with the proposal to update this guideline.
British Nuclear Medicine Society	Yes	No comments provided	Thank you for your response. We note that you agree with the proposal to update this guideline.
Royal College of Physicians		We would like to endorse the response submitted by the BAD	Thank you for your response.

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Royal College of Paediatrics and Child Health	Yes	No comments provided	Thank you for your response. We note that you agree with the proposal to update this guideline.
Myriad Genetics, Ltd	Yes	No comments provided	Thank you for your response. We note that you agree with the proposal to update this guideline.
Novartis Pharmaceuticals UK Limited	Yes	• Under the heading of Genetic testing in early stages of melanoma (page 18 of the review proposal), we recommend that the timing of BRAF testing is reviewed as part of this Guidelines Update. If patients are tested as early as possible (ideally at diagnosis) they are able to access therapy without a repeat biopsy further down the disease pathway. There is no evidence to suggest a patient's BRAF status is altered during the course of the disease and therefore it may be more efficient for the NHS to consider this approach. • We would recommend to include a minimum turn around time and mechanism for BRAF testing as well as provide clear defined criteria for when BRAF re-testing should be considered to minimise false negative readings (i.e negative test results from low sensitivity assays). • We would recommend inclusion of dabrafenib & trametinib adjuvant license under separate heading for adjuvant systemic therapy under the main heading titled '**This guideline includes**	Thank you for your comments. We note that you agree with the proposal to update this guideline. Thank you for recommending that timing of BRAF testing be reviewed in the proposed guideline update. Section 1.2 (Assessing melanoma) covers genetic testing in early stage melanoma. Topic expert feedback during surveillance noted that recommendations in this section should be reviewed considering the increased availability of treatments for later stage melanoma since NG14 publication. However, we did not identify any evidence on early testing in this surveillance review. You recommend inclusion of dabrafenib and trametinib licenses in the guideline. It is planned that the proposed update of this guideline will link to the melanoma pathway in order to provide a cross-referral to the existing NICE-recommended systematic treatments.

		recommendations' and reference it to the recent appraisal decisions for dabrafenib & trametinib in the adjuvant setting	
British Association of Skin Cancer Specialist Nurses	Yes	• AJCC 8th edition drives the need for further update in particular with the management of sentinel lymph node biopsy, adjuvant therapy and different stages of melanoma. • New evidence on completion lymph node dissection should be considered to inform change of practice • With the event of targeted and immunotherapy treatments we have now patients surviving Stage IV melanoma, survivorship and its implications has not been discussed anywhere in the guideline nor is it discussed in the CG138 • With a view to holistic and increasingly more complex management of melanoma patients, the role of the skin cancer CNS is extremely important especially as they may deliver a significant part of the patient's care and should also deliver the "Recovery Package" Holistic Needs Assessment (HNA), End of Treatment Summary (EOT) and Health and Wellbeing Events (HWBE) • The CNS plays a pivotal role in patient support especially with the advent of new adjuvant therapies, managing immunotherapy toxicities and survivorship as a result our roles are becoming more complex and specialised. • Patients like/ would benefit from a personalised care plan that incorporates aspects of holistic assessment and treatment.	Thank you for your comments. We agree that AJCC staging for melanoma has changed since the publication of the guideline and this impacts on its relevance to current clinical practice. We acknowledge that this revision has potential to impact on multiple recommendations in the guideline, including sentinel lymph node biopsy and management of different stages of melanoma. New evidence on completion lymphadenectomy was considered in this surveillance review (including 2 RCTs and additional observational studies) and it was concluded that this evidence has potential to impact on recommendations on completion lymphadenectomy. Thank you for highlighting the issue of survivorship in melanoma and the fact that implications of survivorship are not discussed in this guideline or CG138. No evidence or intelligence was identified on survivorship in the surveillance review. We note your comment relating to the important role of the skin cancer clinical nurse specialist in care and support of people with melanoma. We propose to retain recommendations 1.1.1 to 1.1.5 on communication and support in this guideline. We also note your comment that appropriate sun protection should be discussed at diagnosis (also considering vitamin D and skin surveillance). This is already covered in recommendation 1.1.3.

		• It is imperative at the diagnosis stage to discuss the use of appropriate sun protection, taking into consideration vitamin D and skin surveillance	
Royal College of Nursing		Please be aware that there are no further comments to make on this document on behalf of the Royal College of Nursing	Thank you for your response.

Do you have any comments on areas excluded from the scope of the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
Pierre Fabre Ltd	Yes	Section 1.8 (Systemic treatment) of NG14, should be updated to reflect TA 562; Recommendations on encorafenib (Braftovi) with binimetinib (Mektovi) for treating unresectable or metastatic BRAF V600 mutation-positive melanoma	Thank you for your comments. It is planned that the proposed update of this guideline will link to the melanoma pathway in order to provide a cross-referral to the existing NICE-recommended systematic treatments.
North of England Dermatopathology Service (NEDS)	No	No comments provided	Thank you for your response.
Melanoma Focus	No	No comments provided	Thank you for your response.
Merck Sharp & Dohme Limited	No	No comments provided	Thank you for your response.
British Dermatological Nursing Group (BDNG)	Yes	• Removing 1.1.1 – 1.1.2 , 1.1.4 1.1.5 on communication and support and replace with a cross reference to the Nice guideline on patient experience in adult NHS services.	Thank you for your comments. We note that you do not consider removal of NG14 recommendations 1.1.1, 1.1.2, 1.1.4 and 1.1.5 and replacement by a cross-reference to CG138 patient experience in adult NHS services

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		Patient experience in adult NHS services: improving the experience of care for people using adult NHS services published in February 2012 (CG138), we don't feel that support outlined in here is specific to cancer patients and feel their needs, are significant and should be part of the guideline, we also like to point out, that survivorship has not been considered before and this is another patient experience area where input and expertise is needed. If these needs are not described in any guideline we will lose an opportunity and as a consequence may have difficulty in justifying our roles and services. The evidence for removing these sections you quote in supporting studies on page 10-11 . A survey (3) you quote is stating that patients favour verbal delivery of information from their physician rather than information in a booklet. You also state that information should be individualised. They have stated in their evidence – the patient prefers the information from a physician, in reality this news may in many services be delivered by the Skin Cancer CNS. We would all agree that information given at the point of diagnosis is not always absorbed. The ''physician '' may give that information but it normally the CNS who explains that information in a way the patient can understand. Time pressures in all our skin cancer clinics will no doubt affect patients if CNS are deskilled or removed and the breaking bad news is left to the ''physician''. There was a plethora or research that demonstrated how badly patients received BAD news . Removing the recommendation for staff to have training in delivering BAD news/ advanced communication fills us with great concern. Communication training is briefly mentioned in CG138, but not implication that anyone who	to be an appropriate approach. We note your view that guidance in CG138 is not sufficiently specific to skin cancer patients and that the needs of people with melanoma are significant and they should be included in the guideline. Following consideration of consultation comments, the revised final surveillance decision proposes that recommendations 1.1.1 to 1.1.5 be retained within NG14. Thank you for highlighting the issue of survivorship in melanoma and the fact that this is not considered in the guideline. No evidence or intelligence was identified on survivorship in the surveillance review. Thank you for your comments on the importance of providing appropriate information and support to people with melanoma and the role of the clinical nurse specialist in this delivery. Following consideration of consultation comments, the revised surveillance decision is to retain recommendations 1.1.1 to 1.1.5 in NG14.

		delivers a cancer diagnosis should attend this training, in current NHS climate, we feel these requirement should be stated, failure to do so will lead to inequitable service. In your evidence NICE/ you state that information should to be given to meet patients' individual needs, but then then you continue: " that patients prefer to watch You tube Videos or use the internet to gain information on lymph node examination". However - that does not apply to a large cohort of skin cancer patients - many are elderly who may not have access to internet or know their way around google, so those patients require support of a specialist CNS teaching them these skills, through verbal information they can understand, which can be backed up with written information. Within Northern Ireland our CNS service is mainly relatively new and as our service becomes more established, clinicians look to guidance from NICE to our service There seems to be a deskilling of role to a more general discussion in CG138 As patients become more complex and with an increase in immunosuppressed patients we need Holistic Needs Assessment (HNA) to source information to enable high quality individualised care, a care plan may be drawn up for patients to refer to.	

British Association of Dermatologists (the BAD)	No	No comments provided	Thank you for your response.
British Nuclear Medicine Society	Yes	**SLNB –** This document is out of date. There is a likely survival benefit in the positive SLNB subgroup population by having their disease detected at the microscopic stage (**MSLT-1 study:** DOI: 10.1056/NEJMoa1310460). Furthermore, patients who are SLN+ will be eligible for adjuvant systemic immunotherapy (**Keynote-054 Study** DOI: 10.1056/NEJMoa1802357; **EORTC 18071 Study** DOI: 10.1056/NEJMoa1611299) or targeted therapy (**Combi-AD Study** N Engl J Med. 2017;377(19):1813 and doi: 10.1200/JCO.18.01219) which has definitely shown a relapse-feee and overall survival benefit in this patient group . **PET-CT –** The key meta-analysis on this topic is the study performed by Xing et al (doi: 10.1093/jnci/djq455) indicating the superior performance of PET-CT in detecting stage IV disease. No study shows direct evidence that a PET-CT per se provides a survival benefit for patients but several studies have shown that early introduction of immunotherapy with low-disease burden stage IV disease is associated with a better progression survival (Keynote-006: DOI:https://doi.org/10.1016/S0140-6736(17)31601-X) We propose that the SLNB section is rewritten as it is factually incorrect and PETCT is mentioned as an alternative to CT in specialist centres.	Thank you for your comments. We note your comment that the section of the guideline on SLNB is out of date. We will refer this feedback to the guideline update team. The MSLT-I trial was included in this surveillance review. As this trial was already included in the guideline, it was considered unlikely to have impact on guideline recommendations. There are a range of NICE technology appraisals considering the use of adjuvant immunotherapy. We propose to provide a link from the guideline to the melanoma pathway to account for the range of systemic immunotherapies available. The Xing *et al.*, 2011 meta-analysis was included in the summary of evidence in the surveillance review for CSG8. However, this study was not included in the summary of evidence in the surveillance review for NG14 as it was published before the publication of the guideline.

Royal College of Physicians		We would like to endorse the response submitted by the BAD	Thank you for your response.
Royal College of Paediatrics and Child Health	No	No comments provided	Thank you for your response.
Myriad Genetics, Ltd	Yes	The scope of this guideline does not include assessing equivocal lesions- Melanoma can be difficult to diagnose, particularly in its earliest stages, yet accurate diagnosis of melanocytic neoplasms is vital to optimal patient outcomes. Histopathologic examination has long been the gold standard for melanoma diagnosis, and while it is adequate for most cases, evidence suggests that approximately 15% of all biopsied melanocytic neoplasms are difficult to diagnose by histopathology alone. Even experienced dermatopathologists disagree in some cases, and, depending on the type of lesions evaluated, diagnostic discordance may be substantial. In equivocal cases, patients may receive diagnoses that are indeterminate or inaccurate, leading to inappropriate treatment. Unnecessary re-excisions, sentinel lymph node biopsies, and protracted clinical follow-up may result when a diagnostically challenging benign lesion is reported as indeterminate. Conversely, a diagnostically challenging melanoma mistakenly classified as a benign nevus may result in under-treatment and subsequent progression to late-stage melanoma. Consequently, adjuncts to histopathology have been sought in efforts to improve diagnostic accuracy in equivocal cases.	Thank you for your comments. We note that you raise the issue that assessing equivocal lesions is not included in the guideline scope. We note your comment that there is not a review of technologies for dermatopathologists for assessment of equivocal lesions and that you recommend that molecular tools for differential diagnosis of melanoma be included in the proposed update of NG14. No evidence or intelligence on this area was identified in the surveillance review to support a scope extension.

		Currently, the guidance includes recommendations on genetic testing for targeted systemic therapies as well as in early stage melanoma however there is not presently a review of technologies intended for dermatopathologists confronting primary cutaneous melanocytic neoplasms for which the diagnosis of malignant melanoma versus benign nevus is equivocal / uncertain (i.e. a clear distinction between benign or malignant cannot be achieved using clinical and / or histopathological features alone). Based on the information above we respectfully request consideration for a review of the evidence around molecular tools for differential diagnosis of melanoma to be in scope for this evaluation.	
Novartis Pharmaceuticals UK Limited	Not answered	No comments provided	Thank you for your response.
British Association of Skin Cancer Specialist Nurses	Yes	• Removing 1.1.1 – 1.1.2 , 1.1.4 1.1.5 on communication and support and replace with a cross reference to the Nice guideline on patient experience in adult NHS services. • Patient experience in adult NHS services: improving the experience of care for people using adult NHS services published in February 2012 (CG138), we don't feel that the support outlined in here is specific to cancer patients and feel their needs are significant and should be part of the guideline. We would also point out that survivorship has not been considered before and this is another patient experience area where input and expertise is needed. If these needs are not described in any guideline, we will lose an opportunity and as a consequence may have difficulty in justifying our roles and services.	Thank you for your comments. We note that you do not consider removal of NG14 recommendations 1.1.1, 1.1.2, 1.1.4 and 1.1.5 and replacement by a cross-reference to CG138 patient experience in adult NHS services to be an appropriate approach. We note your view that guidance in CG138 is not sufficiently specific to skin cancer patients and that the needs of people with melanoma are significant and they should be included in the guideline. Following consideration of consultation comments, the revised final surveillance decision proposes that recommendations 1.1.1 to 1.1.5 be retained within NG14. Thank you for highlighting the issue of survivorship in melanoma and the fact that this is not considered in the guideline. No evidence or intelligence was identified on survivorship in the surveillance review.

		• The evidence for removing these sections you quote in supporting studies on page 10-11. A survey (3) you quote is stating that patients favour verbal delivery of information from their physician rather than information in a booklet. You also state that information should be individualised. They have stated in their evidence – the patient prefers the information from a physician, in reality this news may in many services be delivered by the Skin Cancer CNS. We would all agree that information given at the point of diagnosis is not always absorbed. The ''physician '' may give that information but it is normally the CNS who explains that information in a way the patient can understand. Time pressures in all our skin cancer clinics will no doubt affect patients if CNSs are deskilled or removed and the breaking bad news is left to the ''physician''. There was a plethora or research that demonstrated how badly patients received BAD news. Removing the recommendation for staff to have training in delivering BAD news/advanced communication fills us with great concern. Communication training is briefly mentioned in CG138, but no indication that anyone who delivers a cancer diagnosis should attend this training. In the current NHS climate, we feel this requirement should be stated, failure to do so will lead to inequitable service. • In the evidence it is stated that information should be given to meet patients' individual needs, but the guidance continues: "that patients prefer to watch You Tube videos or use the internet to gain information on lymph node examination". However – this is not suitable for a large cohort of skin cancer patients - many of whom are elderly and may not have access to the internet or know their way around	Thank you for your comments on the importance of providing appropriate information and support to people with melanoma and the role of the clinical nurse specialist in this delivery. Following consideration of consultation comments, the revised surveillance decision is to retain recommendations 1.1.1 to 1.1.5 in NG14.

		Google. These patients require the support of a specialist CNS who can provide verbal information they can understand, which can be backed up with written information. • Within Northern Ireland the CNS service is relatively new and as our service becomes more established, clinicians look to guidance from NICE to develop the service. • There seems to be a deskilling of role to a more general discussion in CG138 • As patients become more complex and with an increase in immunosuppressed patients, we need Holistic Needs Assessments (HNA) to source information to enable high quality individualised care, a care plan may be drawn up for patients to refer to.	
Royal College of Nursing		Please be aware that there are no further comments to make on this document on behalf of the Royal College of Nursing	Thank you for your response.

Do you have any comments on equalities issues?

Stakeholder	Overall response	Comments	NICE response
Pierre Fabre Ltd	No	No comments provided	Thank you for your response.
North of England Dermatopathology Service (NEDS)	No	No comments provided	Thank you for your response.
Melanoma Focus	No	No comments provided	Thank you for your response.

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Merck Sharp & Dohme Limited	No	No comments provided	Thank you for your response.
British Dermatological Nursing Group (BDNG)	Yes	Omitting role of CNS with respect to delivery of holistic care and Recovery Package from the guideline, may lead to fewer CNS's in post and as a result inequity of care	Thank you for your comment. Following consideration of consultation comments, the final review proposal has been revised. Therefore, in the final review decision, it is proposed that NG14 recommendation 1.1.4 on holistic needs assessment will be retained.
British Association of Dermatologists (the BAD)	No	No comments provided	Thank you for your response.
British Nuclear Medicine Society	No	No comments provided	Thank you for your response.
Royal College of Physicians		We would like to endorse the response submitted by the BAD	Thank you for your response.
Royal College of Paediatrics and Child Health	No	No comments provided	Thank you for your response.
Myriad Genetics, Ltd	No	No comments provided	Thank you for your response.
Novartis Pharmaceuticals UK Limited	Not answered	No comments provided	Thank you for your response.

British Association of Skin Cancer Specialist Nurses	Yes	Omitting the role of CNS with respect to delivery of holistic care and the Recovery Package from the guideline, may lead to fewer CNSs in post and as a result may lead to inequity of care	Thank you for your comment. Following consideration of consultation comments, the final review proposal has been revised. Therefore, in the final review decision, it is proposed that NG14 recommendation 1.1.4 on holistic needs assessment will be retained.
Royal College of Nursing		Please be aware that there are no further comments to make on this document on behalf of the Royal College of Nursing	Thank you for your response.