NICE National Institute for Health and Care Excellence

Appendix B2: Stakeholder consultation comments table

2019 surveillance of Improving outcomes for people with skin tumours including melanoma (2006)

Consultation dates: 19 March to 1 April 2019

Do you agree with the proposal to withdraw the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
North of England Dermatopathology Service (NEDS)	Yes but qualified as requiring an urgent replacement	It is appropriate to withdraw this on a time basis and the update to NG14 HOWEVER it contains vital guidance that will be lost It currently is the only NHS guidence source for local and specialist skin cancer MDTs , nonmelanoma skin cancer (NMSC) and rare skin tumours including sarcoma, lymphoma and Merkel Cell Carcinoma. These will fall by the wayside and disadvantage patients. It formed the basis of the previous cancer peer review for skin, supranetwork lymphoma MDTs and has been an outstanding success in the development of high quality skin cancer services.	Thank you for your comments. We note that you agree with the withdrawal of the guidance in its current form but that it requires an urgent replacement, particularly regarding community dermatology, local and specialist skin cancer multidisciplinary teams (MDTs) (including structure and function), non-melanoma skin cancer, and rare skin tumours (including sarcoma, lymphoma and Merkel Cell Carcinoma). We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.

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

		This withdrawal MUST be followed urgently by replacement by new skin cancer guidance covering community dermatology , MDT structure and function in secondary care , NMSC and rare tumours including primary cutaneous lymphoma and sarcoma and MCC.	
Melanoma Focus	No	The guidance on service configuration in CSG8 should be maintained. There continue to be serious deficiencies in care, especially in areas where dermatology recruitment is difficult and where private providers of NHS services extend their services into skin cancer care. CSG8 provides useful definition of service standards. It is emphatically not clinical guidance and should not be conflated with the cutaneous melanoma guidelines. Each has a different purpose, although some overlap is unavoidable.	Thank you for your comments. We note that you do not agree with the proposal to withdraw the guidance. Thank you for highlighting the continuing need for guidance on service configuration and the value of CSG8 in defining service standards. We acknowledge that CSG8 is service guidance and agree that the purpose of CSG8 differs from that of the NICE guideline on melanoma: assessment and management (NG14). We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.
British Association of Oral and Maxillofacial Surgeons	Yes	With AJCC 8.0 the changes are unavoidable	Thank you for your comments. We note that you agree with the proposal to withdraw this guidance. We agree that changes in staging of skin cancer since the development of the original guidance have impacted on the relevance of CSG8 to current clinical practice.

			We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.
British Dermatological Nursing Group	No	The reasons / research, that prompted the IOG guidelines (CSG8), still stands today, in a NHS where cost cutting is a daily consideration , a guideline to protect Local & Specialist multidisciplinary teams and clearly defines the structure of the service, is essential. It informed Peer Review Measures. To withdraw this guidance will have potentially a significant impact on the way skin cancer services will be managed and delivered and could as a result see skin cancer care be delivered in a primary care setting without any input from a MDT. For patients this poses a threat, for clinicians, justifying the way our services are run will become very difficult once the guideline is removed. A Trust may therefore decide to restructure their MDT and reduce numbers of Cons Doctors to attend MDT – to a structure that saves them Doctors attendance times or CNS. Or they could disband Local MDT and leave SSMDT only . These services work together and both have their value and should be described in detail. At MDT CNS as core member advocates for patient concerns, wishes and potential treatment options considering the patient holistically The role of the Skin Cancer CNS/ Keyworker was introduced and defined in this guideline, in fact there were very few skin cancer CNS's in the country at the time, as a result of the IOG & Peer Review more CNS's have been	Thank you for your comments. We note that you do not agree with the proposal to withdraw the guidance. Thank you for highlighting your views on the value of CSG8 in supporting MDT care and defining service structure. We note your comment that withdrawing CSG8 would have a significant impact on delivery of skin cancer services, particularly relating to MDTs, peer review, the role of the skin cancer nurse specialist in patient care, and communication skills training. We also note your view that guidance on management of basal cell carcinoma and implications for quality of life is needed. No evidence or intelligence on this area was identified in this surveillance review. However, we have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.

		appointed to posts in the UK, but in some area's the role is still very new and the guidance is essential to ensure stability ultimately benefitting our patients Within Northern Ireland our CNS service is relatively new and as our service becomes more established, clinicians look to guidance from NICE to our service. Advanced communication for all health care professionals working with cancer patients and "Breaking Bad News" was introduced with this guideline, with its withdrawal there will be no guarantee that clinicians attend these trainings, again putting patients at risk of sub-standard care High risk head and neck BCC should be acknowledged as surgical defect can be emotionally and physically impacting on QOL, especially following treatment with MOHS surgery	
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 withdraw this guidance. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.
British Association Plastic Reconstructive Aesthetic Surgeons	No	Points in relation to CSG8. CSG is clinical service guidance. It is about the structure of service provision. It is emphatically not clinical guidance. NICE are conflating CSG8 and NG14, the	Thank you for your comments. We note that you do not agree with the proposal to withdraw this guidance.

		2015 NICE melanoma guidelines. They have a different purpose, though there is unavoidably some overlap. Our views about the need for detailed service guidance are informed by knowledge and experience of reviewing dermatology skin cancer services for the BAD. There continue to be serious challenges in care, especially in areas where dermatology recruitment is difficult, and where private providers of NHS services extend their activities into skin cancer care. CSG8 allows us to define service standards. The preferred approach would be a re-draft of the CSG with contemporary detail, but crucially a structure that allows clinical leadership to hold NHS Services to account when we challenge cuts/changes in care provision.	We acknowledge that CSG8 is service guidance and agree that the purpose of CSG8 differs from that of the NICE guideline on melanoma: assessment and management (NG14). Thank you for highlighting your views that detailed service guidance is needed. We note that you consider that the most appropriate approach would be to update CSG8. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.
British Association of Skin Cancer Specialist Nurses (BASCSN)	No	• The reasons / research, that prompted the IOG guidelines (CSG8), still stands today, in a NHS where cost cutting is a daily consideration, a guideline to protect Local & Specialist multidisciplinary teams and clearly defines the structure of the service, is essential. It informed Peer Review Measures. To withdraw this guidance will potentially have a significant impact on the way skin cancer services will be managed and delivered and could as a result see skin cancer care being delivered in a primary care setting without any input from a MDT. For patients this poses a threat, for clinicians, justifying the way our services are run will become very difficult once the guideline is removed.	Thank you for your comments. We note that you do not agree with the proposal to withdraw the guidance. Thank you for highlighting your views on the value of CSG8 in supporting MDT care and defining service structure. We note your comment that withdrawing CSG8 would have a significant impact on delivery of skin cancer services, particularly relating to MDTs, peer review, the role of the skin cancer nurse specialist in patient care, and communication skills training. We also note your view that guidance on management of basal cell carcinoma and implications

		• A Trust may therefore decide to restructure their MDT and reduce numbers of Consultant Doctors to attend MDT – to a structure that saves them Doctors attendance times or CNS time. Or they could disband Local MDTs and leave SSMDT only. These services work together and both have their value and should be described in detail. • At MDT, the CNS, as a core member, advocates for patient concerns, wishes and potential treatment options considering the patient holistically. • The role of the Skin Cancer CNS/ Keyworker was introduced and defined in this guideline, in fact there were very few skin cancer CNSs in the country at the time, as a result of the IOG & Peer Review more CNSs have been appointed to posts in the UK, but in some area's the role is still very new and the guidance is essential to ensure stability ultimately benefitting our patients • Within Northern Ireland our CNS service is relatively new and as our service becomes more established, clinicians look to guidance from NICE on our service. • Advanced communication for all health care professionals working with cancer patients and "Breaking Bad News" was introduced with this guideline, with its withdrawal there will be no guarantee that clinicians attend this training, again putting patients at risk of sub-standard care. • High risk head and neck BCC should be acknowledged as a surgical defect that can emotionally and physically impact on QOL, especially following treatment with MOHS surgery.	for quality of life is needed. No evidence or intelligence on this area was identified in this surveillance review. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.
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. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.

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

British Association of Dermatologists	No	1.1 Quality is systemic. Ensuring that patients receive high quality care relies on a complex set of interconnected roles, responsibilities and relationships between professionals, provider organisations, commissioners, systems and professional regulators and other national bodies such as NICE. It is not the responsibility of any one part of the system alone, but a collective endeavour requiring collaboration at every level of the system. *References:* *Review of early warning systems in the NHS, National Quality Board, February 2010.* *Quality in the new health system – maintaining and improving quality from April 2013, draft report, National Quality Board, August 2012.* 1.2 The organisation of skin cancer services set out by the NICE IOG underpins the current infrastructure and quality outcomes for patient care. Without an updated version of the NICE IOG the commissioning of services would become fragmented and create inequity of care for patients. 1.3 Updating the clinical guidelines for melanoma, SCCs and BCCs without the NICE IOG or replacement guidance recommendation would remove national infrastructure for the treatment pathways for patients. 1.4 The evidence review fails to recognise the peer review and outcome measures for the provision of skin cancer services. These are based on the requirements of the NICE IOG.	Thank you for your comments. We note that you do not agree with the proposal to withdraw the guidance. Thank you for highlighting your views on the continuing value of CSG8 in organisation of skin cancer services, peer review and outcome measures, and the need for an updated version of CSG8 to support service commissioning and equity of care. We also note your comment that CSG8 plays an important role in defining the infrastructure to support the treatment pathways in the clinical guidelines for melanoma, squamous cell carcinoma and basal cell carcinoma. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.

Do you have any comments on areas excluded from the scope of the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
North of England Dermatopathology Service (NEDS)	No	No comments provided	Thank you for your response. We note that you do not have any comments on areas excluded from the scope of the guidance.
Melanoma Focus	No	No comments provided	Thank you for your response. We note that you do not have any comments on areas excluded from the scope of the guidance.
British Association of Oral and Maxillofacial Surgeons	Yes	By withdrawing CSG8, will it be made clear in future the membership of LSMT and SSMDT	Thank you for your comments. We note your comment that guidance is needed on the membership of local and specialist skin cancer MDTs. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services. We will ensure developers are aware of the continuing need for guidance on MDT membership for their consideration during scoping of the proposed update.
British Dermatological Nursing Group	Yes	Withdrawal of the IOG is alarming as this document not only clearly defines the structure of the service, but also the MDT, and the CNS role Will NICE be making recommendations on how the structure of the MDT will function going forward or will	Thank you for your comments. Thank you for providing your view that CSG8 has continuing value in defining service structure, including MDT care and the role of the clinical nurse specialist.

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

		that be left to each trust or do NICE feel that no changes should be made to the current structures of MDT that were set out in the IOG guideline	We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services. We will ensure developers are aware of the continuing need for guidance on MDT membership for their consideration during scoping of the proposed update.
Royal College of Paediatrics and Child Health	No	No comments provided	Thank you for your response. We note that you do not have any comments on areas excluded from the scope of the guidance.
British Association Plastic Reconstructive Aesthetic Surgeons	No	No comments provided	Thank you for your response. We note that you do not have any comments on areas excluded from the scope of the guidance.
British Association of Skin Cancer Specialist Nurses (BASCSN)	Yes	• Withdrawal of the IOG is extremely concerning as this document not only clearly defines the structure of the service, but also the MDT, and the CNS role. • Will NICE be making recommendations on how the structure of the MDT will function going forward or will that be left to each trust or do NICE feel that no changes should be made to the current structures of MDT that were set out in the IOG guideline?	Thank you for your comments. Thank you for providing your view that CSG8 has continuing value in defining service structure, including MDT care and the role of the clinical nurse specialist. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services. We will ensure developers are aware of the continuing need for guidance on MDT membership for their consideration during scoping of the proposed update.
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. We note that you do not have any comments on areas excluded from the scope of the guidance.

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

British Association of Dermatologists	Yes	2.1 The IOG outlines a structured approach to the organisation of the management of patients with skin cancers, with firm recommendations on which types of skin lesions can be diagnosed and treated in the community, local hospitals and specialist centres. 2.2 The IOG describes at least six mutually exclusive levels of specialisation which, for the purposes of service organisation and for peer review are best dealt with by the 'levels' model. 2.3 Commissioners are required to demonstrate compliance with the commissioning principles and procure services within the required NICE guidance frameworks for BCC. The management of low-risk basal cell carcinomas in the community AND recommendations in this section of the guideline are all current requirements for the commissioning of these services. CSG8 remains relevant to clinical practice. 2.4 The revalidation of GPwER individual practice requires these areas to be met. The RCGP training curriculum and credentialing of these individual requires this evidence of practice to be demonstrated. https://www.rcgp.org.uk/training-exams/practice/guidance-and-competences-for-gps-with-extended-roles-in-dermatology-and-skin-surgery.aspx 2.5 Local arrangements for the commissioning of community skin cancer services has not changed. 2.6 The guidance recommended that research be undertaken on teledermatology in the triage of patients with suspicious skin lesions (including clinical	Thank you for your comments. We note that you consider CSG8 to have value to current practice, particularly in outlining a structured approach to organisation of patient care (including MDTs), describing levels of specialisation, and commissioning of services. We also note your view that updated guidance is required on the use of teledermatology in skin cancer pathways. Evidence from a Cochrane systematic review was included in our surveillance review evidence summary on the diagnostic accuracy of teledermatology in detection of skin cancer. Topic expert feedback also supported the need to reconsider the use of teledermatology. The Cochrane review authors concluded that the evidence base was limited. Therefore, this surveillance review concluded that additional well-conducted primary research on clinical accuracy and cost-effectiveness, patient confidentiality and patient acceptability would be beneficial. Thank you for highlighting the reference to CSG8 and the CSG8 partial update in the British Association of Dermatologists ongoing updates of the basal cell carcinoma and squamous cell carcinoma guidelines. We have noted your comment on the establishment of Cancer Alliances (and that these replace cancer networks) and their role in coordination of care, planning, and leading service delivery. We also note your statement on the importance of local governance structures and peer review of care, and management of follow-up. We note that the points raised in your feedback highlight the ongoing usefulness of this guidance to practice. We acknowledge that some service structures have changed and so this guidance will require update.

		accuracy, cost-effectiveness, patient confidentiality and patient acceptability). There must be an updated reference for the use of teledermatology in the NICE IOG as this area of diagnostic screening increases. It is important for the NICE IOG to provide best practice in the use of this tool in skin cancer pathways. 2.7 The NICE IOG made a key recommendation for two levels of multidisciplinary teams – local hospital skin cancer multidisciplinary teams (LSMDTs) and specialist skin cancer multidisciplinary teams (SSMDTs). The MDT structure is there to standardise care regardless of where the patient is treated and should minimise the risks to patients, because all clinicians who treat patients with skin cancers will be working to the same protocols and have their outcomes audited. It encourages some treatments for patients with precancerous skin lesions and low-risk BCCs to be carried out in the community but ensures that patients with MM, SCC and high-risk BCC have their care managed by a hospital-based MDT with specialist skills. The BAD's Clinical Standards Unit are currently updating their BCC and SCC guidelines, and in the narratives for Linking Evidence To Recommendations (LETR) they have cited CSG8 and its partial update in the "Other Considerations" section. 2.8 A rational network of local and specialist MDTs can only be maintained if; i) there is an agreement on which MDT the patients will normally be referred to and ii) the resulting referral catchment populations are counted once for planning purposes. 2.9 The NHS England National Cancer Strategy, *Achieving World-Class Cancer Outcomes*, was	

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

		published in 2015 by the Independent Cancer Taskforce. This includes the establishment of 16 Cancer Alliances across the country to lead implementation of the strategy locally. Cancer networks have been replaced by Cancer Alliances to bring together the key organisations in an area to coordinate cancer care and to plan for and lead delivery of improved outcomes for patients locally. 2.10 Each organisation that provides cancer services will have a distinctive leadership structure (the core cancer management team). One size will not fit all and there is no best structure for staffing NHS cancer services. What is essential is that organisations develop local governance structures that reflect the complexities of their organisations. It is essential that: • the remits and level of authority of the core cancer management team and individuals within the team are clear and communicated across the organisation; • accountability for cancer delivery is clearly identified; • board level support for the structure is articulated; • sufficient time is made available for individuals to enact their roles; • a clear governance framework is in place. 2.11 Peer review skin measure are based on the outcomes recommended by the NICE IOG. The Quality Surveillance Team (QST), formerly National Peer Review Programme, lead an Integrated Quality	

		Assurance Programme for the NHS. The role of the QST is to improve the quality and outcomes of clinical services by delivering a sustainable and embedded quality assurance framework for all cancer services and specialised commissioned services within NHS England. The programme has taken the best elements of the former National Peer Review Programme and other NHS functions to develop an integrated process for quality assurance which covers all aspects of quality in particular; patient safety, patient experience, clinical effectiveness and outcomes. 2.12 Follow up care: The IOG series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up management agreed within their respective LSMDT/SSMDT and Cancer Alliance to ensure patients have a follow up plan.	

Do you have any comments on equalities issues?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
North of England Dermatopathology Service (NEDS)	Yes	If CSG8 is withdrawn, nonmelanoma skin cancer is being treated inequally to melanoma!	Thank you for your comments. We note your comment that withdrawal of CSG8 could result in inequity of care for non-melanoma skin cancer patients compared with melanoma patients. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.

Melanoma Focus	No	No comments provided	Thank you for your response.
British Association of Oral and Maxillofacial Surgeons	No	No comments provided	Thank you for your response.
British Dermatological Nursing Group	Yes	There will be a high risk of inequity of services and patient care if this guideline is removed	Thank you for your comments. We note your comment that withdrawal of CSG8 could result in inequity of services and patient care. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.
Royal College of Paediatrics and Child Health	No	No comments provided	Thank you for your response.
British Association Plastic Reconstructive Aesthetic Surgeons	No	No comments provided	Thank you for your response.
British Association of Skin Cancer Specialist Nurses (BASCSN)	Yes	• There will be a high risk of inequity of services and patient care if this guideline is removed.	Thank you for your comments. We note your comment that withdrawal of CSG8 could result in inequity of services and patient care. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.

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

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.
British Association of Dermatologists	Yes	3.1 Without the IOG in place equality of care across the UK could differ and therefore not all patients would necessarily get the same care. Discrimination may also occur due to lack of regulation of required pathways and processes. Commissioning of services could be fragmented as not all services may be re-commissioned if not deemed essential. 3.2 Equality of opportunity may also be breached in levels of care and employment of those required for each level. In particular the need for a clinical nurse specialist as part of the IOG is essential for guarding against discrimination and equality issues.	Thank you for your comments. We note your comment that withdrawal of CSG8 could result in inequity of patient care, discrimination due to lack of pathways and processes regulation, and fragmentation of service commissioning. We have considered the responses received during consultation and now propose to update this guidance because of the continuing value of this guidance to delivery of skin cancer services.