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NICE National Institute for Health and Care Excellence

NICE quality standard

Skin cancer

Quality standard

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www.nice.org.uk/guidance/qs130

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This standard is based on NG34, NG14, NG12 and CSG8.

This standard should be read in conjunction with QS124, QS55, QS15 and QS13.

Quality statements

Statement 1 Local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns.

Statement 2 GPs who manage low risk basal cell carcinoma maintain and audit records of their caseload.

Statement 3 People with suspected malignant melanoma are referred using a suspected cancer pathway for an appointment within 2 weeks.

Statement 4 People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy.

Statement 5 People with malignant melanoma or squamous cell carcinoma have access to a skin cancer clinical nurse specialist.

Statement 6 This statement has been removed. For more details see update information.

Statement 7 People with stage IIC to IV primary melanoma are offered BRAF testing of the tumour.

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Quality statement 1: Local health promotion activities

Quality statement

Local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns.

Rationale

Skin cancer is the most common form of cancer and, even though most types are preventable, its incidence has been increasing. People can recognise changes to their skin in early stages of the disease but some are still seeking help too late. Local health promotion activities, with messages consistent with any national campaigns, should minimise public confusion and increase the likelihood of behaviour change.

Quality measures

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

Structure

Evidence that the local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by local authorities, for example records of implementation plans that could include materials sourced from national campaigns such as those by NHS Better Health.

Outcome

a) Incidence of skin cancer.

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Data source:NHS Digital National Cancer Registration and Analysis Service.

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

Data source:NHS Digital National Cancer Registration and Analysis Service.

c) Proportion of non-melanoma skin cancer diagnosed at stage 1 or 2.

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

What the quality statement means for different audiences

Public health practitioners ensure that they implement local authority health promotion activities on preventing skin cancer and recognising early signs using messages consistent with those in any national campaigns.

Commissioners (local authorities) ensure that local authority health promotion activities on preventing skin cancer and recognising early signs are consistent with the messages in any national campaigns.

People in the community are given advice about how to prevent skin cancer, and how to recognise early signs, through local authority health promotion activities that reinforce the messages in any national skin cancer campaigns.

Source guidance

Sunlight exposure: risks and benefits. NICE guideline NG34 (2016), recommendations 1.1.3 and 1.1.13

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Quality statement 2: GPs managing low-risk basal cell carcinoma

Quality statement

GPs who manage low-risk basal cell carcinoma maintain and audit records of their caseload.

Rationale

Low-risk basal cell carcinoma can sometimes be managed by GPs in the community, which can be more convenient for patients. Treatment in the community can also frequently be provided at a lower cost and free up capacity in hospitals. However, it is essential that this is balanced with ensuring that care offered in the community is as safe and effective as that in hospital. Maintaining and auditing records of their caseload can help in demonstrating competence.

Quality measures

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

Structure

Evidence of local arrangements to ensure that GPs who manage low-risk basal cell carcinoma maintain and audit records of their caseload.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals.

Process

Proportion of GPs managing low-risk basal cell carcinoma who audited their caseload within the past 12 months.

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Numerator – number in the denominator who audited their caseload within the past 12 months.

Denominator – number of GPs managing low-risk basal cell carcinoma.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by healthcare professionals.

Outcome

a) Proportion of skin lesions excised by GPs that are subsequently confirmed as low-risk basal cell carcinomas.

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

b) Patient safety incidents reported related to removal of basal cell carcinomas in primary care.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from local risk management systems.

What the quality statement means for different audiences

Service providers (GP practices) ensure that GPs managing low-risk basal cell carcinoma maintain and audit records of their caseload.

Healthcare professionals (GPs, GPs with specialist interest and GPs with extended roles) managing low-risk basal cell carcinoma maintain and audit records of their caseload.

Commissioners (NHS England and integrated care systems) ensure that GPs who manage low-risk basal cell carcinoma maintain and audit records of their caseload.

People who are having treatment from a GP for a type of skin cancer called low-risk

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basal cell carcinoma receive treatment that is safe and effective.

Source guidance

Improving outcomes for people with skin tumours including melanoma. The management of low-risk basal cell carcinomas in the community. NICE cancer service guideline CSG8 (2006, updated 2010), section on models of care

Definitions of terms used in this quality statement

Low-risk basal cell carcinoma

Low-risk basal cell carcinoma is defined in the section on models of care in NICE's guidance on improving outcomes for people with skin tumours including melanoma (2010 update).

Competence in managing low-risk basal cell carcinoma

NICE's guidance on improving outcomes for people with skin tumours including melanoma (2010 update) outlines criteria for assessing competence and accrediting practitioners.

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Quality statement 3: Suspected cancer pathway referrals

Quality statement

People with suspected malignant melanoma are referred using a suspected cancer pathway for an appointment within 2 weeks.

Rationale

Timely referral to a specialist is important for a quick and accurate diagnosis of skin cancer. The specialist will usually be working as part of the local hospital skin cancer multidisciplinary team and can provide rapid diagnosis, treatment, management and follow-up for most people with skin cancer. Some squamous cell carcinomas, basal cell carcinomas and less common skin cancers may also need urgent referrals, in line with clinical judgement.

Quality measures

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

Structure

Evidence of local arrangements and clinical protocols ensuring that a suspected cancer pathway is in place for suspected malignant melanoma.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example service protocols.

Process

Proportion of confirmed malignant melanomas that were referred using a suspected

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cancer pathway for an appointment within 2 weeks.

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

Denominator – number of confirmed malignant melanomas.

Data source:NHS England Cancer waiting times covers information on the 2-week wait for suspected skin cancer.

Outcome

a) Time between GP referral for suspected skin cancer and specialist assessment.

Data source:NHS England Cancer waiting times covers information on the 2-week wait for suspected skin cancer.

b) Time from GP referral for suspected skin cancer to first definitive treatment.

Data source:NHS England Cancer waiting times covers information on 31-day waits for first treatment for suspected skin cancer.

What the quality statement means for different audiences

Service providers (GP practices and secondary care providers) ensure that systems are in place for people presenting with suspected malignant melanoma to be referred using a suspected cancer pathway for an appointment within 2 weeks.

Healthcare professionals (such as GPs or secondary care clinicians) ensure that they refer people with suspected malignant melanoma using a suspected cancer pathway for an appointment within 2 weeks.

Commissioners (NHS England and integrated care systems) ensure that services they commission refer people with suspected malignant melanoma using a suspected cancer pathway for an appointment within 2 weeks.

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Peoplewho have skin lesions, such as damaged or injured patches of skin or new, large, changing or unusual looking moles, and whose GP thinks it is a type of skin cancer called malignant melanoma, are referred for an appointment to see a specialist within 2 weeks.

Source guidance

Suspected cancer: recognition and referral. NICE guideline NG12 (2015, updated 2021), recommendations 1.7.1 and 1.7.2

Definitions of terms used in this quality statement

Suspected cancer pathway referral

The patient is seen within the national target for cancer referrals. This was 2 weeks at the time of publication of the NICE guideline on suspected cancer: recognition and referral. [NICE's guideline on suspected cancer, terms used in this guideline]

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Quality statement 4: Dermoscopy

Quality statement

People with pigmented skin lesions undergoing a specialist assessment have the lesions examined using dermoscopy.

Rationale

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

Quality measures

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

Structure

Evidence of local arrangements and clinical protocols to ensure that people undergoing specialist assessment of pigmented skin lesions are examined using dermoscopy.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations such as in local service specifications.

Process

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

Numerator – number in the denominator examined using dermoscopy.

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Denominator – number of pigmented skin lesions undergoing specialist assessment.

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

Outcome

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

Data source: National Cancer Registration and Analysis Service CancerStats2 tool and local data collection.

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

Data source:NHS Digital National Cancer Registration and Analysis Service.

What the quality statement means for different audiences

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

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

Commissioners (NHS England and integrated care systems) ensure that the specialist services they commission have trained specialists who use dermoscopy to examine pigmented skin lesions.

People with skin lesions (such as damaged or injured patches of skin or new, large, changing or unusual looking moles) that are being assessed by a specialist have the

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lesions examined using a magnifying tool called a dermatoscope, which gives a more accurate view of the lesion.

Source guidance

Melanoma: assessment and management. NICE guideline NG14 (2015, updated 2022), recommendation 1.3.1

Definitions of terms used in this quality statement

Specialist assessment

An assessment carried out by a doctor trained in the diagnosis of skin malignancy, normally a dermatologist, who is a member of either a local hospital skin cancer multidisciplinary team or a specialist skin cancer multidisciplinary team. [Adapted from NICE's guideline on improving outcomes for people with skin tumours including melanoma, key recommendations (page 8)]

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Quality statement 5: Skin cancer clinical nurse specialist

Quality statement

People with malignant melanoma or squamous cell carcinoma have access to a skin cancer clinical nurse specialist.

Rationale

Skin cancer clinical nurse specialists can provide specialist guidance and support at all stages of care and treatment, including follow-up. They can act as a source of information (including about local support groups), psychological support and palliative care if needed. People with other forms of skin cancer may also need support from a skin cancer clinical nurse specialist, depending on their individual needs and the impact of their disease.

Quality measures

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

Structure

Evidence of local arrangements and clinical protocols to ensure that skin cancer clinical nurse specialists are available for people with malignant melanoma or squamous cell carcinoma.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example from workforce plans.

Process

Proportion of people with malignant melanoma or squamous cell carcinoma who have a

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skin cancer clinical nurse specialist.

Numerator – number in the denominator who have a skin cancer clinical nurse specialist.

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

Data source: National Cancer Patient Experience Survey and the National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset.

Outcome

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

Data source: National Cancer Patient Experience Survey.

b) Satisfaction with support received from skin cancer clinical nurse specialist, reported by people with skin cancer.

Data source: National Cancer Patient Experience Survey.

What the quality statement means for different audiences

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

Healthcare professionals (members of local hospital skin cancer multidisciplinary teams or specialist skin cancer multidisciplinary teams) ensure that people with malignant melanoma or squamous cell carcinoma have access to a skin cancer clinical nurse specialist.

Commissioners (NHS England and integrated care systems) ensure that there are enough skin cancer clinical nurse specialists to support all people with malignant melanoma or squamous cell carcinoma.

People with a type of skin cancer calledmalignant melanoma or squamous cell carcinoma

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have a skin cancer nurse specialist who can provide information, advice and support.

Source guidance

- Melanoma: assessment and management. NICE guideline NG14 (2015, updated 2022), recommendation 1.1.4
- Improving outcomes for people with skin tumours including melanoma. NICE cancer service guideline CSG8 (2006, updated 2010), section on organisation of skin cancer services

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Quality statement 6: Sentinel lymph node biopsy

This statement has been removed. For more details see update information.

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Quality statement 7: Genetic testing

Quality statement

People with stage IIC to IV primary melanoma are offered BRAF testing of the tumour.

Rationale

Early determination of BRAF status helps to speed up decisions about treatment for relapsed melanoma and optimise the use of targeted treatments.

Quality measures

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

Structure

Evidence of local arrangements and clinical protocols to provide BRAF testing of the tumours for people with stage IIC to IV primary melanoma.

Data source: No routinely collected national data for this measure has been identified. Data can be collected from information recorded locally by provider organisations, for example local service specifications.

Process

Proportion of people with stage IIC to IV primary melanoma who receive BRAF testing of the tumour.

Numerator – number in the denominator who receive BRAF testing of the tumour.

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

Data source: The National Cancer Registration and Analysis Service Cancer Outcomes and

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Services Dataset contains a data item on BRAF testing.

Outcome

Survival rates in people diagnosed with stage IIC to IV primary melanoma.

Data source: National Cancer Registration and Analysis Service Cancer Survival in England survival estimates for 1 to 5 years split by stage; melanoma. All stage 1- year survival is available by geographic area.

What the quality statement means for different audiences

Service providers (secondary and tertiary care) ensure that systems are in place to provide BRAF testing of the tumour for people with stage IIC to IV primary melanoma.

Healthcare professionals (specialist skin cancer multidisciplinary teams) offer people with stage IIC to IV primary melanoma BRAF testing of the tumour.

Commissioners (NHS England and integrated care systems) ensure that they commission services that offer BRAF testing of the tumour to people with stage IIC to IV primary melanoma.

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

Source guidance

Melanoma: assessment and management. NICE guideline NG14 (2015, updated 2022), recommendation 1.3.10

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Update information

July 2022: Changes made to align this quality standard with the updated NICE guideline on melanoma. Statement 6 on discussion of the advantages and disadvantages of sentinel lymph node biopsy has been removed because it is no longer a priority area for quality improvement. Statement 7 on genetic testing has been updated to align with new recommendations on BRAF testing in the updated NICE guideline on melanoma. Links, definitions and source guidance sections have also been updated throughout.

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

Information about how NICE quality standards are developed is available from the NICE website.

See our webpage on quality standards advisory committees for details about our standing committees. Information about the topic experts invited to join the standing members is available from the webpage for this quality standard.

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

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Diversity, equality and language

Equality issues were considered during development and equality assessments for this quality standard are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

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

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Endorsing organisations

This quality standard has been endorsed by the following organisations, as required by the Health and Social Care Act (2012):

- NHS England
- Department of Health and Social Care

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- British Association of Plastic, Reconstructive and Aesthetic Surgeons
- Royal College of General Practitioners (RCGP)
- College of General Dentistry

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