Kent & Medway Cancer Collaborative

Skin Cancer

A High Level Operational Policy

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1.0 Introduction and background

The purpose of this document is to provide the Kent & Medway Cancer Collaborative (KMCC) Operational & Quality Board, Trusts, Commissioners and all Clinicians engaged in the management of Skin Cancers with an overview of the minimum requirements to be addressed in order to achieve Improving Outcomes Guidance (IOG) compliance.

The KMCC Skin Cancer Tumour Site Specific Group (TSSG) will be the KMCC source of guidance on both the implementation of the Skin Tumours and Melanoma IOG as well as Clinical Protocols and Polices.

An important aim of this document is to provide an overview of the recommendations of the KMCC Skin Cancer TSSG on processes to ensure the delivery of clinically safe, evidenced based, clinically effective and IOG compliant Skin Cancer and Melanoma Services.

This document does NOT aim to provide guidance on the clinical aspects of patient management. The clinical guidance recommendations of the KMCC Skin Cancer TSSG will be found in the locally agreed guidelines.

2.0 Kent & Medway Cancer Collaborative

. Kent & Medway has a resident population of about 1.8 million. Some residents from Sussex flow into Kent for oncological treatments expanding the population to approximately 1.9 million.

Total locality population	**781,376**			**717,470**			**283,534**
Trusts	**EKHUFT** East Kent Hospitals University NHS Foundation Trust			**MTW** Maidstone & Tunbridge Wells NHS Trust		**DG&S** Dartford, Gravesham & Swanley NHS Trust	**Medway** Medway Foundation Trust
Hospitals	**K&C** Kent & Canterbury	**QEQM** Queen Elizabeth the Queen Mother	**WHH** William Harvey	**TWH** Tunbridge Wells	**MS** Maidstone	**DVH** Darent Valley	**MFT** Medway Maritime
Note	Whilst geographically outside K&M, for the purposes of cancer the Queen Victoria Foundation Trust (QVH) at East Grinstead fall under the umbrella of K&M						

3.0 The Skin Cancer Tumour Site Specific Group (TSSG)

The KMCC established a Skin Cancer TSSG in 2003.

- The TSSG has a multidisciplinary / multi-professional membership which is drawn from:
  - Each of the acute Trusts providing Local / Specialist level service
  - Primary Care
  - Patient / Users
- The TSSG is IOG compliant
- The TSSG has multidisciplinary/multiprofessional membership which is drawn from:
  - Each of the acute trusts providing Local Skin cancer Multi-disciplinary Team Service (LSMDTS) and/or Specialist Skin cancer Multi-disciplinary Team (SSMDT) level service
  - Primary Care
  - Patient/Users

Named Leads for the Skin Cancer TSSG are:

Chair	:	Dr Jessica Jenkins, Consultant Oncologist
Vice Chair	:	Dr Kurt Ayerst, Consultant Dermatologist
KMCC Lead	:	Interim: Natalie Aluwalia, KMCC
Non Surgical Oncology Group (NOG) Lead	:	
Research and Trials (RAT) Lead	:	Dr Nick Rowell, Consultant Clinical Oncologist
Users Issues Lead	:	Karen Mackinnon, CNS
Named Admin Support	:	Natalie Aluwalia, KMCC

A full list of current membership is available from the Skin Cancer TSSG attendance record – a copy of which is located on the KMCC website: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/

- A copy of the full Terms of Reference for all TSSGs is located on the KMCC website: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/

- A copy of the TSSG Chair Job Description is located on the KMCC website: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/

4.0 Non-Surgical Oncology Group (NOG)

The Skin and Head & Neck NOG is aligned and was formally established in 2008.

A copy of the NOG full Terms of Reference is available on the KMCC website: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/

A copy of the Oncological Treatment of Skin Cancer is located on the KMCC website: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/

5.0 Research and Trials (RATs)

The Skin TSSG has a 'virtual' Skin Research & Trials Group (RAT) for rare cancers incorporating Head & Neck and Thyroid. It is the responsibility of the TSSG Chair to ensure that the Clinical Trials Report is discussed at the one of the TSSGs meetings in a given 12 month period.

The national initiative to restructure the Research Networks to 15 Local Research Networks has resulted in a reconfigured structure for delivering clinical research across England:-

- The three local Cancer Research Networks are now part of the NIHR Clinical Research Network: Kent, Surrey and Sussex
- The new organisation coordinates clinical research and facilitates study set up and delivery, through 30 disease specialties, of which Cancer is one
- The transition to the new organisational structure is ongoing and when the Research work plan is formalised, it will be included in the TSSG work plan

Role of Research and Trials Groups

- The Research and Trials groups have been responsible for the strategic development and delivery of the Cancer Research portfolio of clinical studies for Kent and Medway
- The Research and Trials groups provide the platform for discussion of cancer clinical studies and act as a resource for information pertaining to those studies

6.0 Provision of Kent & Medway wide skin cancer services

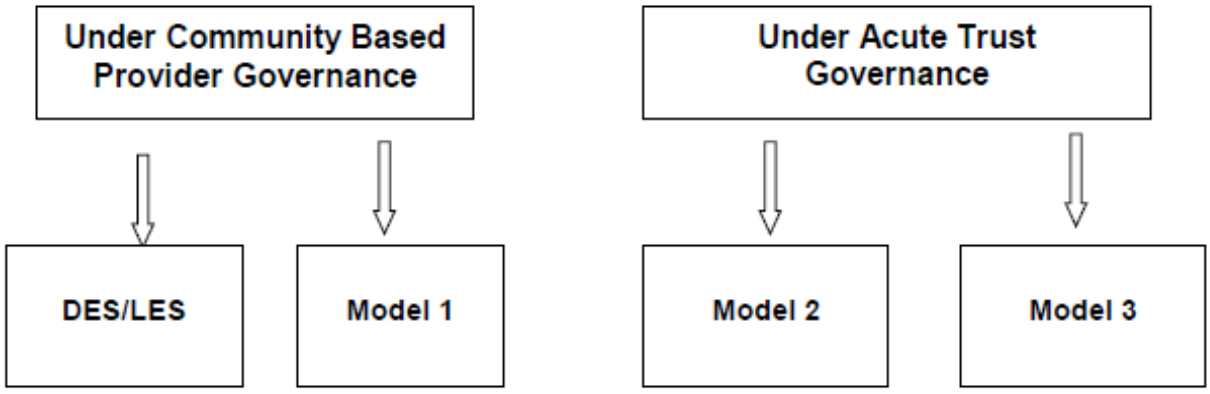
Management of Skin Cancer in the Community

Note June 2012:

The following section describes the current arrangements for managing skin cancer community services. It is recognised there are a number of changes taking place with regards to the role of the PCTs which at the time of issuing these measures remains unclear.

During this transition services are still required to meet the recommendations in the revised and updated guidance on the management of skin cancer in the community, contained in the 2010 update to the NICE IOG on skin cancer, and the 2011 DH Revised guidance on GPwSI dermatology and skin surgery services, however the measures relating to the community skin cancer services have not been issued. Services will not be reviewed or required to self assess against these for 2012

Acceptable Models for the Management of Skin Cancer in the Community by Surgical excision or Curettage



Levels of care for the Management of Skin Cancer

Care Level	Person or Team	Case mix / Procedure
1	Any general practitioner in the community	• Benign lesions • Actinic Keratoses • Precancerous – SCC in situ/Bowen's
2	Community practitioners working to the 'DES/LES' model (Level 2a) or the 'model 1' service model (level 2b). See guidance below in the section on skin cancer in the community. (Page 10 of this document).	DES/LES list of BCCs. (Level 2a) Model 1 list of BCCs (level 2b). See guidance below in the section on skin cancer in the community.
3	LSMDT, hospital staff core team member (May be core member of SSMDT acting as 'local' LSMDT). Without mandatory individual case review by MDT.	• High risk BCC • SCC } Other than categories below
4	LSMDT, hospital staff core team member(s), with mandatory individual case review by LSMDT (may be the SSMDT and its core members acting as 'local' LSMDT)	• High risk BCC • SCC } Recurrent or with +ve excision • Malignant Melanoma (MM) – new, single primary, adult, non-metastatic, not for approved trial entry, up to and including stage II a (must fulfil all these criteria) • Radiotherapy if attendance by clinical oncologist at LSMDT • Lesion where diagnosis is uncertain but may be malignant • Incompatible clinical and histological findings
5	SSMDT hospital staff core team member(s) with mandatory individual case review by SSMDT. (May have been previously reviewed by LSMDT or rapidly referred without prior review). For some cases – only one agreed SSMDT, if more than one in the Network.	• Selected BCCs and SCCs needing plastic/reconstructive surgery by SSMDT core member (as per Network clinical guidelines) • Radiotherapy (as per Network clinical guidelines). If not discussed and treated by LSMDT clinical oncology core team member • Metastatic SCC on presentation or newly metastatic • MM – stage IIb or more, or <19 years or metastatic on presentation or newly metastatic or recurrent or for approved trial entry • Any cases for approved trial entry • Any cases for adjuvant therapy (as per Network clinical guidelines) • Histology opinion from SSMDT core pathology team member
		• Mons surgery • Skin Cancer in immunocompromised patients including organ transplant recipients • Skin Cancer in genetically predisposed patients including Gorlin's Syndrome Cases to be dealt with by only one agreed SSMDT per Network, if more than one in the Network: • Cutaneous lymphoma • Kaposi's sarcoma • Cutaneous sarcoma above superficial fascia. (Below fascia, refer to sarcoma MDT)in cancers • Other rare skin cancers (see appendix 1 in the Skin Cancer IOG pg 128/129. *Notes:* • *Where a network chooses to have a M MDT all cases of MM for level 5 care from the M MDT's catchment area should be referred to the M MDT.* • *There should be agreed working arrangements with site specialised MDT's for SCC of Head and Neck and Sarcoma and mucosal malignant melanoma.*
6	• Supranetwork team. Selected Networks only. Agreed with SCGs. • Clinician responsible for named facilities for photopheresis (very small numbers of patients). Agreed with SCGs.	• T-cell Cutaneous Lymphoma: Total Body Surface Electron Beam Therapy • T-cell cutaneous lymphoma. Photopheresis

Note:

- The KMCC will expect the provision of Skin Cancer Services within the community to be delivered in compliance of the Models 1-3 described in the above table.
- The KMCC will expect the provision of Skin Cancer Services within the Network to be delivered in compliance of the levels of care described in the above table.
- The KMCC will expect that LSMDTs and SSMDTs are established in compliance with the population criteria set described in the IOG and Quality Measures.

6.1 KMCC agreed configuration of Skin Cancer Services

- The KMCC has agreed that the most cost effective and least disruptive way to achieve compliance with the recommendation would be to build on the existing Skin Cancer Services at Medway and Canterbury.
- Both services would function at both LSMDT and SSMDT levels.
- An outreach service from the Medway SSMDT has been established to serve the Tunbridge Wells population.
- The Queen Victoria Foundation Trust at East Grinstead has now merged with Medway NHS Foundation Trust to form a single, combined local and specialist MDT. Both sites will provide 2-WW skin cancer services. QVH will also act as a specialist tertiary level reconstructive surgery centre and be the named centre for block dissections. The combined MDT will be known as the Medway and Queen Victoria Hospital Skin Cancer MDT.

  note *QVH is the named centre for block dissections for patients coming through the West Kent MDT. For East Kent, is is Miss Elizabeth Sharp, QEQM Margate.*
- A very small sub population of West Kent will flow into the Bromley LSMDT for ease of access. These patients will flow into the Guy's SSMDT should this level of management be deemed appropriate.

Configuration of Skin MDTs

<table>
<tr><th></th><th>Trust</th><th>Hospital</th><th>MDT Level</th></tr>
<tr><td>Eastern & Coastal Kent
Population 781,376
(Patients flows from Swale are mainly into Medway Maritime)</td><td>East Kent Hospitals Trust</td><td>K&C</td><td>Joint LSMDT & SSMDT</td></tr>
<tr><td>Medway
Population 283,534</td><td>Medway NHS Foundation Trust Hospital</td><td>MFT</td><td rowspan="4">Joint LSMDT & SSMDT</td></tr>
<tr><td rowspan="3">West Kent
Population 717,470</td><td>Maidstone & Tunbridge Wells NHS Trust</td><td>Maidstone & Tunbridge Wells</td></tr>
<tr><td>Dartford, Gravesham & Swanley NHS Trust</td><td>Darent Valley</td></tr>
<tr><td>Queen Victoria Foundation Trust Hospital East Grinstead</td><td>Queen Victoria</td><td>Tertiary Level Provider</td></tr>
<tr><td>West Kent

A very tiny number of patients from WK will flow into Bromley for ease of access</td><td>Bromley</td><td>Bromley</td><td>LSMDT</td></tr>
</table>

- General Practitioners with an interest in the management of Skin Cancer will sign up to one of the models of care described by the Skin Cancer Quality Measures.
- A “completed” version of the Matrix described in the table below with the names of individual General Practitioners should be set out in the Operational Policies of both KMCC Skin Cancer MDTs.

Note: *Because telephone / fax numbers change on a frequent basis and in the interest of document - “contact point details” will be confined to referral proformas. Please see referral proforma link:* http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/

6.2 Referral and Clinical Guidelines

The Skin TSSG has agreed IOG and Quality Measure compliant clinical guidelines that contain appropriate referral guidelines in the form of Pathways of Care (PoCs) for the appropriate referral of patients between teams. All KMCC Disease Site Specific PoCs are in a standard format, which cover all key stages of the patient's journey: Referral; Diagnosis, Staging; Treatment; Imaging; Pathology; Follow Up; Supportive & Palliative Care.

The Skin PoCs have been developed in discussion with the following groups and appropriate corresponding statements are found in each of the PoC's for each of the listed disease sites: Colorectal TSSG; Gynae TSSG; Haematology TSSG; Head & Neck TSSG; Thyroid TSSG; Urology TSSG.

(Sarcoma guidance conforms to the joint KMCC/Royal Marsden Sarcoma Operational Policy)

Copies of all the KMCC skin cancer Pathways of Care are found on the KMCC website:

- A Pathway of Care for the Management of Basal Cell Cancers
  http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/
- A Pathway of Care for the Management of Squamous Cell Cancers
  http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/
- A Pathway of Care for the Management of Melanoma
  http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/
- A Pathway of Care for the Management of Cutaneous Lymphoma
  http://www.kentmedwaycancernetwork.nhs.uk/resource-library/dermatology-tssg/

Clinical & Referral Guidelines overview for Rare Skin Cancers / conditions

Measure	Action/Response	Care setting
Referral guidelines between teams	1. These are set out in individual Pathways of Care (PoC) 2. These are set out in the Operational Policies of both the LSMDTs and the SSMDTs	
Mycosis fungoides	1. These are set out in the Skin Cancer Lymphoma PoC	St Johns Supranetwork MDT
T-Cell lymphoma	1. These are set out in the Skin Cancer Lymphoma PoC	
Immunocompromised patients	1. These are set out in Operational Policies of each of the KMCC designated LSMDTs and SSMDTs 2. There specifically reserved slots in the defined clinic slots as defined in column 3	Canterbury SSMDT QVH East Grinstead MFT/QVH SSMDT
H&N – ocular mucosal melanoma **H&N – peri-ocular melanoma** **H&N – nasal mucosal melanoma** **H&N – other skin cancers**	1. There will be discussion between the SSMDTs and the Specialist H&N MDTs who will agree on a case by case basis which team will manage individual patients 2. Surgical membership of both KMCC SSMDTs and both H&N Specialist MDTs overlap 3. BCCs referred to H&N teams will be treated by local reconstructive teams depending on local expertise eg Mohs surgery 4. More complex Malignant Melanomas and SCCs of the conjunctiva and globe will be referred to Moorefield's	Canterbury SSMDT Canterbury Specialist H&N MDT MFT/QVH SSMDT MTW Specialist H&N MDT QVH East Grinstead QVH H&N (site for WK H&N surgery & part of MTW Specialist H&N MDT) Moorefield's
Colorectal	1. There will be discussion between the SSMDTs and the CRC MDTs designated to manage anal cancers who will agree on a case by case basis which team will manage individual patients 2. Guidance set out in the updated 2012 KMCC CRC PoC 3. Guidance set out in the KMCC Melanoma PoC	QEQM CRC MDT WHH CRC MDT MTW CRC MDT MFT CRC MDT DVH CRC MDT

Gynae	1. There will be discussion between the SSMDTs and the Specialist Gynae MDTs who will agree on a case by case basis which team will manage individual patients 2. Guidance set out in the updated 2012 KMCC Gynae PoC 3. Guidance set out in the KMCC Melanoma PoC	QEQM Specialist Gynae MDT
		MTW Specialist Gynae MDT
Urology	1. There will be discussion between the SSMDTs and the Specialist Urology MDTs who will agree on a case by case basis which team will manage individual patients 2. Guidance set out in the updated 2012 KMCC Penile Ca PoC 3. Guidance set out in the KMCC Melanoma PoC	EK (Canterbury) Specialist Urology MDT
		WK Specialist Urology MDT
		St Georges Supranetwork MDT for penile cancers
Haematology	1. There will be discussion between the SSMDTs and the Haemato-oncology MDTs who will on a case by case basis which team will manage individual patients 2. Guidance set out in the KMCC Melanoma PoC	Canterbury Haematology MDT
		MFT Haematology MDT MTW Haematology MDT DVH Haematology MDT (Meeting weekly for a SINGLE MDM)
Sarcoma	1. There will be discussion between the SSMDTs and the Supranetwork Sarcoma MDTs to agree on a case by case basis which team will manage individual patients 2. Guidance set out in the updated 2012 KMCC/Royal Marsden Sarcoma Operational Policy 3. Guidance set out in the KMCC Rare Skin Cancer PoC	Canterbury SSMDT
		MFT/QVH SSMDT
		Royal Marsden Supranetwork MDT
Kaposi's Sarcoma	1. There will be discussions between the SSMDTs and the Haematology MDTs and the GUM clinics 2. Guidance set out in the KMCC Rare Skin Cancer PoC	Canterbury SSMDT
		Canterbury Haematology MDT
		EK GUM Clinic
		MFT/QVH SSMDT
		WK Haematology MDM
		MFT GUM Clinic

Due to the geography of Kent and Medway, as with the provision of Head & Neck (H&N) and Thyroid Cancer Services, the KMCC is supporting the two SSMDT model of care on the basis of patient accessibility; one across the whole of East Kent; the other across the whole of West Kent and Medway.

On the basis of accessibility haematology, sarcoma and Kaposi's patients will be managed in both East and West Kent.

6.3 Mohs Surgery

Agreed list of Mohs practitioners:

East Kent Hospitals University Foundation Trust
- Kent & Canterbury Hospital: Dr Juber Hafiji / Dr Andrew Birnie

Medway NHS Foundation Trust
- *Refer to K&C or QVH*

Maidstone & Tunbridge Wells NHS Trust
- *Refer to K&C or QVH*

Dartford, Gravesham & Swanley Trust
- *Refer to K&C or QVH*

Queen Victoria Foundation Trust Hospital
- East Grinstead: *TBC*

7.0 Data Collection

Collection of data at each stage of the pathway is the responsibility of the team looking after the patient at that time.

The minimum dataset agreed by the TSSG will be a combination of those data items that meet national requirements, and additional items as agreed by the TSSG.

National data requirements will include:

- Cancer Waiting Times monitoring, including Going Further on Cancer Waits. The data items required will be as defined in ISB0147 at the time of referral and/or treatment.

  Details of the Cancer Waiting Times dataset are available from:
  http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation

  Cancer Waiting Times data will be submitted according to the timetable set out in the National Contract for Acute Services.

- The Cancer Outcomes and Services Dataset. The data items will be as defined in ISB1521, and any subsequent versions, at the time of diagnosis and/or treatment. The requirement will include those fields listed in the "Core" section of the dataset, and any additional tumour site specific sections, as applicable.

  Details of the COSD are available from:
  http://www.ncin.org.uk/collecting_and_using_data/data_collection/cosd.aspx

  Cancer Registration and Cancer Outcomes and Services (COSD) data will be submitted according to the timetable set out by the National Cancer Registration Service (NCRS).

- Where applicable, teams will also collect additional data items as defined in any corresponding National Clinical Audit Support Programme (NCASP) audit dataset.

  Details of these datasets are available from:
  http://www.ic.nhs.uk/services/national-clinical-audit-support-programme-ncasp/cancer

  Data for NCASP audits will be submitted, where applicable, according to timetables as agreed by the TSSG, and within the overall submission deadlines for each audit.

Submission of data to meet these national requirements will be the responsibility of each individual Trust.

Note that these standards are subject to variation from time to time, and where these requirements change, the data items required to be collected by the team will also change in line with national requirements.

Local data requirements will include any additional data items as agreed by the TSSG. These must be selected to avoid overlap with any existing data items, and where possible must use standard coding as defined in the NHS Data Dictionary.

Where possible and applicable, InfoFlex will be used for the collection and storage of data.

Additional areas of the COSD, relating to pathology, radiotherapy, SACT, diagnostic imaging and basic procedure details will feed into the dataset from other nationally mandated sources. It is the responsibility of each team to ensure that the whole of the relevant dataset is collected, and it is acknowledged that this may come from a variety of sources.

8.0 Pathology

All KMCC reporting pathologists follow The Royal College of Pathologists Histopathology Reporting on Cancers guidelines – a copy of which is available through the KMCC website:- http://www.kentmedwaycancernetwork.nhs.uk/resource-library/pathology-ccag/

Core Cell Path members of the MDT should be taking part in a general (but recognised) EQA scheme. It is expected that the K&M Trusts will monitor this and inform the TSSG in the event of any deviation from this. The Trusts should also take responsibility for agreeing and implementing any remedial actions arising from either [a] any non compliance with this measures and / or [b] matters identified through the EQA process.

9.0 Imaging

Imaging guidelines for skin cancer can be located in the KMCC agreed document located on the KMCC website on the following link: http://www.kentmedwaycancernetwork.nhs.uk/resource-library/diagnostics-ccag/

10.0 General information relating to the management of skin cancer

10.1 Patients requiring referral to local Rapid Access Skin Cancer Clinic or MDM

Patients attending their GP where a diagnosis of the following skin cancer is suspected:

a. Melanoma
b. SCC or keratoacanthoma
c. Special caution: suspicious tumour of uncertain origin and pyogenic granuloma

Special consideration

d. Unexpected invasive cancer (melanoma or SCC) demonstrated on histology

Patients not requiring Rapid Access Skin Cancer Clinic referral:

e. BCC or Bowen's disease (*SCC in situ* on histology)
f. General naevus (mole) checks and screening
g. Benign naevi and any skin lesion not suspicious of cancer

- Refer patients with lesions in category **a, b & c** to the local Rapid Access Skin Cancer Clinic on agreed proforma (see Appendix A). This should be faxed to the local designated cancer booking office to qualify for 2-week wait access
- Refer patients with lesions in category **d** according to local protocols. GPs to ascertain what preferred local referral policy exists. Referral must be accompanied by the histology report. Information regarding the nature of the lesion at presentation, procedure, technique, intent (biopsy or curative) is valuable in assessing for further management. At present the protocol is:
    - East Kent refer on proforma to Rapid Access Skin Cancer Clinic
    - Medway and West Kent refer as urgent to local dermatology department
- Refer patients with lesions diagnosed as **e, f & g** to routine dermatology clinics.
    - Low risk BCCs may be managed by GPwSIs, GP surgeons and doctors in community cancer management centres who are members of the MDT

Patients referred by letter/fax/post or on the *Choose and Book* system may be upgraded by consultants to attend the local Rapid Access Skin Cancer Clinic. These patients should not be treated as routine appointments.

- The Category **d** patient Referral Protocol will be disseminated to all General Practitioners via appropriate PCT communication mechanisms

Patients with suspected skin cancer should not be referred to screening or triage services, nor biopsied in primary care. Such interventions might introduce a delay in appropriate treatment, or affect accurate

histological examination of the lesion. Such interventions might potentially make a significant difference to cancer prognosis, and cause unnecessary stress or harm to the patient. If there is diagnostic doubt, it is better to err on the side of caution and refer to a specialist in secondary care via the rapid access route. Conversely, patients who have been to such a screening service and been told the lesion is 100% guaranteed harmless should not be referred to the rapid access clinic as this may cause unnecessary stress for the patient, and cause further delays to patients with confirmed cancer.

10.2 Patient attending local Rapid Access Skin Cancer Clinic

Patients will be seen at a dedicated skin cancer clinic within the national 2-week wait rule guidance.
Patients will:

- Be reassured if the lesion is clinically thought to be benign
- Undergo photography of lesion to document it if considered necessary
- Undergo a thorough examination including assessment of loco-regional lymph node status if indicated
- Have an appropriate biopsy taken or have arrangements made for biopsy
- Be “discharged” with appropriate information

The visit will be fully documented using the agreed local rapid access proforma. Appropriate tracking/MDS documentation must be completed.

The patient should receive advice, support and appropriate “discharge” information.

Any patient seen outside of the dedicated skin cancer clinic (for whatever reason) and complying with the national 2-week wait rule must still be documented and recorded on the appropriate Rapid Access Skin Cancer Clinic paperwork and be tracked for cancer pathway compliance.

10.3 Patients who fail to attend a Rapid Access Skin Cancer Clinic appointment

- All patients who fail to attend an appointment should be registered on the hospital appointments system as *Did Not Attend (DNA)* and sent a further appointment within 2 weeks.
- Patients who fail to attend a second appointment will be discharged from the cancer 2-ww lists. The referring GP will be informed to allow them to ascertain the reasons for non attendance and re-request an appointment if it is still required.
- Patients should be informed of the decision to refer them to a local Rapid Access Skin Cancer Clinic and expect to be contacted at short notice for an urgent appointment within 2 weeks (14 days) of the referral being sent.

10.4 Patients referred to MDM from other sources & unreferred patients identified with skin cancer

Any patients suspected of having skin cancer, or found on histology of falling into the scope of tumours requiring MDM should be added to the MDT discussion list. This could be from any source or specialty in the Trust. The Pathology department acts as a safeguard to identify and inform the MDT of any unexpected skin tumours received from all sources in the Trust. All lesions must be reviewed and/or documented even when being dealt with by another specialty/MDT.

MDTs function for the management and tracking of cancer patients from the population under the care of the local Trust. Patients referred outside the Trust or to alternative providers fall under the MDT arrangements of that provider.

In practice, where the Pathology Department identifies new cases of skin cancer in patients who have been under the care of alternative providers, reasonable attempts will be made to contact the patient's GP to ensure appropriate onward referrals have been made, although this may not always be possible if there is insufficient clinical information. Details will be added to the National Cancer Registration Service.

Patients seen in the private sector are excluded from the NHS Cancer Waiting Targets – A Guide (Version 5). The Skin TSSG recommends that, in the interests of good practice, NHS doctors refer private patients under their care to the local MDT for discussion.

10.5 Management of patients with lesion suspected of skin cancer attending a Rapid Access Skin Cancer Clinic appointment

All patients seen at the Rapid Access Skin Cancer Clinic, under the 2-ww rule and suspected of having an invasive skin cancer should be documented and tracked to ensure compliance with the management targets below. Basal cell carcinoma is currently excluded from these targets.

A Pathway of Care has been produced by the Skin TSSG for: Basal Cell Carcinoma (BCC); Squamous Cell Carcinoma (SCC); Melanoma; Cutaneous Lymphoma.

The TSSG recommends a “one-stop” clinic for the diagnosis and treatment of all clinically suspected melanomas and SCCs.

Any patient seen outside of the 2-ww rule and suspected of having skin cancer is still subject to the 31 day targets on confirmation of invasive skin cancer.

Patients added to the tracking list may only be removed from the MDT data list on exclusion of skin cancer. All other patients must be tracked to ensure completion of the patient pathway.

10.6 Referrals made outside IOG recommendations/2-ww guidance

- If and when GPs fail to refer appropriately or in a timely manner this should be formally and constructively reported back to them via the appropriate channels.
- In KMCC these are the Trust’s established and formal 2-WW reporting mechanisms via the Clinical Commissioning Groups (CCGs).
- CCG commissioner representatives will be responsible for invoking the CCG governance process designed to address such matters.
- Skin Cancer MDT Clinicians are responsible for ensuring information on referrals made outside IOG recommendations and/or in breach of the 2-WW process is formally provided to Trust Cancer Managers and/or Trust Lead Cancer Clinicians so that they in turn may invoke the correct remedial protocols.

The CCG route is the appropriate mechanism for resolving such matters; it is not helpful for secondary care clinicians to raise these matters directly with Primary Care Clinicians.

10.7 Follow-up protocols

Issues around patient follow-up have become an area of grave concern for clinicians managing skin cancer patients. Follow up should be appropriate to the needs of individual patients and should be based on clinical judgement. Patients should be made aware of the distinction between clinical follow up and support, and know how to access both.

BAD guidelines exist for the follow-up of patients diagnosed with melanoma. *Roberts DLL et al. al. UK Guidelines for the management of cutaneous melanoma. Br J Dermatol 2002; 146: 7-17*. While the skin TSSG recognises that the recommended follow-up guidelines are based on poor evidence, this is currently considered to be the standard of care. For SCC, early detection and treatment improves survival of patients with recurrent disease. 95% of local recurrences and metastatic disease are detected within 5 years. There is good evidence to support regular follow-up of high risk SCCs. High risk SCCs are discussed in the SCC Pathway of Care.

There have been significant advances in the management of malignant melanoma in recent years, and prompt diagnosis of local recurrence and metastasis can lead to improved survival. Prompt treatment with the newer agents such as BRAF inhibitors can be beneficial in a subset of patients. If local recurrence or metastatic disease is clinically suspected in a patient with a history of malignant melanoma, then urgent referral to rapid access skin cancer clinic in secondary care is required for prompt investigation and management. Patients with high risk melanoma should now undergo regular clinical and radiological follow up as defined in the Melanoma Pathway of Care.

The TSSG recommends that all patients with invasive skin cancers should be reviewed and may be discharged at an appropriate time following patient education and agreement. The follow up period should be individualised and may be shorter than the current proposed protocols.

Early detection and treatment improves outcomes of patients with recurrent or new primary BCC disease. Studies suggest that 82% of local recurrences occur within 5 years, 36% of patients develop new primary tumours and 20% of high risk patients (skin type and exposure) develop multiple new lesions.

Patients with BCCs, in-situ and non-invasive melanomas should be reviewed following complete excision of the primary lesion for education and advice. Routine long term follow-up of these patients is usually not required.

By the same token, some patients may require longer than recommended follow-up plans for a variety of reasons. Apart from transplant and immunocompromised patients, families with cancer syndromes and genetic predisposition, some patients have a higher risk, cannot perform self checks or suffer from other complicating factors.

- The key purpose of follow up is patient education
- There is good evidence that educated patients detect their own recurrence
- Patients who do detect recurrence should be fast tracked back to the MDT
- Patients will have access to a clinical nurse specialist for support and advice
- Patients will have access to appropriate information and should always be given relevant “discharge” information

11.0 Immunocompromised skin cancer patients

It has been confirmed with the National Cancer Action Team that this measure only applies to patients who have undergone organ transplantation; it does NOT apply to patients who are on “routine” chemotherapy and/or radiotherapy and who may be transiently immunocompromised as a direct consequence of undergoing such therapy. As a minimum, local OPs should provide specific details in order to complete the table below:

Clinics for immunocompromised patients

2WW skin cancer clinics for immunocompromised patients
MDT
Trust

	Venue	Day	Time	Run by	Contact
Clinic					

12.0 Children & Young People (CYP) / Teenage & Young Adult (TYA)

12.1 Children & Young People (CYP)

Children and Young People with Skin Cancers will be treated in accordance with principles set out in the CYP IOG.

All Children and Young People up to the age of 18 must be referred to the CYP Principle Treatment Centre which for KMCC is based at the Royal Marsden.

All Young People between 16 and 24 years of age must be offered a referral to the CYP Treatment Centre.

Referral to a CYP Principle Treatment Centre does not necessarily mean that treatment will be undertaken at that Centre; shared care management protocols may allow some treatments to be undertaken locally.

12.2 Teenage & Young Adult (TYA)

The main principles in the Teenage & Young Adult guidance are as follows:

- The 16-18 age group should be seen and treated at the TYA Principal Treatment Centre (PTC) and have their management plans discussed by the TYA PTC. Although shared care can be arranged as part of the pathway
- Young People aged 19-24 years must be given choice where they would like to be treated either:
  - in the TYA Principal Treatment Centre.
  Or
  - an adult service designated by commissioners to treat young adults 19 to 24 years.
- In both cases all young people must be given access to the services and resources offered by the TYA MDT at the PTC, this may be remotely or through specified clinical services or supportive activities, and each trust will need a mechanism to identify all new TYA patients regardless of which MDT they initially present to.

13.0 List of reference documents

1. NICE Guidance on Cancer Services; Improving Outcomes for people with Skin Tumours including Melanoma. The Manual February 2006

2. NICE Guidance on Cancer Services; Improving Outcomes for people with Skin Tumours including melanoma (update), The Management of low-risk basal cell carcinomas in the community May 2010

3. National Peer Review Programme; Manual for Cancer Services: Skin Measures Version 1.0, Gateway Ref 10790 – Jan 2014

4. Improving Outcomes: A Strategy for Cancer, Gateway reference 15108 – January 2011

5. Referral Guidelines for suspected cancer: NICE clinical guideline 27 Issued: June 2005 last modified : April 2011

6. Cancer Waiting Times: A Guide (Version 8.0) – Gateway reference 16765 October 2011

7. Going Further on Cancer Waits (GFOCWs) A Guide (V6.8)

8. Marsden JR, et al. Revised UK guidelines for the management of cutaneous melanoma 2010. Br J Dermatol 2010; 163: 238-256.Motley R

9. Motley RJ, Multi-professional guidelines for the management of the patient with primary cutaneous squamous cell carcinoma 2009.

10. M - update of the original guideline which appeared in Br J Dermatol 2002; 146:18-25

11. Telfer NR, Colver GB, Morton CA. Guidelines for the management of basal cell carcinoma. Br J Dermatol 2008; 159:1 35-48

12. Morton CA, et al. British Association of Dermatologists' guidelines for the management of squamous cell carcinoma in situ (Bowen's Disease) 2014. Br J Dermatol 2014; 170: 245-260

13. Whittaker SJ et al. Joint British Association of Dermatologists and UK Cutaneous Lymphoma Group guidelines for the management of primary cutaneous T-cell lymphomas. Br J Dermatol 2003; 149: 1095-110

14.0 Glossary

Acronyms in common usage throughout KMCC documentation:-

CNB	Cancer Network Board
CYP	Children & Young People (in relation to the IOG)
DCCAG	Diagnostic Cross Cutting Advisory Group
DOG	Disease Orientated Group (NSSG/TSSG/TWG)
DVH	Darent Valley Hospital
EK	East Kent
EKHUFT	East Kent Hospitals University Foundation Trust
HoP	High Level Operational Policy
IOSC	Improving Outcomes: A Strategy for Cancer
K&C	Kent & Canterbury Hospital, Canterbury, (EKHUFT)
KMCC	Kent & Medway Cancer Collaborative
KMCN	Kent & Medway Cancer Network
KMCRN	Kent & Medway Cancer Research Network
LSESN	London & South East Sarcoma Network
MFT	Medway Foundation Trust
MTW	Maidstone & Tunbridge Wells NHS Trust
NOG	Non Surgical Oncology Group *(Permanent oncologist sub group of the TSSGs with a specific responsibility for chemo/rad pathways and advice to the TSSG, KMCC and geographical locations on new drugs)*
PoC	Pathway of Care *(KMCC agreed disease site specific clinical guidelines)*
QEQM	Queen Elizabeth the Queen Mother Hospital, Margate (EKHUFT)
QoL	Quality of life
RAT	Research and Trial Group *(Permanent sub-group of the TSSGs with a specific responsibility for taking forward the clinical trials agenda)*

RMH	Royal Marsden Hospital
RNOH	Royal National Orthopaedic Hospital
QVH	Queen Victoria Foundation Trust Hospital East Grinstead
UCLH	University College Hospital London
WHH	William Harvey Hospital, Ashford (EKHUFT)
WK	West Kent

15.0 Revision History

Document Title	Skin Cancer – A High Level Operational Policy
Principle author	K.Ayerst/A.Cooper
Co-author(s)	TSSG Members/ KMCC
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Revision History			
Date of revision	New Version Number	Nature of Revision	Confirmation of Accuracy by
Oct 2008	0.4	Draft - Reworking of original KA Policy to reflect revised Quality Measures and new Peer Review Process	A.Jackson / K.Ayerst
Nov 2008 Nov 2008 Jan 2009	0.5 0.6 0.6/7/8/	Draft - Update following publication of final version of QMs Draft - CYP Draft - General updates from Trusts	A.Jackson A.Jackson A.Jackson
Jan 2009	0.9	Final Draft - Changes to accommodate joint MFT/QVH status	A.Jackson / P.Banwell
Feb 2009	Final	Final - Approved CAT 10 Feb 2009	A.Jackson
June 2010	3.1	Updated links, members, contacts, Board, KMCN and PCT text	C.Tsatsaklas
July 2010	4.0	Final	Skin DOG
June 2012	4.1	Draft – Updated to new format only (no content change)	S.Stanley/C.Tsatsaklas
July 2012	4.2	Draft – Updated content of all sections / Research Section updated / NOG section updated / CYP-TYA section updated	C.Tsatsaklas/I.Vousden B.Mercier/C.Waters/S.Dicker
August 2012	4.3	Draft – Data Collection section updated	A.Brittle/I.Vousden/C.Tsatsaklas
September 2012	4.4	Draft – AC comments included	A.Cooper/I.Vousden
September	5.0	FINAL – approved at the Skin DOG	Skin DOG/A.Cooper /I.Vousden/

2012		13/09/12 – agreed/published	B.Mercier/ C.Waters/ S.Dicker/ A.Brittle
August 2014	5.1	Draft - Removed text relating to DOGs, PCTs, KMCN – replaced with TSSGs, CCGs, Cancer Team, updated weblinks etc	C.Tsatsaklas
November 2014	5.2	Addition of Interim KMCC Lead, Vice Chair and NOG Lead names	N.Aluwalia
Jan 2015	5.3	Rephrase of sentence P14, Para 2	J.Jenkins/N.Aluwalia
February 2015	5.4	Amendments to P9 MoHs section	A.Newberry
February 2015	6.0	Final Published	N.Aluwalia
May 2015	6.1	Amendments to the list of publications detailed in the policy	K.Ayerst / N.Aluwalia
June 2015	7.0	Final Published	N.Aluwalia