Kent & Medway Cancer Network Policy for GP Skin Cancer Surgery Training & Accreditation VERSION 1.0

1. Introduction

In light of national guidelines regarding the management of Skin Cancer published in February 2006 by NICE http://www.nice.org.uk/csgstim and the subsequent 'NHS National Cancer Review Programme, Manual for Cancer Services 2008: Skin Measures', both primary and secondary care are required to provide enhanced services for patients with skin cancer. This document sets out the proposed model for the training, accreditation and continued education of General Practitioners commissioned to perform skin cancer surgery within the Kent and Medway Cancer Network. This document will undergo further development as training and accreditation changes and/or needs are identified. Changes will be made with the agreement of the Kent and Medway Network Skin DOG and those GPs undertaking skin cancer surgery.

2. GP Skin Cancer Surgery Service Provision

The PCTs within the region have committed to commission IOG compliant services. Any changes to this policy and future services would require Network and DOG agreement 08-1A-205j.

General Practitioners and their Practices are invited to sign up to provide Skin Cancer Surgery Services in the community. This service provision would be under the aegis of Model 2 in the 'NHS National Cancer Review Programme, Manual for Cancer Services 2008: Skin Measures' and recognises that Primary Care surgeons may remove skin cancers which are not deemed 'Hospital only' (measure 08-2J-211 *note error in Table 2 affixed below*) as directed and agreed by their associated Core MDT members.

Practitioners wishing to sign up to the Model 2 service will be expected to join a Local Skin Cancer Multidisciplinary Team (LSMDT) and undergo regular training and educational updates as well as comply with the requirements of clinical audit as set out in this document (measures 08-1C-116j and 08-1C-117j). It should be noted that this role is distinct from and separate to a Dermatology GPwSI who would satisfy Model 1 in the Skin Measures.

Practitioners undertaking skin cancer surgery will do so as part of a Locally Enhanced Service (LES) [see 'Local Enhanced Service Agreement for Minor Surgery and the management of Skin Cancer Lesions', Chesover, Weaver and Banwell, 2009] or equivalent SLA and must be associated with a named MDT.

Additional references:
(1) Action On Dermatology (AOD) Good Practice Guidance
(2) NHS Modernisation Agency's Action On Plastic Surgery(AOPS) guidance. (www.wise.nhs.uk/NR/rdonlyres/BBA564B6-2690-49F9-90A1-E4E2E3A9ACAB/1315/doc2_plastic.pdf).

3. GP Skin Cancer Surgery Service Criteria

In order to provide this Service the provider will be expected to demonstrate compliance with the following criteria:

Criteria One: Eligibility

A Service Level Agreement (SLA) with the PCT must be in place with each GPwSI in skin cancer (08-6A-103j). A practice may be accepted for the provision of this local enhanced service if it has a partner, employee or sub-contractor, who has the necessary skills and experience to carry out the contracted procedures in line with the principles of a generic GP or a GP with Special Interest (GPwSI) guidance or specific examples as they are developed. Doctors taking part in skin cancer surgery should be competent in resuscitation and, as for other areas of clinical practice, have a responsibility for ensuring that their skills are regularly updated. Doctors carrying out skin cancer surgery should demonstrate a continuing sustained level of activity, conduct regular audits, be appraised on what they do and take part in necessary supportive educational activities and notwithstanding the above that all doctors undertaking this work will fulfill the requirements described in the 'NHS National Cancer Review Programme, Manual for Cancer Services 2008: Skin Measures'. The doctor will be expected to join a Local Skin Multi Disciplinary Team (LSMDT) and become part of the Kent & Medway Cancer Network. The Network Lead for Skin Cancer Surgery will oversee training and accreditation but doctors will be responsible to the respective Lead Clinicians of the MDTs in East and West Kent

Those doctors who have previously provided services similar to the proposed enhanced service must still satisfy Skin Cancer Surgery Accreditation criteria but may be exempt from certain requirements if agreed by the Advisory (Accreditation) Panel.

Where a PCT believes a doctor carrying out skin cancer minor surgery is not complying with the terms of the contract, it should invoke a remedial notice according to the procedure laid out in Regulation. The Network DOG Lead, MDT Leads, the Network Lead for Skin Cancer Surgery and the PCT Lead should be informed immediately if such concerns are brought to light. There is considerable guidance available on techniques and facilities for conducting minor surgery in general practice, and as national guidance is updated it is expected that practitioners will comply.

Criteria Two: GP Skin Cancer Surgery Accreditation

All GP skin cancer surgeons will need to be accredited according to Kent & Medway Cancer Network Skin DOG-approved guidelines. All Practitioners will need to fulfil the clinical governance requirements (08-6A-103j) for maintenance on the list and annual re-accreditation. See criteria 5 below.

The Skin DOG GP SkIn Surgery Advisory Panel for Accreditation comprises representatives from the MDTs and Primary care (see Appendix for members). This Panel will assess all applicants.

A DOG-approved Training Panel (headed by the Network Lead for Skin Cancer Surgery) will be responsible for providing training components required for Accreditation. All accredited GP skin cancer surgeons will also be offered membership to a mentoring scheme to allow Practitioners access to Skin Cancer Specialists (this scheme aims to further foster excellent relationships between primary and secondary care but is outwith the training requirements for Accreditation). For details of Training and Governance see Criteria Five below.

Criteria Three: Facilities

Practices carrying out minor surgery and other interventional procedures should have such facilities as are necessary to enable them to provide these services properly.

Adequate and appropriate equipment should be available for the doctor or nurse to undertake the procedures chosen, and should also include appropriate equipment for resuscitation. National guidance on premises standards must be followed.

All personnel providing the service through the contract have appropriate indemnity cover to meet in full claims made against them as individuals.

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Criteria Four: Staff Competence

All clinicians must provide evidence that they have the experience and qualifications to undertake the procedure/s. In addition, all personnel providing the service must be competent to provide those aspects of the service for which they are responsible – they too must show evidence that their skills are up to date.

Assistants in minor surgery should be appropriately trained and competent, taking into consideration their professional accountability and the Nursing and Midwifery Council guidelines on the scope of professional practice

Criteria Five: Training & Governance

All GP Skin Cancer Surgeons must comply with Network Guidelines for Training in accordance with 'NHS National Cancer Review Programme, Manual for Cancer Services 2008: Skin Measures' (measures 08-1C-116j, 08-1C-117j, 08-2J-122, 08-2J-123)

A clinician providing services as a GP skin cancer surgeon or GPwSI must be associated with a named LSMDT/SSMDT.

The following requirements are expected by the Kent and Medway Cancer Network and have been approved by the Skin DOG:
(i) Undergo 15 hours CPD in skin cancer surgery per year
(ii) Have one session per year with a skin cancer specialist who is a core member of that MDT.
(iii) Have their community skin cancer practice included in the MDT's contribution to the network audit.

(iv) Attend 4 meetings of the LSMDT per year excluding the two teaching / audit DOG meetings (this may be possible via video link or similar if available)
(v) Keep a personal log of at least 40 surgical excisions for potential skin cancer per year.

Note: The Lead Clinician of the MDT to which the clinician is associated will monitor the adherence to the attendance and audit requirements annually (08-2J-239).

Note: Monitoring of Group 3 GPwSIs in dermatology falls under the clinical governance of the PCT.

Criteria Six: Training Programme for Core Competency

All GP skin cancer surgeons must attend a Skin DOG-approved core competencies training programme as part of the Accreditation schedule within 2 years of the commencement of the LES. Local surgical training in skin cancer management will be made available and updates will be offered every 2 years. Attendance of the bi-annual DOG meetings will be required as this will include education, updates and audit sessions providing the required governance

The training programme will cover all aspects of Skin Cancer care including diagnosis, medical and surgical treatment options. The course content will be flexible and incorporate requests from delegates. There will be an emphasis on practical core surgical skills and local guidelines and pathways of care.

See Appendix for suggested programmes.

If the clinician is unable to attend a training course, exemption may be conferred only if they have had at least 5 years of practice in skin cancer surgery prior to April 2009 and have been approved by the Network Advisory Panel.

Criteria Seven: Identification of patients for GP Skin Cancer Surgery

Model 2 practitioners will be able to remove lesions following agreement with a core MDT member having agreed a diagnosis and treatment plan. Practitioners providing services under this LES will need to be able to take good quality digital photographs which can be used by a core MDT member to assess the lesion. Training to undertake digital photographs of skin lesions will be provided by the PCTs where the need is identified. . Where teledermatology or digital imaging and image transfer is not available or not used the patient must be seen by a core MDT member prior to any agreement that the patient could be treated by a Model 2 practitioner.

Nominated clinicians from both West and East Kent MDTs with secure NHS.net emails addresses will be available for discussion of such cases (see list below).

Criteria Eight: Record-Keeping

Practices must ensure that details of the patient's monitoring as part of the LES is included in his or her lifelong record. If the patient is not registered with the practice providing the LES, then the practice must send this information to the patient's registered practice for inclusion in the patient's records. Clinicians taking part in this LES must personally record, for the purposes of audit, every excision which is potentially malignant recording, at a minimum, the provisional diagnosis, procedure undertaken, histological result and presence or absence of clearance on pathology.

Criteria Nine: Audit

Full records of all procedures should be maintained in such a way that aggregated data and details of individual patients are readily accessible.

Practices should regularly audit and peer-review skin cancer surgery work. Suggested audit topics are:

A Completeness of excision rates
B Histological versus clinical diagnoses
C Individual areas of interest

This list is not exhaustive and will be regularly discussed and updated by the Surgical sub-group.

4. Clinical Governance

The Skin-DOG Chairman, the West and East Kent MDT Clinical Leads, the Network Lead for Skin Cancer Surgery and the PCT Clinical Leads for skin cancer will ensure appropriate clinical governance is in place and followed to ensure that necessary clinical standards and training are maintained.

APPENDIX 1.

GP Skin Cancer Surgery Advisory Panel Membership

Network Lead for Skin Cancer Surgery (Paul Banwell)
Chair, Skin DOG, K&MCN (Kurt Ayerst)
Lead Clinician, West Kent Skin MDT (Larry Shall)
Lead Clinician, East Kent Skin MDT (Kurt Ayerst)
Primary Care Representative, West Kent (David Chesover)
Primary Care Representative, East Kent (John Rine)

GP Skin Cancer Surgery Training Panel Membership

Network Lead for Skin Cancer Surgery (Paul Banwell)
Chair, Skin DOG, K&MCN (Kurt Ayerst)
Lead Clinician, West Kent Skin MDT (Larry Shall)
Lead Clinician, East Kent Skin MDT (Kurt Ayerst)

and

Core members, West Kent MDTs
Core Members, East Kent MDT

Nominated Telemedicine Skin Cancer Specialists

Email addresses

Medway, TBC
QVH, TBC
East Kent hospital, TBC

APPENDIX 2.

Kent & Medway GP Skin Cancer Surgery Training Programme

Moderator

Paul Banwell

Training Faculty

Kurt Ayerst (Network Chair, Skin DOG & Lead Clinician East Kent MDT)
Larry Shall (Lead Clinician West Kent MDT)
Paul Banwell (Network Lead for Skin Cancer Surgery)

Anil Agarwal
Saul Halpern
Catriona Irving
Ashley Cooper
David Chesover
Darryl Coombes
John Rine
Ian Francis
Nick Rowell

+ invited speakers

The program will be regularly reviewed and adapted by the faculty.

Initial Programme (1 day course proposed)

Core knowledge:
IOG/QM updates and national changes influencing skin cancer management

Premalignant skin lesions – diagnosis and treatment (including Network guidelines)

BCC – diagnosis and treatment (including Network guidelines)

SCC – diagnosis and treatment (including lNetwork guidelines)

Melanoma – diagnosis and treatment (including Network guidelines)

Additional areas that could be included:
Role of Imaging in skin cancer (including Network guidelines)

Metastatic Disease & Block dissections – indications and Network pathway

Moh's surgery – indications and Network pathway

Oncology support and treatment in skin cancer (including lNetwork guidelines)

Practical Sessions:

Local anaesthesia

Excision of lesions

Ellipses & dog ears

Suturing techniques

Local flaps

<u>Follow-up programme</u> (1 day course proposed)

Every 2 years (or as required)

Advanced Skin Cancer Course

Advanced surgical skills

Areas identified by delegates for inclusion

APPENDIX 3.

CONSENT

When do health professionals need consent from patients?

1. Before you examine, treat or care for competent adult patients you must obtain their consent.
2. Adults are always assumed to be competent unless demonstrated otherwise. If you have doubts about their competence, the question to ask is: “can this patient understand and weigh up the information needed to make this decision?” Unexpected decisions do not prove the patient is incompetent, but may indicate a need for further information or explanation.
3. Patients may be competent to make some health care decisions, even if they are not competent to make others.
4. Giving and obtaining consent is usually a process, not a one-off event. Patients can change their minds and withdraw consent at any time. If there is any doubt, you should always check that the patient still consents to your caring for or treating them.

Can children consent for themselves?

5. Before examining, treating or caring for a child, you must also seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent (although their parents will ideally be involved). In other cases, some-one with parental responsibility must give consent on the child’s behalf, unless they cannot be reached in an emergency. If a competent child consents to treatment, a parent **cannot** over-ride that consent.

Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Who is the right person to seek consent?

6. It is always best for the person actually treating the patient to seek the patient’s consent. However, you may seek consent on behalf of colleagues if you are capable of performing the procedure in question, or if you have been specially trained to seek consent for that procedure.

What information should be provided?

7. Patients need sufficient information before they can decide whether to give their consent: for example information about the benefits and risks of the proposed treatment, and alternative treatments. If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent may not be valid.

Is the patient's consent voluntary?

8. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends.

Does it matter *how* the patient gives consent?

9. No: consent can be written, oral or non-verbal. A signature on a consent form does not itself prove the consent is valid – the point of the form is to record the patient's decision, and also increasingly the discussions that have taken place. Your Trust or organisation may have a policy setting out when you need to obtain written consent.

Refusals of treatment

10. Competent adult patients are entitled to refuse treatment, even where it would clearly benefit their health. The only exception to this rule is where the treatment is for a mental disorder and the patient is detained under the *Mental Health Act 1983*. A competent pregnant woman may refuse any treatment, even if this would be detrimental to the fetus.

Adults who are not competent to give consent

11. **No-one** can give consent on behalf of an incompetent adult. However, you may still treat such a patient if the treatment would be in their best interests. 'Best interests' go wider than best medical interests, to include factors such as the wishes and beliefs of the patient when competent, their current wishes, their general well-being and their spiritual and religious welfare. People close to the patient may be able to give you information on some of these factors. Where the patient has never been competent, relatives, carers and friends may be best placed to advise on the patient's needs and preferences.

12. If an incompetent patient has clearly indicated in the past, while competent, that they would refuse treatment in certain circumstances (an 'advance refusal'), and those circumstances arise, you must abide by that refusal.

This summary cannot cover all situations. For more detail, consult the *Reference guide to consent for examination or treatment*, available from the NHS Response Line 08701 555 455 and at www.doh.gov.uk/consent

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Extract from NICE

National Institute for Health and Clinical Excellence

1. Patients with pigmented skin lesions

Patients who present to their GP with pigmented skin lesions need careful assessment with a full history and examination of the skin lesion being recorded. If the lesion is thought to be benign the patient may be reassured; however, it is strongly recommended that all such patients should be provided with both oral and written information regarding the changes that may subsequently suggest malignant transformation and instructed to return if any such changes occur or if the lesion continues to concern the patient. If there is any doubt about the lesion, or if there is a history of recent change, the patient should be referred urgently to a specialist who is a member of the LSMDT/SSMDT for further assessment (see below).

2. Patients with lesions suspicious of melanoma or SCC

All patients, where there is a possibility of a melanoma or an SCC of the skin, should be referred urgently (consistent with national targets and the NICE *Referral guidelines for suspected cancer* – see chapter on 'Patient-centred care'), to a specialist who is a member of the LSMDT/SSMDT, usually to the local dermatology/plastic surgery department rapid access skin cancer clinic or pigmented lesion clinic. Ideally these should be 'one-stop' diagnostic and treatment clinics, i.e. where a diagnosis is made and treatment given in the same clinical session. In some areas such clinics are arranged by plastic surgery units. If a GP or a doctor working in the community who belongs to an LSMDT/SSMDT takes an excisional or incisional biopsy of a lesion that is reported as a melanoma or SCC, the patient should be referred urgently to a specialist who is a member of the hospital LSMDT/SSMDT.

3. Patients with BCC

Where a patient has a lesion that may be a low-risk BCC, he or she may be referred either to the local hospital specialist who is a member of the LSMDT/SSMDT, normally a dermatologist, or to a doctor working in the community who is a member of an LSMDT/SSMDT. Those with recurrent and high-risk lesions should be treated by a hospital specialist who is a member of the LSMDT/SSMDT. If the referring GP is uncertain whether or not the lesion is a high- or low-risk BCC, the patient should be referred to a hospital specialist.

Patients with BCCs are excluded from current cancer target times in England.

However, the Welsh Cancer Standards for skin cancer suggest that patients should not wait more than 5 months from receipt of the GP referral letter at the hospital before starting their definitive treatment. Waiting time targets in England for all outpatient appointments will mean that from 2007 no patient will wait more than 18 weeks before being seen. Improvements in waiting time are desirable.

4. Patients with precancerous skin lesions

Precancerous skin lesions such as actinic/solar keratoses (AKs) or in situ SCC of the skin (Bowen's disease) are common, and the GP may treat these using one of the recognised treatments (e.g. cryotherapy, topical drug treatments, curettage and cautery). The patient may also be referred to a doctor working in the community who is a member of an LSMDT/SSMDT or the local dermatology department. If the lesions are hypertrophic or inflamed or if there is any other reason to suspect that they may have developed into an SCC, the patient should be referred to a dermatologist who belongs to the LSMDT/SSMDT.

5. Uncertain diagnosis

If the GP is uncertain of the diagnosis the patient should be referred for further assessment to a dermatologist who is a member of an LSMDT/SSMDT.

Relevant sections regarding Community Cancer Services from the National Cancer Peer Review Programme Manual for Cancer Services 2008:
SKIN SPECIFIC MEASURES GATEWAY No. 10790 - NOV 2008

SKIN SPECIFIC NETWORK BOARD MEASURES

08-1A-203j Policy for the provision of skin cancer services in the community

The network board should, in consultation with the NSSG, agree with the PCTs a policy for provision of skin cancer services in the community which includes the following:

- that the provision of treatment for skin cancer over the network, if carried out by the NHS in the community setting, should take the form of one or other of the following 3 service models only:

(i) management carried out by GPwSIs under the governance of the PCT;
(ii) surgical treatment carried out by medical or nursing practitioners who, while not core MDT members are practising under the supervision of the MDT and the governance of the acute trust;
(iii) core MDT members, acting under the governance of the acute trust as part of a hospital's dermatology outreach service.

Notes:

- *The full description of and distinctions between these models are laid out in the introduction to the skin cancer measures. These full specifications apply to this measure.*
- *PCTs are free not to commission any community skin cancer service, but to rely instead, entirely on MDTs working in the hospital setting.*
- *PCTs may choose to commission some services from the independent sector. This sector is subject to the relevant parts of the IOG and Manual for Cancer Services but this is monitored by the Health Care Commission, not currently, directly by the cancer peer review programme.*

Compliance: The policy agreed by the chair of the network board and a representative of the PCTs in the network.

08-1A-205j Network configuration of community skin cancer services

The network board should agree with the PCTs, the NSSG and cancer lead clinicians of each trust in the network, the networks configuration for community skin cancer services which specifies:
For each named PCT, which of the three models of service provision, it will commission, naming the relevant MDTs, GPwSIs and locations of any relevant community facilities (see 08-1A-203j).

Notes:

- *A given PCT may chose to commission using more than one of the three service models, or may choose not to commission a community skin cancer service, but instead rely entirely on the MDTs working in the hospital setting.*
- *A given PCT may choose to commission some services from the independent sector. This sector is subject to the relevant parts of the IOG and Manual for Cancer Services but this is monitored by the Health Care Commission, not currently directly by the cancer peer review programme.*

Compliance: The network configuration for community skin cancer services agreed by the chair of the network board, a representative of the PCTs, the chair of the NSSG and the cancer lead clinicians of each trust.

FUNCTIONS OF NETWORK SITE SPECIFIC GROUPS (NSSGs)

08-1C-113j Agreed network primary care referral guidelines and their distribution

The NSSG in consultation with the PCTs should agree referral guidelines for GPs, which include the following as far as they are relevant to the network's agreed configurations for hospital based and community based services:
i) that actinic keratoses and precancerous lesions may be dealt with by any GP (level 1 care - see the introduction to skin cancer measures);
ii) that GPs should refer suspected cases of skin cancer requiring treatment, including BCCs, to the contact point of the relevant named MDTs in the network configurations (see measure 08-1A-205j and 08-1A-206j), or for cases of low risk (i.e. non-high risk) BCC there is the option of referral to the contact point of a relevant GPwSI-based service;
iii) the guidance for GPs on identifying potential high risk BCCs (see the introduction to the skin cancer measures - level 2 care).
The primary care referral guidelines should be distributed to the hospital core members of the LSMDTs and the SSMDTs in the network.

Notes:

- *It is inevitable that SCCs and other tumours outside the remit of GPs will be excised accidentally by them, when the diagnosis is not clinically apparent.*

The guidelines are underpinned by an assumption that GPs will not knowingly treat patients beyond their remit. This is monitored by measure 08-1C-116j.

- *The distribution of the primary care referral guidelines to primary care practitioners themselves, is considered for the purpose of peer review, to be the responsibility of the PCT, and is dealt with in measure 08-6A-101j.*

Compliance: The primary care referral guidelines, agreed by the chair of the NSSG, and a representative of the PCTs, naming the contact points for the MDTs and community skin cancer services, as relevant.
The reviewers should enquire as to the distribution process.

Note:
Minor shortcomings in the completeness of the distribution should not preclude compliance with this measure

08-1C-115j NSSG agreed clinical governance arrangements for community

The NSSG should in consultation with MDTs, agree a clinical governance policy for community practitioners which includes the following:

- that GPwSIs and model two practitioners (see the introduction to the skin cancer measures), practising in the network, should each be associated with one named LSMDT or SSMDT;
- that the practitioners associated with a given MDT should undertake the following:

(i) undergo 15 hours CPD in skin cancer per year;
(ii) have one session per year with a consultant dermatologist who is a core member of that MDT;
(iii) have their community skin cancer practice included in the MDT's contribution to the network audit;
(iv) attend four meetings of the MDT per year including the two teaching/audit meetings;
(v) keep a personal log of at least 40 surgical excisions for potential skin cancer per year;

- that the lead clinician of the MDT will monitor the adherence to requirements of the model 2 practitioners associated with the

MDT.
Notes:
- *Monitoring of GPwSIs is the responsibility of the PCTs.*
- *Monitoring the adherence of any individual community practitioner to requirements is not carried out by the peer review programme.*

Compliance: The policy agreed by the chair of the NSSG.
Notes:
The NSSG for compliance with this measure should produce the policy and the MDTs, for their compliance with the relevant team measure, should agree to it and declare their associated practitioners.
Clinical governance of GPwSIs is also covered in topic 6 (PCTs). This measure for NSSGs and MDTs is to establish their role in clinical governance arrangements, even though, for GPwSIs, these arrangements appear in the SLA between the GPwSI and the PCT, and their adherence to the requirements is the final responsibility of the PCT.

08-1C-116j NSSG agreed training policy for model 2 community practitioners with named trainers/assessors

The NSSG should, in consultation with the MDTs, agree a training policy for the network for model 2 community practitioners which includes the following:
- that practitioners should be trained in skin surgical competencies according to the SS1 and SS2 specifications of the DH guidelines (Gateway Ref 7954) unless they fulfil the exemption conditions specified below:
- exemption may be conferred by the practitioner having had two years of practice in skin cancer surgery, verified by the lead clinician of the MDT.

Note:
The two years period will be measured up to October 2008. Following that date, practitioners with less than two years experience will not be exempt from training, for compliance with the measures, and experience gained after October 2008 will not count towards exemption.
The NSSG should, in consultation with the MDTs, agree named trainers/assessors of competence for the network for the model 2 practitioners' training. They should be core dermatologist or surgical members of skin cancer MDTs.
Note:
The trainer and assessor roles should be interchangeable, and such personnel may act for more than one MDT.
Compliance: The policy agreed by the chair of the NSSG.
The named trainers/assessors, agreed by the chair of the NSSG.
Note:
The NSSG for compliance with this measure should produce the policy and name the trainers/assessors and the MDTs, for their compliance with the relevant team measure, should agree to it and provide the trainers/assessors.

SKIN CANCER MULTIDISCIPLINARY TEAMS (MDTs & SSMDT)

08-2J-119 & 08-2J-221 MDT/NSSG agreed clinical governance arrangements for community practitioners

The MDT should agree the clinical governance policy for community practitioners with the NSSG and it should declare all of its associated community practitioners both GPwSIs and model 2 practitioners.
Compliance: The policy agreed by the lead clinician of the MDT. The named practitioners stating whether they are GPwSIs or model 2 practitioners, agreed by the lead clinician of the MDT (see 08-1A-205j and 08-1C-115j).
Notes:
If the MDT is agreed as having no associated community practitioners, according to the network configuration for the community skin cancer service, this part of the measure is not applicable. The MDT should still be in agreement with the policy for compliance.
The reviewers should enquire as to whether all community based practitioners excising skin cancer, under the supervision of the MDT, but who are not core MDT members (i.e. potential model 2 type practitioners) are named and declared.
Lack of compliance with this not only means lack of compliance with this measure, but also lack of compliance with measure 08-2J-222 which reviews the training of model 2 community practitioners. Whether or not all GPwSIs are associated with one MDT or another is the responsibility of the PCTs.

08-2J-120 & 08-2J-222MDT/NSSG agreed training policy for model 2 community practitioners

The MDT should agree the training policy for model 2 community practitioners, and the named trainers/assessors of competence for the network.
Compliance: The policy and the named trainers/assessors, agreed by the lead clinician of the MDT.
Notes:
The agreed trainers/assessors need not be from the membership of the MDT under review.
This measure should be read in conjunction with measure 08-1C-116j.

08-2J-121& 08-2J-223 Named model 2 community practitioners assessed as competent according to network training policy or exempt by way of previous experience

The model 2 community practitioners associated with the MDT should:
- **EITHER** have been trained and assessed as competent in skin surgery, according to the network training.
- **OR** be exempt from training by way of previous experience, according to the network training policy.

Compliance: Confirmation of named practitioners with documentation of competence authorised by a network assessor, or statement of exemption authorised by the lead clinician of the MDT.
Notes:
For compliance with this measure all of the MDT's associated model 2 practitioners should be compliant. See 08-2J-222.
If the MDT is agreed as having no model 2 practitioners according to the network configuration for the community skin cancer service, this measure is not applicable

08-2J-239 MDT lead clinician's annual report to relevant PCT for each associated community skin cancer clinicians, confirming clinical governance requirements have been fulfilled

This measure applies only to an MDT which has associated community skin cancer clinicians declared in measure 08-2J-220.
The lead clinician of the MDT should make an annual report to the relevant PCT GPwSI accreditation group for each of its associated community skin cancer clinicians, confirming (or otherwise) that they have fulfilled the following clinical governance requirements for maintaining accreditation for the previous year:
(i) attend at least 4 meetings per year of the MDT with which they are associated, including the two teaching and/or audit meetings;
(ii) have their skin cancer excision results included in their network skin cancer audit.
Compliance: The reports, agreed by the MDT lead clinician, for the previous year.
Note:

This measure is applicable from a date two years after the start of the national GPwSI accreditation system. (Implementing care closer to home. Convenient quality care for patients. DH April 2007. Gateway ref 7954).
08-2J-138 & 08-2J-240 MDT policy for making recommendations to PCT CCL when non-GPwSIs are found to be excising skin cancers
There should be a policy whereby the lead clinician of the MDT should make recommendations to the cancer clinical lead(s) of referring PCTs when any of their clinicians which are not accredited GPwSIs are found to be excising skin cancers by the alert system of the pathology laboratory. *Compliance:* The policy agreed by the lead clinician of the MDT and relevant PCT cancer clinical leads. *Note:* *See measure 08-6A-103.*

SKIN CANCER MEASURES FOR PCTs

08-6A-101j Network/PCT agreed primary care referral policy and distribution of the primary care referral guidelines
The PCT should agree the network primary care referral policy for skin cancer with the network board and distribute the primary care referral guidelines to all its primary care practitioners. (See measure 08-1A-206j, 08-1A-203j, 08-1C-113j). *Compliance:* The policy, agreed by the PCT cancer clinical lead and the chair of the network board. The reviewers should enquire as to the distribution of the guidelines. *Note:* *Minor shortcomings in the extent of the distribution should not prevent compliance with this measure*
08-6A-102j Network/PCT agreed configuration for community skin cancer services
The PCT should agree its part in the network configuration for the community skin cancer services. *Compliance:* The network configuration agreed by the PCT cancer clinical lead. *Note:* *Any one GP should be attending only one named MDT, but a PCT may have more than one MDT which is attended by one or other GPs from the PCT's catchment population.*
08-6A-103j PCT SLA with each GPwSI in skin cancer
The PCT should have an SLA with each of its GPwSIs in skin cancer. The part of the SLA specific to GPwSIs in skin cancer should include at least the following: • practitioners should be associated with a named LSMDT (or SSMDT acting as an LSMDT to its own local catchment); • they should be on the PCT's list of accredited community skin cancer clinicians, having fulfilled the group 3 training requirements (guidance and competencies for the provision of services using GPs with special interests - GPwSIs. DH April 2007. Gateway ref 7954. Dermatology specialty); • they should fulfil the following clinical governance arrangements for maintenance on the list and for consideration for re-accreditation at intervals determined by the PCT. (Implementing care closer to home: convenient quality care for patients. DH April 2007. Gateway ref 7954). i) undergo 15 hours CPD in skin cancer per year; ii) have one session per year with a consultant dermatologist who is a core member of a skin cancer MDT; iii) have their community skin cancer service included in their cancer network's skin cancer audit for peer review; iv) attend at least 4 meetings per year of the MDT with which they are associated, including the two teaching and/or audit meetings; v) keep a personal log of at least 40 of their surgical excisions for potential skin cancer per year. *Note:* *The PCT may have separate SLAs with individual practitioners or have SLAs which cover a service compromising a number of individual practitioners, as long as, in some way, all such practitioners are covered.* *Compliance:* The SLAs covering all relevant practitioners.
08-6A-104j GPwSI training specific to skin cancer given under the supervision of a named consultant dermatologist
The PCT's group 3 GPwSI training specific to community clinicians in skin cancer should be given under the supervision of a consultant dermatologist who is a core member of a skin cancer MDT. *Compliance:* The named consultant and the membership list of the MDT, agreed by the PCT cancer clinical lead. The reviewers should enquire as to the delivery of the cancer specific GPwSI training. *Note:* *The consultant may supervise other aspects of the GPwSI training. This is not subject to review.*
08-6A-105j GPwSI accreditation group should have a lead clinician of a skin MDT who should be involved in the accreditation and re-accreditation of community skin cancer clinicians
The GPwSI accreditation group for the PCT (implementing care closer to home: convenient quality care for patients. DH April 2007. Gateway ref 7954); should have a specialty member for dermatology who is a lead clinician of a skin MDT, who should be involved in the accreditation and re-accreditation of community skin cancer clinicians. *Compliance:* The named lead clinician and named MDT agreed by the PCT cancer clinical lead. The reviewers should enquire as to the accreditation and re-accreditation process.

Figure 2 (QM pgs 28-29) - Acceptable Models for the Management of Skin Cancer in the Community

Under PCT Governance	Under Acute Trust Governance	
Model 1	**Model 2**	**Model 3**
Dermatology GPwSI • Diagnosis and treatment of low risk BCCs (care level 2) • Receives referrals for this from any other medical practitioner • Training and accreditation is the responsibility of the PCT, according to group 3, GPwSPI training – DH guidance • Practitioners associated with a named skin cancer MDT.	Surgery only, by nurse surgical practitioner or medical practitioners, not a core MDT member, but fulfilling the following: • Carrying out any skin cancer surgical excision other than 'hospital only' procedures (measure 08-2J-213), at MDT's discretion • Receiving referrals only from core MDT members, only of previously diagnosed patients with agreed treatment plans • Trained in competencies for skin cancer surgery (DH – SS1, SS2 competencies) or exempt (measure 08-1C-117j) • Associated with a named MDT, under its clinical governance.	Core MDT members, community outreach service • Diagnosis and management of skin cancer • Delivering treatment in the community • For care levels, see note iv below • Training is covered by conventional specialty training in dermatology, and practitioners are subject to the MDT measures for core members in the Manual for Cancer Services

Notes on Figure 2

i. Diagnosis and treatment of skin neoplasia at care level 1 is open to any medical practitioner, and the details of this area of practice, together with any nurse involvement is outside the scope of these measures

ii. Core MDT members may include NCCGs (non consultant career grade) as well as consultants.

iii. There may be other organizations commissioned to provide secondary care: any other secondary care providers, which are not acute trusts, but which may be used by commissioners, the relevant parts of the IOG and Manual for Cancer Services, but this is monitored by the heath care commission, not currently, directly by the Cancer Peer Review Programme.

iv. The boundaries of an MDT's clinical practice outside the hospital setting are not explicitly specified in the measures, but they would be constrained by:

• The need for formal case discussion by the MDT, for cases at level 4 and above

• The requirements for certain procedures to all be performed in the same hospital for the whole of an MDTs practice

• Apart from the above, the decision as to which other procedures should only be carried out in hospital and not in the community, is currently a matter for clinical judgment. Any given Network may choose to set its own protocols for this. This is not currently subject to the peer review measures.

Document Administration

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Document Location

The document is located in the Kent and Medway Cancer Network office, in hardcopy and electronic format. It is also located on the Kent & Medway Cancer Network Intranet:

http://www.kentmedwaycancernetwork.nhs.uk/

DATE OF NEXT REVIEW

This item is next to be reviewed annually by the Skin DOG surgery sub-group/ GP Surgery Advisory Panel

Revision History

Date	Version	Status	Author	Summary of Changes
Feb 09	0.4	Draft	Paul Banwell	Work in progress
March 09	0.5	Final Draft	GP Surgery Advisory Panel	Wording changes to reflect developmental document
March 09	1.0	Final	GP Surgery Advisory Panel	Further wording changes