

A12/s/b

**2013/14 NHS STANDARD CONTRACT
FOR CANCER: SKIN (ADULT)**

SECTION B PART 1 - SERVICE SPECIFICATIONS

Service Specification No.	A12/S/b
Service	Cancer: Skin (Adult)
Commissioner Lead	
Provider Lead	
Period	12 months
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

National context

Skin cancers are skin growths with differing causes and varying degrees of malignancy. The three most common malignant skin cancers are basal cell carcinoma, squamous cell carcinoma, and melanoma, each of which is named after the type of skin cell from which it arises.

Skin cancer generally develops in the outer most layer of skin, so a tumour can usually be seen. This means that it is often possible to detect skin cancers at an early stage. Unlike many other cancers, only a small minority of those affected will actually die of the disease, although surgery for any skin cancer can be disfiguring.

Non-melanoma skin cancers are the most common skin cancers. The majority of these are basal cell carcinomas. 80% of all cases are found on the head and neck, although there appears to be a recent increase in the incidence of basal-cell cancer (BCC) of the trunk. BCC are thought to be caused by early and intermittent sun exposure. They very rarely if, ever metastasise, and are treated by local excision. Mohs surgery is used for disease affecting critical structures, recurrent tumour and BCCs of more aggressive histological subtypes. Unresectable BCCs which are not suitable for radiotherapy may be treated with new oral agents in the near future. This may be particularly an important therapeutic choice for patients with Gorlin's syndrome.

Squamous cell carcinomas (SCC) are most frequent on the head and neck and arms and are related to chronic over exposure to the sun so that they are more common in men and in outdoor workers. They are more common in the immunosuppressed. Most SCCs are usually cured by surgery, but rare cases metastasise.

Melanoma (MM) is less common than both basal cell carcinoma and squamous cell carcinoma but it is the most serious form of skin cancer. Most cases are caused by sunburn and sunny holidays (intermittent sun exposure), with some evidence of a role for sunbeds. Melanoma survival rates are poorer than for non-melanoma skin cancer, although when melanoma is diagnosed at an early stage treatment is easier so that overall 80% of people survive. It causes the majority (75%) of deaths related to skin cancer. The treatment includes surgical removal of the tumour. Adjuvant treatment, chemotherapy and immunotherapy, or radiation therapy (often in the context of clinical trials) are used for more advanced disease.

Other rare skin tumours include cutaneous lymphoma, and a wide range of adnexal epidermal and appendage tumours and dermal and subcutaneous tumours

Skin cancer differs fundamentally from other types of cancer in these aspects:

- Very high incidence overall, compared to other types of cancer.
- Extremely wide range of seriousness, from extremely good prognosis to life-threatening.
- Ready visibility and accessibility on the surface, giving opportunities for excision and diagnosis by practitioners in the community.

Six levels of care, differing in the degree of specialisation and service consolidation have been defined. These are provided by:

- Any general practitioner in the community
- General Practitioner with a Special Interest (GPwSIs) in skin
- Local Skin cancer Multidisciplinary Team (LSMDT) - without mandatory individual case review by LSMDT.
- LSMDT - with mandatory individual case review by LSMDT
- Specialist skin cancer multidisciplinary team (SSMDT)
- Supra-network team (for the treatment of cutaneous lymphoma, including total body surface electron beam therapy and photopheresis).

Please see the Manual for Cancer Services: Skin Measures Version 2.1 for a more detailed description of the types of case mix and the procedures which make up the different levels and the personnel practising at each level

This specification focuses on the services to be provided at levels 5 and 6.

Local context

Evidence base

This specification draws its evidence and rationale from a range of documents and reviews as listed below but it will evolve over time in conjunction with nationally agreed guidelines:

Department of Health (DH)

- Improving Outcomes; a Strategy for Cancer – Department of Health (2011)
- Cancer Commissioning Guidance – Department of Health (2011)
- Revised guidance and competences for the provision of services using GPs with Special Interests (GPwSIs) dermatology and skin surgery. Department of Health (April 2011)

NICE

- Improving Outcomes Guidance (IOG) for people with skin tumours
- including melanoma and the management of low-risk basal cell carcinomas in the community. NICE 2010
- Improving Outcomes Guidance (IOG) for people with skin tumours including melanoma. Department of Health (2006)
- Improving Outcomes Guidance (IOG) in haematological cancers; sarcoma; teenage and young people's cancer
- Improving supportive and palliative care for adults with cancer – NICE (2004)
- Quality Standard for end of life care for adults - NICE (2011)
- Quality standard for patient experience in adult NHS services - NICE (2012)

National Cancer Peer Review

- National Cancer Peer Review (NCPR) Handbook - National Cancer
- Action Team (2011)
- Manual for Cancer Services: skin measures, version 2.0 - NCPR, National Cancer Action Team (2011)
- Manual for Cancer Services: acute oncology measures - NCPR, National Cancer Action Team (April 2011)
- Manual for Cancer Services: chemotherapy measures - NCPR, National Cancer Action Team (June 2011)

Other

- Chemotherapy Services in England. National Chemotherapy Advisory Group (2009)

2. Scope

2.1 Aims and objectives of service

The aim of the specialist skin cancer service is to deliver high quality holistic care for patients with rare, complicated or poorer prognosis skin cancer so as to increase survival while maximising a patient's functional capability and quality of life and to ensure ready and timely access to appropriate supportive care for patients, their relatives and carers. The service will be delivered through a Specialist Skin Multidisciplinary Team (SSMDT), with some elements delivered through supra-network multidisciplinary teams

The Specialist Skin Cancer SSMDT service should serve a population of 750,000 people or more. The service is required to agree the following areas with their local cancer networks:

- Service configuration and population coverage.
- Agreed referral criteria, clinical protocols, network policies and treatment pathways.
- Engagement with the local network groups and National Cancer Peer Review for skin tumours.

Supra-network multidisciplinary teams are defined by having their role and catchment population agreed by the relevant specialist commissioners. In most cases a supra-network team will cover more than one network.

The overall objectives of the services are:

- To provide an exemplary and comprehensive service for all referred patients with skin cancers.
- To ensure radiological, pathological and diagnostic facilities are available in order to effectively review, diagnose, classify and stage the cancer prior to planning treatment.
- To advise and undertake investigations and to proceed to treatment options if clinically indicated, including high quality surgical treatment of patients with skin cancer.
- To carry out effective monitoring of patients to ensure that the treatment is safe and effective.
- To provide care which promotes optimal functioning and quality of life for the individual patient.
- To provide appropriate follow-up and surveillance after definitive treatment.
- To ensure that all aspects of the service are delivered as safely as possible, conform to national standards and published clinical guidelines and are monitored by objective audit.
- To provide care with a patient and family centred focus to maximise the patient experience.

- To support local healthcare providers to manage patients with skin cancer whenever it is safe to do so and clinically appropriate, within the framework of the IOG.
- To provide high quality information for patients, families and carers in appropriate and accessible formats and media.
- To ensure there is accurate and timely information given to the patient's General Practitioner.
- To ensure that there is involvement of service users and carers in service development and review.
- To ensure there is a commitment to continual service improvement.
- To ensure compliance with Peer Review Cancer Measures.
- To ensure compliance with Care Quality Commission (CQC) regulations.

2.2 Service description/care pathway

The Specialised Skin service is commissioned to provide and deliver high quality clinical care to patients with suspected skin tumours and provide specialist treatment for patients with a confirmed diagnosis of particular types of skin cancer.

The SSMDTs and supra-network multidisciplinary teams will deliver the service in line with the following:

- On referral to the multidisciplinary team, the multidisciplinary team coordinator should be provided with relevant histopathology report details and imaging performed which would ideally be reviewed at the multidisciplinary team meeting prior to the patient's consultation at the SSMDT/supra-network multidisciplinary team.
- Patients will be likely to require subsequent additional review at the multidisciplinary team meeting for example after treatment or progression of the cancer.
- Treatment within the SSMDT/supra-network multidisciplinary team should be in accordance with locally agreed treatment guidelines which should be consistent with nationally agreed guidelines.
- The SSMDT/supra-network multidisciplinary team should offer a prompt appointment at which treatment options should be discussed by the patient (and their family if preferred) and relevant members of the SSMDT/supra-network multidisciplinary team (for stage I to III this would be likely to involve the dermatologist, the plastic surgeon and the skin cancer clinical nurse specialist (CNS)).
- A written summary of the consultation should be offered to the patient as well as written information on the relevant type of skin cancer.
- If surgery is the first planned treatment then efforts should be made to give the patient a date for that surgery at the first visit, and written information provided on that surgery. The timing of surgery is agreed on the basis of evidence based treatment protocols with the local cancer network.
- Patients treated as inpatients should be reviewed daily on a ward round supported by the most appropriate consultant member of the SSMDT/supra-

network multidisciplinary team.

- Accurate and timely information should be shared with the patient's General Practitioner so that they can be in a position to support and advise the patient.
- The providers will hold other meetings regularly to address clinical, service delivery and governance issues.
- Audit should be undertaken as an integral part of improving the delivery of care to provide the evidence to improve and enhance the delivery of the clinical care provided.
- Patients should be actively invited to participate in clinical trials especially those approved by the National Cancer Research Network.

Members of the Specialist Skin Cancer Multidisciplinary Team

All members of the team should be specialists in the management of skin cancer. The number of people required to fulfil each role will depend on the team's workload.

- Dermatologists – minimum of two dermatologists, covering a major interest in skin cancer, skin cancer surgery and cutaneous lymphoma.
- Specialist plastic and reconstructive surgeons – minimum of two surgeons with a designated interest in skin cancer surgery. Surgeons undertaking block dissections must perform at least 15 block dissections each (groin or axilla) per year.
- Skin cancer Clinical Nurse Specialists (CNS).
- Histopathologists - there should be at least two specialist dermatopathologists or histopathologists with a special interest in dermatopathology.
- Radiologists.
- Clinical oncologists.
- Medical oncologists.
- Palliative care specialists.
- The multidisciplinary team coordinator(s).
- Appropriate levels of secretarial support.

NB: A number of expert surgical skills will be required. Radical or conservative neck dissections (for cancer of the head and neck) should only be done by specialists regularly undertaking this procedure or who are members of the head and neck cancer multidisciplinary team. A combination of surgical expertise could include plastic and reconstructive surgeons, surgical oncologists, oral and maxillofacial surgeons, oculoplastic surgeons and ear nose and throat (ENT) surgeons.

It may be appropriate locally to include as extended team members such as oculoplastic surgeons and reconstructive hand surgeons. Oculoplastic surgeons have a specific and important role in the management of skin cancers arising around the eye.

The extended multidisciplinary team is required to include:

- Trained counsellors with experience in cancer.
- Psychologists.

- Liaison psychiatrists.
- Pharmacists.
- Cosmetic camouflage service advisers.
- Clinical geneticists/genetic counsellors.
- Lymphoedema therapists.
- Occupational therapists.
- Prosthetics and orthotics staff.
- Physiotherapists.
- Radiographers.

There should be a single named lead clinician for the specialist skin cancer (SSMDT) service who should also be a core team member.

Additional members not covered above might include research nurses. The SSMDT may have one member who acts as research lead for the multidisciplinary team.

Patient Experience

The service should be patient centred and should respond to patient and carer feedback. Excellent communication between professionals and patients is particularly important and can avoid complaints and improve patient satisfaction. The service should be in line with the markers of high quality care set out in the NICE quality standard for patient experience in adult NHS services.

Patient experience is reported in the National Cancer Patient Survey. In this survey patients with contact with a CNS reported much more favourably than those without, on a range of items related to information, choice and care. The national programme for advanced communications skills training provides the opportunity for senior clinicians to improve communications skills and all core multidisciplinary team members should have attended this.

Patient Information

Every patient and family/carer must be offered information about their condition in an appropriate format. Verbal and written information should be provided in a way that is clearly understood by patients and free from jargon. The information must cover:

- Description of the disease.
- Management of the disease within the scope of the commissioned service as described in the specification, clinical pathways and service standards.
- Drugs and other treatments commissioned in the clinical pathway.
- Self-management and care.
- Contact details of the patient's allocated key worker.
- Details of support organisations or internet resources recommended by the clinical team.

The service must also provide appropriate education to patients and carers on:

- Symptoms of infection (after chemotherapy or surgery).
- Wound healing problems (after surgery).
- Contact in case of concern.
- Self examination for the early detection of new or recurrent skin cancer.

The useful reference is the Information Prescription Service (IPS), which allows users, both professional and public, to create information prescriptions (IPs) for long-term health needs. www.nhs.uk/IPG/Pages/AboutThisService.aspx

Referral Processes and Sources

The service is required to develop and agree local network referral guidelines with their local cancer network, primary care and local skin cancer multidisciplinary team (LSMDT). These guidelines are to be evidence based and in line with national guidelines including:

- The British Association of Dermatologists (BAD) guidelines for BCC, SCC and MM.
- NICE Referral guidelines for suspected cancer.

Referrals from the LSMDT should be in line with the service user groups identified in section 2.2

Patients with Pigmented Skin Lesions

Patients who present to their General Practitioner (GP) with pigmented skin lesions need careful assessment with a full history and examination of the skin lesion being recorded. If there is any doubt about the lesion, or if there is a history of recent change, the patient should be referred via the two week wait cancer pathway to a specialist who is a member of the LSMDT/SSMDT for further assessment.

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 via the two week wait cancer pathway to a specialist who is a member of the LSMDT/SSMDT, usually to the local dermatology department rapid access skin cancer clinic or pigmented lesion clinic.

Patients can be referred to specialist melanoma multidisciplinary team or T-Cell lymphoma supra-network teams if there is an agreed referral pathway agreed with the local cancer network.

There are guidelines which apply to any GP or a doctor working in the community covering both management of skin and pre-cancerous conditions and those treating defined low risk skin cancers. All practitioners need to work within the defined scope of the particular service they provide, and demonstrate the specified CPD and competencies associated with the service. All practitioners must adhere to the network guidance for onward referral and pathology sampling and reporting.

Patients with BCC

Patients with a lesion that may be a low-risk BCC, should be treated appropriately according to current guidelines. The definition of which low risk tumours can be treated by GPs depends upon whether or not the GP is operating as a dermatology/skin cancer GPwSI and attached to their 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, or to a GPwSI with the necessary training and skills.

Patients with Precancerous Skin Lesions

Pre-cancerous lesions of the skin and skin cancers are extremely common and are expected to be treated appropriately in primary care, either by their own GP or by a local dermatology/skin cancer GPwSI, or alternatively by the local or specialist skin cancer multidisciplinary team. If the lesions are hypertrophic or inflamed or if there is any other reason to suspect that they may have developed into a SCC, the patient should be referred to a dermatologist who belongs to the LSMDT/SSMDT under the two week rule.

Patients with multiple atypical naevi, a family history of melanoma and giant congenital naevi, where there is a suspicion of malignant transformation should be referred to the LSMDT/SSMDT for diagnosis and counselling.

Uncertain Diagnosis

If the GP is uncertain of the diagnosis the patient should be referred for further assessment under the 2 week wait cancer pathway to either their local dermatology/skin cancer GPwSI or to a dermatologist all of whom will be attached to the LSMDT/SSMDT.

The receiving clinician at one of the providers may request the referrer to carry out further investigations to aid the proper diagnosis of the patient.

Imaging and Pathology

Most skin cancer patients do not require imaging at diagnosis. The service should agree where imaging is appropriate and the necessary modalities and their specific indications which will include chest X-ray, ultrasound, CT, MRI and PET. All should be available to the patient as part of the pathway. The responsibility for imaging, its interpretation and any decision to inform treatment lies with the SSMDT.

When symptoms or imaging clearly show that the disease is metastatic or inoperable or the patient is not sufficiently fit to undergo radical treatment, the

SSMDT is to discuss appropriate palliative treatment options with the patient.

Histological confirmation of tumour is required before treatment. The pathology services should comply with Clinical Pathology Accreditation (UK) Ltd (CPA)² and the Human Tissue Authority (HTA).³

Diagnosis

The specialist service should develop, with primary care local skin cancer services and their local cancer network, locally agreed guidelines on appropriate referral for patients with suspected skin cancer in line with national guidelines and best practice. Compliance with these guidelines should be audited.

Where there is any doubt about the diagnosis the patient should be referred for a specialist opinion.

All excised skin specimens should be sent for histopathological examinations as recommended in the NICE Referral guidelines for suspected cancer and diagnostic procedures may include:

- Direct inspection using the dermatoscope.
- Histopathology.
- Incision or punch biopsy (although this is to be avoided for melanoma other than in rare circumstances in the SSMDT).
- Sentinel node biopsy for melanoma patients with tumours stage IB to IIC
- Bone marrow aspirate and trephine biopsy (for patients with B-cell and NK-cell lymphomas and late stage cutaneous T-cell lymphoma).

Patients should be seen by designated clinicians and have access to fast track diagnostic clinics, and pre-admission clinics if needed.

The SSMDT is required to have access to or have close working relationships with the following services, specifically for:

- High-quality medical photography and storage of digital (ideally dermoscopy) images.
- Specialist laboratory testing of tumour tissue and blood for immunophenotyping, molecular analysis and blood viral serology.
- Immunophenotypic, molecular biological and cytogenetic facilities. There will be an increasing proportion of patients for whom molecular biological tests will be required as targeted therapies evolve.
- Soft tissue / bone sarcoma service for cutaneous sarcoma (specifically those that penetrate the superficial fascia or require chemotherapy).
- Organ transplant centres for patients who have had an organ transplant.
- Head and neck cancer service for some skin cancer subtypes on the head or neck.
- Haematological cancer service for patients with systemic/nodal lymphomas and primary cutaneous lymphoma.
- Specialist children's services for joint management of children and young

people.

- Genetic services for patients with evidence of genetic predisposition.

Patients who present as an emergency on their route to being diagnosed with cancer have poorer survival. Although for malignant melanoma cancer overall only 3 per cent of patients present as emergencies, it is still important to have good emergency systems in place. Providers should promote referral to the SSMDT as an emergency communication alert system service for GPs/A&E/ Assessment units/ clinicians to enable rapid specialty assessment, in- and out-patient investigations where appropriate

Staging

Providers must include American Joint Committee on Cancer (AJCC) staging information in their cancer registration dataset (this will become mandated in the Cancer Outcomes Service Dataset from early 2013). Staging data are essential for directing the optimum treatment, for providing prognostic information for the patient and are also essential to the better understanding of the reasons behind the UK's poor cancer survival rates. Cancer stage is best captured electronically at multidisciplinary team meetings and transferred directly to cancer registries. Staging and other pathological data can also be extracted direct from pathology reports and sent to cancer registries.

Treatment

All appropriate management options should be discussed with the patients.

The treatment each patient receives should be tailored to fit their individual values and situation, so it is essential that patients are actively involved in decision-making. This requires that they receive adequate and accurate information, both through meetings with members of the multidisciplinary team, and in published forms that they can study at home. Patients should be given sufficient time to consider all the options available to them.

The service should develop and agree evidence based network treatment policies with their local cancer network.

The majority of skin cancer patients are treated using surgery alone. Surgery is only to be provided by an active member of the skin cancer multidisciplinary team.

Most patients require excision to achieve surgical clearance with clear histological margins as described by national clinical guidelines. Most will be treated by simple excision or a flap: some will need a skin graft. Non melanoma skin cancers may need Mohs surgery. Surgical defects resulting from excision will require reconstruction of the defect ranging from direct closure to skin grafts, flaps or complex composite tissue transfers.

Sentinel node biopsy (SNB) is offered as a staging procedure for stage IB to IIC melanoma in the majority of SSMDT, usually by the plastic surgeons (usually as a

day case).

If the SNB is positive or if palpable metastases are detected in regional lymph nodes, then regional lymphadenectomy will be advised to be carried out by the SSMDT. Fine needle aspiration cytology with immediate reporting of masses is an important component of high quality care in patients with palpable lymph node masses.

Loco-regional metastases e.g. in transit metastases may be treated by surgery and intra-lesional therapy, carbon dioxide laser therapy, Isolated limb perfusion (ILP) or Isolated limb infusion (ILI).

Active clinical follow up by members of the SSMDT will form an important part of the treatment although better prognosis patients or patients seeking care nearer to home may be followed up by the LSMDT.

Occasionally patients will require surgery to be carried out by additional specialist surgeons working in other specialist multidisciplinary teams, e.g. neurosurgery for brain metastases, hepatobiliary teams for liver metastases.

Non-surgical procedures may include:

- Surveillance (with medical photography) is essential especially for melanoma patients with multiple moles, patients with the atypical mole syndrome and patients with familial melanoma, or in patients with a history of a changing mole.
- Cryotherapy/cryosurgery may be used for selected pre-malignant lesions or superficial BCC where the diagnosis is established.
- Topical treatment such as Imiquimod and topical 5 fluoro-uracil predominantly for pre-cancerous skin changes.
- Photodynamic therapy (PDT).
- Systematic treatment with chemotherapy.
- Radiotherapy / palliative radiotherapy including use of the gamma knife for brain metastases which are common in melanoma patients.

Chemotherapy and Radiotherapy

Chemotherapy and radiotherapy are important components of the treatment of some patients and should be carried out at designated centres by appropriate specialists as recommended by a SSMDT. Audits of compliance with agreed protocols will need to be demonstrated.

Providers will also need to refer to the following documents for more detailed description of these services:

- Adult Systemic Anti-Cancer Therapy (SACT/Chemotherapy) service specification.
- Radiotherapy Service Specification.

Follow-up

The IOG series of documents made recommendations on follow-up care. Providers will need to adhere to cancer specific guidelines for follow up agreed through the network site specific groups (NSSG) and ensure patients have a follow up plan. The cancer specific guidelines will identify that some patients will need to continue receiving follow up from the specialised service but it is expected the majority will be able to receive follow up locally. The provider will need to ensure effective hand over of care and/or work collaboratively with other agencies to ensure patients have follow up plans appropriate to their needs.

Rehabilitation

There should be appropriate assessment of patients' rehabilitative needs across the pathway and the provider must ensure that high quality rehabilitation is provided in line with the network agreed skin rehab pathway (in development) at: www.ncat.nhs.uk/our-work/living-with-beyond-cancer/cancer-rehabilitation

Supportive and Palliative Care

The provider will give high quality supportive and palliative care in line with NICE guidance. The extended team for the multidisciplinary teams includes additional specialists to achieve this requirement. Patients who are managed by a specialist skin cancer multidisciplinary team will be allocated a key worker, normally the CNS.

Patients who require palliative care will be referred to a palliative care team in the hospital and the team will be involved early to liaise directly with the community services. Specialist palliative care advice will be available on a 24 hour, seven days a week basis.

Each patient should be offered a holistic needs assessment at key points in their cancer pathway including at the beginning and end of primary treatment and the beginning of the end of life. A formal care plan should be developed. The Nurse specialist(s) should ensure the results of patients' holistic needs assessment are taken into account in the multidisciplinary team's decision making.

Survivorship

National Cancer Survivorship Initiative (NCSI) is testing new models of care aimed at improving the health and well being of cancer survivors. The new model stratifies patients on the basis of need including a shift towards supported self management where appropriate. In some circumstances traditional outpatient follow-up may be replaced by remote monitoring. The model also incorporates care coordination through a treatment summary and written plan of care.

Providers are expected to work effectively with local services to develop local support to patients whose care will return to their more local health providers once specialist care is no longer required.

End of Life Care

The provider should provide end of life care in line with NICE guidance and in particular the markers of high quality care set out in the NICE quality standard for end of life care for adults.

Acute Oncology Service

All hospitals with an A&E department should have an “acute oncology service” (AOS), bringing together relevant staff from A&E, general medicine, haematology and clinical/medical oncology, oncology nursing and oncology pharmacy. This will provide emergency care not only for cancer patients who develop complications following chemotherapy, but also for patients admitted suffering from the consequences of their cancer.

Trusts should ensure AOS services are in place (as described) and patients know how to access it. Full details on AOS please refer to the service specification for chemotherapy.

Care Pathways

The local care pathway for melanoma should be consistent with the national pathway in the Map of Medicine. The process of producing the pathway and subsequent updates has been accredited by the National Cancer Action Team.

<http://eng.mapofmedicine.com/evidence/map/melanoma1.html>

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England; or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays?: Establishing the Responsible Commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges).

Specifically, this service is for adults with suspected or established skin cancers requiring specialised intervention and management, as outlined within this specification.

The service must be accessible to all patients with a suspected or established skin cancer regardless of sex, race or gender. Providers require staff to attend mandatory training on equality and diversity and the facilities provided offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information available in multiple languages.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation

The SSMDT will review and, where appropriate, treat patients who meet the following criteria:

- Patients referred from the LSMDT
- Patients with high-risk SCCs that pose difficulty in management.
- Patients with MM managed by other site specialist teams (e.g. gynaecological, mucosal and head and neck (excluding ocular)).
- Patients newly diagnosed with MM stage 1B or higher (AJCC staging system) where sentinel node biopsy is available.
- Patients newly diagnosed with MM stage 2B or higher AJCC staging system) where sentinel node biopsy is not available.
- Patients with MM stage 1B or above who are eligible for clinical trials that have been approved at cancer network level.
- Patients with multiple MM.
- Children younger than 19 years with MM, in conjunction with the Children's cancer service.
- Teenagers & Young Adults 19 to 24 years with MM, in conjunction with the TYA PTC MDT service.
- Any patient with metastatic MM or SCC diagnosed at presentation or on follow-up.
- Patients with giant congenital naevi for counselling or where there is suspicion of malignant transformation.
- Patients with BCCs that are metastatic.
- Patients with malignant skin lesions of uncertain pathological diagnosis.
- Patients with rare skin cancers, including lymphoma and sarcoma.
- For periodic review, patients developing skin cancers who are immune-compromised, have Gorlin's syndrome or other genetic predisposition syndromes.
- Patients needing nodal dissection including sentinel lymph node biopsy (SNB).
- Patients who may benefit from radiotherapy, if not available at the LSMDT.
- Patients who require adjuvant treatment (where this is shown to be beneficial).
- Patients who are eligible for clinical trials.

The supra-network multidisciplinary team will review and where appropriate treat patients with:

- Skin disease suggestive of cutaneous lymphoma but where the diagnosis is not yet established.
- All advanced stages of mycosis fungoides (IIB-IV) for consideration of total skin electron beam therapy (TSEB), extracorporeal photophoresis and high cost licensed drugs and trials.
- Other rare cutaneous T-cell lymphoma variants including Sezary syndrome.

2.4 Any acceptance and exclusion criteria

The role of the specialist skin cancer service is described in this document but the detailed specification for local skin cancer services will be described in a separate document as these services are expected to be commissioned by clinical commissioning groups (CCGs).

2.5 Interdependencies with other services.

Internally the specialist skin cancer service will link into multiple clinical and administrative teams including:

- Primary care.
- Local Skin MDT.
- Specialised head and neck cancer service for tumours on the head and neck which meet referral criteria to the skin cancer SSMDT.
- Local/Specialist Haematological Cancer service for the lymphomas.
- Other specialist multidisciplinary teams as appropriate e.g. gynaecological for vulval melanoma, urology for penile melanoma, lower Gastro-Intestinal (GI).
- Specialist soft tissue/bone sarcoma service.
- Transplant centres.
- Specialist children's services.
- Genetic services.
- Specialist palliative care teams.

External to this the specialist skin cancer service providers are the leaders in the NHS for patient care in this area. They provide a direct source of advice and support when other clinicians refer patients into the specialist services.

The specialist skin cancer service providers also provide education within the NHS to raise and maintain awareness of skin cancer and to support local and regional efforts to promote the awareness and earlier detection of skin cancer.

Further comments on co-location of services/interdependences are covered earlier in section 2.2.

Strategic Clinical Networks

Strategic Clinical Networks (SCN) are part of the new NHS England architecture from April 2013. There are 12 SCNs all including cancer within their brief. There may be other models in place, for example integrated cancer provider networks. SCNs are a non-statutory organisational model. Within this model, commissioners will remain accountable for the commissioning of services and providers for the quality of service delivery. SCNs will have an annual accountability agreement, with NHS England for delivering a programme of quality improvement. SCNs will need to work with Clinical Commissioning Groups and NHS England primary and specialised commissioners within its area.

The Skin Cancer NSSG is the primary source of the clinical opinion on issues relating to skin cancer within the defined commissioning area and is an advisor to commissioners locally. Each SSMDT should ensure they fully participate in the SCN or similar systems for planning and review of services.

Each NSSG should agree an up-to-date list of appropriate clinical trials and other well designed studies for skin cancer patients and record numbers of patients entered into these trials/studies by each multidisciplinary teams.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

Care delivered by the specialist skin cancer service providers must be of a nature and quality to meet the CQC care standards and the IOG for skin cancers. It is the trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches any consequences will be deemed as being the trust's responsibility.

Skin cancer services are required to achieve the two week wait for all patients where skin cancer is suspected. In addition the services are required to meet the following standards for all skin cancer patients:

- 31 day wait from diagnosis to first treatment.
- 31 day wait to subsequent treatment.
- 62 day wait from urgent GP referral or screening referral or consultant upgrade to first treatment.

Teams should as a minimum aim to achieve the median value for compliance with the cancer peer review measures, and if a team had immediate risks or serious concerns identified then remedial action plans should be in place. Further details are available at www.cquins.nhs.uk.

The provider must be able to offer patient choice. This will be both in the context of appointment time and of treatment options and facilities including treatments not available locally.

The service will comply with the relevant NICE quality standards which defines clinical best practice.

4. Key Service Outcomes

The service is expected to comply with the data requirements within the Cancer Outcomes Strategy Dataset (COSD) and monitor the following clinical outcomes AJCC stage at diagnosis for all skin cancers:

- 3 and 5 year survival rates for melanoma adjusted and un-adjusted for AJCC stage at diagnosis. In the first instance 3 year survival will be recorded and as data systems improve, also 5 year survival

Quality and Performance Standards

The suggested standards have been included as a guide but are not mandated for 13/14. The Clinical Reference Groups for cancer and skin will support the development of standards for wider consultation as part of the annual work programme. This will be informed by the development of national guidance as this becomes available.

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
<u>Quality</u>	3 year survival adjusted for AJCC stage at diagnosis.			
	Proportion of patients seen in clinics staffed by specialists working together or in parallel clinics (dermatologist, plastic surgeons and oncologists).			
	Proportion of patients with melanoma stage at IIIB and higher who have molecular testing of their tumours for targetable mutations.	67%	Follow up ratios.	Not regularly reported. TBC Reported in peer review submissions Attendance at advanced communication skills course

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
IOG Compliance	Compliance with specified measures.	Compliance with specific measures for tumour site as set out in IOG documentation.	Regular updates to board and network performance report	
Compliance with peer review	Compliance with all other Peer Review measures (other than where agreed with commissioners when the provider should have an action plan in place that has been agreed with the commissioner).	National median compliance level	National peer review reports / regular verbal feedback to board	
Performance & Productivity	The Provider should ensure that these targets are achieved for the part of the patient pathway that it delivers and that when the patient pathway crosses outside the locality border, appropriate scheduling of patients/activity supports achievement of the target by other providers in the pathway wherever possible, except when informed patient choice or clinical appropriateness mitigate against this.			
Waiting Time Compliance				
	62 day wait - % treated in 62 days from GP referral, consultant referral and referral from screening programme.	>~86%		
Aggregate Measures	14 day suspected cancer referral standard performance (A20).	93%	Regularly reported to board	
	31 day first treatment standard	96%		

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
	performance (A15)			
	31 day subsequent treatment (Surgery) standard performance (A17).	94%		
	31 day subsequent treatment (Drugs) standard performance (A16).	98%	Regularly reported to board.	
	31 day subsequent treatment (Radiotherapy) standard performance (A17).	94%	Live from 1 st January 2011 and regularly reported to board.	
	31 day subsequent treatment (Other Treatments) standard performance.	TBC	Live from 1 st January 2011 and regularly reported to board.	
	31 day subsequent treatment (Palliative) standard performance.	TBC	Live from 1 st January 2011 and regularly reported to board.	
	62 day standard from 14 day referral performance (A18).	85%	Regularly reported to board.	
	62 day standard from	TBC	Live from December 2008	

	consultant upgrade performance (A19).		and regularly reported to board	
	Diagnostic Test Waiting Times	TBC	Not regularly reported to Board, no longer a national CQC target.	

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
Audits	Annual review conducted.		NSSG	
	Additional audits undertaken.	N/A	Reported at NSSGs but not board unless specific service change.	
Activity	Threshold for number of procedures.	Establish baseline cancer activity data for :- number of procedures for elective, day case, non elective non emergency, non elective emergency, outpatient follow-up attendance, outpatient follow-up, outpatient procedures all by speciality.	Not currently regularly reported to Board.	
	Length of stay, benchmarking.			
	Level of admissions.			
	Choice.			
Service user experience	National Cancer Patient Experience survey (ref A46 main contract).	National survey report when published.	National findings reported to board. Currently establishing a baseline.	If the provider does not take part they will be required to meet with the commissioners to explain reasons for not doing so and activity planned to enable the

				information to be captured through alternative mechanisms.
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<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
	Improving service user experience.	Of responses received, 75% should express overall satisfaction with the service. Trust to evidence the measures it has taken to improve our service user experience and outcomes achieved and numbers / percentage stratified.		
	Addressing complaints.	Trust to evidence the measures it has taken to address complaints and outcomes achieved.		
	Patient involvement.	Trust to evidence the actions it has taken to engage with patients and demonstrate where this has impacted.		
Staff Survey	Staff survey results.			
Trial Activity	Recruitment into trials.	Patients eligible for an existing clinical trial should be offered the chance to be treated in a clinical trial.	Reported to Board on a regular basis but not part of the performance report.	
Outcomes	Three and five year survival.		Part of network.	

<i>Performance Indicator</i>	<i>Indicator</i>	<i>Threshold</i>	<i>Method of Measurement</i>	<i>Consequence of breach</i>
	30 day readmission rates for cancer patients.		Performance report.	
	Registry dataset submission status.	Numbers and percentage baseline to be set in year.	Not currently reported to board.	
Data Submission	DCOs	As required by registry	Not currently regularly reported to board.	
	Staging data.		Regular updates to network.	
		As required by registry	Not currently reported to board.	

Additional Information

Although registration of melanoma skin cancer in England is considered complete, there is variation amongst registries in the recording of non-melanoma skin cancer (NMSC) and therefore accurate data on the number and incidence rate of NMSC are not available. Differentiating between BCC, SCC and other skin cancers requires morphology data specifically 'histopathological confirmation'.

Skin cancer is classified using the international classification of diseases version 10 (ICD10), as:

C43: malignant melanoma, with approximately 10,000 newly diagnosed cases per year in England, a crude rate of 19.3 per 100,000 population.

C44: Non-melanoma skin cancer. Recording of NMSC in England is known to be incomplete but it is estimated that non-melanoma skin cancers are 10 times as common as malignant melanomas. The majority of NMSCs are either BCCs or SCCs.

Incidence data for patients diagnosed in 2009, England. Source: UK Cancer Information System, accessed August 2012.

Emergency presentation data for patients diagnosed 2006-2008, source: National Cancer Intelligence Network.

Cancer waiting times

Basal cell carcinomas are excluded from the cancer waiting times dataset. These are determined by the relevant morphology codes. Please see <http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/clincoding#appB> for further information.

Interim for adoption from 21/10/13