Skin Cancer MDT
Operational Policy 2011

Date agreed by the Skin Cancer MDT Members and MDT Lead Clinician, Mr Duncan MacKenzie 20th June 2011

Review date June 2012
The following multi disciplinary team (MDT) members have read and agreed the content of this skin cancer policy.

Mr Duncan Mackenzie - Consultant Plastic Surgeon /Lead Clinician MDT
Dr Toby Chave - Consultant Dermatologist
Mr Rob Morris – Consultant Plastic Surgeon
Mr Anthony Fitton - Consultant Plastic Surgeon
Mr David Camp – Consultant Plastic Surgeon
Mr Krish Kumar - Associate Specialist in Plastic Surgery
Mr Jacob Manushakian - Consultant Plastic Surgeon
Mr Lachlan Currie - Consultant Plastic Surgeon
Surgeon Commander Rory Rickard RN – Consultant Plastic Surgeon
Dr Martin Highley – Medical Oncologist
Dr Dean Harmse - Lead Consultant Histopathologist
Dr P Suresh – Consultant Radiologist
Ruth Devlin – Skin Cancer Nurse Specialist
Diana Morgan – Biopsy Nurse
Mrs Lisa Glover – MDT Co-ordinator
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The aim of the Skin Cancer Multidisciplinary Team (MDT) Service

The aim of the Specialist Skin Cancer Multidisciplinary Team (SSMDT) at Derriford Hospital, Plymouth, is to provide a co-ordinated approach to diagnosis, treatment and care for patients diagnosed with melanoma, squamous cell carcinoma and basal cell carcinoma. Members of the skin MDT are committed to the aims of the national and local cancer agenda. Clinical care is based on the National Institute of Clinical Excellence (NICE) Guidance of Commissioning Cancer Services – Improving Outcomes for People with Skin Tumours including Melanoma (2006) and 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), The NHS Cancer Plan (2000), the Manual of Cancer Services (2004) and the Cancer Reform Strategy (2008). This document also makes reference to the British Association of Dermatologist (BAD) and the British Association of Plastic Surgeons (BAPS) guidelines of care for patients with malignant melanoma and squamous cell carcinoma. These national guidelines and policies for the management of skin cancer are further supported and underpinned by the Guidelines for the Management of Skin Cancer (Appendix 1).

Skin Cancer Pathway (local) June 2009 (Appendix 2)

Operational Policy (11-2J-208).

This operational policy has been written to ensure all members are aware of the purpose and organisation of the MDT meeting, the scope of the service offered by the specialist team and their individual roles within the team. The policy will ensure that all members have a policy of agreed standards and processes. This will provide quality, patient focused care and management for people who have been diagnosed with skin cancer in the region. The skin Cancer MDT will meet annually to discuss, review and record operational policies.

Scope of the service (11-2J-210)

The NICE/IOG guidelines recommend that all patients with malignant melanoma, squamous cell carcinoma and high-risk basal cell carcinoma (i.e. tumours on the face and neck) be referred to secondary care for treatment by a member of the SSMDT.

The SSMDT at Derriford Hospital is a multi-professional group serving the people of Plymouth and the surrounding catchment area, which is a population of 450,000. This includes patients from Plymouth Primary Care Trust (PCT), Devon PCT and Cornwall PCT. It is also a part of the Peninsula Skin Cancer Network.

The MDT is committed to meet the needs of skin cancer patients by developing and improving the service offered to local patients by

- Working towards the implementation of National Institute of Clinical Excellence (NICE) Guidance of Commissioning Cancer Services – Improving Outcomes for People with Skin Tumours including Melanoma (2006) NICE, Improving Outcomes for People with Skin tumours including Melanoma (update) (2010) guidance for skin cancer
- Being active in the Peninsula Network Site Specific Group (NSSG) for skin cancer and contributing to the development of local patient pathways and clinical guidelines.
- The MDT will send a representative to at least two thirds of the NSSG meetings, a record of attendance will be recorded
- Collecting high quality relevant data.
- Undergoing regular audit, both within the MDT and as part of the NSSG.
- Recruiting patients into national clinical trials and incorporating new research and best practice into patient care.
- Providing high quality and comprehensive information to primary care physicians, patients and their carers.
- Undertaking patient satisfaction surveys and involving patients in service design.
- Produce an annual report
- Produce an annual work programme to outline the objectives for current year
Lead Clinician and Core Team Membership (11-2J-201)

The Lead Clinician of the MDT is Mr Duncan MacKenzie Consultant Plastic Surgeon (11-2J-201). This has been agreed with the Trust Lead Cancer Clinician.

The written responsibilities/job description of the Lead Clinician agreed by the Cancer Lead for the Trust is attached (Appendix 3).

- The MDT will agree one of the members as a lead for integration of research and recruitment into clinical trials. This is currently Dr Martin Highley, Consultant Medical Oncologist.
- The MDT will allocate responsibilities for user issues including patient/carer information, users’ issues, service improvement and Key worker responsibility. This is currently Ruth Devlin, Skin Cancer Nurse Specialist.

GPwSI – (11-2J-221/222/223)

GP’s with special interest (GPwSI’s) and Model 2 practitioners who regularly engage in seeing skin cancer patients or undertake skin cancer surgery will attend the Skin Cancer MDT as part of their contracted activities and will be recognised where appropriate for continuing medical education (CME). They must attend at least four MDT meetings per year which will include the two teaching and/or audit meetings. The results of their skin cancer excisions must be included in their network skin cancer audit. The Derriford Hospital Skin Cancer MDT will encourage full implementation of the NICE/IOG guidelines with accreditation for GP with special interest (GPwSI) as agreed in the Peninsula Guidelines for the Management of Skin Cancer (Appendix 1).
<table>
<thead>
<tr>
<th>Name</th>
<th>Mr Duncan MacKenzie</th>
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<tr>
<td>Title</td>
<td>Lead Clinician Skin Cancer MDT/Consultant Plastic Surgeon</td>
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**Responsibilities**

- Ensure that objectives of MDT working are met by
  - to ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of the individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions
  - to ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit
  - to ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent
  - overall responsibility for ensuring that the MDT meeting and team meet peer review quality measures
  - ensure attendance levels of core members are maintained in line with quality measures;
  - ensure that the target of 100% of skin cancer patients discussed at the MDT is met
  - provide link to NSSG either by attendance at meetings or by nominating another MDT member to attend
  - organise and chair an annual meeting examining functioning of team and reviewing operational policies and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members)
  - ensure the MDT activities are audited and results documented
  - organise a bi-annual audit/CME meeting where the MDT’s activities are presented
  - ensure that the outcomes of the meeting are clearly recorded and clinical validated and that appropriate data collection is supported
  - ensure target of communicating MDT outcomes to primary care is met
  - produce an Annual Report for the MDT

<p>| Cover arrangement | Dr Toby Chave, Consultant Dermatologist |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Role</th>
<th>Cover arrangement</th>
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</table>
| Dr Toby Chave      | Consultant Dermatologist                   | • To adhere to policies agreed by the MDT  
• To attend 2/3 of the MDT meetings in one year  
• Ensure patients are discussed within the MDT meeting  
• Input into discussions relating to patients  
• Contribute to the development of the Operational Policy of the MDT and attend Annual meeting | Mr Duncan MacKenzie, Consultant Plastic Surgeon |
| Dr Urszula Brudnik | Consultant Dermatologist                   | • To adhere to policies agreed by the MDT  
• To attend 2/3 of the MDT meetings in one year  
• Ensure patients are discussed within the MDT meeting  
• Input into discussions relating to patients  
• Contribute to the development of the Operational Policy of the MDT and attend Annual meeting | Dr Toby Chave                       |
| Dr Martin Highley  | Lead Consultant Medical Oncology           | • To adhere to policies agreed by the MDT  
• To attend 2/3 of the MDT meetings in one year  
• Ensure patients are discussed at the MDT meeting  
• Input into discussions relating to patients, policies and guidance  
• Manage any chemotherapy treatment for patients and liaise with clinical oncologist for radiotherapy treatment  
• Lead on the integration of research and recruitment for NCRN trials  
• Contribute to the development of the Operational Policy of the MDT and attend Annual meeting | No cover                            |
| Mr Krish Kumar     | Consultant Plastic Surgeon – Associate Specialist | • To adhere to policies agreed by the MDT  
• To attend 2/3 of the MDT meetings in one year  
• Ensure patients are discussed within the MDT meeting  
• Input into discussions relating to patients, policies and guidance  
• Contribute to the development of the Operational Policy of the MDT and attend Annual meeting | Mr David Camp                       |
### Cover arrangement

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Dr P Suresh – Consultant Radiologist</td>
<td><em>Discuss appropriate imaging</em>&lt;br&gt;<em>Interpret imaging</em>&lt;br&gt;<em>Arrange and co-ordinate investigations</em>&lt;br&gt;<em>To adhere to policies agreed by the MDT</em>&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em></td>
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<tr>
<td>Mr Ramya Thiagarajah</td>
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<tr>
<td>Mr Rob Morris</td>
<td>- cover Mr MacKenzie&lt;br&gt;<em>To adhere to policies agreed by the MDT</em>&lt;br&gt;<em>Ensure patients</em>&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em></td>
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<tr>
<td>Mr Anthony Fitton</td>
<td>- cover Mr MacKenzie&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em></td>
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<tr>
<td>Surgeon Commander R Rickard RN</td>
<td>- cover Mr Camp&lt;br&gt;<em>To adhere to policies agreed by the MDT</em>&lt;br&gt;<em>Ensure patients</em>&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em></td>
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<tr>
<td>Mr Jacob Manushakian</td>
<td>- cover Mr Kumar&lt;br&gt;<em>To adhere to policies agreed by the MDT</em>&lt;br&gt;<em>Ensure patients</em>&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em></td>
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<tr>
<td>Mr Lachlan Currie</td>
<td>- cover Mr Camp&lt;br&gt;<em>To adhere to policies agreed by the MDT</em>&lt;br&gt;<em>Ensure patients</em>&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em></td>
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<tbody>
<tr>
<td>Mr David Camp</td>
<td>Consultant Plastic Surgeon&lt;br&gt;<em>To adhere to policies agreed by the MDT</em>&lt;br&gt;<em>To attend 2/3 of the MDT meetings in one year</em>&lt;br&gt;<em>Ensure patients are discussed within the MDT meeting</em>&lt;br&gt;<em>Input into discussions relating to patients, policies and guidance</em>&lt;br&gt;<em>Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</em>&lt;br&gt;<em>To take the lead on axillary and inguinal block lymph node dissections</em></td>
</tr>
<tr>
<td>Mr Lachlan Currie</td>
<td></td>
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</tbody>
</table>
### Sister Diana Morgan – RGN, Basic Surgical Skills.

**Title**: Nurse biopsyist

**Role**
- To adhere to policies agreed by the MDT
- To attend 2/3 of the MDT meetings in one year
- Ensure patients are discussed within the MDT meeting
- Input into discussions relating to patient, policies and guidance
- Contribute to the development of the Operational Policy of the MDT and attend Annual meeting
- Provide expert nursing advice and support to other health professionals in the nurse’s specialist area of practice
- Act as an expert resource and contribute to the education and training
- Initiates and contributes to clinical audit and research
- Utilises research in specialist area

### Ruth Devlin - Clinical Nurse Specialist (MDT only)

**Cover arrangement**

### Dr Dean Harmse

**Title**: Lead Consultant Histopathologist

**Role**
- To adhere to the policies agreed by the MDT
- Attend 2/3 of the MDT meetings in a year
- To review the histology of cases to be discussed at the MDT to validate diagnostic accuracy, grading, staging.
- To advise the MDT of pathological issues relating to skin cancers, including tests of diagnostic or prognostic significance
- Input into discussions relating to patients, policies and guidance
- Contribute to the development of the Operational Policy of the MDT and attend Annual meeting
- Take part in the National Specialist Dermatopathology EQA (11-2J-215)
- Participate in local audit and contribute to the NSSG commissioned audit

### Tim Bracey - 2nd Consultant Histopathologist
<table>
<thead>
<tr>
<th>Name</th>
<th>Ms Ruth Devlin - RGN, BSc (Hons) - Cancer Nursing,  BSc (Hons) Community Health Care Nursing, Enrolled on MSc Advance Practitioner 30 Credit Module. Completed level 2 psychological support for cancer patients.</th>
</tr>
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<tbody>
<tr>
<td>Title</td>
<td>Clinical Nurse Specialist Skin Cancer</td>
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<tr>
<td>Responsibilities</td>
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<tr>
<td>(11-2J-201)</td>
<td>- To adhere to policies agreed by the MDT</td>
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<tr>
<td>(11-2J-202)</td>
<td>- To attend 2/3 of the MDT meetings in one year</td>
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<tr>
<td>(11-2J-217)</td>
<td>- Ensure patients are discussed within the MDT meeting</td>
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<tr>
<td>(11-2J-218)</td>
<td>- Contribute to MDT discussions and patients assessment/care planning decision of team</td>
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<td>(11-2J-219)</td>
<td>- Provide expert skin cancer nursing advice and support to other health care professionals</td>
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<td>- Act as the Key Worker or be responsible for nominating the Key Worker to the patients who require further treatment and follow up</td>
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<td>- To lead on patient and carer communication issues and co-ordination of the patient’s pathway for patients referred to the team</td>
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<td>- To offer an information prescription</td>
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<td>- Ensure that results of the patients’ holistic needs assessment are taken into account in the decision making</td>
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<td>- Utilise research in the specialist area of practice</td>
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<td>- Involvement in clinic audit</td>
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<td></td>
<td>- Contribute to the overall running and management of the service</td>
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<td></td>
<td>- Responsible for integration of service improvement</td>
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<td></td>
<td>- Take the lead on user involvement</td>
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<td></td>
<td>- Contribute to the development of the Operational Policy of the MDT and attend Annual meeting</td>
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<tr>
<td>Sister Diana Morgan – Nurse biopsyist (MDT only)</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Judy Horne</td>
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<tr>
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<tr>
<td>Title</td>
<td>Skin Cancer MDT co-ordinator</td>
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| Responsibilities | • To facilitate and co-ordinate the functions of the MDT meetings  
|               | • To attend all MDT meetings  
|               | • Ensure members or their deputy are advised of meetings and any changes of date, venue etc.  
|               | • Ensure the appropriate patients are discussed at the MDT and a list of patients to be discussed is distributed in advance  
|               | • Ensure all correspondence, notes, x-rays, results are available for the meeting  
|               | • Record team attendance and keep a comprehensive diary of all team meetings  
|               | • Help with changes to the proforma used and ensure all patients are discussed  
|               | • Ensure patients’ diagnoses, investigations, management and treatment plans are completed and added to the patient’s notes  
|               | • Record any other discussions which take place other than patient discussions  
|               | • Assist the Skin Cancer Nurse Specialist in tracking patients  
|               | • Be involved in process mapping to identify bottlenecks  
|               | • Data collection and recording of data  
|               | • Take minutes at the MDT meetings, type notes back in the required format and distribute to all concerned  
|               | • Inform lead cancer manager of waiting times for patients when these exceed appropriate targets  
| Cover arrangement | MDT co-ordinator              |
### Extended members and Role (11-2J-220)

<table>
<thead>
<tr>
<th>Extended members</th>
<th>Role (11-2J-220)</th>
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<tbody>
<tr>
<td>Mrs Barbara Carroll</td>
<td>Clinical Nurse Specialist Palliative Care</td>
</tr>
<tr>
<td>Mrs Penny Mabin</td>
<td>Point of referral for lymphoedema service at St. Luke’s Services, Plymouth</td>
</tr>
<tr>
<td>Mrs Flo Chow</td>
<td>Occupational therapist, Lynher/Out Patients</td>
</tr>
<tr>
<td>Wendy Easton, The Mustard Tree</td>
<td>Clinical psychologist /person to provide counselling</td>
</tr>
<tr>
<td>Mr Gary Parfett</td>
<td>Contact for orthotics service</td>
</tr>
<tr>
<td>Mr Clayton Smith</td>
<td>Contact for prosthetic service</td>
</tr>
<tr>
<td>Anita Harper</td>
<td>Physiotherapists</td>
</tr>
<tr>
<td>Christine Graham-Wilson</td>
<td>Advising on cosmetic camouflage</td>
</tr>
<tr>
<td>Dr Carol Brewer</td>
<td>Consultant Clinical geneticists/person to provide counselling</td>
</tr>
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#### THE MDT MEETING (11-2J-205)

The Skin Cancer MDT is held on a weekly basis, currently between 1330 – 1430 hrs on a Tuesday, (X-ray Meeting Room B, Level 06, Derriford Hospital). Members of the MDT are requested to sign in and a record of attendance is held by the MDTC.

The MDT meetings will be co-ordinated by the MDT co-ordinator (MDTC). The co-ordinator will compile a list of patients for discussion, which will be distributed to the MDT member prior to the MDT meeting. Any other patients that need to be added to the list will be done before 10am on the day before the MDT. The hospital notes will then be organised by the MDTC to be available at the meeting.

#### Attendance (11-2J-206/11-2J-207)

All Consultants working in Plymouth Hospital NHS Trust who are involved in the elective delivery of any major modalities to skin cancer patients, must be a core member of the skin cancer MDT.

Core members or their arranged cover are required to attend in person at least 66% of the MDT meetings. A record of attendance will be kept by the MDT co-ordinator (MDTC) and this will be audited to ensure that core members are attending. Each member is responsible for signing the register, if they do not sign the attendance register their attendance is not recorded. The results of this audit can be found in the Annual Report. If a core member is
unable to attend, it is their responsibility to inform their nominated cover. The MDT clinical lead will write to members to where their attendance is less than 66%.

**Patients requiring treatment planning before next MDT (11-2J-205)**

If a patient requires a therapeutic decision prior to the next MDT, it is the responsibility of the patient’s Consultant to make a management decision. The Consultant will discuss cases with other MDT members by telephone, e-mail or in person. The information will then be fed back at the next MDT by the Consultant or relayed via the Clinical Nurse Specialist or MDTC either by e-mail, telephone, letter or in person. If there is a difference in opinion this will be documented on the Cancer Database and the outcome filed in the patient’s medical record.

**Patients discussed at the MDT (11-2J-210).**

Patients who are to be discussed in the skin cancer MDT meeting will be added to a list from one of two sources. The majority will be identified using the Derriford Hospital Histopathology database. All patients who have a confirmed histological diagnosis of malignant melanoma (MM), squamous cell carcinoma (SCC) or a basal cell carcinoma, which has been incompletely excised, will be added to the MDT list through the histopathology database. All malignant melanomas and severely atypical naevi should be double reported (where capacity exists) with a turnaround time of two weeks (NICE IOG 2006). Members of the MDT can forward patient information to the MDTC to add any other patients whom they wish to discuss, generally those who would not be identified from the above route.

As per the NICE/IOG guidelines, the meeting functions as both Local Skin MDT (LSMDT) and Specialist Skin MDT (SSMDT) level. Patients included for discussion are identified below and include all patients at level 4, 5 and 6 care as per network guidelines.

- Malignant melanoma – primary, recurrent and metastatic
- Squamous cell carcinoma – primary, recurrent and metastatic
- Incompletely excised or recurrent Basal cell carcinoma
- Patients with malignant skin lesions of uncertain pathological diagnosis
- Patients with rare skin cancers
- Patients suitable for Mohs surgery
- Patients suitable for nodal dissection or sentinel lymph node biopsy
- Patients with Gorlins or other genetic diseases and immuno compromised patients with skin cancers or risk of developing them
- Patients for whom there is a discrepancy between the clinical diagnosis and histopathology report
- Patients who may be eligible for enrolment into clinical trials
- Any patient who are referred to the skin cancer MDT from another source

**Treatment/management plan (11-2J-227)**

The MDT must clearly identify and record on the Taunton and Somerset Cancer Register an individual patient treatment plan which preferably has been agreed by all members of the MDT present. If an agreement cannot be reached by the MDT, the clinician responsible for the patient must make the final decision as to the treatment offered thereafter. Such cases should be rare but any such case will need to be recorded by the MDT co-ordinator and discussed in one of the annual audit meetings.

**MDT outcomes (11-2J-227)**

The MDT outcomes are distributed electronically within 24 hours to the core MDT members for action. A copy of the electronic outcome, the proforma and patient checklist is filed in the patient’s notes (if available). If the notes are unavailable for the MDT then the paper copies are delivered to the Consultant or their secretary where it becomes their responsibility to ensure the notes are obtained and the outcomes filed in the appropriate section behind the purple cancer MDT divider.

To ensure that the MDT influences and advises on the most appropriate management the patient should be seen and given their diagnosis after they have been discussed at the MDT.
It is the responsibility of the person/s identified on the outcome form to action the recommendations of the MDT. If there is a disagreement with the outcome then the clinician will refer the case back to the MDT and attend in person to discuss the case again. The outcome for patients who have been treated by a GP who require further treatment, will receive a letter from the MDT lead within 24 hours with the recommended actions required. It is the responsibility of the CNS to ensure this is drafted, recorded and sent.

**Data collection (11-2J-232)**

The Peninsula Cancer Network has agreed the minimum dataset for skin cancers. The data which is collected at the Skin Cancer MDT comprises of Cancer Waiting Times monitoring in accordance with DSCN 20/2008 and the Cancer Registration Dataset as specified in the National Contract for Acute Services. The Network Policy can be found in Appendix 1

The minimum dataset (MDS) which has been agreed by the Peninsula Cancer Network, is collected on a proforma by the Dermatology/Plastic surgery SHO and MDT co-ordinator (MDTC). This proforma is filed in the patients notes. The MDS and outcomes are also recorded live on to the Taunton and Somerset database.

**Specific procedures 11-2J-212/11-2J-213**

Mr Krish Kumar has now resigned as the nominated lead for groin and axillary dissections from June 2011. Mr David Camp, who is a core member of the SSMDT and has now taken over as the nominated lead for axillary and groin node dissections. Mr Lachlan Currie will provide cover when he has annual leave. The procedure and the acute post operative care is carried out in Derriford Hospital.

Metastatectomy/dubulking for recurrent melanoma and reconstruction procedures involving micro vascular surgical techniques is carried out by all of plastic surgeons at Derriford Hospital.

Patients who require sentinel lymph node biopsy are referred to Mr Chris Stone or Mr David Oliver at the Royal Devon and Exeter Hospital.

Patients for isolated limb perfusion/infusion are referred to Dr Jerry Marsden at Selly Oak Hospital in Birmingham.

**Immuno compromised patients (11-1D-101J)**

There is a dedicated clinic once a month run by Mr Krish Kumar with CNS cover and is included in their work plan. This is held on the first Wednesday of each month in the Out-patient Department, Level 06 at Derriford Hospital. Patients are referred by their Consultants and/or the Renal and Liver Transplant Clinical Nurse Specialists. The referral can be by a red top referral or a letter direct to Mr Kumar’s secretary who arranges an appointment for them to be seen at the next available clinic. Patients will be referred for their annual skin cancer checks. If treatment is required this will be arranged by Mr Kumar who will follow up according to the guidelines.

**MDT/Network referral guidelines between teams and clinical guidelines (11-2J-228/11-2J-229)**

The MDT has agreed specific network-wide clinical guidelines with the NSSG. These guidelines are attached Appendix 1. Agreed Pathology Guidelines are in Appendix 4 and imaging is incorporated into the Network Guidelines in Appendix 1.

**Operational policy for the Key Worker (11-2J-214)**

For the purpose of this policy, the Key Worker is defined as ‘the person who, with the patient’s consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice’ (NICE 2004). The implementation of the key worker role is a requirement of the NICE Manual of Cancer Services Quality Measures (2004) and Manual for Cancer Services (2008) – Improving Outcomes Guidance.
Patients who have been diagnosed with skin cancer will be offered the single name and contact details of a key worker. The identification of a single named key worker will be the responsibility of the designated core nurse member at the MDT meeting which will then be recorded on the Taunton and Somerset database. The name of the key worker will also be recorded in the patient notes on the information checklist Appendix 5 and on the electronic outcome form from the MDT. Patients will be offered a named key worker and their contact details at diagnosis, this will be the responsibility of the CNS.

**Aim of the key worker**

- Act as the main contact for the patient and carer at a specific point in the pathway
- Offer support, advice and provide information for the patient and carers, accessing services as required.
- Ensure continuity of care along the patients pathway and that all relevant plans are communicated to all members of the MDT involved in that patients care
- Ensure that the patient and carer have their contact details, that these details are documented and available to all professionals involved in that patients care
- Ensure that when a handover of the key worker is indicated, it is implemented in full consultation with the patient and carer and the patient is provided with revised contact details
- Ensure that the next key worker has the appropriate information about the patient to fulfil the role
- Support the patient in identifying their needs, review these as required and co-ordinate care accordingly
- Liaise and facilitate communication between the patient, carer and appropriate health professionals.
- Assist to empower patients as appropriate.

**Operational policy for GP communication (11-2J-211)**

The patient’s GP will be informed of the confirmed diagnosis and treatment plan within 24 hours of the patient being given their diagnosis. This will be achieved by either faxing the GP 24 hour notification fax sheet Appendix 7 or by direct telephone contact. It is the responsibility of the clinician delivering the diagnosis and the CNS to complete the GP 24 hour notification form. The GP 24 hour form will be collected by Cancer Services from a designated tray in the main out patient department they will then fax it within 24 hours.

24-hour notification to the GP will be recorded on the cancer database by Cancer Service or the CNS for annual audit purpose. This will be reported back to the MDT at the bi-annual audit meetings. It is also recorded on the Patient Checklist Appendix 5 which is filed at the back of the MDT section in the patient’s notes.

**Patient information (11-2J-226)**

All new patients who have a diagnosis of malignant melanoma should be given their diagnosis face to face. Whenever possible the Clinical Nurse Specialist (CNS) should be present when a diagnosis is given which involves breaking bad news. This is to act as the patients advocate, give emotional support, to assess the patient’s needs and concerns and to give information and advice. If the CNS is not present their contact details should be offered to patients and their carers. The consultations with the patient should be documented within the clinical case notes and communicated to the patients GP as appropriate.

Skin cancer patients will be offered comprehensive written information throughout their pathway. They will be offered a hand held record, which will include information on how to access a permanent record of their treatment plan (11-2J-225). The patient will also be verbally offered a permanent written record of their treatment plan and this will be recorded on the patient checklist Appendix 5 and filed in their notes for audit purposes. A permanent record or summary will be offered when the diagnosis, treatment options/plan and relevant follow up (discharge) arrangements are discussed. The information available as a hard copy is listed below

**Local Information**
The Skin Cancer Team at Derriford Hospital

Information about the MDT

The Skin Cancer Nursing Service

Patients treatment plan

Malignant Melanoma

Squamous cell carcinoma

Basal cell carcinoma

Pre op assessment

Groin dissections

Chemotherapy

Radiotherapy

The Mustard Tree Macmillan Centre Leaflet

Jeremiah's Journey

Complementary Therapy

Bridges Project

External information (Macmillan Booklets)

Lymphoedema

Chemotherapy

Radiotherapy

Coping with Fatigue

Understanding thin melanoma

Understanding thick melanoma

Cancer Research – being SunSmart

All Patients will be assessed and offered an information prescriptions with tailored, individualised information to meet the needs of the patient and/or their carers at that point in their cancer journey. All professionals involved in providing written information in the team are aware of and know how to use the Information Prescriptions Service (IPS) hosted by NHS Choices. The information prescription provided will be recorded on the reverse of the patient checklist Appendix 6 which is filed in the patient’s notes. It will be recorded in the patient’s notes if an information prescription is declined by the patient or not given following assessment with documentation of rationale for non issue. The monitoring and recording of use of information prescriptions will be reviewed annually as part of the Trust internal validation case note review. Qualitative analysis of the patient experience of information will be undertaken as part of the annual user satisfaction survey.

National Advanced Communication Skills Training (11-2J-219)

The core members of the Plymouth Skin Cancer MDT who have direct clinical contact with patients are committed to attending the national advanced communication skills training. Attendance has been recorded in the Plymouth MDT Annual Report.

Palliative Care and bereavement support

The St Luke’s Palliative Care Team provides a specialist palliative care service for in-patients and out-patients at Derriford Hospital. The Skin Cancer MDT has a named extended member Mrs Barbara Carroll. Direct referrals are made through the Skin Cancer CNS for those patients in hospital or in the community. Bereavement and Hospice care are also provided by St Luke’s Services for patients attending Derriford Hospital. Patients with cancer are also offered a range of supportive care, complementary therapies and financial advice by The Macmillan Mustard Tree Centre based in Derriford Hospital.

Audit/ Continuing Medical Education (CME) meetings (11-2J-209)

The MDT will meet bi-annually for their educational/audit meeting. Any authorised clinicians practising in the community will be invited to attend. The MDT will engage in a rolling programme of audit as recommended by the IOG/NICE guidelines (April 2006). The progress and results of the network or local audit will be presented at this meeting and teaching on aspects of skin cancer management will take place.

Network audit (11-2J-233/225)
The Skin Cancer MDT will participate in one agreed NSSG Audit annually. The MDT will review progress and present the results of the completed project to the NSSG.

The MDT will undertake an exercise to obtain feedback on the patients’ experience of the services offered. The exercise will ascertain whether the patient was offered a key worker, a holistic needs assessment and what information they received. The exercise will also show if a summary of their consultation and treatment plan was provided. The results of this exercise will be presented and discussed at the MDT audit meeting and at least one action point will be agreed. The Patient Satisfaction Survey for 2011 is located in the Annual Report.

**Clinical trials (11-2J-234)**

The MDT will discuss the NSSG’s approved list of trials and other well designed studies at their annual MDT operational meeting. The MDT Clinical Trial Lead, Dr Highley, will produce an annual written response to the NSSG, outlining their progress on entry into clinical trials and any remedial actions identified to improve recruitment. The response to the NSSG will also include progress on the implementation of the remedial actions that have been identified.

The MDT lead for clinical trials is Dr Martin Highley, Medical Oncologist. Together with Sr Nikki Donlin, Oncology Clinical Trials CNS, they are responsible for recruitment into oncology clinical trials. Patients eligible for entry into clinical trials are identified at the MDT and their eligibility is recorded in the MDT outcomes. The trial will be briefly discussed at their next dermatology/plastics out patient appointment and a referral will be made, if the patient is in agreement, to Dr Highley to discuss the trial further.
GUIDELINES FOR THE MANAGEMENT OF SKIN CANCER
Final 21 December 2009

08-1C-110j  Agreed network-wide clinical guidelines for the management of skin cancer

These Guidelines have been agreed by:

<table>
<thead>
<tr>
<th>Position</th>
<th>Chair Peninsula Cancer Network Skin Cancer Group</th>
<th>Date agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Karen Davies</td>
<td>14/12/09</td>
</tr>
<tr>
<td>Organisation</td>
<td>Northern Devon Healthcare NHS Trust</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Position</th>
<th>MDT Led Clinicians</th>
<th>Date agreed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Organisation</td>
<td></td>
</tr>
<tr>
<td>Andrew Watts</td>
<td>Northern Devon Healthcare NHS Trust</td>
<td>14/12/09</td>
</tr>
<tr>
<td>Toby Chave</td>
<td>Plymouth Hospitals NHS Trust</td>
<td>8/12/09</td>
</tr>
<tr>
<td>Tom Lucke</td>
<td>Royal Cornwall Hospitals NHS Trust</td>
<td>18/12/09</td>
</tr>
<tr>
<td>Tony Downs</td>
<td>Royal Devon &amp; Exeter NHS Foundation Trust</td>
<td>9/12/09</td>
</tr>
<tr>
<td>Jill Adams</td>
<td>South Devon Healthcare NHS Foundation Trust</td>
<td>8/12/09</td>
</tr>
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<td>08-1A-216j</td>
<td>Arrangements with haemato-oncology teams for lymphoma involving skin</td>
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<td>08-1A-209j</td>
<td>Agreed network referral guidelines to named supra-network T-cell lymphoma MDT for TSEBT</td>
<td>24</td>
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<td>08-1A-210j</td>
<td>Agreed network guidelines for referral for photopheresis</td>
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<td>08-1A-212j</td>
<td>Arrangements for head and neck skin cancer</td>
<td>25</td>
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<td>08-1A-213j</td>
<td>Arrangements for anal and perianal skin cancer</td>
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<td>08-1A-214j</td>
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<td>Network agreed referral guidelines between teams</td>
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<td>Agreed network distribution of clinics for immunocompromised patients with skin cancer</td>
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<td>28</td>
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<tr>
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<td>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</td>
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<td>NSSG agreed training policy for model 2 community practitioners with named trainers/assessors</td>
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<td>08-1C-113j</td>
<td>Agreed network primary care referral guidelines and their distribution</td>
<td>31</td>
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<tr>
<td>08-6A-101j</td>
<td>Network/PCT agreed primary care referral policy and distribution of the primary care referral guidelines</td>
<td>31</td>
</tr>
<tr>
<td>08-1A-207j</td>
<td>Network agreed referral guidelines between teams</td>
<td>32</td>
</tr>
</tbody>
</table>
### Premalignant Lesions

**Primary care referral guidelines**

<table>
<thead>
<tr>
<th>Premalignant lesions</th>
<th>May be treated by any GP in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes actinic keratoses, Bowens disease (SCC in situ)</td>
<td></td>
</tr>
</tbody>
</table>

### Basal Cell Carcinoma

**Primary care referral guidelines**

**High Risk BCC**
High risk of incomplete excision and recurrence, defined as:
- recurrent BCCs
- BCCs on the head (face and scalp)
- large BCCs > 2cm diameter unless they are superficial BCCs that can be managed non-surgically
- lesions that have a clinical appearance of morphoeic, infiltrative or basosquamous
- lesions with poorly defined margins
- BCCs in patients who are immunosuppressed or have Gorlin's syndrome
- BCCs located over important underlying anatomical structures (for example, major vessels or nerves) or where primary surgical closure may be difficult (for example, digits or front of shin).

Refer to core member of Local MDT
Suspected BCCs should NOT be referred by a 2 week referral.

**Low Risk BCC**
Defined as any non-high risk BCC

Refer to either
1. Core member of local MDT
2. Accredited community practitioner in skin cancer surgery

Suspected BCCs should NOT be referred by a 2 week referral.

**BCC where there is any doubt about high or low risk status**
Refer to core member of Local MDT
Suspected BCCs should NOT be referred by a 2 week referral.

### Treatment

<table>
<thead>
<tr>
<th>BCC Type</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small well-defined BCCs on trunk and limbs</td>
<td>excision (with 3-4mm margin) or curettage &amp; cautery</td>
</tr>
<tr>
<td>Superficial BCCs</td>
<td>excision, cryotherapy, imiquimod, 5-fluorouracil, curettage or PDT: all treatment options guided by site, size, clinician and patient preference</td>
</tr>
<tr>
<td>High-risk BCCs</td>
<td>Surgical excision with at least 4mm margins</td>
</tr>
</tbody>
</table>
Consider Mohs surgery for more difficult and high risk cases such as:
- Recurrent BCC
- Poorly defined BCC
- Aggressive histology
- High risk sites
- Where tissue conservation is particularly important

Radiotherapy may be useful, particularly for patients unwilling or unable to tolerate surgery.

Incomplete excisions:

<table>
<thead>
<tr>
<th>Lateral margins</th>
<th>Offer re-excision or observation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deep margins</td>
<td>Recommend immediate re-excision (and possibly Mohs) unless patient very elderly in which case observation may be more appropriate, or consider radiotherapy.</td>
</tr>
</tbody>
</table>

BCC Follow up:

Complete excision or other definitive treatment – no follow up required, re-referral by GP if any sign of recurrence.

Exceptions where follow-up may be appropriate:
- Skin graft/flap reconstruction: review once at 3 months in selected cases to check cosmesis/complications.
- High tumour load (ie 2 or more new BCCs per year or previous history of >10 BCCs). This decision to be at the discretion of the treating clinician.
- Incomplete excision and opt for observation – consider follow-up 6 monthly for 1 year, then annually for 2 years – or discuss self-observation or GP follow-up.
- Treatment with PDT/Imiquimod/Cryotherapy/C&C. Consider review once at 3 months to check on effectiveness of treatment.

Squamous Cell Carcinoma

Primary care referral guidelines

<table>
<thead>
<tr>
<th>Squamous Cell Carcinoma</th>
<th>2 Week Referral to core member of Local MDT</th>
</tr>
</thead>
</table>

Primary treatment:

<table>
<thead>
<tr>
<th>SCC Type</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low risk SCC</td>
<td>Excision with 4-5mm clinical margins</td>
</tr>
<tr>
<td>High risk SCC</td>
<td>Excision with 6 – 10 mm clinical margins (see below).</td>
</tr>
</tbody>
</table>

Small well-defined and obviously well-differentiated tumours in elderly patients may be suitable for treatment via curettage and cautery by practitioners experienced in this technique. Also in patients with high tumour load, where patient is already having long-term follow-up.

Re-excision:

If incomplete re-excision with 5mm margin.

Further treatment

Dependent upon relative risk of tumour metastasising/recurring. Adjuvant radiotherapy should be considered for large poorly differentiated tumours and those close to excision margins.
Follow up:

<table>
<thead>
<tr>
<th>SCC Type</th>
<th>Follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low risk SCC</strong></td>
<td>None required</td>
</tr>
<tr>
<td>Low risk SCC defined as: small, well differentiated tumours.</td>
<td>Consider 3 or 6 monthly follow-up for 2 – 5 years depending on clinical situation (more need for follow-up if more than 1 poor prognostic factor present). Examine for local recurrence, and lymph node draining basins. Consider GP or patient self follow-up if appropriate/acceptable</td>
</tr>
<tr>
<td><strong>High risk SCC</strong></td>
<td>Consider 3 or 6 monthly follow-up for 2 – 5 years depending on clinical situation (more need for follow-up if more than 1 poor prognostic factor present). Examine for local recurrence, and lymph node draining basins. Consider GP or patient self follow-up if appropriate/acceptable</td>
</tr>
<tr>
<td>higher risk of recurrence/metastasis defined as:</td>
<td></td>
</tr>
<tr>
<td>• poorly differentiated,</td>
<td></td>
</tr>
<tr>
<td>• recurrent tumours,</td>
<td></td>
</tr>
<tr>
<td>• tumours &gt;2cm across,</td>
<td></td>
</tr>
<tr>
<td>• perineural or lymphovascular extension histologically</td>
<td></td>
</tr>
<tr>
<td>• depth &gt; 6mm</td>
<td></td>
</tr>
<tr>
<td>• transplant or immunosuppressed patients</td>
<td></td>
</tr>
<tr>
<td>• large &gt;2cm lesions</td>
<td></td>
</tr>
<tr>
<td>• site: ear/lip/non-sun-exposed</td>
<td></td>
</tr>
<tr>
<td>• SCCs developing in scars/sinuses/chronic inflammation</td>
<td></td>
</tr>
</tbody>
</table>

Clinical Imaging
High-risk SCC require CT for recurrent tumours
Not required for other primary SCC unless clinically indicated eg lymphadenopathy.

Malignant Melanoma

Primary care referral guidelines

<table>
<thead>
<tr>
<th>Melanoma</th>
<th>2 Week Referral to core member of Local MDT</th>
</tr>
</thead>
</table>

Primary Excision
2-5mm clinical margins

Wide excision:
Dependent on Breslow thickness:

| Lentigo maligna               | 2-5mm clearance adequate                   |
| In-situ MM                    | 5mm excision adequate                     |
| MM Breslow <1mm               | 1cm margin                                 |
| MM Breslow < 0.75mm           | 0.5-1cm margin                             |
| MM Breslow >1mm, <2mm         | 1-2 cm margin                              |
| Breslow >2mm                  | 2cm margin                                 |

Imaging:
Stage IIb and above (Breslow >4mm, or >2mm with ulceration): Staging CT required
Follow up

<table>
<thead>
<tr>
<th>Follow up Type</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>LM or in-situ MM</td>
<td>One follow up and then discharge</td>
</tr>
<tr>
<td>Breslow thickness &lt;1mm</td>
<td>3 monthly for 3 years</td>
</tr>
<tr>
<td>Breslow thickness &gt;1mm</td>
<td>3 monthly for 3 years, then 6 monthly for a further 2 years</td>
</tr>
</tbody>
</table>

At follow up:
- Examination of scar, in-transit metastases, lymph node basins, liver.
- General skin check.
- Discuss self-examination.

Skin Lymphoma

Referral
Systemic or nodal lymphomas should be referred to the haematology MDTs.
Primary cutaneous lymphoma should be discussed at the Skin SSMDTs.

08-1A-216j Arrangements with haematology teams for lymphoma involving skin

T Cell
St John’s Institute of Dermatology (Guy’s & St Thomas’ NHS Foundation Trust) is the Supra Network T-cell Lymphoma MDT to which the Peninsula relates. It is part of the South East London Cancer Network. See Appendix 3 for the relevant extract from the South East London Cancer Network Skin NSSG Constitution.

Stage above 1b: consider/offer referral to Lymphoma Unit, St Johns.
BUT may not be appropriate or feasible in certain clinical situations eg:
- single isolated tumours
- very ill erythrodermic patients who are unable to travel

Photopheresis and Total Skin Electron Beam Therapy
- Patients with erythrodermic cutaneous T cell lymphoma (stage 3 and 4) should be referred to the Lymphoma Unit at St John’s for consideration of photopheresis.
- Patients with nodular mycosis fungoides (Stage 2b or over) should be referred to St John’s for consideration of Total Skin Electron Beam Therapy.
- Some patients may be given Total Skin Electron Beam Therapy locally (in Plymouth) if this is more acceptable for the patient and where the management has been planned by St John’s.

08-1A-209j Agreed network referral guidelines to named supra-network T-cell lymphoma MDT for TSEBT

08-1A-210j Agreed network guidelines for referral for photopheresis

B Cell
For systemic disease: refer to haematology as above.
For primary cutaneous disease:
- Multiple or recurrent lesions: refer to St Johns
- Local isolated disease: local skin/haematology SSMDT

Skin Cancer of Specific Anatomical Sites
The pathology for these cases should be referred to the following specified MDTs for an opinion on management.
<table>
<thead>
<tr>
<th><strong>Anatomical Site</strong></th>
<th><strong>Cancer Type</strong></th>
<th><strong>MDT to refer to</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head &amp; Neck</td>
<td>Nasal Mucosal MM</td>
<td>Head And Neck MDT</td>
</tr>
<tr>
<td></td>
<td>Ocular Mucosal MM</td>
<td>Ophthalmologists refer to oncologists</td>
</tr>
<tr>
<td></td>
<td>Periocular</td>
<td>Oculoplastic/Plastic as Extended Member Of Skin MDT</td>
</tr>
<tr>
<td>Anal Cancer</td>
<td>Any</td>
<td>Colorectal MDT</td>
</tr>
<tr>
<td>External female genitalia</td>
<td>SCC</td>
<td>Gynae MDT</td>
</tr>
<tr>
<td></td>
<td>MM</td>
<td>Skin And Gynae MDT</td>
</tr>
<tr>
<td></td>
<td>BCC</td>
<td>Skin And Gynae MDT</td>
</tr>
<tr>
<td>External male Genitalia/penile</td>
<td>Any</td>
<td>Bristol Urology MDT [?? PHT]</td>
</tr>
<tr>
<td>Any</td>
<td>Sarcoma (see below)</td>
<td>Sarcoma MDT Exeter or Plymouth</td>
</tr>
<tr>
<td>Rare Tumours</td>
<td>Merkel Cell Tumours</td>
<td>SMDT Which Offers SNB &amp; Mohs (RDE or RCH)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>Any SMDT</td>
</tr>
</tbody>
</table>

08-1A-212j Arrangements for head and neck skin cancer
08-1A-213j Arrangements for anal and perianal skin cancer
08-1A-214j Arrangements for skin cancer of external female genitalia
08-1A-215j Arrangements for skin cancer of external male genitalia
08-1A-217j Arrangements with sarcoma MDTs for sarcoma involving skin
08-1A-207j Network agreed referral guidelines between teams

Sarcoma includes all dermal and subcutaneous tumours, namely:
- Histiocytoma, superficial sarcoma not otherwise specified.
- Dermatofibrosarcoma protuberans (DFSP).
- Leiomyosarcoma.
- Angiosarcoma.
- Kaposi's sarcoma.
- Haemangioendothelioma.
- Epithelioid sarcoma.
- Primary cutaneous rhabdomyosarcoma.
- Cutaneous malignant nerve sheath tumours (including cutaneous neurofibrosarcoma and malignant Schwannoma).

Epidermal and appendage tumours
- Apocrine carcinoma.
- Hidradenocarcinoma.
- Eccrine porocarcinoma.
- Sebaceous carcinoma.
- Tumours associated with Muir–Torre syndrome.
- Eccrine epithelioma (syringoid carcinoma).
- Microcystic adnexal carcinoma.
- Primary adenoid cystic carcinoma.
- Primary mucoepidermoid carcinoma.
- Primary mucinous carcinoma.
- Digital papillary adenocarcinoma.
- Malignant cylindroma.
- Malignant spiradenoma (spiradenocarcinoma).
- Malignant pilar tumour.
- Malignant pilomatrixoma.
- Neuroendocrine carcinoma (Merkel cell tumour/trabecular carcinoma).

Merkel Cell tumours should be referred to a centre where they offer sentinel node biopsy and Mohs (Royal Cornwall Hospital or Royal Devon & Exeter Hospital).
Immunocompromised and Transplant Patients
Clinics for transplant patients to be held at all 5 centres

<table>
<thead>
<tr>
<th>NDH</th>
<th>Dr Karen Davies</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHT</td>
<td>Mr Krish Kumar</td>
</tr>
<tr>
<td>RCH</td>
<td>Dr Sarah Woodrow (Clinical Lead)</td>
</tr>
<tr>
<td>RDE</td>
<td>Dr Rebecca Batchelor</td>
</tr>
<tr>
<td>SDH</td>
<td>Dr Jill Adams/ Dr Tessa Frost</td>
</tr>
</tbody>
</table>

Clinics to be held 1 – 3 monthly depending on need/numbers

08-1A-211j  Agreed network distribution of clinics for immunocompromised patients with skin cancer

Initial assessment
1 year post transplant: advice and information particularly sun protection and self monitoring.
Assessment for high risk factors including:
- older patients
- white skinned patients who have had excess sun exposure
- presence of pre-malignant warty lesions or actinic keratoses

Follow up
Frequency of follow-up to be decided by clinician on basis of clinical need. This should be annual follow-up as an ideal minimum, but then 3-6 monthly for patients with skin cancers, depending on various factors including tumour type and presence of high risk factors (eg poorly differentiated SCC).

Pre-malignant lesions
There should be active treatment of all pre-malignant lesions.

New or fast-growing skin tumour
Patients should be given instructions on how to access service at short notice in the event of a new or fast-growing skin tumour.

Secondary prevention
Retinoids and/or reduction of immunosuppression as below should be considered.

Alteration in immunosuppression
Transplant physicians should be contacted with regard to possible alteration in immunosuppression particularly with:
- >25 NMSCs per yr
- high risk SCC
- Merkel cell tumour
- melanoma especially stage Ila or above

Management will vary according to type of transplant.

Mohs Surgery
08-1C-114j  NSSG designated hospital practitioners for Mohs surgery and their caseload

The only practitioners authorised to carry out Mohs surgery (including 'Slow Mohs surgery') are the following:
Dr Samantha Hann, Dr Tom Lucke (RCHT)
Dr Chris Bower, Dr Emily McGrath (RD&E)

The Mohs surgery practice is well established in Cornwall, and is just starting up in Exeter. The only of these practitioners to have completed at least 50 cases in the year prior to peer review is Dr Lucke. However, it is envisaged that the other practitioners will increase their caseload to fulfil the necessary criteria. The availability of Mohs at Exeter will allow more equal access to this service for patients across the peninsula.
Levels of care that may be treated in the community
The Levels of Care can be found at Appendix 4.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Practitioners who may diagnoses &amp; treat in the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All GPs and MDT members</td>
</tr>
<tr>
<td>2 (low risk BCCs)</td>
<td>See below</td>
</tr>
<tr>
<td>3</td>
<td>Community outreach from Local or Specialist MDT</td>
</tr>
<tr>
<td>4</td>
<td>Community outreach from Local or Specialist MDT</td>
</tr>
<tr>
<td>5</td>
<td>Community outreach from Specialist MDT</td>
</tr>
<tr>
<td>6</td>
<td>None</td>
</tr>
</tbody>
</table>

The following providers may diagnose and treat low risk BCCs

<table>
<thead>
<tr>
<th>Provider</th>
<th>Accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group 3 community cancer GPwSIs</td>
<td>• On PCT GPSI list (^1) see 0 \</td>
</tr>
<tr>
<td></td>
<td>• Annually accredited by Local MDT according to 0 \</td>
</tr>
<tr>
<td>Community outreach from Local or Specialist MDT (a consultant led service that may include staff grade and associate specialist [SAS] doctors, specialist nurses and new model 2 practitioners45).</td>
<td>• 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.</td>
</tr>
<tr>
<td>GP expert in skin lesions</td>
<td>• Completion of SS1 and SS2 modules of GPSI training (without having completed full GPSI training) \</td>
</tr>
<tr>
<td></td>
<td>• Annually accredited by Local MDT according to 0 \</td>
</tr>
<tr>
<td>GPs performing minor surgery within the Directed Enhanced Services (minor surgery) arrangements under General Medical Services Personal Medical Services (PMS).</td>
<td>• Annually accredited by Local MDT according to 0 \</td>
</tr>
</tbody>
</table>

Model 2 Practitioners may treat any patients following a referral from a core member of the Local MDT.
The types of cases referred to model 2 practitioners is at the discretion of the core MDT members

<table>
<thead>
<tr>
<th>Provider</th>
<th>Accreditation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2 practitioners (^2)</td>
<td>• Annually accredited by Local MDT according to 0</td>
</tr>
</tbody>
</table>

Accreditation Body

**For GPwSIs**

- The accreditation body will be the Local Site Multi-disciplinary Team for Skin Cancer (the Skin MDT) to which the community skin cancer surgeon will relate.


- The chair of the MDT will accredit community skin cancer clinicians, and may accredit them on the recommendation of other core consultant members of the Skin MDT.
- The Skin MDT will keep a log of accredited community skin cancer clinicians.
- The MDT Lead will be responsible for accrediting any such practitioners based on this protocol.
- The MDT Lead is responsible for monitoring adherence to requirements of the model practitioners.
- The PCT has the final responsibility for monitoring GP practicing in the community as general practitioners (GPs practicing in the community as an employee of an acute provider will be covered by the governance of the Local MDT).

08-6A-104j GPwSI training specific to skin cancer given under the supervision of a named consultant dermatologist
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 accreditation for other GPs will be the Primary Care Trust

Dermatology GPwSI

These practitioners need to follow the recommended training and accreditation procedures specified in the DoH guidelines (reference above). In order to be GPwSIs providing community skin cancer services (group 3 GPwSIs according to the guidance), they need to fulfill the whole GPwSI training requirement. This means they need to be competent in the diagnosis and management of skin disease as well as skin cancer. The guidance clarifies training in the core dermatology curriculum and competencies which includes attachment to a secondary care dermatology unit, under the supervision of a consultant dermatologist, for 50 clinics. Completion of the Diploma in Dermatology is recommended. For further details of the training requirements see the DoH document.

Accreditation for the diagnosis and treatment of skin cancer

Experienced skin cancer GPs

GPs that have treated 320 cases of suspected skin cancer in the previous year will be accredited if they can demonstrate the following:

<table>
<thead>
<tr>
<th></th>
<th>Service configuration</th>
<th>Identify an MDT to which they relate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Audit of service</td>
<td>A log book of all cases of suspected skin cancer managed</td>
</tr>
<tr>
<td>3</td>
<td>Accuracy of diagnosis</td>
<td>70% of suspected low risk BCCs are confirmed as low risk BCCs by histology</td>
</tr>
<tr>
<td>4</td>
<td>Quality of excision</td>
<td>80% of excisions of low risk BCCs have a clear margin on histology</td>
</tr>
<tr>
<td>5</td>
<td>Continuing professional development</td>
<td>Attendance once in the previous year at a Network educational meeting where the annual BCC network results are presented along with a breakdown of individual healthcare professional data. This meeting should also include one CPD session (a total of 4 hours) on the diagnosis and management of low-risk BCCs.</td>
</tr>
</tbody>
</table>

Practitioners who are unable to meet these quality requirements will need to undergo further training and accreditation as per new practitioners.

GPs without prior experience of skin cancer

GPs that do not have sufficient previous activity may be accredited by an assessment by the Skin MDT Chair (or other core MDT member), which will include:

---

3 Using any treatment modality
| 1 | Assessment of the clinician’s knowledge | • lesion diagnosis  
• appropriate treatment selection  
• understanding of their own surgical limitations (ie when they should refer patients on)  
• understanding of the need to send all surgical specimens for histological assessment, and adequacy of completion of histology request forms  
• understanding of the NICE guidelines for treatment of skin cancer |
| 2 | Completion of 4 satisfactory formal assessments | • 2 clinical assessments (modified mini-CEX) relating to benign and malignant skin lesions  
• 2 DOPS (Directly Observed Practices Assessments). |

**Accreditation for the treatment of skin cancer (Model 2 Practitioners)**

Practitioners (medical or nursing) providing surgery only, not a core MDT member, but receiving referrals from core MDT members, only of previously diagnosed patients with agreed treatment plans.

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

**Experienced Practitioners**

Practitioners that have treated 4 20 cases of suspected skin cancer in the previous year will be accredited if they can demonstrate the following:

| 1 | Service configuration | Identify an MDT to which they relate |
| 2 | Audit of service | A log book of all cases of suspected skin cancer managed |
| 4 | Quality of excision | 80% of excisions of low risk BCCs have a clear margin on histology |
| 5 | Continuing professional development | Attendance once in the previous year at a Network educational meeting where the annual BCC network results are presented along with a breakdown of individual healthcare professional data. This meeting should also include one CPD session (a total of 4 hours) on the diagnosis and management of low-risk BCCs. |

Practitioners who are unable to meet these quality requirements will need to undergo further training and accreditation as per new practitioners.

**New practitioners**

Practitioners that do not have sufficient previous activity may be accredited by an assessment by the Skin MDT Chair (or other core MDT member), which will include:

| 1 | Assessment of the clinician’s knowledge | • appropriate treatment selection  
• understanding of their own surgical limitations (ie when they should refer patients on)  
• understanding of the need to send all surgical specimens for histological assessment, and adequacy of completion of histology request forms  
• understanding of the NICE guidelines for treatment of skin cancer |
| 2 | Completion of 4 satisfactory formal assessments | • 2 clinical assessments (modified mini-CEX) relating to benign and malignant skin lesions  
• 2 DOPS (Directly Observed Practices Assessments). |

---

4 Using any treatment modality
Association with Skin Cancer MDTs

All community skin cancer services should identify the Local Skin Cancer MDT to which they relate. Good communication should be established to ensure the consistency and continuity of services for patients.

Facilities

Community skin services may only be carried out in facilities approved by the PCT (with guidance as appropriate by the MDT).

Facilities should be assessed for:
- Operating equipment
- Lighting
- Storage and use of liquid nitrogen (if being used, should be in line with Health and Safety guidance)
- Infection control and decontamination issues

Support Services

Community skin cancer services are responsible for:
- The provision of information, advice and support for patients managed in primary care and their carers
- Assessment and management of risk within the service

Community skin cancer services should have their own guidelines to include:
- Type of patients seen
- Frequency of consultations
- Range of interventions
- Referral criteria
- Communication pathways
- Confidentiality

Community skin cancer services must be supported by:
- Adequate record keeping and appropriate documentation
- Close links to the Skin MDT
- Clinical audit programme, including patient satisfaction survey
- Complaints process and review
- Incident reporting process and review, including significant event monitoring
# Primary care referral guidelines for skin cancer

<table>
<thead>
<tr>
<th><strong>Premalignant lesions</strong></th>
<th><strong>May be treated by any GP in the community</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Includes actinic keratoses, Bowens disease (SCC in situ)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>High Risk BCC</strong></th>
<th><strong>Refer to core member of Local MDT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk of incomplete excision and recurrence, defined as:</td>
<td>Suspected BCCs should NOT be referred by a 2 week referral.</td>
</tr>
<tr>
<td>- recurrent BCCs</td>
<td></td>
</tr>
<tr>
<td>- BCCs on the head (face and scalp)</td>
<td></td>
</tr>
<tr>
<td>- large BCCs &gt; 2cm diameter unless they are superficial BCCs that can be managed non-surgically</td>
<td></td>
</tr>
<tr>
<td>- lesions that have a clinical appearance of morphoeic, infiltrative or basosquamous</td>
<td></td>
</tr>
<tr>
<td>- lesions with poorly defined margins</td>
<td></td>
</tr>
<tr>
<td>- BCCs in patients who are immunosuppressed or have Gorlin's syndrome</td>
<td></td>
</tr>
<tr>
<td>- BCCs located over important underlying anatomical structures (for example, major vessels or nerves) or where primary surgical closure may be difficult (for example, digits or front of shin).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Low Risk BCC</strong></th>
<th><strong>Refer to either</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Defined as any non-high risk BCC</td>
<td>3. Core member of local MDT</td>
</tr>
<tr>
<td></td>
<td>Or 4. Accredited community practitioner in skin cancer surgery</td>
</tr>
<tr>
<td></td>
<td>Suspected BCCs should NOT be referred by a 2 week referral.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>BCC where there is any doubt about high or low risk status</strong></th>
<th><strong>Refer to core member of Local MDT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected BCCs should NOT be referred by a 2 week referral.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Squamous Cell Carcinoma</strong></th>
<th><strong>2 Week Referral to core member of Local MDT</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Melanoma</strong></th>
<th><strong>2 Week Referral to core member of Local MDT</strong></th>
</tr>
</thead>
</table>

It is recognised that some skin cancers will be excised accidentally by GPs where the diagnosis was not apparent. These guidelines assume that GPs will not knowingly treat patients beyond their remit.

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

08-6A-101j Network/PCT agreed primary care referral policy and distribution of the primary care referral guidelines
Referral guidelines between Local and Specialist MDTs

REFERRAL GUIDELINES BETWEEN SKIN TEAMS

<table>
<thead>
<tr>
<th>Local MDT</th>
<th>Specialist MDT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plymouth Hospital</td>
<td>Plymouth Hospital</td>
</tr>
<tr>
<td>North Devon Hospital</td>
<td>Royal Devon and Exeter Hospital</td>
</tr>
<tr>
<td>Royal Devon and Exeter Hospital</td>
<td>Royal Devon and Exeter Hospital</td>
</tr>
<tr>
<td>South Devon Hospital</td>
<td>Royal Cornwall Hospital</td>
</tr>
<tr>
<td>Royal Cornwall Hospital</td>
<td>Royal Cornwall Hospital</td>
</tr>
</tbody>
</table>

Patients requiring care level 5 and above should be referred from the Local to the Specialist MDT, including:

- Metastatic SCC
- Radiotherapy
- Other adjuvant therapy
- Mohs’ surgery
- Selected SCCs and BCCs
- Skin lymphoma
- Sarcoma
- Other rare tumours
- Patients with genetic syndromes including Gorlin’s (these patients may be reviewed regularly by the LSMDT team, with input as necessary from the SSMDT).
- Malignant melanomas stage 11b or above
- All malignant melanomas for patients under 19yrs (whose management plan need to be agreed with the principal Treatment Centre for Children’s Cancer in Bristol)
- Metastatic Malignant melanomas

See Section 5 for referral guidance for Skin Lymphomas
See Section 6 for referral for kaposi's sarcoma and other rare skin cancers

08-1A-207j Network agreed referral guidelines between teams
Extract from the South east London Cancer Network Constitution for Skin Cancer


The St John’s Institute of Dermatology, Guys’ and St Thomas’ NHS Foundation Trust will provide supra Network specialist services and the supra Network MDTs for SE London and wider populations to be determined in conjunction with the Specialist Commissioning Group. St John’s operates as a supraregional centre for skin cancers, and in the three years to 2006 received more than 600 referrals for primary cutaneous T-cell and B-cell lymphoma, of which three quarters came from outside SE London. It will continue to offer supra regional services for skin cancers referred from across the country.

**Patient Pathway**

<table>
<thead>
<tr>
<th>Joint Skin Tumour Unit Out Patients St Johns Institute, St Thomas’ Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Clinical Oncologist makes decision to offer TSEBT</td>
</tr>
<tr>
<td>Patient Consent and Information given</td>
</tr>
<tr>
<td>Patient Planning Appointment</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Patient Treatment</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Patient Follow up</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Audit and Outcome Monitoring</td>
</tr>
</tbody>
</table>

There is a photopheresis facility available at St John's Institute of Dermatology, Guy's & St Thomas Hospital.

Cutaneous tumour Stage T3 N0-1 M0 (IIB)
Complete responses with TSEBT are lower with stage T3 tumours in the region 36 – 54% 4,6,12 This is however much superior to skin directed superficial radiotherapy and topical Nitrogen Mustard which has complete response rates of 8%. 4,12 Therefore patients with stage IIB disease are offered TSEBT as first line treatment for its superior response rate and rapid palliative effect. It is combined with adjuvant treatment such as PUVA which improves the 5 year relapse free survival from 30% with TSEBT alone to 55% with TSEBT and adjuvant PUVA.

Erythroderma stage T4N0-1M0 (III)
TSEBT can produce rapid and sustained responses in erythrodermic MF ameliorating the severe cutaneous symptoms experienced by such patients. The reported complete response to TSEBT for stage III MF ranges from 60-100% 6,13 with 5 year progression free survival of 69%. The complete response rate and progression free survival is less in patients with blood or visceral involvement. These patients may benefit from adjuvant photopheresis. TSEBT is an appropriate first line therapy for these patients. We currently use it as second line therapy following treatment with PUVA, A-interferon, photopheresis or methotrexate.
# Levels of Care

<table>
<thead>
<tr>
<th>Care Level</th>
<th>Case mix or Procedures</th>
</tr>
</thead>
</table>
| 1          | • Benign lesions  
             • Actinic Keratoses  
             • Precancerous – SCC, in situ/Bowen’s |
| 2          | • Low risk BCC – defined as not high risk (see Level 3) |
| 3          | • High risk BCC other than categories below  
             • High Risk BCC - defined as  
                • recurrent BCCs  
                • BCCs on the head (face and scalp)  
                • large BCCs > 2cm diameter unless they are superficial BCCs that can be  
                  managed non-surgically  
                • lesions that have a clinical appearance of morphoeic, infiltrative or  
                  basosquamous  
                • lesions with poorly defined margins  
                • BCCs in patients who are immunosuppressed or have Gorlin’s syndrome  
                • BCCs located over important underlying anatomical structures (for  
                  example, major vessels or nerves) or where primary surgical closure may  
                  be difficult (for example, digits or front of shin).  
             • SCC other than categories below |
| 4          | • High risk BCC Recurrent or with +ve excision  
             • 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          | • 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  
             • Mohs 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. |
| 6          | • T-cell Cutaneous Lymphoma: Total Body Surface Electron Beam Therapy |

**Notes:**
- Where a network chooses to have a MMDT all cases of MM for level 5 care  
  from the MMDT’s catchment area should be referred to the MMDT.  
- There should be agreed working arrangements with certain site specialised  
  MDT’s (see topic 08-1A).
Appendix 2 - Melanoma Process Mapping - June 2009
CANCER SERVICES

APPENDIX 3

JOB DESCRIPTION

TITLE: Lead Clinician for Cancer Site-Specific Team – Skin

LIAISON WITH: Director of Cancer Services
                Lead Manager/Nurse, Cancer Services
                NSSG Site Specialist Group
                Members of the Trust Cancer Team

Job Summary

To provide clinical leadership in cancer services within a site-specific group/speciality area.

Ensure that objectives of MDT working (as laid out in Manual of Cancer Service Standards) are met:

- To ensure that designated specialists work effectively together in teams such that decisions regarding all aspects of diagnosis, treatment and care of individual patients and decisions regarding the team’s operational policies are multidisciplinary decisions.
- To ensure that care is given according to recognised guidelines (including guidelines for onward referrals) with appropriate information being collected to inform clinical decision making and to support clinical governance/audit.
- To ensure mechanisms are in place to support entry of eligible patients into clinical trials, subject to patients giving fully informed consent.

Principal Responsibilities

- To establish and maintain effective multidisciplinary teams according to the standards laid out in the Manual of Cancer Services Standards (2004).
- To encourage and participate in audit within multidisciplinary teams across the Trust and within the Peninsula Cancer Network site-specific groups.
- To advise the Trust Cancer Lead Clinician and Cancer Services Manager on issues likely to affect the strategic development of cancer services.
- To participate in the Trust Cancer Team meetings.
- Overall responsibility for ensuring that MDT meeting and team meet Peer Review Quality Measures.
- Ensure attendance levels of core members are maintained, in line with Quality Measures.
- Ensure that target of 100% of cancer patients discussed at MDT is met.
- Provide link to NSSG, either by attendance at meetings or by nominating another MDT member to attend.
- Lead on, or nominate lead for service improvement within team.
- Organise and chair annual meeting examining functioning of team and reviewing operational policies, and collate any activities that are required to ensure optimal functioning of the team (e.g. training for team members).
- Ensure MDT’s activities are audited and results documented.
- Ensure that the outcomes of the meeting are clearly recorded and clinically validated and that appropriate data collection is supported.
- Ensure target of communicating MDT outcomes to primary care is met.
- Agree structures with the Core Cancer Team by which waiting times information is collated and discussed in accordance with the requirements of the NHS Cancer Plan.
- Ensure any of the issues affecting Cancer Waiting Times are discussed and actions agreed within the MDT.

Signed ___________________________ Director of Cancer Services Date: ________________

Signed ___________________________ Lead Clinician MDT Date: ________________
APPENDIX 4 – Hard copy in supporting evidence folder

Peninsular Cancer network Pathology Network Reporting Guidelines, June 2009

PCN Skin Pathology
Reporting Guidelines:

PCN Pathology
External Referral Poli
## Patient Information Checklist

(To be filed in patient notes- Oncology/MDT section)

### Patient Details (Addressograph):
- Name: ...........................................
- Address: ...........................................
- ....................................................
- ....................................................
- DoB: .............................................
- Unit number: ....................................

### Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Yes/no</th>
<th>Name</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 hour notification to GP</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diagnosis already known</td>
<td></td>
<td></td>
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<tr>
<td>Offered a Key worker</td>
<td></td>
<td></td>
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<tr>
<td>Offered Holistic needs assessment</td>
<td></td>
<td></td>
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<tr>
<td>Offered Information prescription</td>
<td></td>
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<tr>
<td>Offered a permanent record of their consultation</td>
<td></td>
<td></td>
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<tr>
<td>Referred to AHP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred to LWBC team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Treatment

| Offered Holistic assessment                                             |        |      |      |
| Offered a permanent record of their consultation                        |        |      |      |
| Offered Information prescription                                          |        |      |      |
| Referred to LWBC team                                                    |        |      |      |
| Referred AHP                                                             |        |      |      |

### Recurrence

| 24 hour notification to GP                                              |        |      |      |
| Diagnosis already known                                                  |        |      |      |
| Offered a key worker                                                    |        |      |      |
| Offered Holistic assessment                                             |        |      |      |
| Offered Information prescription                                          |        |      |      |
| Offered a permanent record of their consultation                        |        |      |      |
| Referred to AHP                                                          |        |      |      |
| Referred to LWBC team                                                    |        |      |      |

### Survivorship

| Referred to LWBC team                                                    |        |      |      |
| Offered Information prescription                                          |        |      |      |
| Referred to Mustard Tree Cancer Support Centre                            |        |      |      |

### End of life care

| Patient has been raised with the GP to go on the End of Life Register   |        |      |      |
| Offered Planning your future care leaflet                               |        |      |      |
| Offered Community Specialist Palliative Care                            |        |      |      |
| Referred to AHP                                                          |        |      |      |
| Offered DLA/AA/DS1500                                                    |        |      |      |
Patient Information Prescription Record Sheet

☐ The Cancer Guide
☐ Help with the cost of Cancer
☐ A guide to benefits for financial help

☐ Prevention and risk factors
☐ Symptom awareness and early detection
☐ Referral tests and investigations
☐ Diagnosis and staging

Treatment
☐ Chemotherapy
☐ Radiotherapy
☐ Specific Treatments and side effects
☐ Surgery
☐ Treatments for specific conditions

☐ Follow up and cancer in remission
☐ Recurrence and advanced disease
☐ Other information from the IPS
☐ Other publications ..........................

Dispensed by: .................................

Date: ..............................................
### 24 hr Notification to GP for Diagnosis of Cancer

**GP DETAILS**

**PATIENT DETAILS**

**PLEASE PASS TO DEPUTY IN ABSENCE OF OWN GP**

Consultant (please print)  

Clinical Diagnosis /Tumour site

Date patient informed of Diagnosis

**Treatment plan** *(Please tick relevant box)*

- [ ] Radiotherapy
- [ ] Palliative treatment
- [ ] Chemotherapy:  
- [ ] Hormone therapy
- [ ] Surgery  
- [ ] Not decided

Comments (including other referrals/further investigation)

Signature………………………………………………..Date: ……………………. 