**Service - Cancer: Skin (Adult)**

| Indicator | Sub Service | Report Section | Indicator Title | Descriptor | Notes |
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| A12/S/b-16-001 | Specialist Skin Team | Structure and Process | There is a named lead clinician with responsibility for the Skin Cancer service. | There should be a single named lead clinician with agreed list of responsibilities for the skin service who should then be a core team member. | The role of lead clinician of the MDT should not of itself imply chronological seniority, superior experience or superior clinical ability. |
| A12/S/b-16-002 | Specialist Skin Team | Structure and Process | There is an MDT that meets the requirements as specified in the Skin cancer service specification. | The MDT should provide the names of core team members and their cover for named roles in the team.(1)<br><br>The core team specific to the skin cancer SMDT should include:<br>• two dermatologists;<br>• two surgeons, at least one of whom should be a consultant surgeon trained in plastic and reconstructive surgery;<br>• clinical oncologist;<br>• medical oncologist;<br>• two histopathologists who should be taking part in the national specialist dermatopathology EQA; (3)<br>• imaging specialist; (2)<br>• skin nurse specialist;<br>• MDT co-ordinator/secretary;<br>• at least one clinical core member of the team with direct clinical contact, should have completed the training necessary to enable them to practice at level 2 for the psychological support of cancer patients and carers, and should receive a minimum of 1 hours clinical supervision by a level 3 or level 4 practitioner per month;<br>• an NHS-employed member of the core or extended team should be nominated as having specific responsibility for users' issues and information for patients and carers;<br>• a member of the core team nominated as the person responsible for ensuring that recruitment into clinical trials and other well designed studies is integrated into the function of the MDT. | (1)Where a medical specialty is referred to, the core team member should be a consultant. The cover for this member need not be a consultant. Where a medical skill rather than a specialty is referred to, this may be provided by one or more of the core members or by a career grade non-consultant medical staff member. All consultants responsible for the delivery of any of the main treatment modalities should be a core member of the MDT.<br>(2) The role of the imaging specialist can be met by a group of named specialists provided each meets the required workload.<br>(3) The role of the histopathologist can be met by a group of named histopathologists provided each meets the workload and EQA requirements. |

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| A12/S/b-16-003 | Specialist Skin Team | Structure and Process | There is a weekly MDT meeting for treatment planning attended by all the relevant disciplines. | The MDT should have treatment planning meetings scheduled every week unless the meeting falls on a public holiday.<br>The attendance at each individual scheduled treatment planning meeting should constitute a quorum, for 95% or more, of the meetings. (1)<br>The quorum for the skin cancer SMDT is made up of the following core members, or their cover (2)<br>• one dermatologist;<br>• one surgeon;<br>• one clinical oncologist;<br>• one medical oncologist; (3)<br>• one histopathologist;<br>• one imaging specialist;<br>• one skin nurse specialist;<br>• one MDT co-ordinator. | (1) The % should be calculated over the last complete calendar year prior to the assessment.<br>(2) The members counting towards the quorum should be drawn from the list of named core members or their named cover as specified in the core membership measures and are therefore subject to the definition of acceptable core members or their cover.<br>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion.<br>(3) For a SSMDT sharing its catchment population with that of a MMDT: The level 5 care for malignant melanoma should be referred to the MMDT and the SSMDT need not have a medical oncologist as a quorum member.<br>All core members should have a job plan that includes weekly attendance at the MDT meeting as part of their schedule of activities.<br>This measure does not imply any policy for what to do when an MDT meeting is not quorate. This is left to the MDT members' discretion. |
| A12/S/b-16-004 | Specialist Skin Team | Structure and Process | There are clinical guidelines in place which, where available, reflect national guidelines | There should be agreed clinical guidelines (i.e. how a given patient should be clinically managed, usually at the level of which modalities of imaging and pathology investigation and which modalities of treatment are indicated, rather than detailed regimens or techniques).<br>The guidelines should include:<br>• the pathology requesting and reporting protocol with failsafe mechanisms, applicable to community and hospital practice.<br>• that there should be a named histopathologist for the network, to whom all new presumed cases of cutaneous lymphoma, should be referred for a second histology opinion; (1)<br>• that cases referred to an SSMDT (or MMDT if relevant) from another MDT should be subject to a review of their histology by a core histopathologist member of the SSMDT.<br><br>There should be an agreed list of acceptable chemotherapy treatment algorithms, that is updated bi-annually. | Clinical guidelines should reflect national guidelines<br><br>(1) This pathologist would normally be a core histopathology member of the<br>single SSMDT dealing with cutaneous lymphoma, for a networking area.<br><br>Where there are nationally agreed requirements for clinical guidelines it is recommended that these are adopted. |

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| A12/S/b-16-005 | Specialist Skin Team | Structure and Process | There are agreed patient pathways in place for Skin Cancer. | The pathways should encompass primary, secondary and tertiary care and include the relevant contact points for the hospitals<br>and MDTs (1,2) and cover the following:<br>• that LSMDTs should refer cases of the types of skin cancer needing care level 5, to a named SSMDT for discussion and management, stating which named LSMDTs will refer to which named SSMDTs. If there is more than one SSMDT in the network or sub-region, the single named SSMDT to which each of the following types of case should be referred: (3,4)<br>o cutaneous lymphoma;<br>o kaposi's sarcoma;<br>o cutaneous sarcoma above superficial fascia;<br>o other rare skin cancers.<br>• besides the specific case mix and procedures which make up each level, the network group should agree any other parameters which should determine whether a case should be referred for the opinion of:<br>o a surgical core member of the SSMDT and for associated MDT review;<br>o an oncological core member of the SSMDT and for associated MDT review.<br><br>Any supra-network pathways should include the relevant contact points for the hospitals and MDTs and cover the following:<br>• that cases of nodular mycosis fungoides (stage 2B or over) should be referred for discussion and consideration of TSEB to a named supranetworkT-cell lymphoma MDT;<br>• that cases of erythrodermic cutaneous T-cell lymphoma, stages 3 and 4, having both skin involvement and circulating T-cell clonal cells, should be discussed with the clinician in charge of a named photopheresis facility for potential referral and treatment by photopheresis. | (1) This should include, where relevant, any services, hospitals or MDTs outside those associated with the network group.<br>(2) Rehabilitation pathways should include reference to the NCAT rehabilitation pathways.<br>(3) Where there is a MMDT the guidelines should state which LSMDTs and SSMDTs should refer level 5 cases to the MMDT.<br>(4) LSMDTs may make referrals to SSMDTs in another network and SSMDTs may receive referrals from a LSMDT in another network. These inter-network arrangements should be agreed and stated, naming teams and their host hospitals. The responsibility for these inter-regional arrangements lies for review purposes, with the referring CCG and the referring MDT.<br><br>Regarding referral of specified skin cancer types to a single SSMDT, although each type in the list should be referred to a single SSMDT, they do not all need to be referred to the same SSMDT. |
| A12/S/b-16-006 | Specialist Skin Team | Structure and Process | Participation in activities on preventing skin cancer and recognising its early signs consistent with the messages included in national campaigns. | The Skin SMDT participates in activities on preventing skin cancer and recognising its early signs consistent with the messages included in national campaigns. | This may be in collaboration with local authorities, primary care and/or local CCG's to support them in meeting the NICE Quality Standards for Skin cancer Statement 1: Local authorities and clinical commissioning groups commission local health promotion activities on preventing skin cancer and recognising its early signs consistent with the messages included in national campaigns. |