

# Skin cancer

Quality standard

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[www.nice.org.uk/guidance/qs130](https://www.nice.org.uk/guidance/qs130)

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This standard is based on NG34, NG14, NG12, CSG8 and NG102.

This standard should be read in conjunction with QS124, QS55, QS15 and QS13.

## Quality statements

Statement 1 Integrated care boards work with local partners to implement strategies to raise awareness of skin cancer and the risks of over-exposure to sunlight and exposure to artificial UV light, particularly for people in at-risk groups. **[new 2024]**

Statement 2 People with suspected melanoma, squamous cell carcinoma or a rare skin cancer are referred for an assessment using a suspected cancer pathway to have a diagnosis confirmed or ruled out within 28 days of referral. **[2016, updated 2024]**

Statement 3 People with suspected melanoma undergoing a specialist assessment have the lesion examined using dermoscopy. **[2016, updated 2024]**

Statement 4 People with melanoma, high-risk squamous cell carcinoma or a rare skin cancer have access to a skin cancer clinical nurse specialist. **[2016, updated 2024]**

Statement 5 People with stage IIB to IV primary melanoma have BRAF analysis of the tumour. **[2016, updated 2024]**

Statement 6 People with stage IIC to IV melanoma have a staging scan. **[new 2024]**

In 2024 this quality standard was updated and statements prioritised in 2016 were updated (2016, updated 2024) or replaced (new 2024). For more information, see [update information](#).

The [previous version of the quality standard for skin cancer](#) is available as a pdf.

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# Quality statement 1: Local health promotion activities

## Quality statement

Integrated care boards work with local partners to implement strategies to raise awareness of skin cancer and the risks of over-exposure to sunlight and exposure to artificial UV light, particularly for people in at-risk groups. **[new 2024]**

## Rationale

Skin cancer is the most common form of cancer and, even though most types are preventable, its incidence is increasing. People can recognise changes to their skin in early stages of the disease, but some are still seeking help too late. Integrated care boards should adopt a consistent multiagency approach to implement strategies to ensure consistent, relevant messages on the risks of over-exposure to sunlight and exposure to artificial UV light. This will increase the likelihood of behaviour change, particularly for people in at-risk groups. They should work with partners such as local authorities, members of their cancer alliance or equivalent local partnership, local skin cancer multidisciplinary teams and community pharmacies.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Structure

a) Evidence that integrated care boards use joint strategic needs assessments to determine local needs related to skin cancer awareness.

**Data source:** Data can be collected from information recorded locally by integrated care boards, for example from a joint strategic needs assessment.

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b) Evidence that integrated care boards have an action plan that identifies key strategies to raise awareness of skin cancer and the risks of over-exposure to sunlight and exposure to artificial UV light, particularly for people in at-risk groups.

**Data source:** Data can be collected from information recorded locally by integrated care boards, for example from an action plan.

c) Evidence of local campaigns to raise awareness of skin cancer and the risks of over-exposure to sunlight and exposure to artificial UV light, particularly for people in at-risk groups.

**Data source:** Data can be collected by information recorded locally by integrated care boards and partners, for example from campaign materials such as posters, leaflets, skin-type charts, texts and social media messaging.

## Outcome

a) Proportion of melanoma diagnosed at stage 1 or 2.

Numerator – the number in the denominator diagnosed at stage 1 or 2.

Denominator – the number of melanomas diagnosed.

**Data source:** [NHS Digital's Cancer registration statistics England](#), reports annual counts, age-specific and directly age-standardised rates of cancer incidence by ICD-10 codes including melanoma of the skin and stage at diagnosis.

b) Proportion of non-melanoma skin cancer diagnosed at stage 1 or 2.

Numerator – the number in the denominator diagnosed at stage 1 or 2.

Denominator – the number of non-melanoma skin cancers diagnosed.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

## What the quality statement means for different

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## audiences

**Service providers** (such as local authorities) ensure that they work with integrated care boards to address local needs for improving skin cancer awareness, particularly for people in at-risk groups identified by a joint strategic needs assessment. They should ensure training provided to public health practitioners and health care professionals covers the risks of over-exposure to sunlight and exposure to artificial UV light and the importance of conveying consistent, tailored messages.

**Public health practitioners and healthcare professionals** (such as members of the local cancer alliance or equivalent local partnership, local skin cancer multidisciplinary team and community pharmacists) support local health promotion activities that focus on raising awareness of skin cancer and the risks of over-exposure to sunlight and exposure to artificial UV light, particularly for people in at-risk groups. They deliver consistent, tailored messages.

**Commissioners** ensure that they have a joint strategic needs assessment that includes skin cancer awareness and the risks of over-exposure to sunlight and exposure to artificial UV light, particularly for people in at-risk groups. They work with partners such as local authorities and cancer alliances or equivalent local partnerships to address local needs. They identify local opportunities to raise awareness of the risks of over-exposure to sunlight and exposure to artificial UV light, such as identifying health, social care and other practitioners in contact with people in at-risk groups, including in specific settings such as schools, workplaces, communal and leisure environments.

**People who should take extra care to avoid skin damage and skin cancer and those identified as at increased risk of skin cancer**, are given advice about how to prevent skin cancer and how to recognise early signs, through health promotion activities from local services.

## Source guidance

- [Melanoma. NICE clinical knowledge summary \(2022\), risk factors](#)
- [Community pharmacies: promoting health and wellbeing. NICE guideline NG102 \(2018\), recommendation 1.2.8](#)
- [Sunlight exposure: risks and benefits. NICE guideline NG34 \(2016\), recommendations](#)

## Definitions of terms used in this quality statement

### Raise awareness of skin cancer and the risks of over-exposure to sunlight and exposure to artificial UV light

Communication of consistent, balanced messages about sunlight exposure, including risks from excessive exposure. This should include:

- environmental, biological and behavioural factors
- how to minimise the risks and maximise the benefits of sunlight exposure
- the strength of sunlight at different times of day, and different times of the year
- advice for at-risk groups, including children and young people, and according to people's skin type, including people with brown or black skin
- approaches to protecting skin
- information on how to apply suncream
- checking for possible signs of skin cancer
- clarifying common misconceptions about sunlight exposure and artificial UV light.

[Adapted from [NICE's guideline on sunlight exposure](#), recommendations 1.1.2, 1.1.3 and supporting information for practitioners, and expert opinion]

### At-risk groups

- Groups of people who should take extra care to avoid skin damage and skin cancer, including:
  - children (particularly babies) and young people
  - people who tend to burn rather than tan
  - people with white skin, fair or red hair, blue or green eyes, or who have lots of



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freckles

- people with many moles
  - people with medical conditions associated with an increased risk of developing skin cancers
  - people who are immunosuppressed (that is, they have less resistance to skin problems as a result of a disease or use of particular drugs)
  - people with a personal or family history of skin cancer (even if their natural skin colour is darker than that of the family member who had cancer).
- Groups who spend a lot of time in the sun and so are at increased risk of skin cancer, such as:
    - outdoor workers
    - those with outdoor hobbies, for example, sailing or golf.
  - Groups with high, but intermittent, exposure to sunlight and who are therefore at increased risk of skin cancer. This includes people who sunbathe or take holidays in sunny countries.
  - People frequently exposed to artificial UV light, including from a sunbed, before the age of 25.

[[NICE's guideline on sunlight exposure](#), recommendation 1.1.1, [NHS website](#), Are sunbeds safe? accessed 30 June 2023, [NICE's clinical knowledge summary on melanoma](#), risk factors, and expert opinion]

## Equality and diversity considerations

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed.

For people with additional needs related to a disability, impairment or sensory loss,

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information should be provided as set out in NHS England's Accessible Information Standard or the equivalent standards for the devolved nations.

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# Quality statement 2: Suspected cancer pathway referrals

## Quality statement

People with suspected melanoma, squamous cell carcinoma or a rare skin cancer are referred for an assessment using a suspected cancer pathway to have a diagnosis confirmed or ruled out within 28 days of referral. **[2016, updated 2024]**

## Rationale

Timely referral to a specialist for assessment is important for a quick and accurate diagnosis of skin cancer. This may be referral for a face-to-face appointment or a virtual referral for assessment of images of the skin lesion. The specialist will usually be working as part of the local hospital skin cancer multidisciplinary team and can provide rapid diagnosis, treatment, management and follow-up for most people with skin cancer.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of confirmed melanomas, squamous cell carcinomas and rare skin cancers that were referred for an assessment using a suspected cancer pathway.

Numerator – the number in the denominator that were referred for an assessment using a suspected cancer pathway.

Denominator – the number of confirmed melanomas, squamous cell carcinomas and rare skin cancers.

**Data source:** Data can be collected from information recorded locally by healthcare

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professionals and provider organisations, for example from patient records.

## Outcome

a) Proportion of melanoma, squamous cell carcinoma and rare skin cancers in which the person had a diagnosis of cancer confirmed or ruled out within 28 days of referral.

Numerator – the number in the denominator in which the person had a diagnosis of cancer confirmed or ruled out within 28 days of referral.

Denominator – the number of suspected melanomas, squamous cell carcinomas and rare skin cancers.

**Data source:** [NHS England's Cancer waiting times](#) reports waiting times for people with suspected cancer including the 28-day faster diagnosis standard for suspected skin cancer. Details of coding and data collection are available in [NHS England's National Cancer Waiting Times monitoring dataset guidance \(v12.0\)](#).

b) Proportion of melanoma, squamous cell carcinoma and rare skin cancers that were first treated within 31 days of the decision to treat.

Numerator – the number in the denominator that were first treated within 31 days of the decision to treat.

Denominator – the number of melanomas, squamous cell carcinomas and rare skin cancers.

**Data source:** [NHS England's Cancer waiting times](#) reports waiting times for people with suspected cancer including the 31-day wait from decision to treat to treatment of cancer. Details of coding and data collection are available in [NHS England's National Cancer Waiting Times monitoring dataset guidance \(v12.0\)](#).

c) Proportion of melanoma, squamous cell carcinoma and rare skin cancers that were first treated within 62 days of referral.

Numerator – the number in the denominator that were first treated within 62 days of referral.

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Denominator – the number of melanomas, squamous cell carcinomas and rare skin cancers.

**Data source:** [NHS England's Cancer waiting times](#) reports waiting times for people with suspected cancer including the 62-day wait from referral to first treatment of cancer. Details of coding and data collection are available in [NHS England's National Cancer Waiting Times monitoring dataset guidance \(v12.0\)](#).

## What the quality statement means for different audiences

**Service providers** (such as GP practices, community hubs and secondary care services) ensure that systems are in place for people presenting with suspected melanoma, squamous cell carcinoma or a rare skin cancer to be referred for an assessment using a suspected cancer pathway to have a diagnosis confirmed or ruled out within 28 days of referral. In accordance with [NHS England's Faster diagnostic pathways: implementing a timed skin cancer diagnostic pathway, guidance for local health and care systems; 28-day best practice timed pathway](#), referrals should include a locally agreed minimum dataset, and macroscopic and dermatoscopic images to an agreed standard and format if a virtual referral is used. Services should have the necessary equipment and digital tools to take and transfer high-quality images of the skin lesion if a virtual referral is used (see [NHS England's A teledermatology roadmap: implementing safe and effective teledermatology triage pathways and processes](#)).

**Healthcare professionals** (such as GPs) ensure that they refer people with suspected melanoma, squamous cell carcinoma or a rare skin cancer for an assessment using a suspected cancer pathway to have a diagnosis confirmed or ruled out within 28 days of referral.

**Commissioners** ensure that services they commission refer people with suspected melanoma, squamous cell carcinoma or a rare skin cancer for an assessment using a suspected cancer pathway to have a diagnosis confirmed or ruled out within 28 days of referral. If virtual referral services are used locally, commissioners should ensure that services have the necessary equipment and digital tools.

**People who have skin lesions, such as damaged or injured patches of skin or new, changing or unusual looking moles and whose GP thinks it is a type of cancer called**

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melanoma, squamous cell carcinoma or a rare skin cancer are referred for an urgent assessment of their lesion by a specialist.

## Source guidance

- [Suspected cancer: recognition and referral. NICE guideline NG12 \(2015, updated 2023\)](#), recommendations 1.7.1, 1.7.2 and 1.7.4
- [Improving outcomes for people with skin tumours including melanoma. NICE guideline CSG8 \(2006, updated 2010\)](#), box 1, page 78

## Definitions of terms used in this quality statement

### Rare skin cancer

Including epidermal and appendage tumours and dermal and subcutaneous tumours. [[NICE's guideline on improving outcomes for people with skin tumours including melanoma](#), appendix 1]

### Suspected cancer pathway referral

People with suspected melanoma, squamous cell carcinoma or a rare skin cancer receive a diagnosis or ruling out of cancer within 28 days of being referred urgently by their GP. For further details, see [NHS England's webpage on faster diagnosis of cancer](#). [[NICE's guideline on suspected cancer](#), terms used in this guideline]

### Assessment

Face-to-face clinical assessment or a virtual (teledermatology) referral by the local skin cancer team working within the multidisciplinary team. Face-to-face clinical assessment could take place in a standard skin cancer diagnosis clinic, one-stop skin cancer clinic, or community- or hospital-based 'Spot' clinic. An assessment following virtual (teledermatology) referral uses high-quality images including dermatoscopic images by a clinician experienced in teledermatology and teledermoscopy and supported by a systematic quality assurance process. [[NHS England's Faster diagnostic pathways: implementing a timed skin cancer diagnostic pathway, guidance for local health and care systems; 28-day best practice timed pathway](#)]

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# Quality statement 3: Dermoscopy

## Quality statement

People with suspected melanoma undergoing a specialist assessment have the lesion examined using dermoscopy. [2016, updated 2024]

## Rationale

Dermoscopy done by suitably trained specialists may more accurately distinguish between benign and malignant skin lesions than clinical examination with the naked eye. It lessens the chance of missing a diagnosis of melanoma and reduces the number of unnecessary surgical procedures to remove benign lesions.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of people with suspected melanoma undergoing a specialist assessment who have the lesion examined using dermoscopy.

Numerator – the number in the denominator who have the lesion examined using dermoscopy.

Denominator – the number of people with suspected melanoma undergoing a specialist assessment.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

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## Outcome

a) Proportion of suspected melanomas not selected for biopsy that are subsequently confirmed as melanoma.

Numerator – the number in the denominator subsequently confirmed as melanoma.

Denominator – the number of suspected melanomas not selected for biopsy.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records.

b) Proportion of melanomas diagnosed at stage 1 or 2.

Numerator – the number in the denominator diagnosed at stage 1 or 2.

Denominator – the number of melanomas diagnosed.

**Data source:** [NHS Digital's Cancer registration statistics, England](#) reports annual counts, age-specific and directly age-standardised rates of cancer incidence by ICD-10 codes including melanoma of the skin and stage at diagnosis.

## What the quality statement means for different audiences

**Service providers** (such as local hospital multidisciplinary teams and specialist multidisciplinary teams) ensure that systems are in place for using dermoscopy during a specialist assessment of suspected melanoma. Service providers should also ensure that those using dermoscopy have formal training.

**Healthcare professionals** (such as members of local hospital skin cancer multidisciplinary teams) undertaking a specialist assessment of suspected melanoma ensure that they examine the lesion using dermoscopy. They should include formal training as part of their continuing professional development.

**Commissioners** ensure that the specialist services they commission have trained specialists who use dermoscopy to examine lesions that suggest melanoma.



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People with a skin lesion that suggests skin cancer (such as damaged or injured patches of skin or new, changing or unusual looking moles) that is being assessed by a specialist have the lesion examined using a magnifying tool called a dermatoscope, which gives a more accurate view.

## Source guidance

- [Suspected cancer: recognition and referral. NICE guideline NG12](#) (2015, updated 2023), recommendations 1.7.1 to 1.7.3
- [Melanoma: assessment and management. NICE guideline NG14](#) (2015, updated 2022), recommendation 1.3.1
- [Improving outcomes for people with skin tumours including melanoma. NICE guideline CSG8](#) (2006, updated 2010), page 84

## Definitions of terms used in this quality statement

### Specialist assessment

An assessment carried out by a clinician trained in the diagnosis of skin malignancy who is a member of either a local hospital skin cancer multidisciplinary team or a specialist skin cancer multidisciplinary team. [Adapted from [NICE's guideline on improving outcomes for people with skin tumours including melanoma](#), key recommendations (page 8), and expert opinion]

### Dermoscopy

Skin scoping or observing the skin directly using a special hand-held microscope, called a dermatoscope, usually performed on a mole or suspicious lesion on living skin. Dermatoscopes can be adapted to allow a camera or smartphone to take static images of a skin lesion to assist in referral, assessment and triage of suspected skin cancer (teledermoscopy). [Adapted from [NICE's guideline on improving outcomes for people with skin tumours including melanoma](#), glossary of terms; dermatoscope and dermatoscopy, and expert opinion]

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# Quality statement 4: Skin cancer clinical nurse specialist

## Quality statement

People with melanoma, high-risk squamous cell carcinoma or a rare skin cancer have access to a skin cancer clinical nurse specialist. [2016, updated 2024]

## Rationale

Skin cancer clinical nurse specialists can provide specialist guidance and support at all stages of care and treatment, including follow-up. They can act as a source of information (including about local support groups) and provide psychological support.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Process

Proportion of people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer who have access to a skin cancer clinical nurse specialist.

Numerator – the number in the denominator who have access to a skin cancer clinical nurse specialist.

Denominator – the number of people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer.

**Data source:** The [National Cancer Patient Experience Survey](#) reports the proportion of respondents with melanoma who had a specialist nurse as a main contact person within the team looking after them who would support them through treatment (Q17). Data for people with high-risk squamous cell carcinoma or a rare skin cancer can be collected from

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information recorded locally by provider organisations, for example from patient records.

## Outcome

a) Quality of life among people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer.

**Data source:** The [Cancer Quality of Life survey](#) reports quality of life reported by people with melanoma, including functional categories for quality of life (EORTC QLQ-C30), overall health (EQ-5D) and summary scores. Data for people with high-risk squamous cell carcinoma or a rare skin cancer can be collected from information recorded locally by provider organisations, for example from patient surveys.

b) Satisfaction with support received from skin cancer clinical nurse specialist, reported by people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer.

Numerator – the number in the denominator who were satisfied with the support received.

Denominator – the number of people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer supported by a skin cancer clinical nurse specialist.

**Data source:** Data can be collected from information recorded locally by provider organisations, for example from patient satisfaction surveys. [The National Cancer Patient Experience Survey](#) includes a number of questions and responses on satisfaction with cancer services by people with melanoma.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services or tertiary care services) ensure that local and specialist skin cancer multidisciplinary teams have a skin cancer clinical nurse specialist to support people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer under their care.

**Skin cancer clinical nurse specialists** ensure that people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer have access to support at diagnosis and all stages of treatment, particularly at points of transition and follow-up. They provide advice

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and information about problems or concerns relating to their cancer and signpost to other relevant services, such as local support groups. They may also provide surveillance following treatment for melanoma, high-risk squamous cell carcinoma or a rare skin cancer.

**Commissioners** ensure that there are enough skin cancer clinical nurse specialists to support all people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer.

**People with a type of skin cancer called melanoma, high-risk squamous cell carcinoma or a rare skin cancer** have access to a skin cancer clinical nurse specialist who can provide information, advice and support.

## Source guidance

- [Melanoma: assessment and management. NICE guideline NG14 \(2015, updated 2022\), recommendations 1.1.4 and 1.9.2](#)
- [Improving outcomes for people with skin tumours including melanoma. NICE guideline CSG8 \(2006, updated 2010\), section 3 on organisation of skin cancer services](#)

## Definitions of terms used in this quality statement

### Rare skin cancer

Including epidermal and appendage tumours and dermal and subcutaneous tumours. [[NICE's guideline on improving outcomes for people with skin tumours including melanoma](#), appendix 1]

### Access to a skin cancer clinical nurse specialist

People with melanoma, high-risk squamous cell carcinoma or a rare skin cancer should be able to access support from a skin cancer clinical nurse specialist. Roles include dermatology, surgery and oncology skin cancer clinical nurse specialists and may encompass nurse consultants and advanced clinical practitioners. Skin cancer clinical nurse specialists provide information and patient advocacy to people with melanoma, high-risk squamous cell carcinoma or a rare skin cancer from the time of diagnosis to treatment periods, points of transition and during follow-up. They provide practical

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support, such as during the postoperative period, psychosocial support and advise on appropriate referral. They may perform risk factor assessment, holistic needs assessment and personalised care and support planning. They may also carry out skin cancer surveillance and follow-up clinics in parallel with an appropriately trained doctor. [Adapted from [NICE's guideline on improving outcomes for people with skin tumours including melanoma](#), section 3; core membership of the local multidisciplinary team (LSMDT), page 53, the [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](#), data fields for clinical nurse specialist and risk factor assessment, clinical nurse specialist – holistic needs assessment and clinical nurse specialist – personalised care and support planning, and expert opinion]

## Equality and diversity considerations

People should be provided with information that they can easily read and understand themselves, or with support, so they can communicate effectively with health and social care services. Information should be in a format that suits their needs and preferences. It should be accessible to people who do not speak or read English, and it should be culturally appropriate and age appropriate. People should have access to an interpreter or advocate if needed. If a need for advocacy is identified, healthcare professionals should allow enough time for the advocate to help the person to prepare before any appointments or discussion and to ensure that they understand the outcome afterwards. People should be supported to use an advocate by healthcare professionals involved in their care, including a skin cancer clinical nurse specialist [Adapted from [NICE's guideline on advocacy services for adults with health and social care needs](#), section 1.5].

For people with additional needs related to a disability, impairment or sensory loss, information should be provided as set out in [NHS England's Accessible Information Standard](#) or the equivalent standards for the devolved nations.

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# Quality statement 5: Genetic testing

## Quality statement

People with stage IIB to IV primary melanoma have BRAF analysis of the tumour. [2016, updated 2024]

## Rationale

BRAF analysis should be carried out on melanoma tissue samples from people with stage IIB to IV primary melanoma. Early determination of BRAF status helps to optimise the use of targeted treatments and may speed up decisions about treatment for relapsed melanoma.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### Process

Proportion of people with stage IIB to IV primary melanoma who have BRAF analysis of the tumour.

Numerator – the number in the denominator who have BRAF analysis of the tumour.

Denominator – the number of people with stage IIB to IV primary melanoma.

**Data source:** Data on performance of immunohistochemistry tests can be collected from information recorded locally by provider organisations, for example from patient records. National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core records the gene or stratification biomarker analysed (including BRAF), date reported and reporting laboratory as part of the section on somatic testing for targeted therapy and personalised medicine.

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# What the quality statement means for different audiences

**Service providers** (such as secondary care services, tertiary care services and laboratory services) ensure that systems are in place to provide BRAF analysis of the tumour for people with stage IIB to IV primary melanoma.

**Healthcare professionals** (such as histopathologists, oncologists or members of a local or specialist skin cancer multidisciplinary team) arrange BRAF analysis of the tumour for people with stage IIB to IV primary melanoma and state the preferred tissue block for analysis.

**Commissioners** ensure that they commission services that provide BRAF analysis of the tumour to people with stage IIB to IV primary melanoma.

**People with a type of skin cancer called primary melanoma (at stages IIB to IV)** have genetic testing of their tumour to help find out whether a type of drug treatment called targeted therapy might be suitable for them. It can also help to speed up treatment decisions if the cancer comes back.

## Source guidance

Melanoma: assessment and management. NICE guideline NG14 (2015, updated 2022), recommendation 1.3.10

## Definitions of terms used in this quality statement

### BRAF analysis

Analysis of the BRAF gene in melanoma tissue samples from people with stage IIB to IV primary melanoma. Local or specialist skin cancer multidisciplinary teams should specify the preferred tissue block for analysis. Consider immunohistochemistry as the first test for BRAF V600E, if available. [NICE's guideline on melanoma, recommendations 1.3.10 to 1.3.12 and evidence review A: genetic testing for melanoma]

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# Quality statement 6: Imaging

## Quality statement

People with stage IIC to IV melanoma have a staging scan. **[new 2024]**

## Rationale

Accurate staging, including the use of imaging, can help in determining clinical follow-up, informing choice of therapy and early detection of metastases. Whole-body contrast enhanced (CE)-CT or MRI and brain CE-CT or MRI should be considered as part of follow-up surveillance for people who have had stage IIC to IV melanoma and so the choice of imaging for staging should be consistent with this.

## Quality measures

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## Process

a) Proportion of adults 25 and over with stage IIC to IV melanoma who have staging with whole-body CE-CT and brain CE-CT or MRI.

Numerator – the number in the denominator who have staging with whole-body CE-CT and brain CE-CT or MRI.

Denominator – the number of adults 25 and over with stage IIC to IV melanoma.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](#) records cancer imaging modality, anatomical site and date of procedure as part of the section on imaging.



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b) Proportion of under 25s, pregnant women and pregnant people with stage IIC to IV melanoma, who have staging with whole-body and brain MRI.

Numerator – the number in the denominator who have staging with whole-body and brain MRI.

Denominator – the number of under 25s, pregnant women and pregnant people with stage IIC to IV melanoma.

**Data source:** Data can be collected from information recorded locally by healthcare professionals and provider organisations, for example from patient records. The [National Cancer Registration and Analysis Service Cancer Outcomes and Services Dataset – Core](#) records cancer imaging modality, anatomical site and date of procedure as part of the section on imaging.

## What the quality statement means for different audiences

**Service providers** (such as secondary care services or tertiary care services) ensure that systems are in place for people with stage IIC to IV melanoma to have staging confirmed by whole-body and brain CE-CT or MRI as appropriate for the stage of their cancer, their age and whether they are pregnant.

**Healthcare professionals** (such as dermatologists, clinical or medical oncologists, surgeons and radiologists) use suitable imaging techniques for confirmation of staging in people with stage IIC to IV melanoma. Adults 25 and over with stage IIC to IV melanoma should have whole-body and brain CE-CT and under 25s, pregnant women and pregnant people with stage IIC to IV melanoma, should have whole-body and brain MRI. Brain MRI can be considered for adults 25 and over who are not pregnant if locally available and after discussion and agreement with the specialist skin cancer multidisciplinary team.

**Commissioners** ensure that they commission services in which people with stage IIC to IV melanoma have staging confirmed by whole-body and brain CE-CT or MRI as appropriate for the stage of their cancer, their age and whether they are pregnant.

**People with a type of skin cancer called melanoma (at stages IIC to IV)** have a scan that can show how advanced their cancer is. This can help them to choose the right care for

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them and can help with follow-up after the cancer has been treated.

## Source guidance

Melanoma: assessment and management. NICE guideline NG14 (2015, updated 2022), recommendations 1.4.7 to 1.4.9

## Definitions of terms used in this quality statement

### Staging scan

Adults 25 and over with stage IIC to IV melanoma should have a whole-body and brain CE-CT. Brain MRI can be considered for adults 25 and over who are not pregnant after discussion and agreement with the specialist skin cancer multidisciplinary team. Under 25s, pregnant women and pregnant people with stage IIC to IV melanoma, should have whole-body and brain MRI. This is consistent with the imaging included in the protocol for follow-up after stages I to IV melanoma in the section on planning routine follow-up in NICE's guideline on melanoma. [[NICE's guideline on melanoma](#), recommendations 1.4.7 to 1.4.9]

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# Update information

**January 2024:** This quality standard was updated and statements prioritised in 2016 were replaced. The topic was identified for update following the annual review of quality standards. The review identified:

- changes in the priority areas for improvement
- updated guidance on melanoma.

Statements are marked as:

- **[new 2024]** if the statement covers a new area for quality improvement
- **[2016, updated 2024]** if the statement covers an area for quality improvement included in the 2016 quality standard and has been updated.

The [previous version of the quality standard for skin cancer](#) is available as a pdf.

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# About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Resource impact

NICE quality standards should be achievable by local services. The potential resource impact is considered by the quality standards advisory committee, drawing on resource impact work for the source guidance. Organisations are encouraged to use the resource

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impact products for the source guidance to help estimate local costs:

- [resource impact statement for NICE's guideline on suspected cancer](#)
- [resource impact summary report for NICE's guideline on melanoma](#).

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the quality statements are highlighted in each statement.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

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## Endorsing organisation

This quality standard has been endorsed by NHS England, as required by the Health and Social Care Act (2012)