

# Early diagnosis of skin cancer: innovating the two-week wait skin cancer referral pathway as part of the NHS post COVID-19 targeted intervention recovery plan

## Document Control

### Amendments

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08.02.2021	Julia Schofield	1	Document created
09.02.2021	Julia Schofield	2	Further document development
10.02.2021	Vanessa Vale	3	Amendments as per Emma Leroux comments
11.03.2021	Vanessa Vale	4	Amendments made as per Sabrina Kamayah comments / additional information added
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19.03.2021	Benjamin Smith	10	Final review before sending to Kate Branchett
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### Reviewers

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Tanya Bleiker and Carolyn Charman	BAD and NHS-X	President of BAD and Clinical Lead for NHS-X A&G	14.04.2021
Advisory Group Stakeholders	Regional	N/A	13.05.2021

# Early diagnosis of skin cancer: innovating the two-week wait skin cancer referral pathway as part of the NHS post COVID-19 targeted intervention recovery plan<sup>1</sup>

## 1. Summary

This document offers innovative solutions to the challenge posed by increasing skin cancer referral workload. Two models are principally proposed:

1. The harnessing of new technology, in particular tele-dermatology, digital referral platforms and the use of remote consultations to reduce the need for unnecessary hospital attendances.
2. 'Spot clinics', a successfully piloted cost-effective intervention, offering a quick way for consultant led dermatology teams to review large numbers of suspected skin cancer two week wait referrals in a community or specialist setting.

In the context of the COVID-19 pandemic, and the need to meet potential demand from those who have not come forward during 2020, the urgent need to adopt new approaches has never been greater. Cancer Alliances, working through their Rapid Diagnostic Centre programme, should consider how they can apply these models to their own services.

## 2. Introduction

The purpose of this paper is to describe new and innovative approaches to the skin cancer two week wait referral pathway in the context of the following:

- The post COVID-19 recovery model which includes targeted interventions for specific cancer sites where the pandemic has impacted the diagnosis of certain cancers.
- An 18% shortfall in melanoma first treatments in the period March to December 2020, compared with March to December 2019, reflecting a possible cohort of 2400 patients with melanoma not yet seen. There is an ongoing need to continue to see a large number of people with suspected skin cancer, to identify early melanomas and squamous cell carcinomas.
- The development of Cancer Rapid Diagnostic Centre pathways and how the skin cancer two week wait pathway will meet the new 28 Day Faster Diagnosis Standard, to be rolled out in 2021/22.
- The need to continue to follow the requirements of the NHS constitution relating to two week wait referrals whilst they are in place.
- The need to respond to the challenge of the reduction in Primary Care face to face activity due to the Remote Total Triage Model introduced in Primary Care in response to the COVID-19 pandemic<sup>2</sup> as well as a commitment to reduce face to face specialist hospital attendances by 30% (NHS Plan).
- The Getting It Right First Time (GiRFT) report, which identified a shortage of dermatologists and increasing skin cancer workload that would require new ways of working.
- The current requirements of the NHS Constitution.

This proposal describes how new two week wait skin cancer referral pathway models might look based on the following key principles/requirements:

- [NICE guideline \(NG12\)](#) relating to the recognition and referral of skin cancer, and the criteria it lays out, remains the key document facilitating referral of the most appropriate patients using the two week referral pathway.
- Locally agreed solutions based on available resources; one size does not fit all.
- Shared learning from successful pilot sites that have successfully tested different models of virtual two-week wait services.
- The support of the Cancer Rapid Diagnostic Centres (RDCs) with implementation.
- The need to identify local Primary and Secondary Care dermatology champions across cancer alliances to support successful implementation of new models.
- Two-week wait referral services are consultant led dermatology services, so engagement with the dermatology specialist community will be pivotal to ensure successful implementation; in principal support for these proposals has been provided by the British Association of Dermatology.
- Engagement with NHS-X to ensure that systems and processes are aligned with the digital agenda; we have in principle support for this model and the models align with the funding allocations to regions for tele-dermatology in January 2021.
- Systems and processes in place to enable all relevant data capture and to evaluate outcomes.

### 3. Background

Skin cancer is the most common cancer in the UK and dermatology services receive more urgent referrals for suspected cancer than any other specialty. Approximately 50% of the one million dermatology referrals are suspected skin cancer two week wait referrals<sup>3</sup>. The number of patients diagnosed with melanoma and squamous cell carcinoma is approximately 6%<sup>3</sup> of all two-week wait skin referrals. It is recognised that a significant proportion of patients are seen with non-relevant skin lesions. Prior to the COVID-19 pandemic, the requirement was that all patients have face-to-face appointments in specialist dermatology departments.

The ageing population is expected to put further pressure on the specialty, as skin cancer occurs much more frequently in the elderly and can be more difficult to treat in the presence of age-associated co-morbidities.

The Primary Care Remote Total Triage Model has meant that, since the COVID-19 pandemic, many people with skin lesions and other problems have been assessed remotely. Additionally, incidental findings of suspicious skin lesions when examining patients for other problems e.g. during a chest or back examination are not being identified. Moving forwards attention will need to be directed to raising awareness in Primary Care of the need to return to, or even increase, pre COVID-19 two-week wait skin cancer referral rates.

This guidance details new models of service delivery that systems should consider to optimise suspected skin cancer referrals in dealing with both the existing backlog of patients and new demand as services are restored.

Further information relating to cancer waiting times can be found [here](#). All information within this guidance applies with the exception of those changes to guidance during the Covid-19 pandemic.

#### 4. Proposed new models of delivery

To manage suspected skin cancer two-week wait referrals in a more streamlined way, systems should consider adopting a range of different services to meet local need. These can supplement the traditional face to face model by enabling systems to consider adapting solutions to local circumstances, capacity, and workforce. In keeping with national cancer requirements, two-week wait skin cancer services are led and delivered by consultant dermatologists and their teams working in secondary care settings. This model of clinical leadership should continue.

New models implemented should:

- Ensure that health care professionals continue to use the criteria stated in the [NICE guideline \(NG12\)](#) relating to the recognition and referral of skin cancer when considering referral on a two week wait pathway.
- Reduce the inconvenience and stress for people needing to visit an acute hospital setting unless it's essential.
- Personalise the pathway for the patient by ensuring a face to face consultation where appropriate, for example for people with more than one suspicious skin lesion or other high-risk features.
- Harness new technology, in particular tele-dermatology, digital referral platforms and the use of remote consultations to reduce the need for unnecessary hospital attendances.
- Develop community diagnostic hubs for image capture and transfer to mitigate against the reduction in primary care face to face activity.
- Link to the learning from the 100-day project outputs and recommendations (Transforming Elective Care Services in Dermatology 2019) and other published examples of good practice, such as community-based diagnostic 'spot' clinics<sup>4</sup> and similar rapid access clinic models in secondary care settings.
- Reduce the unintended consequence of Acute Trusts prioritising skin cancer targets to the detriment of the care of people with rashes and long-term skin conditions who are no longer seen in a timely fashion.
- Facilitate the automatic upgrade of an advice and guidance interaction to a two-week wait referral where clinically appropriate; for example where the primary care clinician was unsure whether the skin lesion was suspicious; this possible outcome should have been clearly communicated to the patient.
- Support health care professionals and patients in the taking and transfer of high quality images to support the diagnosis and management of skin lesions through both advice and guidance (non-2 week wait lesions) and the two week wait pathway. There are a range of guidance videos available to support in taking photographs of the skin, these can be found as follows:
  - [Patient video](#) of taking photos of their skin and sending them securely to their GP
  - [Clinician video](#) of taking and uploading photos using secure smartphone apps
  - [Administration staff video](#) of requesting advice and guidance in dermatology:

- Ensure an advice and guidance skin lesion service is set up to provide GP practices with an alternative decision making resource.

The current and possible new pathways are described below and illustrated in appendix one.

#### 4.1 Traditional pathway

Currently most patients are referred on a two week wait pathway, often with the use of a referral proforma ([NICE guideline NG12](#)) and are offered a face to face appointment in a specialist dermatology service. This traditional model will continue to be available where clinically appropriate or where other clinical pathways are unsuitable or unavailable. This pathway is particularly well suited to patients with multiple suspicious lesions, a history of skin cancer and other risk factors.

#### 4.2 Tele-dermatology referral

The type of tele-dermatology referred to in this model is the use of asynchronous store and forward tele-dermatology, where high quality images accompany the two-week wait dermatology referral to enable consultant triage, ensuring face to face attendance only when necessary.

A virtual tele-dermatology two week wait pathway will require the following:

- The use of high quality macroscopic and dermoscopic images as the 'reasonable diagnostics' required to exclude cancer.
- A triage outcome that permits the specialist clinician to request to see the patient face to face if required.
- The facility to communicate directly with the patient and their GP.

Outcomes from the virtual tele-dermatology two week wait referral that will 'stop the clock' on the two week wait referral could be as follows:

- The patient has an interaction with a consultant or a member of their team via telephone, video or face to face consultation.
- The patient is booked directly for surgery and receives appropriate pre-operative advice and counselling.

Different models for high quality image capture will be required to support this model and will need to be locally agreed. This can include:

- Images taken by a suitably trained health care professional in a GP surgery.
- Images taken by health care professionals in a community hub e.g. medical photographers, community nursing teams or other suitably trained health care professionals.
- Where specialist dermatology services provide the image capture then this is classified as a 'First Diagnostic Test ' Further information about this can be found in the most up-to-date national waiting times monitoring dataset guidance which can be accessed [here](#).

Further information relating to digital tools to support the delivery of patient pathways can be found [here](#).

Information is available in the National Outpatient Transformation Programme Tele-Dermatology Roadmap available from NHS Futures<sup>5</sup> and other publications<sup>6</sup> about a range of issues relating to taking and sharing images securely for use with teledermatology.

### **4.3 Rapid access diagnostic consultant-led 'spot' clinics in community or hospital settings**

Rapid access diagnostic 'spot' clinics enable experienced, trained specialists (usually consultants and core members of the skin cancer MDT) to review large numbers of suspected skin cancer two week wait referrals in community or hospital settings, offering a rapid assessment of the suspicious lesion. These clinics might include a mix of patients with two week wait and non-two week wait skin lesion referrals.

In addition to 'stopping the clock' on a two week wait referral the outcomes of the rapid access 'spot' clinic can include:

- Treatment such as cryotherapy.
- The patient is discharged back to their GP with or without treatment plan.
- The patient is booked directly for surgery.
- Upgrade of a non-two week wait referral to the two week wait cancer pathway.

Community based diagnostic 'spot' clinics were successfully piloted as part of the Elective Care Development Collaborative 100 Day Challenge, where teams developed and tested innovation in delivering elective care in 100 days. In Lincolnshire, since the start of the one hundred days, 43% of the 73 patients seen during four spot clinics were diverted away from secondary care, a further 9% of patients received treatment in the community. Only 7 of the 73 patients were referred to the two-week wait pathway when previously, all 73 patients would have been. Hospital based rapid 'spot clinics' using the same model have been developed in some acute hospitals and shown to work well.

Further details of this work can be found [here](#). When based in a community setting, this approach can provide high quality, accessible care for elderly patients with suspected skin cancer.

## **5. Implementation**

The models outlined in this document can be implemented quickly and successfully. Support from the Rapid Cancer Diagnostic Centres will be crucial in the development of local pathways and planning for roll out. Some additional elements that will support successful implementation are detailed below.

### **5.1 Engagement**

Achieving buy in from across Primary and Secondary Care and wider stakeholders will be essential as part of developing new pathways and implementation. Early engagement with primary care, the dermatology specialist community and clinical leaders in NHS-X leading to the identification of dermatology primary care and specialist clinical champions in each NHS Cancer Alliance area will support the roll out of these new models of care.

### **5.2 Administration**

Support with administration will be crucial in ensuring capacity is built into job planning, that clinic arrangements are in place and booking systems are enabled to support the new pathways and ensure available clinical capacity is maximized and cost effective.

### 4.3 Communications

The development of a communications plan will help to ensure all the key activities in launching the new service have been considered inclusive of the development of promotional materials, patient information and how key messages will be communicated. Regular communication to those who are likely to use the new pathway will support in ensuring relevant information is readily available at key stages along the development.

### 4.4 Measuring success

Giving some thought as to how the overall impact of the new pathways will be measured is worthwhile at the start to ensure there is access to the required information and systems in place to support the collation of the data. When determining how to measure the impact consider both quantitative and qualitative information.

Further information to support implementation planning and measuring success can be found [here](#).

## 6. Summary

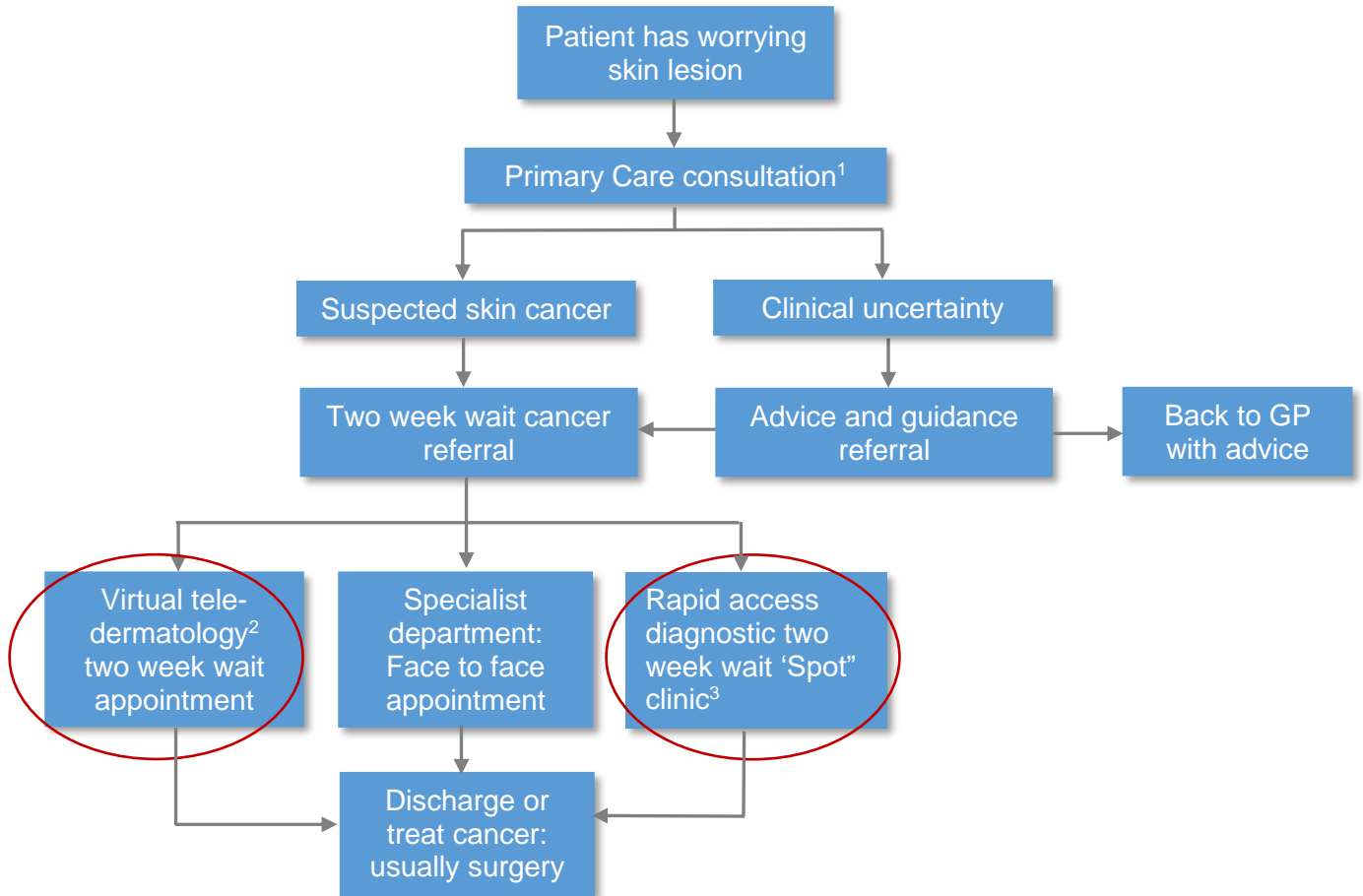
The need for targeted interventions to recover the lost activity during the COVID-19 pandemic, particularly in relation to the early diagnosis of people with melanoma, requires new approaches to the two-week wait skin cancer referral pathway. The dermatology specialist team at the National Outpatient Transformation Programme NHS England and Improvement welcome the opportunity to take forward and support this initiative working closely with the Rapid Cancer Diagnostic Centres.<sup>7</sup>

## 7. References

1. [Urgent cancer diagnostic services during Covid-19](#) (page 19)
2. [Advice on how to establish a remote total triage model in general practice](#)
3. [Cancer waiting times conversion and detection rates](#)
4. [Transforming elective care day services in dermatology](#) (pages 23-28)
5. [National outpatient transformation programme teledermatology roadmap](#)
6. [Urgent cancer diagnostic services during Covid-19](#)
7. [Rapid diagnostic centres implementation specification](#)

## Appendix 1

Possible new two week wait suspected skin cancer diagnostic pathway (new pathways highlighted in red).



### Notes

1. Whilst systems are in place to allow GPs to make 2 week wait suspected cancer referrals, referrals can be made via other sources, such as an Advanced Nurse Practitioner (ANP) or direct from an A&E attendance. This needs to be locally agreed jointly by commissioners and providers and be in the context of appropriate training and local governance frameworks. Further information relating to this can be found [here](#).
2. The teledermatology pathway requires high-quality images; poor quality images from a patient will not support safe and effective functioning of the virtual pathway. Therefore, before making a teledermatology referral, primary care clinicians should satisfy themselves that any image attached to a referral is of sufficient quality to facilitate a virtual assessment or that they have seen the patient in person to review a potential lesion.
3. Although the rapid access clinics were piloted in community settings, the model lends itself to a hospital based model