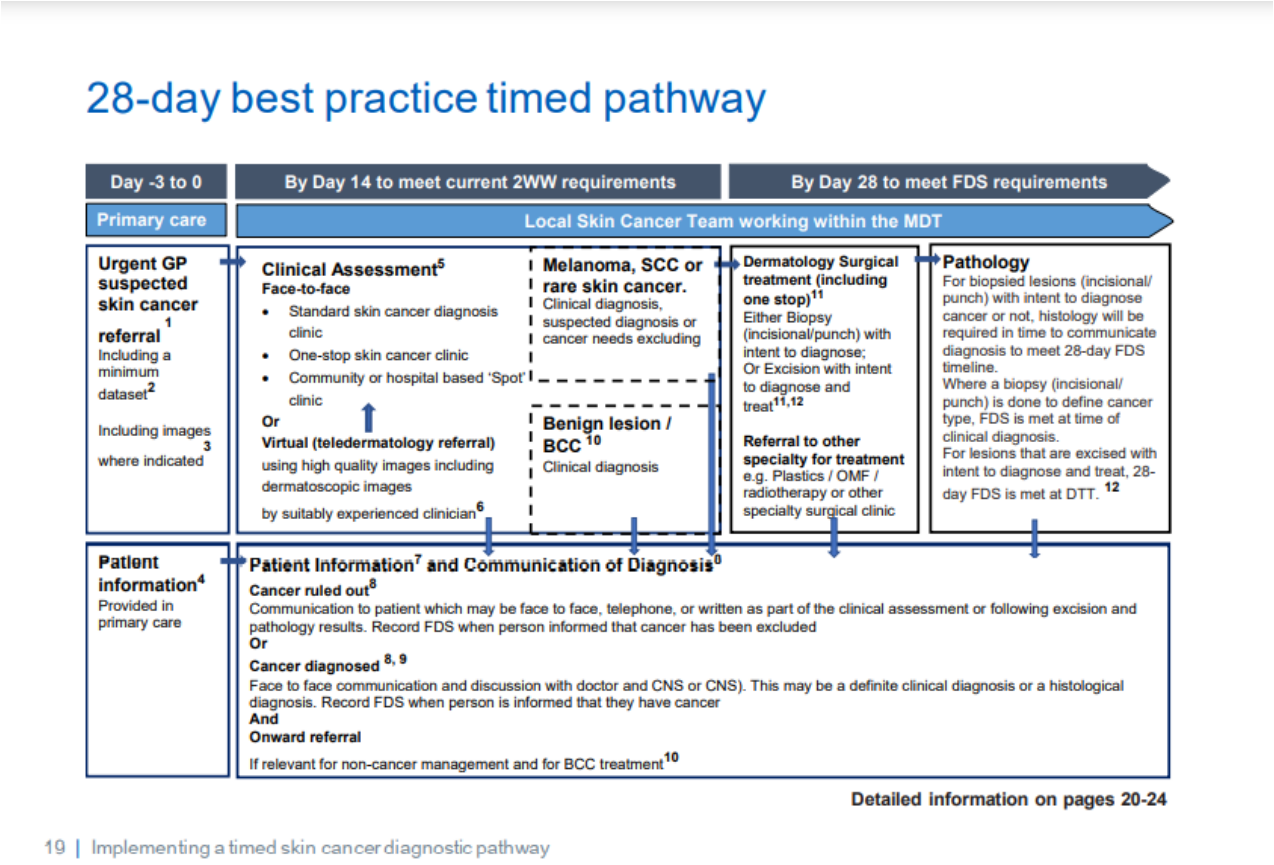
Skin Cancer Pathways

Figure 1: 28-Day Best Practice Timed Pathway



19 | Implementing a timed skin cancer diagnostic pathway

The government has approved the removal of the outdated two-week wait target. This will be replaced with the Faster Diagnosis Standard (28 days) from 1st October 2023 see updated Cancer Waiting TImes Guidance. Additional information is provided in The Faster diagnostic pathways Implementing a timed skin cancer diagnostic pathway guidance (October 2022).

GPs (or other referrer) will still refer people with suspected cancer in the same way, but the focus will be on getting people diagnosed or cancer ruled out within 28 days from receipt of urgent referral [Operational Standard –75.0%].

The Faster Diagnosis Standard would also apply if the GP (or other referrer) makes an urgent referral for a suspected recurrence which is covered by the 31- day subsequent treatment standard. If the urgent patients is diagnosed as a new primary they will be covered by both the 31- day treatment standard and the 62-day standard.

Clock start date urgent suspected cancer

The Faster Diagnosis Standard start point is the receipt of the referral by the provider who will first see the patient (recorded as the CANCER REFERRAL TO TREATMENT PERIOD START DATE). Receipt of referral is day zero.

Referrals received after a working day has finished should have the CANCER REFERRAL TO TREATMENT PERIOD START DATE set as the date that the referral was received and not the next working day.

Patients referred on a Faster Diagnosis Standard pathway should still be recorded in the dataset as: PRIORITY TYPE CODE – 3 (Two Week Wait)

First seen date for urgent suspected cancer

Although the Two Week Wait performance standard no longer applies[1], it is still necessary to record DATE FIRST SEEN. The patient is seen either in person or virtually for the first time by a consultant (or member of their team) [2] following the referral as follows:

1. Appointment in secondary care where the image /photo and clinical history is taken by a nurse or medical illustration team.
2. Date that a specialist reviews the images and clinical history taken in primary care (sent with a referral).

The patient must be informed of the results of the specialist's review, either that cancer is ruled out or that attendance at a dermatology clinic is required.

A virtual consultation can only count as a first seen date, where it is a consultant led clinic (including a nurse acting on behalf of a consultant), and a patient's full symptoms are considered. The patient would have to be present for this consultation.

Communicating the Diagnosis

All diagnoses of cancers should be made through direct face-to-face communication with the patient, (unless otherwise explicitly agreed with the patient.) with conversation date recorded as the date CANCER FASTER DIAGNOSIS PATHWAY END DATE.

If cancer is ruled out the date of this communication to the patient should be recorded using a phone call or letter. The point at which this is communicated to the patient should be recorded as the CANCER FASTER DIAGNOSIS PATHWAY END DATE.

Reasonable forms of communication with patients to confirm cancer has been ruled out include:

- direct communication with the patient, over phone, Skype or similar;
- written communication by letter, or by email (this can include a pathology report as a patient facing communication with any medical terminology explained in full);
- face to face communication at an outpatient appointment.

Where direct communication is not possible due to the patient not having the mental capacity to understand a diagnosis either temporarily or permanently, communication to the patient's recognised carer or a parent/guardian should be recorded in the same way as if the patient was told directly.

[1] For the purposes of managing high number of cancer referrals it is recommended that Trusts continue to see their patients within 14 days to avoid breaching the 28 day standards and increasing the number of patients on waiting lists.

[2] Any doctor knowingly diagnosing and treating these skin cancer patients must be employed by their NHS hospital and be a core member of the skin MDT (Improving outcomes for people with skin tumours including Melanoma (nice.org.uk)), as shown in Figure 1. Consultants who diagnose skin cancer and do not carry out any surgical work should be named as an extended member of the MDT. Their attendance is required four times a year which includes level 4 skin cancer mandatory case discussions of their patients. The consultant's role on a Skin MDT is required for each hospital where they are seeing (triaging) 2WW referrals.

There may be cases where a decision to treat is made before a diagnosis is made and communicated to the patient, in such cases the CANCER TREATMENT PERIOD START DATE should be recorded as the decision to treat date, as normal. Once the patient is told their diagnosis, the CANCER FASTER DIAGNOSIS PATHWAY END DATE should be recorded as the date of communication with the patient as normal, even where this falls after the treatment date.

Patient seen as an emergency prior to being seen following a referral

Where a Faster Diagnosis Standard patient is admitted as an emergency for the same condition (i.e. related to the suspected cancer) before they are seen they should no longer be recorded against the 28-day FDS. The emergency admission is the referral into the system and supersedes the original referral. However, the patient should be upgraded to the 62-day pathway by a consultant or authorised member of their team from the emergency admission if cancer is suspected, and this is the cause of the admission.

This would not apply where a patient attends an accident and emergency (A&E) department and is not admitted. In such a scenario the original clock start would apply.

Referrals not made via e-RS

For urgent suspected cancer referrals received by a route other than e-RS, referrals should not be rejected in the interests of patient safety. A patient should be offered an appointment. In the interest of patient safety, if there is no response from the GP practice within the next working day, the provider will contact the patient to make an appointment, regardless of whether they have received the e-RS referral from the GP practice or not.

Referral sent to wrong trust

There should be agreed local referral protocols in place between primary and secondary care so that the referrer knows where to send patients. If they have sent a referral to a wrong provider, that provider could liaise with the referrer and ask them to withdraw the referral and re-refer to a correct provider. This new referral would be recorded as the start of the pathway. Alternatively, the wrong provider could forward the referral on to the correct provider if this is faster and in the patient's interest. In this case the clock start would still be the original from the referrer.

NHS E-RS Advice and Guidance (A&G) for cancer pathways

The A&G function should not be used in place of a two week wait referral. For example, where a patient clearly meets NG12 criteria this should usually result in an urgent suspected cancer referral.

A&G can be converted into an urgent suspected cancer referral in line with the local referral and commissioning guidelines and where this happens must be classed as an urgent suspected cancer referral, not a consultant upgrade. Where an A&G referral is converted the e-RS pathway start will capture the date on which the provider converts the referral. When making the decision on if to convert A&G directly into a referral and appointment, the clinician reviewing should take into consideration whether they have the required information, and whether the patient is likely to know there is a suspicion of cancer.

For the skin cancer pathway, FDS clock stops may be applied when:

Scenario 1

Most people will be immediately reassured that they do not have skin cancer and be discharged from the specialist service; this will stop the FDS clock.

Scenario 2

Some people will be advised that the clinical diagnosis is skin cancer and will either have skin surgery on the same day (one-stop) or be booked on to a surgical list at a later date to meet the 31-day cancer treatment standard; this is an FDS 'clock-stop' as a clinical diagnosis of skin cancer has been given.

Scenario 3

Sometimes the diagnosis of skin cancer is uncertain and in this situation the patient will be advised that the skin lesion might be cancer and needs to be removed (excised) to confirm or exclude cancer. The surgery may be on the same day or booked for a later date (to achieve the 31-day treatment standard).

The FDS will continue in the background until confirmatory histology is received and communicated to the patient. For recording purposes, the cancer faster diagnosis pathway end date should be recorded as the date of communication with the patient as normal, even where this falls after the treatment date.

Scenario 4

Sometimes a sample of tissue may need to be taken to make a diagnosis – biopsy (incisional or punch biopsy) with intention to diagnose. A biopsy is needed to decide whether benign or malignant, e.g. actinic keratosis or SCC. For those patients for whom it is not possible to give a clinical diagnosis, the biopsy will need to be performed in a timely fashion to allow histopathology processing in time to inform the patient of diagnosis within the 28-days FDS timeline. For these patients, access to timely histopathology services will be key to improving the patient journey.

Scenario 5

Where a clinical diagnosis of skin cancer has been made and a referral to another specialist service is required to perform treatment (such as plastic, maxilla-facial surgeons or for radiotherapy), if a cancer diagnosis has been given, the FDS clock will be stopped at the point of communication (a referral should be made at the same time to avoid treatment management delays). Patients with melanoma and SCCs should be managed within 31 days.

Scenario 6

Where a clinical diagnosis of skin cancer is not known and referral to another specialist service is required to perform treatment (such as plastic or maxillo-facial surgeons), the patient is seen by the other specialist service and the FDS clock will stop on the day that a decision to treat is made. It is important that this appointment falls within the 28-day FDS.