BRITISH ASSOCIATION OF DERMATOLOGISTS
HEALTHY SKIN FOR ALL

NHS

Classification: Official

Publication approval reference: PAR1350

Faster diagnostic pathways

# Implementing a timed skin cancer diagnostic pathway

## Guidance for local health and care systems

21 October 2022

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# Best practice timed diagnostic pathways

Best practice timed pathways support the ongoing improvement effort to shorten diagnosis pathways, reduce variation, improve people's experience of care, and meet the Faster Diagnosis Standard (FDS). The guidance will support cancer alliances and constituent organisations to adopt consistent, system-wide approaches to managing this diagnosis pathway.

This guidance sets out how the diagnosis of squamous cell carcinoma (SCC), malignant melanoma and rare skin cancers can be achieved within 28 days in the urgent suspected skin cancer referral pathway.

The most common skin cancer, basal cell carcinoma (BCC), is usually locally malignant and unlikely to spread to other areas. The treatment of people with this cancer sits outside the cancer waiting times (CWT) guidance. However, the large number of people presenting with this skin cancer will impact on the ability of systems to implement a best practice diagnostic pathway for other skin cancers. Therefore, organisations may wish to review their pathways for the diagnosis and management of BCC as part of any skin cancer pathway review.

Alongside the pathway itself, resources are highlighted to support implementation of the pathway.

This skin pathway is part of a series, published since April 2018. From previous pathways implemented by cancer alliances, implementation guidance was shared in June 2021. These identified areas that are key to success, such as setting up with clinical and operational engagement, auditing pathways, allocating project management resources, ensuring good leadership, analysing data, and sharing successes.

This guidance complements existing resources such as National Institute for Health and Care Excellence (NICE) guidelines and should therefore be read alongside such guidance.

While the guidance stipulates recommended clinical actions and timings, it is recognised that this will not apply to all people in all circumstances. Responsibility

for clinical decision making remains with local clinical teams with the knowledge and expertise to make appropriate decisions and policies.

The pathway in this document was developed by a multidisciplinary consensus group with clinical leaders from local and specialist services across England, expert advice from cancer alliances, NHS England, National Outpatient Transformation Programme (NOTP), Getting it Right First Time (GIRFT), the British Association of Dermatologists, and patient and public partners.

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# The Faster Diagnosis Standard

There is a commitment in the NHS Long Term Plan to provide a faster diagnosis for people through the introduction of the FDS. This standard aims to ensure people are told they have cancer, or that cancer is excluded, within a maximum of 28 days from referral. The new standard is intended to:

- reduce the time between referral and diagnosis of cancer
- reduce anxiety for the cohort of people who will be diagnosed with cancer or receive an 'all clear'
- reduce unwarranted variation in England by understanding how long it is taking people to receive a diagnosis or 'all clear' for cancer
- represent a significant improvement on the current two-week wait to first appointment target, and a more person-centred performance standard.

FDS performance data, including a breakdown by suspected cancer pathway, have been published since June 2021, and faster, more streamlined pathways will be a priority.

As the key system-wide organisations for cancer services, cancer alliances will need to work across the local system. This will ensure that implementation is prioritised by senior stakeholders, clinical leaders, and NHS managers, and that capacity is prioritised to enable the standard to be delivered.

The FDS has been formally performance managed since October 2021, in line with cancer services recovery, aiming to meet the standard in at least 75% of people referred with suspected cancer. Cancer alliances will need to ensure that they have plans to meet the initial 75% threshold, which will need to be increased in subsequent years to contribute to achieving the early diagnosis ambitions in the NHS Long Term Plan.

# The case for change

Skin cancer is the most common cause of cancer in England (around 215,000 cases per year). BCC is by far the most common type of skin cancer, followed by cutaneous squamous cell carcinoma (cSCC) and melanoma. Recent improvements in national data collection in England has resulted in more accurate reporting of BCC and cSCC incidence, with over 155,000 new BCCs diagnosed (around 72% of skin cancers) in 2018 (the latest available data).

Ideally most people with BCC will not be referred on the urgent skin cancer pathway, although high risk BCCs should be referred urgently.

In 2018 there were around:

- 45,000 new cases of cSCC (around 21% of skin cancers)[1]
- 15,000 new cases of melanoma (around 7% of skin cancers).[2]

Many – but not all – of the people with melanoma and cSCC are referred and treated via the urgent suspected skin cancer referral route.

Referrals and treatments for skin cancer on the urgent cancer pathway have almost doubled since 2015 (See figures 1 and 2 below).

Skin cancer is the second most common suspected cancer referred on cancer pathways in England with 509,668 referrals in 2019/20. This represents around 21% of all urgent suspected cancer referrals (two-week wait standard).

In 2019/20, 54,688 people received a first treatment for skin cancer from all referral routes, accounting for 17% of all cancer first treatments (31-day standard). About a third of patients with SCC or melanoma are not referred on an urgent cancer pathway which may lead to delays in diagnosis and management.

Systems may wish to look at developing rapid turnaround skin lesion diagnostic services using images sent using specialist advice (advice and guidance) for lesions where there is diagnostic uncertainty. While the two-week wait (2WW) virtual/teledermatology pathway requires macroscopic and dermoscopic images,

[1] https://onlinelibrary.wiley.com/doi/10.1002/ski2.61
[2] https://www.gov.uk/government/statistics/cancer-registration-statistics-england-2018-final-release

systems may choose to implement specialist advice (advice and guidance) for non-2WW skin lesion diagnosis that do not include the need for dermoscopic images.

Currently most people (around 93%) who are referred urgently with suspicious skin lesions will not have cancer, although there is variation across cancer alliances, ranging from 81% to 98%. These people are usually seen promptly, with 91% seen within 14 days of an urgent referral, and many will be reassured and discharged at their first appointment. However, there is variation across cancer alliances and a number of people are currently not seen in a timely manner. The slowest 5% of referrals take 27 days or longer for the person to be seen for the first time.

Between April 2021 and November 2021, around 83% of 340,000 people referred for suspected skin cancer received a confirmed communication of diagnosis within 28 days of referral (as defined in National CWT Guidance). However, this varied by cancer alliance with a range of 73% to 94%.

Between October 2020 and September 2021, 91% of 38,392 people diagnosed with skin cancer commenced treatment within 62 days of referral. It is recognised that the COVID-19 pandemic impacted all services.

In 2018 (the latest published data), the variation by cancer alliances between time from referral to treatment for people with melanoma was 51 to 77.5 median days. There is ongoing variation which should be addressed.

The early diagnosis of skin cancers (see annex 1 for further classification of skin cancers that would normally be diagnosed using this pathway) is important as prompt treatment will improve chances of survival. Many people who are referred using the urgent skin cancer pathway are seen quickly and have their cancer removed within cancer standards' target times. Other people, particularly those whose melanoma is identified from a non-urgent referral, may experience delays in their diagnosis and treatment.

The introduction of the FDS provides the opportunity to review and streamline pathways using new and innovative approaches to optimise suspected skin cancer referrals and ensure timely diagnosis and management. This will reduce the variation currently seen across England in cancer diagnosis and treatment.

Alongside adoption of the best practice timed pathway, cancer alliances must ensure the appropriate resources and capacity are in place to deliver high-quality services to more people.

**Figure 1: Skin 2WW referral to treatment CWT data for England, 2015/16 Q1 to 2021/22 Q2**

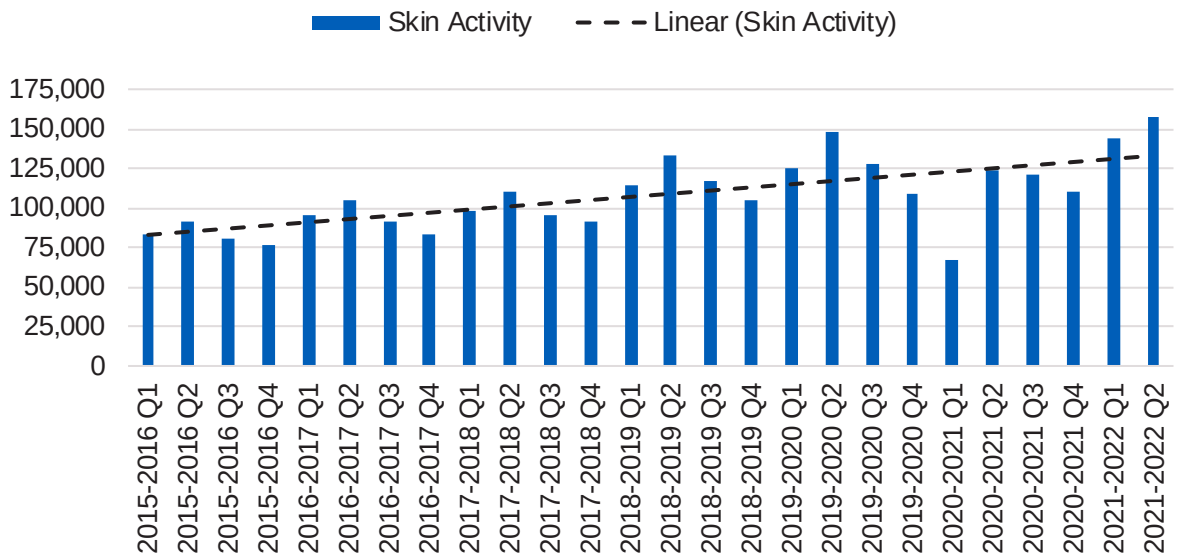
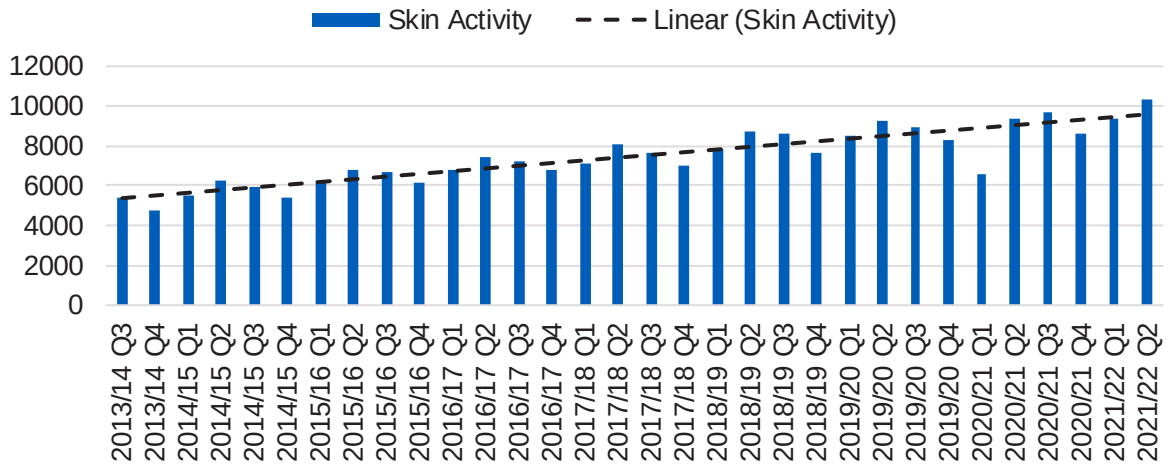



**Figure 2: Skin 62-day referral to treatment, CWT date for England, 2013/14 Q1 to 2021/22 Q2**




# Actions for cancer alliances

The planning guidance for 2022/23 makes clear the overarching principles and actions that need to be taken by cancer alliances on behalf of integrated care systems (ICSs). This section lists the specific actions that should be considered when implementing a best practice skin cancer diagnostic pathway.

- Draw up an action plan for improving operational performance, with a particular focus on specific elements which are most adversely affecting overall performance.
- Work with GPs and the local population to develop best practice skin lesion referral, triage and diagnostic pathways using specialist advice (advice and guidance/referral assessment services) to increase the number of appropriate people being referred with suspected cancer (see NOTP referral optimisation guidance and A teledermatology roadmap for further information).
- Ensure primary care staff referring people with suspected skin cancer have received education and ongoing training in diagnosis of skin cancer including dermoscopy.
- Increase the take-up of teledermatology and teledermoscopy, by appropriately trained individuals, to support skin lesion diagnostic pathways particularly the teledermatology skin cancer pathway.
- Consider linking the development of Community Locality Image Centres to Community Diagnostic Centres, to provide high quality images for teledermatology and teledermoscopy activity; these could be developed by Primary Care Networks or Specialist Dermatology services.
- Consider using community or hospital based 'spot clinics' which can provide locally accessed high volume rapid access face to face skin lesion services (see Transforming elective care services dermatology and teledermatology skin cancer pathway).
- Consider development of multidisciplinary cross-speciality 'super-clinics' to manage high volume of skin cancer referrals (see Dermatology Getting it Right First Time (GIRFT) Programme National Specialty Report).
- Consider an action plan for improving operational performance of histopathology/dermatopathology services with a 'Getting It Right First Time' approach (see Dermatology GIRFT programme national specialty report).
- Consider using histopathology digital referral pathways, including digital pathology and digital image sharing, to enable virtual diagnostic histopathology networks aimed at improving workflow, access to specialist opinions and reduce duplication.

- Optimise training of appropriate health care professionals to diagnose and treat skin cancer including histopathology and dermatopathology (see Dermatology GIRFT programme national specialty report).

**NHS England provide** support, funding and guidance to help cancer alliances improve outcomes and reduce variation. The following support is available in 2022/23:

- Funding and programme management to support delivery to achieve the Faster Diagnosis Standard and for site-specific pathways.
- Implementation Guidance for achieving best practice timed pathways.
- Collaboration and networking events to share best practice.
- NOTP resources to support referral optimisation and implementation of teledermatology services.
- Dermatology GIRFT programme national specialty report.

# The suspected skin cancer pathway

The pathway for most people, from referral by primary care to diagnosis or the exclusion of skin cancer is very straightforward. The CWT dermatology communication provides clarification about recording FDS and decision to treat date in the CWT dataset, and sets out a flow chart and examples. For the skin cancer pathway, FDS clock stops may be applied when:

- A clinical diagnosis is given to the patient. This may be (although does not have to be) at the same time as a decision to treat date for any treatment modality.
- A patient is informed of a histopathological diagnosis following biopsy, where it has not been possible to give a clinical diagnosis previously.
- A decision to treat a lesion when cancer cannot be excluded (any treatment that is intended to remove or reduce the cancer), where it has not been possible to give a clinical diagnosis previously.

There are a range of possible outcomes of the clinical assessment of the patient – there follow a list of scenarios with examples.

## 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.

**Examples**

| Referral | Clinical assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in a face-to-face clinic on 10 October.<br>Clinical assessment: Diagnosis is benign seborrhoeic keratosis.<br>Patient advised of non-cancer diagnosis. | FDS 'clock stop' is 10 October, the date the patient is informed of non-cancer diagnosis by a member of the specialist dermatology team. |
| Primary care urgent suspected skin cancer teledermatology referral[3] date on 1 October. | Teledermatology referral received and reviewed on 3 October.<br>Teledermatology diagnosis is benign seborrhoeic keratosis<br>Patient contacted by a member of the dermatology team and advised of non-cancer diagnosis on 10 October. | FDS 'clock stop' is 10 October, the date the patient is contacted and informed of non-cancer diagnosis by a member of the dermatology team. |

## 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.

[3] These teledermatology scenarios relate to images taken in primary care and sent for specialist review. Where the images are taken by members of the secondary care specialist team (first diagnostic test) this will usually be recorded as the date first seen. After review of the images, the patient will either be discharged with a non-cancer diagnosis or a decision to treat/excise a suspected cancer is made, at which point the FDS clock will stop. Where the images are taken by members of the secondary care specialist team, communication of a non-cancer diagnosis may be by letter if best for the patient and the FDS clock stop is the date the letter is sent. If the patient is seen in clinic the FDS clock continues in line with the face-to-face pathway.

**Examples**

| Referral | Clinical assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in a face to face clinic on 14 October.<br>Clinical assessment: Diagnosis is basal cell carcinoma; patient advised of diagnosis. | FDS 'clock stop' is the clinic date 14 October. |
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in a face-to-face clinic on 12 October.<br>Clinical assessment: Diagnosis is melanoma.<br>Patient advised of cancer diagnosis. | Patient may have excision the same day or on a booked list but the FDS 'clock' has been stopped; the patient has been told they have cancer.<br>FDS 'clock stop' is the clinic date on 12 October. |

## 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 clock is stopped at the time of the consultation as a decision to treat (DTT) has been made. The formal diagnosis (and ending of FDS) will be shared with the patient once the histology result is available.

**Examples**

| Referral | Clinical assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in face-to-face clinic on 10 October.<br>Clinical assessment: Diagnosis is atypical melanocytic lesion.<br>Patient advised that this is an unusual lesion that requires removal as there is the possibility that it could be cancerous.<br>Arrangements are made for the whole lesion to be removed 'excision with intention to treat'. | DTT has been made before a diagnosis has been communicated to the patient, therefore this date is used for the clinical FDS 'clock stop'.[4] |
| Primary care urgent suspected skin cancer teledermatology referral date on 1 October. | Teledermatology referral reviewed on 4 October.<br>Teledermatology diagnosis is atypical melanocytic lesion.<br>Face-to-face clinical assessment arranged for 10 October.<br>Lesion is considered to be atypical and melanoma cannot be excluded.<br>Arrangements made for excision. | DTT has been made before a diagnosis has been communicated to the patient, therefore this date is used for the clinical FDS 'clock stop'.[4] |
| Primary care urgent suspected skin cancer teledermatology referral date on 1 October. | Teledermatology referral reviewed on 3 October.<br>Diagnosis is atypical melanocytic lesion so face-to-face appointment is made.<br>Face-to-face clinical assessment on 10 October.<br>Lesion is considered clinically benign.<br>Patient advised of non-cancer diagnosis. | DTT has been made before a diagnosis has been communicated to the patient, therefore this date is used for the clinical FDS 'clock stop'.[4] |

[4] Although the FDS clock has stopped because a DTT has been made, the FDS will continue in the background until confirmatory histology is received and communicated to the patient. This ongoing FDS period is not relevant in terms of the **clinical** FDS clock stop data capture; however, 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.

### Examples

- A biopsy is needed to decide whether benign or malignant, eg 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.

| Referral | Clinical assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in face-to-face clinic on 12 October.<br>Clinical assessment: skin lesion which could be an SCC but where the diagnosis is clinically uncertain.<br>Biopsy is needed and arrangements are made for a 'biopsy with intention to diagnose'.<br>Biopsy same day or later date between 12-19 October.<br>Histological diagnosis of SCC discussed with patient, or letter/email sent if previously explicitly agreed with and preferred by the patient, on 28 October | The FDS 'clock stop' is the date that the histology result is discussed with the patient on 28 October, as this is when the diagnosis is given to the patient. |

- A biopsy is needed to decide which type of skin cancer, eg SCC vs BCC. As the patient has been told at the initial appointment that it is a 'cancer' the FDS clock will be stopped at the initial appointment date.

| Referral | Clinical assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in face-to-face clinic on 10 October.<br><br>Clinical assessment: skin lesion which could be a BCC or an SCC.<br><br>Patient advised that this is skin cancer but there is uncertainty about the type.<br><br>Biopsy is needed and arrangements are made for a 'biopsy with intention to diagnose'.<br><br>Biopsy same day or later date between 10 and 17 October.<br><br>Histological diagnosis of SCC discussed with patient, or letter/email sent if previously explicitly agreed with patient, on 28 October.<br><br>If histological diagnosis of BCC, communicated to patient on 28 October. | The FDS 'clock stop is the first clinic date on 10 October, as at the time of the clinical assessment a cancer diagnosis has been given. |

## Scenario 5

Where a clinical diagnosis of skin cancer has been made and referral to another specialist service is required to perform treatment (such as plastic, maxillo-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).

**Examples**

| Referral | Clinical Assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in face-to-face clinic on 10 October.<br>Clinical assessment: Large skin lesion on the vertex, clinical diagnosis is SCC.<br>The lesion cannot be removed in dermatology (depending on local services) and the patient is referred to plastic or maxillo-facial team for surgery.<br>Biopsy may or may not be needed to confirm the diagnosis.<br>Patient advised that this is skin cancer and that onward referral is being made. | FDS 'clock stop' is the clinic date on 10 October as patient has been told of the cancer diagnosis. |
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in face-to-face clinic on 10 October.<br>Clinical assessment: Large skin lesion on the vertex, clinical diagnosis is SCC.<br>Patient is referred for radiotherapy.<br>Biopsy may or may not be needed to confirm the diagnosis.<br>Patient advised that this is skin cancer and that onward referral is being made. | FDS 'clock stop' is the clinic date as patient has been told of the cancer diagnosis. |

## 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. Important that this appointment falls within the 28-day FDS.

**Examples**

| Referral | Clinical assessment | FDS outcome |
|---|---|---|
| Primary care urgent suspected skin cancer referral date on 1 October. | Patient seen in face-to-face clinic on 10 October.<br><br>Clinical assessment: Large skin lesion on the vertex, clinical diagnosis is unknown.<br><br>The lesion cannot be removed in dermatology (depending on local services) and the patient is referred to plastic or maxillo-facial team for assessment.<br><br>Patient advised by maxillo-facial team that this is likely skin cancer and decision to treat/excise is agreed on 15 October. | FDS 'clock stop' is date the maxillo-facial team agree treatment with patient, on 15 October as decision to treat has been agreed. |

Effective administration of the pathway including excellent support for patients and timely access to clinical nurse specialist (CNS) is also required.

Key to successful implementation will be a whole system approach linking any new pathway to published best practice for referral optimisation, teledermatology and an efficient skin cancer diagnosis virtual pathway which will reduce the need for patients to attend a hospital appointment unless necessary.

Attention should be given to effective onward referral when treatment from other specialties is required, so that people receive appropriate treatment within 62 days.

Multidisciplinary team (MDT) meetings will need to be streamlined in their approach and held sufficiently regularly to ensure timely discussion of relevant cases (see Streamlining multidisciplinary team meetings).

Consideration should also be given to reviewing pathways for diagnosis, triage and management of BCC as part of the pathway work.

# Benefits of pathway change

**For patients and unpaid carers**

- Reduced anxiety and uncertainty by providing a prompt diagnosis that excludes skin cancer.
- Reduced need to attend a hospital for skin lesion diagnosis and management.

**For systems**

- Reduced demand in outpatient clinics by using teledermatology pathways and direct booking to surgery where appropriate.
- Improved quality, safety, and effectiveness of care with reduced variation and improvement in outcomes.

**Experience of care**

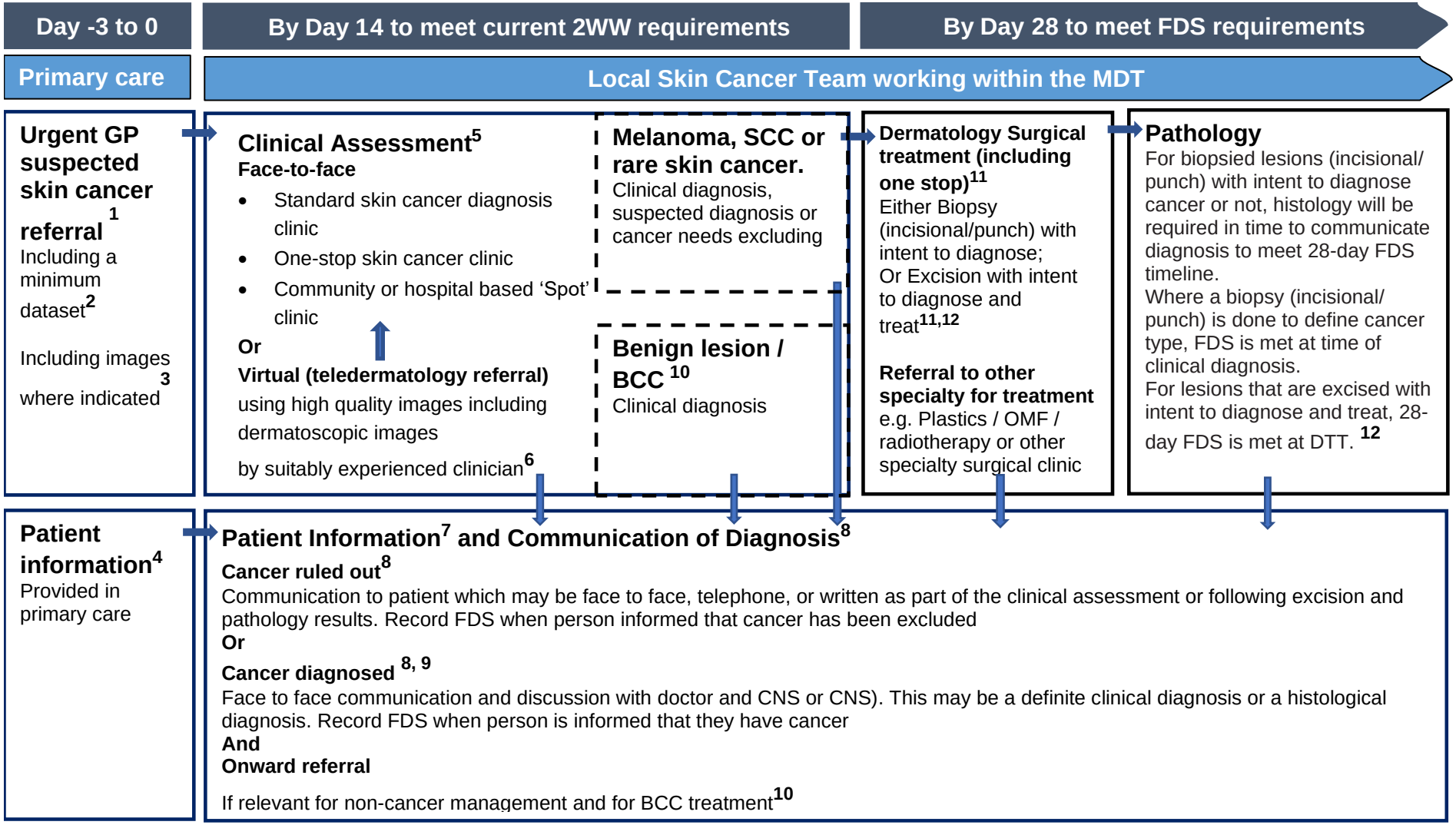
- Patients and carers know they are urgently referred for assessment of suspected cancer and should expect clinical diagnosis within 28 days.
- Ensure that patients and carers' ability to attend appointments is taken into account and additional support is offered, where necessary.
- Patients are communicated with clearly (in non-technical terms), understand the information provided, and are given additional support, such as access to a CNS or navigator, psychological support, buddy system, where necessary.

**For clinicians**

- Using a nationally agreed and clinically endorsed pathway to support quality improvement and reconfiguration of skin cancer diagnostic services.

- Provides the opportunity to review skin cancer diagnosis and management pathways in the context of national best practice guidance for referral optimisation and the use of teledermatology and teledermoscopy to reduce unnecessary face to face hospital attendances.
- Improved ability to meet increasing demand and ensure best utilisation of the highly skilled workforce.

# 28-day best practice timed pathway




**Detailed information on pages 20-24**

## Detailed information

1. **Urgent suspected skin cancer GP referral pathway** should be used for people who meet NG12 criteria for urgent suspected cancer pathway referrals. For genital lesions suspected to be cancer, local referral pathways should be agreed which may be via specialist genital skin, urology or gynaecology suspected cancer clinics.

   The National CWT monitoring dataset guidance v11.0 sets out consultant upgrade rules, including from non-GP scenarios such as advanced nurse practitioner, A&E and acute settings. This needs to be locally agreed between commissioners and providers and in the context of appropriate training and local governance frameworks.

2. **A minimum dataset should be agreed locally with GPs**, to accompany the referral and facilitate the clinical assessment. It should be the minimum information required to make a clinical assessment. Referrals to a virtual clinical assessment may need more information than those for straight to clinic.

   The minimum information agreed with primary care, may include the following:

   - symptoms in line with NG12, including:
     - location
     - size and shape
     - duration
     - evolution
     - bleeding
     - itching
   - UV exposure
   - family history
   - past medical history of skin cancer
   - chronic skin inflammation
   - immunosuppression
   - demographics
   - anticoagulant status
   - WHO performance status
   - co-morbidity
   - prescribed medication (when auto-populated in practice IT system)
   - presence or not of pacemaker or other internal electronics
   - any known allergies
   - need for interpreter
   - mental capacity to consent
   - other needs.

   If suspicion of melanoma, the minimum dataset may also include information about asymmetrical shape, border irregularity, colour irregularity, diameter>6mm, evolution of the lesion, and bleeding/itching.

3. **If referring to a teledermatology service for virtual assessment, the minimum dataset should also include macroscopic and dermoscopic images to an agreed standard and format.** See A teledermatology roadmap and NOTP referral optimisation guidance for further information.

   Before making a teledermatology referral, primary care clinicians should satisfy themselves that the images attached to a referral meet the requirements and are of sufficient quality for a virtual assessment or that they have seen the patient in person to review a potential lesion.

   To ensure that images are of high quality, primary care may wish to make use of community locality image centres. Teledermatology of skin lesions, like other skin conditions, is not always helpful in identification of skin cancers in darker skin tones, but will be helped by the use of dermoscopic images as well as straightforward clinical images.

4. **Primary care clinicians should inform people** that they are being referred for an urgent suspected cancer pathway, although stating that the vast majority of referrals result in non-cancer diagnoses. See NHS e-referral service advice and guidance recommendations for cancer pathways for further information.

   People should be informed if advice and guidance is used, that it may be converted to a 2WW, urgent or routine appointment. Primary care clinicians should also make people aware of their responsibilities to make themselves available for the first four weeks for assessment and skin surgery or assessment and biopsy.

5. **Clinical assessment** will be undertaken by a suitably experienced clinician in a recognised skin cancer dermatology service who is part of the skin cancer MDT. One-stop clinics or 'super-clinics' (see Dermatology GIRFT programme national specialty report) may be used to provide co-ordinated assessment and treatment to reduce visits and improve patient experience.

   An alternative approach is high volume single lesion 'spot' clinics offered in community settings to reduce unnecessary hospital attendances. A similar model can be used in a hospital setting.

6. **Teledermatology skin lesion diagnostic service** may be used as the first contact and clinical assessment. Clinicians should be suitably trained and experienced in teledermatology and teledermoscopy and supported by a systematic quality assurance process.

If there is clinical uncertainty after reviewing the images, a face-to-face assessment should be offered in a timely way to enable the 28-day timed pathway to be met**.** Specialist dermatology services may wish to develop community image taking hubs to ensure that images are of high quality.

7. **Patients and carers** provided with all necessary information about what to expect with confirmation of appointment. This is particularly important if patients are likely to have same day local anaesthetic skin surgery where information about what this might involve and any relevant limitations such as driving afterwards should be included.

   Information about accessing necessary support for people with any disabilities or language barriers is essential. Preferences for amount of information and when it is provided will vary, and therefore single point of contact may include:

   - access to caseworker/navigator to provide support throughout the pathway and outside of clinic times
   - signposting to charities and support services
   - information about carers attending appointments
   - offer of follow-up if patients do not receive confirmation of appointment in expected timescale.

   Where possible, continuity of caseworker / navigator should be provided to enable familiar contact and to build trust.

8. **A diagnosis of cancer** (either clinical or histology diagnosis) should be communicated through a face-to-face contact unless otherwise explicitly agreed with the patient and clearly documented. Alternative communication agreed by the patient could include a telephone call or letter/email.

   Communication of cancer should be between a doctor and the patient, and carer if required, supported by a CNS. Cancer tracking teams and clinicians should agree a consistent approach for recording and tracking FDS data items, covering different communication methods. In this timed pathway, this can be done at the initial clinical assessment or in a follow-up clinic which might be a face-to-face or telephone consultation, or written, if the patient has agreed to this method of communication.

   **Where cancer is ruled out**, information about relevant benign conditions should be considered. Telephone or written communication is particularly suited

where a cancer diagnosis has been ruled out and reduces unnecessary hospital attendances, where this is preferred by patients.

Information on the clinical diagnosis given should be available in a format that patients would prefer, where possible (such as a written leaflet, email or website) and presented in a way that they will understand, taking account of language, cultural, sensory, learning or other needs.

Where cancer is ruled out or confirmed and communicated with the patient, the FDS pathway can be completed. **Cancer waiting time rules** (including 'clock start', 'adjustments' and 'clock stop') are set out in the National cancer waiting times monitoring dataset guidance v11.0.

9. **Personalised care and support planning** should be based upon the person and clinician(s) completing a holistic needs assessment (HNA), usually soon after diagnosis. The HNA ensures conversations focus on what matters to the person, considering wider health, wellbeing, practical issues and support in addition to clinical needs and fitness. This enables shared decision-making regarding treatment and care options.

10. **Management of BCC should follow local and national guidelines and pathways.**

11. **Surgical excision** may be included as part of a one-stop service at initial assessment, provided adequate time is allowed for consent. Some people will be booked for surgical excision on a routine dermatology surgery list and others will be directed to specialist surgical services including, plastic surgery, maxillo-facial surgery, oculo-plastics or other specialties following initial clinical assessment.

    Patients booked for dermatology surgery or referred to other specialities for surgery are likely to have been given a cancer diagnosis at the clinical assessment appointment. The FDS 'clock stop' can be completed at this point. Excision with intent to treat will be recorded as first treatment and will complete the CWT 31-day first treatment standard.

12. **Where a clinical diagnosis has not yet been given to the patient, and a suspicious lesion (such as a clinically atypical melanocytic lesion) is to be fully removed to exclude or confirm cancer**, at the point of a decision to treat being agreed with the patient (recorded as 'CANCER TREATMENT PERIOD

START DATE' in the CWT dataset), the FDS calculation will be stopped. Further information is available in the National cancer waiting times monitoring dataset guidance v11.0 and in the examples above.

# Additional information

## Audit tool

Can be used to undertake a baseline audit of services being delivered and whether sufficient capacity is in place to routinely deliver, identify areas for improvement, select measurements for improvement, and conduct re-audits as part of continuous improvement.

| Day | Pathway step | Service in place? | Capacity in place? |
|---|---|---|---|
| -3 to 0 | GP referral and locally agreed minimum dataset | | |
| | Patient information resources, co-developed with patients | | |
| By day 14 | Clinical assessment | | |
| By day 28 | Surgical management | | |
| | Histopathology results should be reported to provide sufficient time to provide FDS communication within 28-days of referral | | |

## Cancer alliance workspace

Cancer alliances access this workspace for national guidance, resources, and to share learning. Please use this space to upload materials you have developed locally and that you think would be useful for colleagues implementing this pathway across the country.

## Acknowledgements

This guidance was developed by the Skin Task and Finish Group membership, including clinical representatives: Katie Elliott, Stephen Keohane, Nick Levell, Claire Lusted, Carolyn Charman, Julia Schofield, Rebecca Penzer-Hick, Jo Lowton-Mayo,

Tanya Bleiker, Luisa Motta, Agata Rembielak, Vijay Patel; operational representative: Robert Radford; patient and charity representatives: Diane Cannon, Paul Osman, and the NHS Cancer Programme.

# Annex 1: List of cancer types relevant to the skin cancer best practice timed diagnosis pathway

**In-scope:**

- Melanoma
- Invasive squamous cell carcinoma
- Rare skin cancers:
  - Cutaneous adnexal/appendageal carcinomas
  - Merkel cell carcinoma
  - Extramammary Paget's disease (EMPD)
  - Angiosarcoma
  - Pleomorphic dermal sarcoma
  - Dermatofibrosarcoma protuberans (DFSP)
  - Cutaneous metastasis of solid tumours

**Out of scope:**

- Basal cell carcinoma
- Soft tissue sarcoma
- Lymphoma.

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