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of Dermatologists  
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# The two-week wait skin cancer pathway: innovative approaches to support early diagnosis of skin cancer as part of the NHS COVID-19 recovery plan<sup>1</sup>

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## Summary

Targeted interventions are needed to help recover from the ongoing COVID-19 pandemic, particularly in relation to the early diagnosis of melanoma, as well as to manage the increase in demand from those who have been reticent about coming forward. This guidance details new models of service delivery for systems to consider as they seek to optimise suspected two-week wait skin cancer referrals both to tackle the backlog and meet new demand as services are restored by:

1. Harnessing new technology, in particular teledermatology and digital referral platforms to reduce unnecessary hospital attendances.
2. Developing 'spot clinics' – these allow consultant-led dermatology teams to review a large group of suspected skin cancer two-week wait referrals in a community or hospital setting.

## 1. Introduction

This document describes new and innovative approaches to the skin cancer two-week wait referral pathway, building on local experience, in the context of:

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<sup>1</sup> [Urgent cancer diagnostic services during COVID-19](#) (p19)

- The COVID-19 recovery model which includes targeted interventions for those cancers where diagnosis has been particularly impacted by the pandemic.
- The significant increase in referrals for suspected skin cancer since March 2021, and the urgent need to appropriately manage people with suspected skin cancer, demands efficient identification of early melanomas and squamous cell carcinomas.
- The need for the skin cancer two-week wait pathway to meet the new 28-day faster diagnosis standard.
- The need to continue to follow the requirements of the NHS Constitution as this relates to two-week wait referrals, while these remain in place.
- The [Getting It Right First Time \(GIRFT\) report](#), which identified that new ways of working are needed given the shortage of dermatologists and increasing skin cancer workload.
- The National Outpatient Transformation Programme interventions on [pathway redesign](#), [referral optimisation](#) and [skin lesion diagnostic pathways](#).

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

- Follow [NICE guideline \(NG12\)](#) on the recognition and referral of skin cancer, and the criteria it lays out. This remains the core guidance on appropriate patient referral to the two-week referral pathway.
- Locally agreed solutions based on available resources; one size does not fit all.
- Shared learning from pilot sites that have successfully tested different models of virtual two-week wait services.
- 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 essential for successful innovation.
- Engagement with NHSX to ensure that systems and processes align with the digital agenda.
- Systems and processes in place to capture all relevant data and to evaluate outcomes.

## 2. Background

Dermatology services receive more urgent referrals for suspected cancer than any other specialty. About half of the one million dermatology referrals per year are suspected skin cancer two-week wait referrals, and patients diagnosed with melanoma and squamous cell carcinoma make up about 6%<sup>2</sup> of all two-week wait skin referrals. It is recognised that a significant proportion of patients referred have non-relevant skin lesions. Before 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 is much more common in the elderly and can be more difficult to treat in the presence of age-associated co-morbidities.

Further information relating to cancer waiting times guidance can be found [here](#). All information in this guidance continues to apply to skin cancer pathways. Some exceptional measures are in place to support the response to the COVID-19 pandemic – further details of these can be found [here](#).

## 3. Proposed new models of delivery

The traditional pathway for skin cancer two-week wait referrals requires all patients to attend a secondary care dermatology department for a face-to-face appointment.

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 adapt solutions to local circumstances. The use of teledermatology for a new virtual pathway will significantly reduce the need for patients to attend hospital.

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 should:

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<sup>2</sup> [Cancer waiting times conversion and detection rates](#)

- Ensure that healthcare professionals continue to follow the criteria in [NICE guideline \(NG12\)](#) for the recognition and referral of skin cancer when considering referral on a two-week wait pathway.
- Reduce the inconvenience and stress for people of visiting an acute hospital setting unless this is 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 teledermatology and digital referral platforms to reduce the need for unnecessary hospital attendances.
- Use the development of community diagnostic centres to support image capture and transfer for effective teledermatology pathways.
- Link to the learning from the 100-day project outputs and recommendations and other published examples of good practice, such as community-based diagnostic ‘spot clinics’<sup>3</sup> and similar rapid access clinic models in secondary care settings.
- Ensure skin cancer targets are not prioritised to the detriment of the timely care of people with rashes and long-term skin conditions.
- 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 is unsure about a skin lesion. The possibility of this outcome should be clearly communicated to the patient.
- Support healthcare professionals and patients to take and transfer high quality images to support the diagnosis and management of skin lesions through both advice and guidance (non-two-week wait lesions) and the two-week wait pathway. These videos may be helpful:
  - [video](#) of a patient 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](#), showing how to request advice and guidance in dermatology via the e-Referral System (e-RS)
- Ensure an advice and guidance skin lesion service is set up to provide general practices with an alternative decision-making resource.

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<sup>3</sup> [Transforming elective care day services in dermatology](#) (pp23-28)

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

### 3.1 Traditional pathway

Most patients referred on a two-week wait pathway, often using a referral pro forma ([NICE guideline NG12](#)), and are offered a face-to-face appointment in a specialist dermatology service. This model will continue to be available 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.

### 3.2 Teledermatology referral

This refers to the use of asynchronous store and forward teledermatology, where high quality images accompany the two-week wait dermatology referral to enable consultant triage, ensuring face-to-face hospital attendance only when necessary.

A virtual teledermatology two-week wait pathway requires:

- High quality macroscopic and dermoscopic images as these are the 'reasonable diagnostics' needed 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 teledermatology two-week wait referral that 'stop the clock' on the referral can include:

- 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 preoperative advice and counselling.

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

- Images taken by a suitably trained healthcare professional in a GP surgery.

- Images taken by suitably trained healthcare professionals (for example, community nurses or medical photographers) in a community hub or secondary care setting.<sup>4</sup>

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

The National Outpatient Transformation Programme teledermatology roadmap, available on [Future NHS](#), and [Urgent cancer diagnostic services during COVID-19](#) give more information on issues relating to taking and sharing images securely for use with teledermatology.

### **3.3 Rapid access diagnostic consultant-led ‘spot’ clinics in community or hospital settings**

Rapid access diagnostic ‘spot’ clinics enable an experienced, trained specialist (usually a consultant who is a core member of the skin cancer multidisciplinary team) to assess a large number of people with a single suspicious skin lesion usually in a community setting. These clinics may include a mix of patients with two-week and non-two-week wait skin lesion referrals. Further details about this model of care are available [here](#).

In addition to ‘stopping the clock’ on a two-week wait referral, the outcomes for a ‘spot’ clinic can include:

- Treatment such as cryotherapy.
- Discharge of the patient back to their GP with or without a treatment plan.
- Direct booking of the patient 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, over the 100 days, 43% of the 73 patients seen during four spot clinics have not required investigation in secondary care and a further 9% received treatment in the community. Only seven were referred to the two-week wait pathway when previously all 73 patients would have been. Further details of this work can be found [here](#).

Although this work piloted a triage model prior to a two-week wait referral being made, exactly the same clinical model and principles can be applied to a group of patients who

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<sup>4</sup> 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](#).

have already received a two-week wait referral. In these cases, review by a specialist in a spot clinic would stop the two-week wait clock.

Acute hospital-based rapid 'spot clinics' using the same model have also been developed and shown to work well in terms of increasing throughput and efficiency of managing suspected skin cancer referrals, but without the benefit of reducing hospital attendances.

## 4. Implementation

The models outlined in this document can be implemented quickly and successfully. Support from the Faster Diagnosis Pathways will be crucial in developing local pathways and planning for rollout. Further elements that will support successful implementation are detailed below.

### 4.1 Engagement

Buy-in across primary and secondary care and wider stakeholders will be essential in developing new pathways and implementation. Having dermatology primary care and specialist clinical champions in each Cancer Alliance area will support the rollout, with these individuals identified through early engagement with primary care, the dermatology specialist community and clinical leaders in NHSX.

### 4.2 Administration

Administrative support is needed to build capacity into job planning, put clinic arrangements in place and enable booking systems to support the new pathways and ensure available clinical capacity is maximised and cost-effective.

### 4.3 Communications

The development of a communications plan will help ensure all the activities key to launching the new service have been considered, including the development of promotional materials, patient information and how key messages will be communicated. Regular communication with those likely to use the new pathway will inform what information needs to be available.

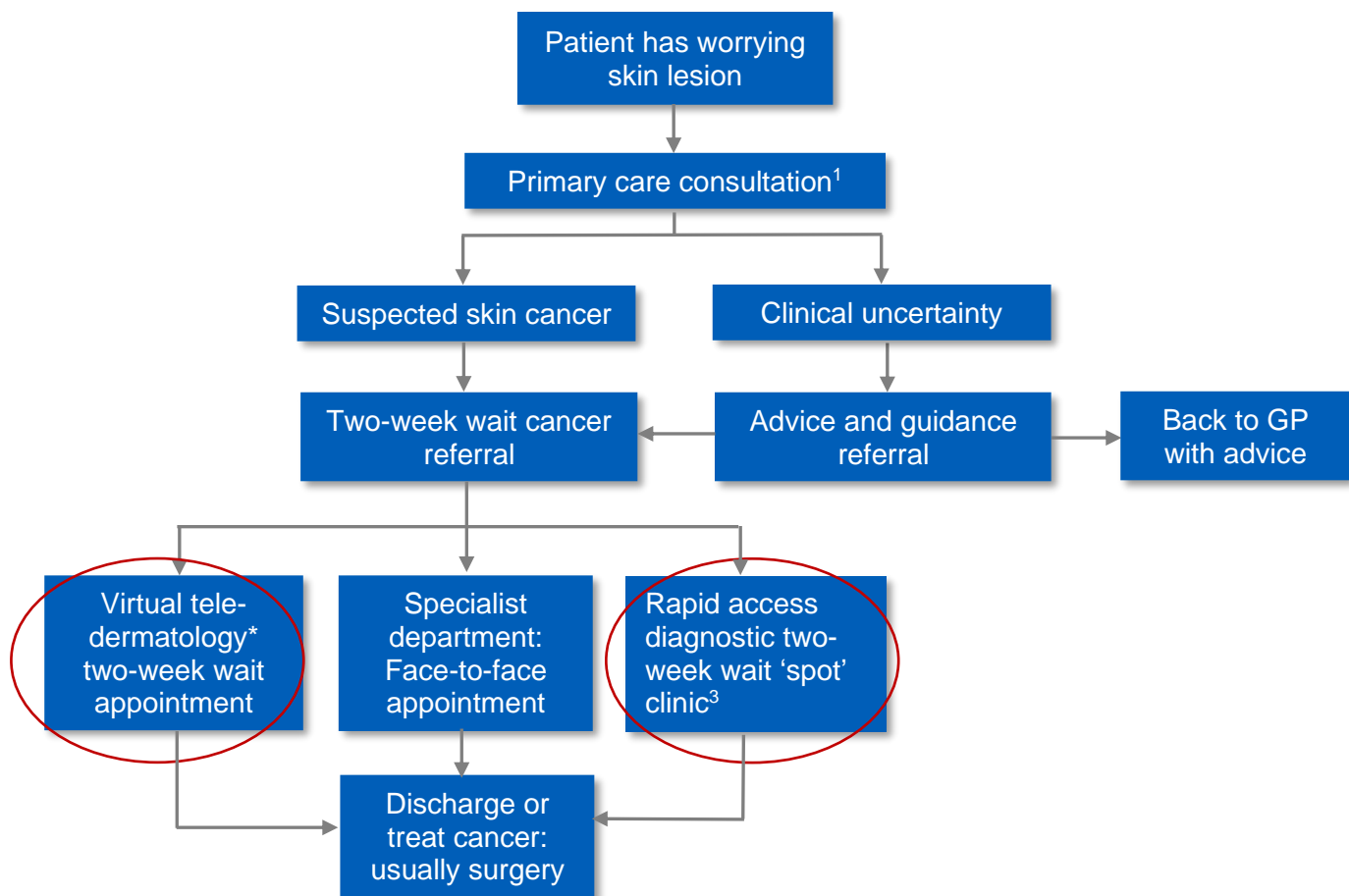
### 4.4 Measuring success

Some thought at the start should be given to how the impact of the new pathways will be measured, to ensure the required quantitative and qualitative information will be accessible and systems in place to collate the data.

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



## Appendix: Possible two-week wait suspected skin cancer diagnostic pathways



### Notes

1. While systems are in place to allow GPs to make two-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 between commissioners and providers and 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 for a virtual assessment or that they have seen the patient in person to review a potential lesion.
3. Although the rapid access spot clinics were piloted in community settings to reduce unnecessary hospital attendances, the model could also be implemented in a hospital setting.