Key components of skin lesion pathway

Dermatology v1 (Clinician)

This is an overview of the key components needed to develop effective dermatology pathways and aims to help commissioners, managers and clinicians to see the overall shape of secondary care services for specific diseases or presentations. There are some examples (shaded blue) which may improve quality or efficiency. They do not provide detailed guidance on disease management or referral criteria (see www.bad.org.uk).

Patient seeks NHS help - Initial Referral	Triage	Assessment	Management	Outpatient / Post-acute follow up
GP or appropriately trained HCP decides lesion is high enough suspicion of squamous cell carcinoma (SCC), melanoma (MM) or critical basal cell carcinoma (BCC) to meet 2 week wait (2WW) referral criteria in line with NICE guidance	Non-2WW lesion: A&G or teletriage if full history and good quality images with dermoscopy. May facilitate return to GP with advice, or prioritise to appropriate OP assessment including direct to surgery, with pre-operative phone consultation where indicated. Inefficient if poor quality images or incomplete history: See FutureNHS Teledermatology Roadmap and referral optimisation advice	Most seen in dermatology OP, some in plastics/ max-fax depending on skill mix and staffing: agree shared action plan: Benign- discharge; precancers and some cancers topical treatment/ cryotherapy/ photodynamic therapy (PDT) and usual disharge; biopsy or surgery or MDT discussion if possible cancer.		Onwards referral to oncology/ radiotherapy for advanced skin cancer as defined by MDT
If lesion does not meet criteria for 2WW but GP uncertain if lesion benign consider advice and guidance A&G with high quality and dermascopy photos	2WW: see face to face. Or consider teletriage if full history + high quality images with dermoscopy to enable dermatologist to make remote consultation to facilitate discharge as per NHS e-referral advice for cancer pathways (face to face more time efficient for many)	Skin Cancer Nurse involvement for appropriate patients (e.g melanoma, Mohs patients, SCC those with metastatic disease). Can be involved from assessment to surgery to MDT but must be appropriately trained and banded		Involvement of palliative care when appropriate
If primary care identifies lesion as probably benign, patient can self- photo and self monitor for change, with safety netting	Some non-2WW lesions triage directly to plastics or max-fax or to appropriate GPwER. Depends on local skill mix and staffing.	MDT discussion for defined problems, specialist histopathologist and radiology (as per NICE and national guidelines) involvement is key		Follow up according to national guidelines www.bad.org.uk with PIFU or PSFU when appropriate
People with lesions at A&E back to primary care unless uncontrolled haemorrhage		On call dermatology/plastics /max fax service – may see or give advice on lesions with uncontrolled haemorrhage such as pyogenic granulomas	Excision surgery with safety checklists in safe facilities by trained surgeons (nurse. dermatologist,plastics, max-fax etc) Mohs surgery: monitor rates and develop services to reduce unwarranted geographic variation	Joint skin cancer clinics with dermatologists/ surgeons and oncologists

GPwERs deal with some low risk BCCs according to RCGP 2019 rules and can help GPs avoid hospital referral of benign and pre-cancer lesions

Ongoing assessment of comorbid psychological issues with appropriate support, management and counselling and/or mental health services

Invest in education: GP education packages to include dermoscopy training	Threshold policies control referral of cosmetic lesion issues/ minor problems. CCGs should ensure buy-in and audit	High quality photography and WHO checklist reduce wrong site surgery never events	Same day surgery in one stop clinics for suitable people shortens patient pathway (may be with plastics/ max-fax)	Audit infection and incomplete excision and biopsy rates. High rates require further analysis	Primary/secondary shared care for selected patients
Monitor A&G + teletriage + total referral numbers to ensure that these do not escalate rapidly. A&G should be used to educate and improve primary care treatment of common conditions and not to shift care to secondary care		Confocal microscopy may in future replace skin biopsy for some lesions	BAD Service standards for Mohs and PDT for safety		Telephone or video clinics – follow up may help for patients with lesions unable to travel
		Super-clinics or spot clinics (multiple practitioners, nurses, junior doctors and GPwERs supervised by consultant without own list who sees nearly all patients) increases outpatient efficiency by reducing follow ups and ensuring all patients get consultant direct opinion			

Follow national specialist society (BAD/ BAPRAS etc) guidelines; NICE guidelines including audit and training recommendations

Clinicians should encourage self-management and patient education via virtual information sources – regarding sun exposure, skin self monitoring for new or recurrent disease and patient packs

Collect patient reported data and participate in relevant NIHR studies. Clinical research units usually have better outcomes

Appropriate use of digital technology throughout the pathway to improve patient experience rather than as an end in itself: see the dermatology digital playbook