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Correspondence and Communications

Achieving 62-day targets in the management of skin cancer: Lessons learned and future directions for the post-COVID era

Dear Sir,

For the past 20 years, the delivery of skin cancer care in the United Kingdom (UK) has been governed by a 62-day target to achieve the first definitive treatment from the time of referral. This objective was set out by the Department of Health in the National Health Service (NHS) Cancer Plan 2000[1] and adjusted in the 2007 Cancer Reform Strategy[2] to include an expected compliance of 85%.

Now, in the year 2020 where the world as we know it has been drastically upended due to Coronavirus-2019 (COVID-19), how too will the delivery of cancer services change?

While the provision of skin cancer surgery has varied considerably from unit to unit across the country during the pandemic[3], there are some centres who will experience a considerable backlog of referrals, resulting in subsequent breaches. The Royal Stoke University Hospital was one centre which continued delivering skin cancer surgery throughout the 'peak' of the pandemic. As a baseline, we reviewed the reasons for delay in skin cancer treatment in the two years (2017–2019) prior to COVID-19 as a means of preparation for how best to streamline the service should the system become stressed by a pandemic backlog.

- During this 2-year period, 72 patients (mean age 79 [SD 10.9]) with 65 SCCs and 7 melanomas breached the 62-day target. This represented 10% (72/713) of the skin cancers treated for the time period.
- The median time from referral to procedure in patients who breached was 75 days (IQR 68–90).
- The longest delays were from initial diagnostic biopsy (69/72 patients) to formal procedure (mean 49.6 days [SD 30]) or for those who had an initial appointment with dermatology and were subsequently referred to plastic surgery (mean 41.7 (SD 25) days), as shown in Figure 1.
- Where a reason was coded for delays, these were most commonly due to inadequate operating capacity (29%), followed by delays due to patient fitness for surgery (26%).
- In accordance with summer being the busiest time for referrals in our centre, the peak of breaches occurred in November, and additionally in February following a decrease in service provision over the Christmas period (Figure 2).

How, then, will this information equip us and other UK skin cancer units to face a potential influx of referrals during and following second and potential subsequent 'waves' of the pandemic, while resources may be limited? It is evident that answer, as suggested across the subspecialties in the post-COVID era[4], is to streamline the service. From our analysis of pre-pandemic problems, we have identified three key areas to target to reduce waiting times:

1. First, appropriate triaging of patients to either plastic surgery or dermatology (or other specialties as relevant) in order to reduce delays caused by inter-specialty referrals. This may be done at the GP referral stage or upon receipt of the referral by specialist teams. The use of electronic 2-week-wait forms with mandatory fields may provide the evidence needed to decide which lesions are best managed directly by plastic surgery, for example suspected skin cancers greater than a certain size or lesions in the head and neck. This information can then arm administrative staff to book the patients for either plastics or dermatology review in accordance with an agreed protocol. This has been implemented at our centre at a preliminary level for lesions in the head and neck, where location of lesion is adequately described by the referrer.

Telemedicine, through telephone and video consulting has proven beneficial in the triage process – both in increasing the number of patients administrators can book to be seen in a session, and acting as a second line of triage to remove patients who do not likely have a cancer from the pathway. Teledermatology following the COVID-19 outbreak may already be decreasing the two-week-wait time for the specialty.[5]

2. Secondly, combined dermatology and plastic surgery clinics would allow any patients who are deemed to benefit from plastic surgical input to avoid waiting 49 days for a second appointment. We have implemented "parallel" clinics where dermatologist and plastic surgeon are consulting in adjacent rooms. In very busy clinics, extra time may be allocated to allow cross-specialty review of any patients immediately.

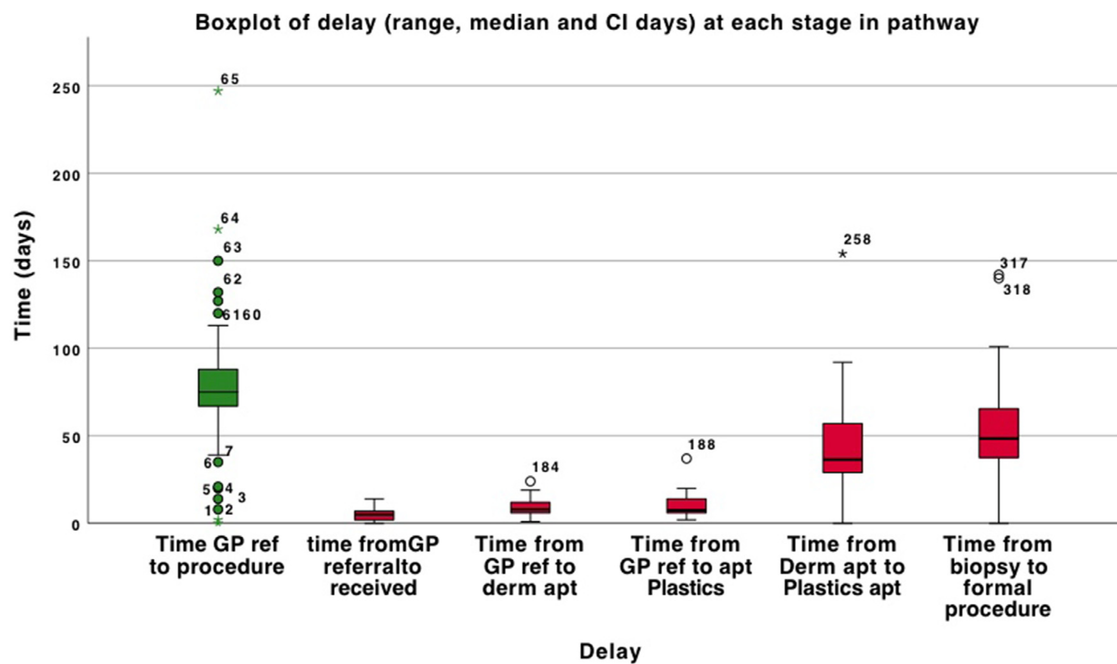

Figure 1 Boxplot showing median delay and range in days at each stage of the 62-day pathway, with the total time from GP referral to first definitive treatment in green for all patients who breached between 2017-2019.

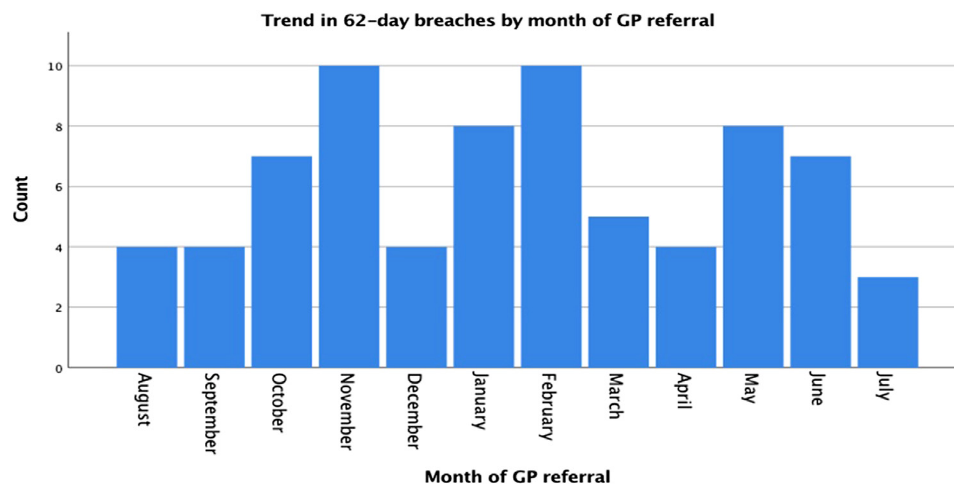

Figure 2 Seasonal variation in 62-day breaches of skin cancer patients.

3. Lastly, streamlining may be achieved at an individual patient level by combining or reducing steps in the diagnostic pathway. Patients referred directly to plastic surgery may not need an initial incision biopsy, for example, if it is not likely that the lesion will require graft or flap reconstruction. To this end, the decision can be made not to proceed with incision biopsy after the initial consultation. Sixty-nine of the 72 patients in this cohort had an incision biopsy which in our minds highlights it as a key target for change. Where there is a clinical need for incision biopsy, these should be fast-tracked for pathology so that their definitive surgery can be undertaken in a timely manner.

With the above efforts, these authors believe that both the number of patient encounters with the healthcare service and the length of time they spend waiting for diagnosis and treatment of skin cancer will be reduced. Perhaps a hopeful prospect of the tragic events of 2020 may be that it served as an alarming reminder to re-evaluate our National Health Service and innovate for our future population.

Declaration of Competing Interest

None declared.

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Ethical approval

Not required.

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