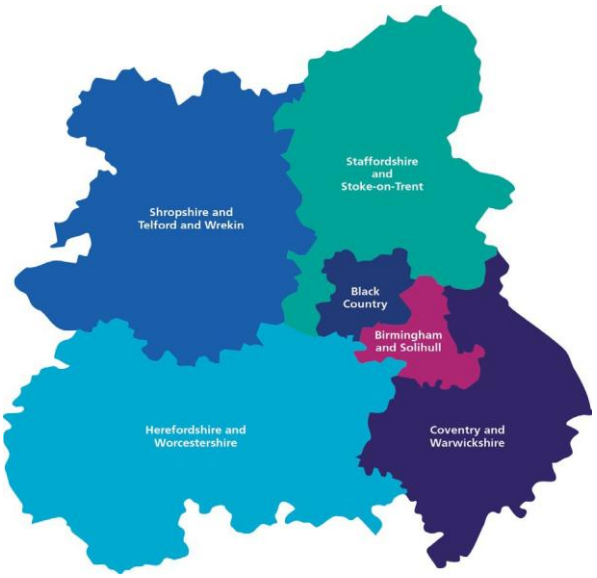
West Midlands Cancer Alliance Personalised Stratified Follow Up (PSFU) Guidelines for people with a Skin Cancer Diagnosis

Report by : West Midlands Cancer Alliance, Skin Cancer Expert Advisory Group

Date : 04/12/2025



EAG name	Skin Expert Advisory Group (EAG)	
Document Title	West Midlands Cancer Alliance Personalised Stratified Follow Up (PSFU) Guidelines for people with a Skin Cancer Diagnosis	
Published date	January 2026	
Document Purpose	The skin PSFU guidelines aim to personalise post treatment care for skin cancer patients by offering tailored follow-up pathways, either traditional or self-managed, to empower patients to live well beyond cancer with clinical support.	
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Approved by

This document must be approved by the following people:

Governance	Description	Who	Date
WMCA Skin EAG Chair	Approved	EAG chair	20.11.2025
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V1.0	16/4/25	• Various changes discussed during initial working group meeting	Angela Heathcote
V2.0	4/6/25	• Various changes discussed during second working group meeting	Angela Heathcote
V2.1	5/6/25	• Email correspondence – appendices and references	Angela Heathcote
V2.2	17/6/25	• Presentation to skin EAG members for comment	Angela Heathcote
V2.3	2/7/25	• Patient advocate feedback added to end of treatment review	Angela Heathcote
V2.4	14/7/25	• Patient advocate feedback – pages 3&4	Angela Heathcote
V2.5	07/8/25	• Updated contents	Angela Heathcote
V2.6	10/9/25	• Updated GP section following presentation at GP and Primary Care EAG	Angela Heathcote
V2.7	25/9/25	• Included health inequalities paragraph to section 10 following presentation at September skin EAG	Angela Heathcote
V2.8	06/11/2025	• Review Cancer Care Review Statement	Sandra Smith
V2.9	14/11/2025	• Primary Care EAG update	Sandra Smith
V3.0	27/11/2025	• Updated contents	Sandra Smith
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Contents

1. Introduction and Purpose of this guideline

Personalised Stratified Follow Up (PSFU) involves adapting care to the needs of the patient after cancer treatment. Pathways should be tailored to the individual needs. For skin cancer, this involves personalisation of cancer follow up with some patients staying on traditional follow-up schedules whilst other patients who are suitable can be moved to a self-managed pathway. This aims to empower people diagnosed with skin cancer to self-manage and live well with and beyond cancer with a greater emphasis on quality of life and responsibility to the individual with remote support of the clinical team.

The aim of PSFU involves improving patient experience and quality of life whilst also making services more efficient and cost-effective.

2. Context

Skin cancer is the most prevalent cancer in the UK, with over 265,000 cases diagnosed annually, encompassing both melanoma and non-melanoma types.

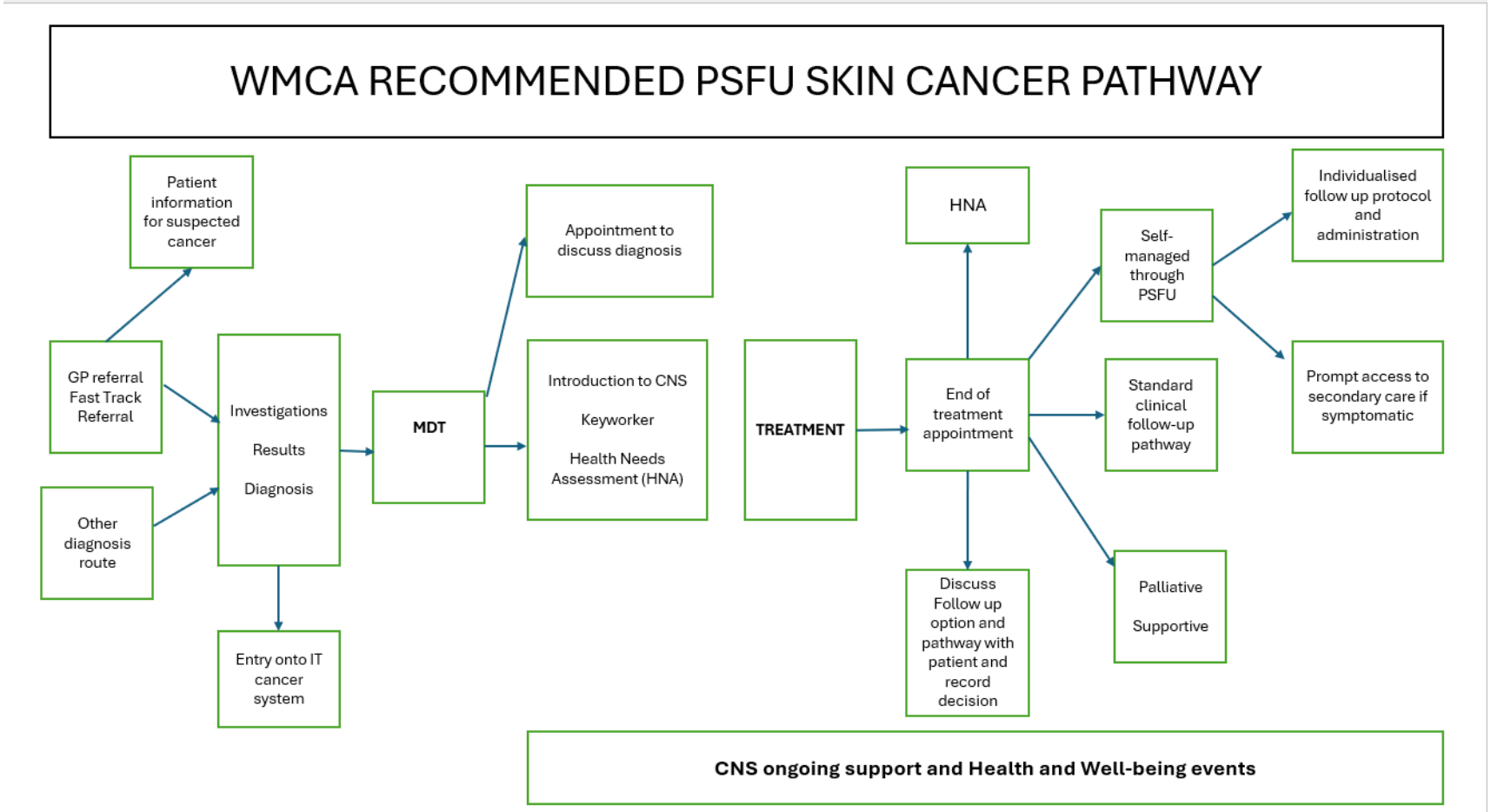
The escalating incidence has placed immense pressure on dermatology services. NHS dermatology departments receive about 1.2 million referrals annually, with 60% categorized as urgent for suspected skin cancer. However, only 6% of these referrals confirm a cancer diagnosis, leaving the majority to be managed as non-urgent cases. Despite an increase in dermatologists from 833 in 2010 to 1,284 in 2024, staff shortages persist, leading to significant backlogs and delays in treatment. In 2023-24, over 38,000 patients in England were on waiting lists for skin cancer treatment, a 26% increase from 2019-20.

One solution to help address this capacity challenge is implementation of PSFU and is identified as a priority within the NHS Long Term Plan. Implementing PSFU aims to achieve substantial redeployment of outpatient appointment slots to new referrals and people with complex needs. This has been successfully deployed in other cancer types including prostate cancer, colorectal cancer and breast cancer and implementation is now being advised for skin cancer. NHS England has advised that ICBs and commissioners must come together as part of their cancer alliance to plan and deliver PSFU.

As per NHS England PSFU guidance, the expectation is that up to 1 million slots can be repurposed over 5 years of the long-term plan.

Alongside the implementation of PSFU, the following should be in place:

- Written information about signs and symptoms to look out for which could suggest their cancer has recurred or progressed.
- Rapid access back to their cancer team, including telephone advice and support, if they are worried about any symptoms.
- Advice, if any regular surveillance scans or tests are needed and how they will be arranged.
- Personalised care and support planning and support for self-management, to help them to improve their health and wellbeing in the long term. All patients diagnosed with SCC, melanoma and other rare skin cancers should have a holistic needs assessment and an end of treatment summary prior to entering onto a PSFU pathway.


WMCA RECOMMENDED PSFU SKIN CANCER PATHWAY
Patient information for suspected cancer
GP referral Fast Track Referral
Other diagnosis route
Investigations
Results
Diagnosis
Entry onto IT cancer system
MDT
Appointment to discuss diagnosis
Introduction to CNS
Keyworker
Health Needs Assessment (HNA)
TREATMENT
HNA
End of treatment appointment
Discuss Follow up option and pathway with patient and record decision
Self-managed through PSFU
Standard clinical follow-up pathway
Palliative
Supportive
Individualised follow up protocol and administration
Prompt access to secondary care if symptomatic
CNS ongoing support and Health and Well-being events

3. Implementing the PSFU pathway

For successful implementation of a PSFU pathway, the following must be in place at the trust:

- A process to explain the PSFU pathway to patients and/or carers, with the opportunity to ask questions or raise concerns. If they do not understand the arrangements, PSFU may not be suitable.
- Patients should be assessed as able to review their skin and lymph nodes either by themselves or with the help of a carer.
- Patients should be offered timely access to see a clinician if they raise any concern about recurrence/spread of their skin cancer during the designated follow up period.
- Using teledermatology is recommended for rapid assessment if the patient raises a concern about recurrence on the skin (if the concern is a lymph node or subcutaneous lesion, a face-to-face appointment may be more appropriate). If teledermatology is not available for patients on a PSFU pathway, an alternate system should be in place for patients to securely send a photo of the lesion for initial triage.
- Consider having a CNS-led clinic with open appointments for patients on a PSFU pathway for rapid access within 2 weeks if there is a concern about recurrence.
- Patients should be given tailored, written information on their diagnosis and how to monitor for recurrence/spread.
- Any patients moved onto a Patient Stratified Follow Up (PSFU) should be logged and tracked on the organisations IT system.
- Any scans which are indicated as per MDT outcomes or national guidance should remain in place whilst on a PSFU pathway.

4. Workforce planning

Departments planning to implement PSFU should undertake a workforce planning exercise to ensure successful delivery of this pathway. This is to ensure that patients can be fully supported remotely and have ease of access for advice or to be seen when required. Skin cancer care navigators and clinical coordinators can help to manage and organise the pathway to release and realign clinical time of clinical nurse specialists (CNS) to areas of priority.

Skin CNSs routinely carry out HNA and end of treatment reviews for all patients; however, dedicated time and resources must be made available for CNSs to support patients who choose to pursue a PSFU pathway.

Using templates (see appendices) for HNAs and end of treatment reviews will help to free up clinical time. In future, some of this work may also be supported by artificial intelligence.

5. Identifying patients suitable for PSFU

- Identify at the initial appointment who might be suitable if skin cancer is confirmed (e.g. patients understanding and capacity, including frailty and care needs and ability for care team to support PSFU).
- Where possible discuss and document in the MDT, if suitable for PSFU
- Patients meeting criteria as per this guideline – have an informed discussion in clinic to determine best pathway for patient with shared decision making.

6. Documentation of PSFU

- Written information should be provided about their diagnosis, treatment and PSFU
- The outcome of the PSFU discussion should be documented in the patient medical record and on the IT system
- Where possible, the patient should be moved to a PSFU pathway and provided with written information on what the route of contact is, if there are any concerns during the designated follow up period, as per current national guidance.
- Where possible, patients should be seen by a skin cancer CNS prior to entering PSFU to provide education on self-monitoring and to undertake the holistic needs assessment. This also provides a named point of contact, if there is a concern.
- Advice should be given on how often to check lymph nodes and skin.
- Advice on self-monitoring for new skin cancers and skin cancer prevention should be provided.
- Where possible, the patient should be provided with video resources on self-monitoring, including lymph node examination and the PSFU pathway (see appendix for resources).
- A separate letter documenting the PSFU should be forwarded to the patient's GP with the contact details and length of follow-up. This can be auto generated.

7. Diagnosis specific advice related to PSFU – Eligibility for Entry onto a self-managed pathway

Basal Cell Carcinoma

All fully treated BCCs can be discharged via letter results without need for face to face follow up, unless there is a recommendation by the MDT to offer PSFU, especially if there is a very

high risk of further skin cancers. Patients should be given advice on self-monitoring and skin cancer prevention via written information and/or video. A PSFU pathway is not required.

Squamous Cell Carcinoma

Patients with "**Low Risk**" SCCs as per British Association of Dermatologist guidelines 2020 – should be seen once in clinic, to provide information and advice on self-monitoring, if not provided already at the initial appointment. This could be undertaken by a trained Skin Cancer Nurse Specialist with oversight by a Consultant Dermatologist. The patient can then be discharged with advice on self-monitoring. A PSFU pathway is not required. If new concern in future, advice to be referred on Urgent Suspected Skin Cancer Referral Pathway.

Patients with "**High Risk**" SCC: Offer PSFU pathway for suitable patients via informed discussion using previously mentioned guidance. The PSFU should be available for 1-2 years as per MDT decision and as per guidelines. E.g. one risk factor a year may be sufficient, or two years if several risk factors are present.

Patient who may not be suitable include:

- Patients who unable to self-examine e.g. sight or mobility impairment or due to cognitive impairment (unless there is a carer who can be involved in supporting monitoring and follow up).
- Patients with history of multiple SCCs or other high risk skin cancers

Patients with "**Very High risk**" SCC: Offer face to face follow ups unless patient declines and opts for PSFU. Ensure that it is documented that the risks have been explained to the patient and that they understand.

Melanoma in situ or Lentigo Maligna

Following adequate surgical clearance or other treatment, as per MDT, the patient can be informed of results by letter and discharged with advice on surveillance for local recurrence. PSFU not indicated.

Melanoma:

pT1a melanoma <0.8mm, non-ulcerated – consider PSFU for 1 year.
pT1b and higher – offer face to face appointments as per guidelines, but with option for patients to choose a PSFU pathway based on informed discussion of risks.

Rare cancers: Offer face to face follow ups unless patient declines and opts for PSFU based on informed discussion of risks.

8. Discharge from the PSFU pathway

Upon completion of the supported self-management follow-up pathway, both the patient and their general practitioner (GP) will be formally notified by letter of the patient's discharge from secondary care. This correspondence will include recommendations for the ongoing management and long-term care plan to be implemented in primary care.

The letter should include advice on what to do if the individual has a concern about the recurrence of their skin cancer or a new skin cancer. This should indicate they should see their GP for a referral back to the hospital (where there are red flags symptoms or side effects, this should be on an urgent suspected skin cancer referral pathway).

9. Types of Personalised Follow-Up Pathways – Method of delivery

A Holistic Needs Assessment (HNA) is a collaborative discussion between the patient and the healthcare team aimed at identifying the individual's specific needs and concerns. This process facilitates the development of a tailored supportive care plan. The needs assessed can encompass various aspects of life impacted by cancer, including:

- **Physical Needs**: Issues such as pain, weight loss, mobility challenges, and sleep difficulties.
- **Emotional Needs**: Concerns like fear of surgery and worries about family.
- **Practical Needs**: Challenges related to attending outpatient and surgical appointments.
- **Financial Needs**: The impact of cancer or surgery on employment and the ability to afford transportation or parking.
- **Spiritual Needs**: How appointments, treatments, or the cancer diagnosis affect personal beliefs.

The HNA should be conducted by a Clinical Nurse Specialist (CNS), Cancer Care Support Worker, or Navigator, who possess up-to-date knowledge of local and national services for

appropriate referrals. It is recommended that the HNA be offered at the time of diagnosis and during or after treatment.

10. End of treatment review

An End of Treatment Summary is a tailored document provided to skin cancer patients and their general practitioners (GPs) upon the completion of treatment. This summary should include:

1. **Diagnosis Overview**: A detailed description of the skin cancer diagnosis, specifying the type (e.g., basal cell carcinoma, squamous cell carcinoma, melanoma), stage, and any relevant histopathological findings.
2. **Treatment Details**: A comprehensive account of the treatments administered, such as surgical excision, Mohs surgery, radiation therapy, or systemic therapies, along with dates and outcomes.
3. **Aftercare Plan**: Instructions on the aftercare to be provided by the dermatology or oncology team, including follow-up appointments, skin examinations, and any ongoing treatments or medications.
4. **Self-Care Guidance**: Recommendations for the patient on how to manage their skin health post-treatment, including sun protection strategies, skin self-examinations, and signs or symptoms to watch for that may require medical attention.
5. **GP Support Instructions**: Specific guidance for the GP on how to support the patient, including any necessary skin checks if the patient presents, referrals to dermatology, or interventions that may be required as part of the patient's ongoing care.
6. **Access to Services**: Information on how the patient can access dermatology or oncology services if new symptoms or concerns arise, including contact details for the care team and emergency protocols.

Prior to discharge, clinicians may opt to initiate a virtual MDT triage to support ongoing care and planning. However, this intervention is not a mandatory requirement of the discharge process.

This summary serves as a critical tool for ensuring continuity of care and empowering skin cancer patients and their GPs with the information needed to manage post-treatment health effectively. An example of this is provided in Appendix II by Sandwell & West Birmingham NHS Trust Skin Cancer CNS team.

Health inequalities can affect patient access to follow-up care, diagnostic pathways, and outcomes in skin cancer. Timely referral, access to high-quality imaging, and early detection may be particularly challenging for underserved or socioeconomically disadvantaged populations, where barriers such as geography, digital access, and resource availability widen gaps in care. This highlights the need for equitable and personalised follow-up approaches to ensure all patients benefit from timely detection and treatment.

11. Evaluating the service

Implementation of PSFU should involve evaluating the outcomes at each trust (at least 6 monthly):

- The number of patients moved to a PSFU pathway, diagnoses and number of discharges.
- Number and clinical information of those re-accessing the service, the route and time taken to access services
- Recurrence rates and new tumours
- Outpatient capacity released

12. Clinical Governance

Whilst these Cancer Alliance guidelines are advisory for the West Midlands, responsibility remains with trusts' clinical governance arrangements to ensure that PSFU protocols are adopted safely, and that data is kept secure.

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Abbreviations

CNS – Clinical nurse specialist
GP – General practitioner
ICB – Integrated Care Board
BCC – Basal Cell Carcinoma
HNA – Health Needs Assessment
MDT – Multi-disciplinary team
MIS – Melanoma in situ
PSFU - Personalised Stratified Follow Up
SCC – Squamous Cell Carcinoma

APPENDICES

APPENDIX I – Example of PSFU commencement letter

Dear [Patient Name],

Re: Your Follow-Up Plan After Skin Cancer Surgery

Following our discussion during your recent outpatient clinic appointment, I am writing to confirm that you are now being placed on a Personalised Stratified Follow-Up (PSFU) pathway which will continue for ***1/2 years*** and complete on ***DATE***. You will find further explanation about PSFU in the leaflet that is enclosed with this letter.

This means that instead of having routine follow-up appointments, you will have open access to our team and can contact us directly if you experience any new or concerning symptoms related to your skin cancer. This approach is considered safe and appropriate for you at this stage of your recovery.

What to expect next:

- You will not have regular follow-up appointments scheduled, but you can contact us at any time if you have concerns.
- You will shortly receive an End of Treatment Summary letter, which includes:
    - Information on symptoms to watch for
    - Guidance on self-monitoring
    - Contact details for how to reach our team if you need support

We will also be writing to your GP to inform them of this follow-up arrangement and to provide recommendations for your on-going care.

We will make a final appointment to review you at the end of the period in ***Month Year*** before we discharge you to your GP. This will either be face to face or by telephone as discussed with you.

If you have any further questions or require support at any point, please do not hesitate to get in touch using the contact details provided in your End of Treatment Summary letter.

Yours sincerely,

APPENDIX II – Example of End of Treatment Summary for SCC patients.

Treatment Summary for Squamous Cell Carcinoma (SCC) Skin Cancer

Consultant : ***Please insert***
Diagnosis: ***Please insert***
Summary of Surgical Treatments
**Please insert*

Summary of medical/oncology treatments and at which Hospital:
**Please insert*

Follow Up Plan
(insert guideline follow up along with consultant/MDT recommended)
Or PSFU guidance.

Self-Managed Follow Up
1. Self-monitoring of the scar site every month for potential recurrence.
2. Perform regular checks of skin for new lesions and lymph nodes for lumps monthly.
3. Contact your clinical nurse specialise (CNS) with any lesions or lumps of concern.
4. Practice sun safety advice.

You will be notified for appointments by letter, text message or telephone

Recommended General Practice actions
1. Following a patient initiating a concern about a new skin lesion or lymph node to primary care, primary care team to support with an appropriate examination and refer/treat as required.
2. General Practice to complete the Cancer Care Review within 12 months of a patient's diagnosis.

Imaging Considered (yes/no)
Follow Up Blood Tests required (yes/no)

Signs and Symptoms you should report to your specialist team

Treatment will be much easier if your Squamous Cell Carcinoma is detected early. It is, therefore, important to see your doctor if you have any marks on your skin which are

- Growing
- Bleeding
- Changing in appearance in any way
- Never healing completely.

Check your skin for changes once a month which a friend or family member can help you. If you see anything on your skin that is changing, go to your GP or contact your CNS.
You were given a full information pack at diagnosis, if you require a new information pack or have any questions please contact the CNS team.

Holistic Needs Assessment was completed on *DATE* and you spoke with your cancer care navigator on the telephone. Please see the clinic letter dated.....If you would like another conversation with them, please do contact her on 0121-******.

Prescription charge exemption arranged: Yes/No

Health and Wellbeing Support and Information
More people than ever are living with and beyond cancer. Receiving care that is tailored to your needs can have a significant impact on your experience and quality of life. We ensure that every person receives personalised care and support from Cancer diagnosis onwards. You will receive the chance to complete a Holistic Needs Assessment with the Cancer Care Navigator and they will contact you to do this.
Health and well-being events are set up by SWBH Trust for everyone who has had a cancer diagnosis. There will be clinical and non-clinical staff at the event and you will be provided with health promotion information and

<table>
<tr><td colspan="2">ore people than ever are living with and beyond cancer. Receiving care that is tailored to your needs can have a significant impact on your experience and quality of life. We ensure that every person receives personalised care and support from Cancer diagnosis onwards. You will receive the chance to complete a Holistic Needs Assessment with the Cancer Care Navigator and they will contact you to do this.
Health and well-being events are set up by SWBH Trust for everyone who has had a cancer diagnosis. There will be clinical and non-clinical staff at the event and you will be provided with health promotion information and information about activities going on around Sandwell and West Birmingham. This event is designed to be a relaxed and informal event. Your Cancer Care Navigator will invite you to the event when you speak with them.</td></tr>
<tr><td colspan="2">Important contacts for queries or concerns</td></tr>
<tr><td>CNS Team
Clinical Nurse Specialists (CNS)- Phone number
Cancer Care Navigator - Phone number</td><td>Living with and Beyond Cancer Team (LWBC)
Phone – 0121 ******
Email -</td></tr>
<tr><td colspan="2">Other useful information sources
Information on Squamous Cell Carcinoma visit
https://www.skinhealthinfo.orguk/a-z-conditions-treatments
For further information and patient support groups got to
www.skinhealthinfo.org.uk
Macmillan Cancer Support
www.macmillan.org.uk
Tel: 0808 808 0000 (8am-8pm everyday)
Sun Safety
www.cancerresearchuk.org/about-cancer/causes-of-cancer/sun-uv-and-cancer/sun-safety
www.skcin.org</td></tr>
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