Kent & Medway Cancer Collaborative

**Skin Tumour Site Specific Group Meeting**
**Thursday 21st May 2026**
**Conference Room, Postgraduate Centre, 1st Floor, William Harvey Hospital, Kennington Road, Willesborough, Ashford. TN24 0LZ**
**14:00-17:00**

**Final Meeting Minutes**

| Present | Initials | Title | Organisation |
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| Andrew Birnie (Chair) | **AB** | Consultant Dermatologist & Dermatological Surgeon | EKHUFT |
| Richa Tripathi | **RT** | Specialty Doctor in Dermatology | EKHUFT |
| Raghuram Boyapati | **RB** | Consultant Oral & Maxillofacial Surgeon | EKHUFT |
| Roopa Farooki | **RF** | Dermatology Registrar | EKHUFT |
| Wendy Willmore | **WW** | Skin Cancer CNS | EKHUFT |
| Asha Rajeev | **AR** | Consultant Dermatologist | EKHUFT |
| Sara O'Kelly | **SOK** | ST5 Dermatology Registrar | EKHUFT |
| Remya Prasannan | **RP** | Specialty Doctor in Dermatology | EKHUFT |
| David Tighe | **DT** | Consultant Oral & Maxillofacial Surgeon | EKHUFT |
| Kim Peate | **KP** | Lead Skin Cancer CNS | EKHUFT |
| Saul Halpern | **SH** | Consultant Dermatologist | EKHUFT |
| Nina Hayes | **NH** | Skin Cancer CNS | EKHUFT |
| Gautami Agrawal | **GA** | Consultant Radiologist | EKHUFT |
| Feroza Ahmad | **FA** | Medical Education Fellow | EKHUFT |
| Annapoorna Pai | **AP** | Consultant – OMFS | EKHUFT |
| Ann Courtness | **AC** | Macmillan Primary Care Nurse Facilitator | KMCA |
| Jonathan Bryant | **JB** | Primary Care Cancer Clinical Lead | KMCA |
| Chris Singleton | **CS** | Senior Programme Manager | KMCA |
| Karen Glass | **KG** | PA/Business Manager | KMCA/KMCC |
| Colin Chamberlain | **CC** | Administration & Support Officer | KMCC |
| Sam Williams (Minutes) | **SW** | Administration & Support Officer | KMCC |
| Nikki Jagger | **NJ** | Endoscopy Programme Manager | Kent & Medway ICB |
| Thomas Webb | **TW** | Consultant Medical Oncologist | MTW |
| Sarah Qureshi | **SQ** | Consultant Medical Oncologist | MTW |
| Ann Fleming | **AF** | Consultant Pathologist | MTW |
| Camilla Oliver | **CO** | Clinical Nurse Specialist | QVH |
| Caspie Graham | **CG** | Macmillan Skin Cancer CNS | QVH |

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| Louise Wibberley | **LW** | Business Development Manager | Skin Analytics |
| Margot McLauchlan | **MM** | Digital Health & Clinical AI Fellow | Skin Analytics |
| Darren Jalink | **DJ** | Head of Commercial (NHS) | Skin Analytics |
| Andrew Taylor | **AT** | GP with Extended Role in Minor Surgery | Len Valley Practice |
| **Apologies** | | | |
| Marcia Ruddock | **MR** | Advanced Surgical Nurse Practitioner | EKHUFT |
| Suzie Chate | **SC** | CIS Infoflex Development Manager | EKHUFT |
| Denis Bajramoski | **DB** | Consultant Dermatologist | EKHUFT |
| Danielle Mackenzie | **DM** | Macmillan Lead Nurse for Personalised Care | EKHUFT |
| Casey Powell | **CP** | Consultant Histopathologist | EKHUFT |
| Elizabeth Julian | **EJ** | Specialty Doctor in Dermatology | EKHUFT |
| Jesuloba Abiola | **JA** | Consultant Oral & Maxillofacial Surgeon | EKHUFT |
| Nic Goodger | **NG** | Consultant Maxillofacial Surgeon | EKHUFT |
| Peter Such | **PS** | Reporting Radiographer | EKHUFT |
| Nicola Handford | **NHa** | Reporting Radiographer | EKHUFT |
| Rhiannon Leppard | **RL** | Skin Cancer Support Worker | EKHUFT |
| Ritchie Chalmers | **RC** | Medical Director | KMCA |
| Laura Mullens | **LM** | Macmillan Rare Tumour Clinical Nurse Lead | MTW |
| Laura Abdey | **LA** | Melanoma CNS | MTW |
| Tracey Spencer-Brown | **TSB** | Head of Nursing – Oncology & Cancer Performance | MTW |
| Heba Hassan | **HH** | SpR – Medical Oncology | MTW |
| Nicholas Greenwood | **NG** | Melanoma CNS | MTW |
| Anthi Zeniou | **AZ** | Consultant Clinical Oncologist | MTW |
| Jennifer Dormer | **JD** | Consultant Clinical Oncologist | MTW |
| Siva Kumar | **SK** | Consultant Plastic, Reconstructive & Aesthetic Surgeon | QVH |
| Jennifer O'Neill | **JON** | Consultant Plastic, Reconstructive & Aesthetic Surgeon | QVH |
| Lisa Vincent-Smith | **LVS** | Consultant Physician /Cancer Lead | MFT |
| Andrew Morris | **AM** | Consultant Dermatologist | SCDS |
| Helen Graham | **HG** | Cancer Research Delivery Manager | NIHR |

| **Item** | | **Discussion** | **Agreed** | **Action** |
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| **1.** | **TSSG Meeting** | **<u>Apologies</u>** | | |

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| | | • The apologies are listed above.<br><br>**Introductions**<br><br>• AB welcomed the members to the meeting and everyone introduced themselves.<br><br>**Action Log Review**<br><br>• The Action Log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting.<br><br>**Review Previous Minutes**<br><br>• The final minutes from the previous meeting which took place on 20th November 2025 were not reviewed but previously agreed as a true and accurate record. | | |
| **2.** | **Clinical Reference Group & Update from Cancer Conference** | **Update provided by Andrew Birnie**<br><br>• AB outlined the current members of the CRG and encouraged the group to contact him if they are interested in joining the CRG. AC to be added to the list of members.<br><br>• The CRG meet monthly and this feeds into the TSSG.<br><br>• AB attended the Cancer Conference held in January 2026 and encouraged members to view the 'Limbo Land' video.<br><br>• AB highlighted the Key Drivers for the NHS which included Hospital to Community, Analogue to Digital and Sickness to Prevention. Key points of the Conference included, Moving End of Life Care to the Community which could save millions of pounds.<br><br>• KP attended a recent KMCA meeting with Clinical Leads and AB felt that they might be able to | | **Presentation circulated to the group on 22nd May 2026.** |

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| | | streamline their MDT's with the introduction of pre-meetings to review all listed patients and agreement of which patients could proceed under SOP guidance. This would save on time, longer term. He will work with KP to see how this could be implemented. | | |
| **3.** | **Cancer Dashboard** | **<u>Update provided by Andrew Birnie</u>**<br><br>• AB went through the Data Pack Slides provided by David Osborne.<br><br>• Kent and Medway is generally around or above the England average for FDS and 62 Day performance. FDS at Kent & Medway is at 88.9%. 62-day performance is at 86.1%.<br><br>• Performance is highest at EKHUFT and lowest at QVH. FDS at EKHUFT is at 90.9%, SCDS is at 85.3% and QVH is at 83.8%.<br><br>• 62-day Performance at EKHUFT is at 89.9%, SCDS is at 83.2% and QVH is at 82.6%.<br><br>• AM advised that QVH are working on their 28 days and SCDS have been bought out by a different company.<br><br>• AB explained that Biopsy does not stop the clock. Cancer survival from melanoma/SCC - no significant difference to nationally.<br><br>• AB encouraged everyone to gain access to the to the Dashboard.<br><br>**<u>How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards</u>**<br><br>• Register for access to Kent and Medway ICB Power BI reports by completing the form at https://forms.office.com/r/svyPSvktHw.<br><br>• Email David.Osborne11@nhs.net to say you have completed the form for access to the dashboard. It can take up to a week for the ICB to grant access.<br><br>• Once access has been granted, you can access the dashboard at https://app.powerbi.com/home?ctid=4cfbd3c4-a42e-48a1-b841-31ff989d016e. Click on the **KM ICB Main** app and you will see **Cancer in Primary Care** and **Cancer Pathways** listed on the left- | | **Data Pack circulated to the group on 22nd May 2026.** |

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| | | hand menu. | | |
| **4.** | **Neoadjuvant ICI Therapy for Melanoma** | **<u>Presentation provided by Kim Peate</u>**<br>• The Neoadjuvant Immunotherapy Checkpoint Inhibitors Presentation provided an overview of Guidelines for Neoadjuvant followed by Adjuvant Pembrolizumab for Stage III Macroscopic Resectable Melanoma.<br>• NHS England recommends routine commissioning of Neoadjuvant followed by adjuvant Pembrolizumab and applies to Stage IIIB-D Macroscopic Resectable Melanoma for patients aged 12 years and older. This is not an MSD funded trial and is off-label.<br>• KP discussed Current Standard Treatment (3x weekly cycles), the new treatment Pathway using a Neoadjuvant and Adjuvant approach, Eligibility and Exclusion Criteria and Dosing Schedule.<br>• Treatment is discontinued if there is disease progression, unacceptable toxicity or if the patient withdraws their consent.<br>• KP outlined the CDF Criteria, Key Takeaways and the NADINA Trial which is approved in Scotland and Wales but not in England.<br>• Pembrolizumab can be given as a sub-cut and is available at MFT, EKHUFT and DGT but not at MTW.<br>• It has been recently approved and it is important to now offer this to specific patients and bring adjuvant treatment up in MDT's.<br>• TW encouraged members to scan patients before surgery.<br>• KP advises their Support Worker to monitor and organise appointments. | | **Presentation circulated to the group on 22nd May 2026.** |
| **5.** | **BCC Diagnosis Audit** | **<u>Presentation provided by Ann Fleming</u>** | | **Presentation circulated to** |

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| | | • AF has been leading on this Audit which is looking at the assessment of clinical diagnosis of BCC versus histology result in a community dermatology setting.<br><br>• 111 consecutive cases where the request form stated BCC in the Clinical Details were collected and collated with the final histology diagnosis. 57 cases where the request form stated 'Lesion' were also extracted and collated. The results were graphically illustrated for both components and where the final diagnosis did not match with BCC, the diagnoses were sub-categorised.<br><br>• AF explained the results of diagnostic accuracy, analysis of incorrect diagnoses and diagnoses for cases described as 'Lesion'.<br><br>Patients in both West and East Kent are getting a similar service which is re-assuring. | | **the group on 22nd May 2026.** |
| **6.** | **Skin Analytics** | **<u>Presentation provided by Margot McLauchlan</u>**<br><br>• The Skin Analytics DERM Clinical Deep-Dive Presentation provided an overview of why change is needed in UK Dermatology Pathways and how DERM (the AI) works and implementation.<br><br>• Skin Analytics built DERM (an AI Medical Device) and it has been designed to give capacity back to the pathways. It is the only medical device for dermatology that can direct patient management, has a CE Class III mark and has a recommendation from NICE. DERM is being used in various Trusts across the UK since 2020 and assesses images of lesions to direct the next step for patients. There have been 30 existing NHS deployments to date – 250,000 patients.<br><br>• Images are captured on phones, DERM runs the image quality checks and then provides instant assessment. DERM can be deployed into any skin lesion pathways, before or after referral. There is consent for automated decisions, patient facing communications and detailed monitoring. Patients can be discharged effectively after an AI review.<br><br>• NHSE has developed an implementation tool kit to support sites deploying DERM and provides guidance for Initiation, Planning Implementation, Monitoring, Optimisation and Sustainability.<br><br>MM added that there are safety processes in place across the pathway. They receive feedback from patients and partners. DERM can diagnose certain benign conditions. There are training and audits for | | **Presentation circulated to the group on 22nd May 2026.** |

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| | | image takers. If there are false negatives they will carry out route analysis. DERM performance results are all available on the website. They claim to be able to effectively discharge 40% of benign lesions.<br><br>AB highlighted that there is a high chance that we will have to use this service, but may also choose to use it. It would be a 3-year contract and will be effectively cost free for these 3 years. DJ explained that after the 3 years a structured six-month de-mobilisation would happen if the contract was not renewed.<br><br>Telederm is being used in SCDS though they chose not to use DERM AI following a cost analysis and has commenced at QVH and is cutting down the number of USC referrals needing to be seen in person.<br><br>A lengthy discussion was held after the presentation where some members outlined that it is a great model for the first 3 years. There was good marketing but it would involve paying twice - for the software and then for a clinician to look at the images – once the 3-year trial period was up. It was suggested that it is needed in a primary care setting in order to stop flooding secondary care.<br><br>AB stated that discussions are taking place with the ICB and this will be implemented in the next six months, perhaps as a Pilot at one Trust.<br><br>KP added that nurses have not been trained to use this and requested funding potentially from the Cancer Alliance to train a nurse to use it. CS had previously said at a CRG meeting that he would try and establish whether there would be funding available for this. | | |
| **7.** | **SCC Recurrence after Biopsy** | **<u>Presentation provided by Sara O'Kelly</u>**<br><br>• The Presentation outlined whether Surgical excision may not be necessary for biopsy confirmed cutaneous squamous cell carcinoma with a clinically resolved biopsy site.<br><br>• SOK reported that 319 patients were looked at over a 3-year period (September 2022 to 2025) and this study was carried out locally with 2 Fellows. The Aim was to evaluate oncological outcomes for patients with biopsy proven cSCC and in particular, that of those who had clinically resolved at follow-up and subsequently managed conservatively.<br><br>• Of the 319 patients who had had a biopsy of an SCC, rather than straight to excision, 251 (79%) went ahead with surgery. Of these, 136 (54%) showed scar tissue or residual AK and 115 (46%) | | **Presentation circulated to the group on 22nd May 2026.** |

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| | | had residual tumour.<br><br>• Thus, 68 (21%) did not have surgery. None of these patients had recurrence of SCC. This suggests that it may be safe to watch, rather than operate on, patients with a biopsy proven SCC whether there was no clinically obvious tumour remaining at the biopsy site. The TSSG agreed that this would be a safe way to proceed. | | |
| **8.** | **AFX/PDS Outcomes** | **<u>Presentation provided by Roopa Farooki & Richa Tripathi</u>**<br><br>• The AFX/PDS Outcomes Update Presentation included the Current 2022 European Guidelines and the outcomes of 75 consecutive patients diagnosed with AFX and PDS between 2014 and 2020 in East Kent and followed up over 5 years.<br><br>• The mean clinial excision margins were 8.5mm for PDS, 5mm for AFX and 6mm for mixed tumours. 94% had clear clinical margins without Mohs surgery.<br><br>• There were no local recurrences for PDS, 3 for AFX and 1 for mixed tumours.<br><br>• There was one distant (lung) metastasis for an immunosuppressed patient.<br><br>• RF raised the following questions to all TSSG Members :-<br><br>1) Do we agree that for AFX we continue with 5mm margin (Consistent with European guidelines and reassuring from our own outcomes data), one follow-up and discharge?<br><br>**TSSG Members agreed that they would continue with current practice for AFX of 5mm margin excision, one follow-up and discharge.**<br><br>2) Do we agree for PDS we can aim for margin of 9mm (Reassuring from our own outcomes data) rather than European guidelines of 20mm?<br><br>**TSSG Members agreed to aim for an excision margin of 10mm for PDS.**<br><br>3) Do we agree for PDS that we will continue with 5 year follow up (Consistent with European | | **Presentation circulated to the group on 22nd May 2026.** |

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| | | guidelines and reassuring from our own outcomes data), and can consider annual chest imaging (eg. for immunosuppressed patients)<br><br>AB asked if it was necessary due to financial, time and radiation risks.<br><br>**TSSG Members agreed with 5 year follow up for PDS and that annual chest imaging can be offered at clinician discretion, but is not specifically recommended unless high risk, eg. Immunosuppressed, incompletely excised.** | | |
| **9.** | **Mohs for SCC** | Not discussed due to time constraints. | | |
| **10.** | **CNS Updates** | **EKHUFT**<br><br>• The Lead Skin CNS has resigned and there will be a vacancy from the end of June 2026. The remaining team comprises of 2 Band 7 CNS's and 2 Band 4 Cancer Support Workers, plus a Nurse Consultant.<br><br>**MTW**<br><br>• One CNS has commenced and is being trained.<br><br>**QVH**<br><br>• CO has just commenced as CNS.<br><br>**SCDS**<br><br>No update provided. | | |
| **11.** | **Clinical Pathway Updates**<br><br>**Basal Cell Carcinoma,** | **Update provided by Andrew Birnie**<br><br>• AB stated that the SOP's need to be in place first and then actual Pathways need to updated.<br><br>**ACTION – KP and AB will complete a Basic SOP for the most common skin cancers along with the MDM** | **KP & AB** | |

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| | **Cutaneous Lymphoma, Melanoma & Squamous Cell Carcinoma PoC's.** | **Streamlining Plan.** | | |
| **12.** | **AOB** | • KP raised that patients being referred to QVH from East Kent who are eligible for SLNB are sometimes not being offered one. TW, who is a new consultant covering West Kent, would like everyone to be offered SNLB, so this is unlikely to be an issue going forward.<br><br>• A SLNB scanning centre is required at East Kent – there is no appetite from East Kent management to invest in this and this needs to be discussed further with Managers. KP recommended completing a Business Case. DT offered to lead on this, to include the addition of SLNB for Merkel Cell Carcinoma.<br><br>**ACTION – Bring the nuclear medicine part of the SLNB Service to East Kent from KIMS and to include Merkel Cell Carcinoma, in addition to melanoma.**<br><br>• AB thanked everyone today for the good discussions that had taken place. | **DT** | |
| | **Next Meeting** | • Thursday 5th November 2026 – 2.00pm to 5.00pm – Lecture Theatre, Postgraduate Centre, William Harvey Hospital. If a sponsor is agreed – lunch to be provided prior to the meeting. | | |