Kent & Medway Cancer Collaborative

Skin Tumour Site Specific Group meeting
Thursday 10th November 2022
Great Danes (Mercure) Hotel
14:00-16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Rosemeen Parkar (Chair)	**RP**	Consultant Medical Oncologist	MTW
Ann Fleming	**AF**	Consultant Histopathologist & Clinical Lead for Cellular Pathology	MTW
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Kim Peate	**KP**	Lead Macmillan Skin Cancer CNS	EKHUFT
Andrew Birnie	**AB**	Consultant Dermatologist & Dermatological Surgeon	EKHUFT
Nina Hayes	**NH**	Macmillan Skin Cancer CNS	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Wendy Willmore	**WW**	Macmillan Skin Cancer CNS	EKHUFT
Gemma Larking	**GL**	Skin CSW	EKHUFT
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Sue Green	**SGr**	Project Manager – LWBC/PC&S	KMCA
Sarah Barker	**SB**	Project Manager – Early Diagnosis	KMCA
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Susannah Lowe	**SL**	Melanoma/Skin Cancer CNS	MTW
Holly Groombridge	**HG**	Cancer Commissioning Project Manager	NHS Kent & Medway ICB
Mandy Charles	**MC**	Macmillan Skin Cancer Clinical Nurse Specialist	QVH
Siva Kumar	**SK**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Andrew Morris	**AM**	Consultant Dermatologist & Dermatological Surgeon	Sussex Community Dermatology Service
Samantha Collins	**SC**	North Kent Service Manager	Sussex Community Dermatology Service
Cherng Jong	**CJ**	Consultant Dermatologist	Sussex Community Dermatology Service
Grace Hancock	**GH**	Acute Services Manager	Sussex Community Dermatology Service
Davish Kalmi	**DK**	Consultant Dermatologist	Sussex Community Dermatology Service
Apologies			
Sue Drakeley	**SD**	Oncology (Solid Tumour) Research Team Leader	EKHUFT
Khari Lewis	**KL**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Abigail Brunning	**AB**	Skin Cancer CNS	Kent Integrated Dermatology Service
Cathy Finnis	**CF**	Programme Lead – Early Diagnosis	KMCA
Maggie Curtis	**MC**	Macmillan Skin Cancer CNS	QVH

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Item		Discussion	Action
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • RP, who stood in as chair for today's meeting, welcomed the attendees to the meeting and asked them to introduce themselves. **Action log Review** • The action log was reviewed, updated and will be circulated to the members along with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting were not reviewed.	
2	**HUHY Campaign**	**Presentation provided by Sarah Barker** • SB's presentation provided the group with an overview of: - The groups, organisations and events the HUHY campaign utilised/partnered with. - The beskinsmart campaign materials (produced by NHS Create). - How social media platforms (including Facebook, Twitter and Instagram) have been utilised in terms of promoting/highlighting the campaign. - The roadshows (including where they took place). There was a total of 847 unique contacts made at the roadshows (254 in Folkestone, 226 in Sheppey and 367 in Broadstairs). - The impacts of the roadshows. 187 visitors committed to sun safety advice and 89 visitors committed to seeking medical advice from a GP. - The East Kent 2ww skin cancer referrals. SB highlighted there is an upward trend in 2ww skin cancer referrals. In the previous years, 2018/19 to 2020/21, it is seen that referrals are usually less in August. During the campaign, however, referrals did not drop in August and remained the highest levels since 2018/19. • In summarising, SB stated: - Overall the campaign went well, with good proof of impact for a reasonable financial cost. - The stakeholder group are grateful to all the staff and volunteers who volunteered their time to help with the campaign and roadshows. - The campaign demonstrated real partnership working. - The campaign demonstrated that by going out into the community they have the opportunity to influence health behaviour. - The Alliance are aiming to repeat the campaign next summer (but earlier in the season) and to work even closer with their partners.	
3	**PSFU**	**Presentation provided by Sue Green** • SGr has been working with KP and AB over the last 6 months in order to take forward the PSFU piece at EKHUFT.	

		• Personalised Care and Support (PCS) in the cancer setting has 4 elements (HNAs/care planning, health and wellbeing information and support, end of treatment summaries and Cancer Care Reviews) and is a system based on shared decision-making and the concept of ‘what matters to me’. It uses an individual’s strengths and potential to deliver better outcomes and experience. • PCS includes surveillance and aftercare tailored to individual needs (personalised stratified follow-up). It starts from the point of diagnosis and utilises HNAs, care planning and health and wellbeing support in order to provide care and access to support. It aims to ensure patients have the knowledge and confidence to manage their own care, address changing needs throughout the treatment pathway and the patient’s experience and to enable them to live as well as possible. • PSFU was developed and piloted about 10 years ago as a response to the problems around traditional follow-up models. A one-size-fits-all approach does not account for individual needs and can increase levels of anxiety. • Many outpatient appointments have little value to patients – a number of them are scheduled to give test results or to provide reassurance all is well. Research shows the vast majority of recurrent disease is picked up by patients between appointments or by radiological/haematological investigations. • Increasing incidence of and survival from cancer equals an increasing demand for services making achieving access times more challenging. Resources could be used differently to support newly diagnosed patients or those with complex needs. • PSFU is a tailored approach with fewer follow-up appointments alongside regular surveillance tests where required and access to the team emphasises individual patients’ ability to self-manage their health. Choosing the best method of follow-up is a collaborative approach, involving the individual with cancer, thereby moving away from the one size fits all approach. • PSFU offers a range of benefits. The whole system is underpinned by clinical advice, informed choice and the ability to self-manage and the patient only attends hospital for scheduled tests, not face-to-face or telephone clinics. • PSFU aims to meet physical and emotional needs through: - Assessment and care planning. - Management of long-term treatment effects. - Rapid access to the cancer team when necessary. - Support and information for self-management. - Referral for support services e.g. managing long-term side-effects and returning to work. • End of treatment summaries can be utilised for effective communication and information sharing with both patients and their GPs, which in turn informs Cancer Care Reviews in GP practices. • As well as RMS, the system can: - Automate a population of letters and treatment summaries. - Keep a record of patient contacts with the team.	

		- Keep a record of HNAs and care plans. - Have a patient portal to record PROMS, patients contacting the team and test results. - All hopefully leading to: a better patient experience, a responsive service with opportunities for new roles such as CSWs and a better use of clinical resources. • AM stated nurse-led follow-up for melanoma and SCC cases takes place in North and West Kent.	
4	**Follow-up for SCC**	**Update provided by Kim Peate** • KP provided the group with an overview of the draft flowchart which had been put together relating to the supported self-management pathway for cSCC cases which will be circulated to the members in due course. • EKHUFT do not currently undertake holistic needs assessments (HNAs) on SCC patients due to lack of staff resources. • A post-operative MDT takes place within 2 weeks of a patient's treatment/surgery. A results letter will be sent, along with an offer of an HNA and they are then followed up in a nurse-led clinic 3 months later. Low-risk patient groups are discharged to primary care and high-risk and very high-risk patient groups are followed-up for 2 and 3 years respectively. • During the pandemic, photographs by patients were sent to the team which worked well. It is hoped a portal on InfoFlex will enable patients to upload photos directly – they currently come in via the Cancer Care Line. • KP asked the group if they were happy for stratified pathways for SCC cases to be moved forward at EKHUFT. The consensus was this should proceed. KP mentioned this could also potentially be replicated for melanoma in due course.	
5	**Adjuvant treatment for stage 2b and 2c melanomas**	**Presentation provided by Rosemeen Parkar** • RP's slides provided the group with an overview of: - Staging for melanoma within the context of the AJCC 8th edition guidance, particularly in relation to stage 2b-2c T3-T4 (with or without ulceration) cases. - Melanoma-specific survival rates at 5 and 10 years according to AJCC 8th edition pathologic staging criteria. In 2017 data across 10 institutions was analysed. The 10 year survival rates of 2c were worse than those of stage 3b melanomas. - The MSKCC single centre analysis which showed stage 2c cases had higher relapse rates than stage 2b cases, with a median follow-up of 4.3 years. Stage 2c cases had a higher rate of distant relapse. The median time to relapse for patients who relapsed was 23 months for stage 2b patients and 15 months for stage 2c patients. - The KEYNOTE-716 trial (including its inclusion and exclusion criteria). The baseline characteristics for the 2 arms of the trial (pembrolizumab and placebo) were similar. The median age was 60, 40% of patients were 65 years or older, approximately 60% were male, >90% had ECOG pS0 and the most common T categories were T3b and T4. >2/3 patients had stage 2b disease. The subgroup analysis favoured the pembrolizumab arm but the study was not powered to detect differences in the subgroups. - At the first interim analysis, the median follow-up was 14.4 months. 11% of pembrolizumab patients had first recurrence and 17% of placebo patients had first recurrence. At the second interim analysis, the median follow-up	

		was 20.9 months. 15% of pembrolizumab patients had first recurrence and 24% in the placebo group had first recurrence. - The safety profile was consistent with previous studies with skin reactions, thyroid dysfunction, fatigue and musculoskeletal side effects being the most common ones. Treatment was discontinued in 16% of patients under the pembrolizumab arm versus 2% of patients under the placebo arm due to grade 3-4 side effects. • In summarising the presentation, RP stated adjuvant pembrolizumab for fully resected stage 2b/2c melanoma offers sustained recurrence free survival (RFS) and distant metastasis free survival (DMFS). • RP questioned whether there is capacity to absorb these patients in to the services at the moment. The consensus was that there is not currently capacity from a CNS/chemotherapy/pharmacy/SLNB/chair space perspective. • There is currently not an immunotherapy toxicity service in place in East and West Kent. KP and SL have highlighted the benefits of having such a service in place to senior management for a number of years (with Clatterbridge a prime example), but have made little progress in this direction. AB believes if the TSSG as a whole recommends having this service in place (which would also be of benefit to other tumour groups), this may help the case. He believes articulating what resource is required and escalating it to the relevant people who can effect change is needed, however oncology capacity to deliver this is currently limited. • It was highlighted that it may be worth the Kent Oncology Centre looking in to/considering whether an SLA with other providers/Trusts could be put in place to treat patients requiring immunotherapy support. • It was felt additional oncology resources for chemotherapy services across the region is required.	
6	**New NICE guidelines on MM**	**Update provided by Andrew Birnie** • AB provided the group with an update in relation to whether EKHUFT was meeting or would adopt the latest NICE guidance on malignant melanoma. • AB highlighted the importance of ensuring all healthcare professionals have attended training for advanced communication (often run at hospices). • AB's slides provided the group with an overview of: - Assessing melanoma, particularly with regard to dermoscopy (it is important that maxillofacial consultants are trained in its use). SGi stated 28 dermatoscopes across Kent & Medway had been funded by the KMCA. Molecular analysis for BRAF will continue to be performed. - The new guidance which recommends only offering SLNB in patients with 0.8-1mm Breslow and one other higher risk feature, though Mr Nick Williams' SLNB data between 2019-2022 were presented, which demonstrated that 4 out of the 6 positive sentinel nodes in those 4 years would not have had a SLNB if the new guidance was followed. It was agreed that they would continue to offer SLNB for this cohort of patients until further data had been collated. Following the discussion around the SLNB data collected by Mr Nick Williams, SK believes it would be advisable for QVH to also collate data on this. - Follow-up after treatment for melanoma. It was agreed to follow the new guidance. • AB highlighted how efficient the PET service is at EKHUFT, though the new guidelines do not recommend their routine use on grounds of cost. PET scans are more expensive than CT scans, with the former being funded by	

		NHSE and the latter by Trusts. Given the efficiency of the local service and the inefficiency of the local radiology service, accompanied by the greater sensitivity, it was agreed to continue using PET CT for the first two years of follow-up then switch to CI CT if no disease progression noted.	
7	**Performance**	**<u>EKHUFT - update provided by Andrew Birnie</u>** • Please refer to the performance slide pack for an overview of the Trust's data. • Around 1000 patients are being referred on a 2ww each month. **<u>SCDS - update provided by Andrew Morris</u>** • Please refer to the performance slide pack for an overview of the organisation's data. • 2ww referral numbers continue to increase. • AM mentioned he still sees a lot of patients who have not been physically examined by a GP prior to referral. **<u>QVH</u>** • No update provided. • SK stated the government want to try and reduce the number of skin cancer patients presenting to A&E.	
8	**CNS updates**	**<u>EKHUFT – update provided by Kim Peate</u>** • GL has been in post as the Skin CSW since February 2022 and has worked on implementing the recovery package piece. **<u>MTW – update provided by Susannah Lowe</u>** • SL stated the Consultant Nurse will help to support RP. **<u>SCDS - update provided by Andrew Morris</u>** • 2 CNS' have been appointed since the last meeting, the details of which will be shared with AW/CC so they can be invited to future Skin TSSG meetings. **<u>QVH - update provided by Mandy Charles</u>** • A development nurse has been in place for the service since June 2022. • The nursing team comprises of 3 WTE CNS'. • A results clinic will commence on 14.11.2022.	
9	**Lack of non-melanoma oncologist in Kent**	• Anthi Zeniou went on maternity leave at the end of May 2022 and an individual identified to cover decided not to commit to the post in the end. In view of this, BCC referrals to West Kent for radiotherapy have not been seen since Anthi went on maternity leave and are unlikely to until she returns next year. This issue has been added to the risk register. • Andriana Michaelidou has been picking up urgent SCC cases.	
10	**Cancer Alliance update**	**<u>Presentation provided by Holly Groombridge</u>** • HG provided the group with an overview of the various projects relating to the following workstreams: - Faster diagnosis and operational improvement.	

		- Early Cancer Diagnosis. - Treatments & Personalised Care. - Cross Cutting Themes.	
11	**Clinical Pathways Discussion**	• The 5 PoC documents and HOP have not been updated for a number of years. • KP and SK believe having 1 operational policy/SOP for the region is not advisable as the processes involved following a 2ww referral in to both East and West Kent differ. • **Action: AW to circulate the aforementioned documents to the group so they are cited on what they contain.**	**AW**
12	**AOB**	• **Action: JT to send AW information pertaining to a Merkel guidance online meeting which is taking place on 23.11.2022 for circulation to the group.** **Expression of Interest** • AW stated an EOI for the chair position had been sent out and 2 reminders followed. • KP mentioned she would be happy to take on the role of chair if EKHUFT are provided with another CNS. • AM suggested the chair position be rotated amongst the organisations and to discuss this further within the next fortnight. • **Action: AW to circulate the TSSG ToR and TSSG Chair Job Description to the members.** • AW thanked RP for chairing today's meeting. • A poll was suggested to determine the date of the next meeting.	**JT** **AW**
	Next Meeting Date	• To be confirmed.	