Kent & Medway Cancer Collaborative

Skin Tumour Site Specific Group Meeting
Thursday 22nd May 2025
Park View Meeting Room, Mercure Great Danes Hotel, Ashford Road, Maidstone. ME17 1RE
14:00-17:20

Final Meeting Minutes

Present	Initials	Title	Organisation
Andrew Birnie (Chair)	**AB**	Consultant Dermatologist & Dermatological Surgeon	EKHUFT
Richa Tripathi	**RT**	Specialty Doctor in Dermatology	EKHUFT
Remya Prasannan	**RP**	Dermatology Specialist	EKHUFT
Raghuram Boyapati	**RB**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Asha Rajeev	**AR**	Consultant Dermatologist	EKHUFT
Denis Bajramoski	**DB**	Consultant Dermatologist	EKHUFT
Denise Burt	**DBu**	Lead Skin Cancer CNS	EKHUFT
Marcia Ruddock	**MR**	Advanced Surgical Nurse Practitioner	EKHUFT
Nick Williams	**NW**	Consultant Breast & General Surgeon	EKHUFT
Gordon Ellul	**GE**	Lead Clinician and Consultant in Nuclear Medicine and PET/CT	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Claire Harper-Brown	**CHB**	Dermatology Specialist Nurse	EKHUFT
Nina Hayes	**NH**	Skin Cancer CNS	EKHUFT
Carly Woods	**CW**	Skin Cancer Support Worker	EKHUFT
Wendy Willmore	**WW**	Skin Cancer CNS	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
Karen Glass	**KG**	Business Support Manager	KMCA/KMCC
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Sam Williams (Minutes)	**SW**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Tracey Spencer-Brown	**TSB**	Head of Nursing – Oncology & Cancer Performance	MTW
Nataliya Martynuk	**NM**	Consultant Medical Oncologist	MTW
Heba Hassan	**HH**	SpR Medical Oncology	MTW
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Sarah Qureshi	**SQ**	Consultant Medical Oncologist	MTW

Natalie Smith	**NS**	Melanoma CNS	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Ann Fleming	**AF**	Consultant Pathologist	MTW
Clare Reeder	**CR**	Macmillan Consultant Clinical Psychologist	MTW
Laura Abdey	**LA**	Melanoma CNS	MTW
Jennifer O'Neill	**JO**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Siva Kumar	**SK**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Alice Hubbard	**AH**	Skin Cancer CNS	KIDS
Arianne Kempton	**AK**	Skin Cancer CNS	KIDS
Kirstyn Parratt	**KP**	Skin Cancer Service Manager	SCDS
Andrew Taylor	**AT**	GP with Extended Role in Minor Surgery	Len Valley Practice
Theo Bennett	**TB**	GP with Extended Role in Dermatology & Skin Surgery	East Kent Community Dermatology
Robert White	**RW**	GP with Extended Role in Dermatology & Skin Surgery	East Kent Community Dermatology
Apologies			
Khari Lewis	**KL**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Kim Peate	**KPe**	Lead Skin Cancer CNS	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Casey Powell	**CP**	Consultant Histopathologist	EKHUFT
Suzie Chate	**SC**	CIS Infoflex Development Manager	EKHUFT
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Nick Goodger	**NG**	Consultant Maxillofacial Surgeon	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Rhiannon Leppard	**RL**	Skin Cancer Support Worker	EKHUFT
Joanne Jackson	**JJ**	Early Diagnosis Project Manager	KMCA
Ian Vousden	**IV**	Director	KMCA
Emma Lloyd	**EL**	Cancer Pathways Improvement Project Manager	KMCA
Kannon Nathan	**KN**	Consultant Clinical Oncologist	MTW
Lorraine Brooker	**LB**	Interim General Manager – Cancer Performance	MTW
Andrew Morris	**AM**	Consultant Dermatologist	SCDS
Nicolas Nicolaou	**NN**	Consultant Dermatologist	SCDS
Hayley Martin	**HM**	Macmillan Personalised Care & Support Facilitator	MFT
Kusu Orkar	**KO**	Consultant Plastic & Reconstructive Surgeon	QVH

Sandra Varga	SV	Consultant Dermatologist	Whitstable Medical Practice

Item		Discussion	Agreed	Action
1.	TSSG Meeting	**Apologies** • The apologies are listed above. **Introductions** • AB welcomed the members to the meeting and everyone introduced themselves. AB was pleased with the good attendance at today's meeting. **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 final minutes from the previous meeting which took place on 21st November 2024 were agreed as a true and accurate record.		
2.	Clinical Reference Group	**Presentation provided by Andrew Birnie** • AB stated that the Cancer Alliance are encouraging regular CRG meetings outside of the TSSG with representation from members of teams. • The CRG members are Andrew Birnie (Chair), Chris MacDonald (Plastic Surgery), Gautaumi Agarwal (Radiology), Ann Fleming (Pathology), Ann Courtness (Cancer Alliance), Kim Peate (Nursing) and Anthi Zeniou (Oncology). • The CRG Priorities are Pathway Review and Development, MDT Streamlining, Strategic Priorities,		**Presentation circulated to the group on Tuesday 27th May**

		Innovation and Treatment Variation. • The CRG still requires GP and Maxillofacial representation and AB is keen for others to be involved and to contact him directly. • The CRG will meet once a month for 1hr on a Monday morning (previously held on a Friday) it attracts 0.5PA. **ACTION – AW to re-send Expression of Interest and Job Description.** • MDT Streamlining is efficient at present in East and West Kent. The Cancer Plan will be coming out in the Autumn.		**AW**
3.	**Dashboard Performance**	**<u>Update provided by Andrew Birnie</u>** • AM went through the Data Pack Slides sent by David Osborne. • Kent and Medway are close to the England average for FDS and 62 Day performance. FDS at Kent & Medway is at 88.1%. 62 day performance is at 85.0%. • QVH is below the England average for FDS Performance and SCDS is below the England average for 62 day performance. FDS at SCDS is at 88.91%, EKHUFT at 87.1% and QVH is at 82.8%. • 62 day Performance at EKHUFT is at 90.1%, QVH at 85.6% and SCDS is at 76.2%. There is trouble with recording the data at SCDS. • Conversion of 2ww referrals to Melanoma is double in EKHUFT, compared with SCDS, mainly due to the older population. Targeted interventions might be worthwhile in some areas. AB suggested a Service Improvement Project could be undertaken targeting specific high referring/low conversion to cancer GP Practices. • AB encouraged everyone to gain access to the to the Dashboard including Junior Doctors.		**Data Pack circulated to the group on Thursday 15th May.**

		How to sign up to the Cancer Pathways and Cancer in Primary Care Dashboards • Register for access to Kent and Medway ICB Power BI reports by completing the form at https://forms.office.com/r/svyPSvktHw. • 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. • 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-hand menu.		
4.	**Cancer Psychological Service for Kent & Medway (CaPS-KM)**	**Presentation provided by Clare Reeder** • The Cancer Psychological Service for Kent & Medway (CaPS-KM) covers all 4 acute Trusts. The CaPS-KM team are separate but work closely with the Oncology Counselling teams. • CaPS-KM has received 2-years of funding from KMCA and Macmillan (May 2024-26) with the hope of being a fully commissioned service from 2026. • The aims of the service are to :- i) Build on previous scoping to understand local psychosocial services ii) Demonstrate unmet psychological need iii) Set up and evaluate a Kent & Medway-wide cancer psychological service iv) Secure permanent NHS funding. • They have a small team in place based at MTW including :- ○ India Barton (Macmillan Assistant Psychologist) ○ Sophie Lansdowne (Honorary Assistant Psychologist) ○ Janet Bates (Macmillan Counsellor) ○ Dr Chris Bonner (Macmillan Clinical Psychologist) ○ Dr Clare Reeder (Macmillan Consultant Clinical Psychologist and Service Lead)		**Presentation circulated to the group on Tuesday 27th May**

		○ Rachel Maciag (Trainee Clinical Psychologist) • CR highlighted what the team have carried out to date :- i) Scoping and relationship building ii) Patient engagement – 4 patients on Steering Groups iii) Setting up a clinical service iv) Teaching and supervision – - Level 2 psychological skills training for cancer CNS's & AHP's - Haematology & Oncology Doctors - Level 1 + training and psychological support for CSW's • CR highlighted the type of patient their team would be keen to see and the referral process which is in place. CR explained there is a single point of referral and the psychological team will triage to either a counsellor or to psychological support. They will aim to see a patient within 1-2 weeks with the caveat that they are a very small resource covering the whole of K&M. They are happy to support families of patients but would not see children directly. However, they can support children through the family and also schools. • CR confirmed the referral process in place for each trust and the direct email for CaPS-KM - mtw-tr.caps-km@nhs.net and clare.reeder@nhs.net. • CR added that funding is only for cancer diagnosed patients and they will need to build a Business Case in order to fund this service after 2 years and welcomed feedback. • AZ thanked CR and her team for their support.		
5.	**Oncology Update – Adjuvant/Neo Adjuvant Treatment Updates -**	**<u>Presentation provided by Sarah Qureshi</u>** • The Adjuvant/Neo Adjuvant Treatment Update – Melanoma Presentation provided an overview of the following :-		**Presentation circulated to the group on Tuesday 27th May**

	Melanoma	• Melanoma-Specific Survival by Stage Graph. • Adjuvant Therapy for Resectable High-Risk Melanoma – Approved Treatments – Adjuvant Treatment for Stage III Melanoma and Approved Treatments for Stage II Melanoma. • Keynote-716 Trial : Adjuvant Pembrolizumab vs Placebo in High-Risk, Resected Stage II Melanoma. • Keynote-716: RFS in ITT Population Graph. • CheckMate 76K Trial : Adjuvant Nivolumab vs Placebo in Resected Stage IIB/11C Melanoma. • CheckMate 76K Trial : RFS Graph. • Immunotherapy in Stage 3 Population. • BRAF-MEKi in Stage 3. • Adjuvant Dabrafenib + Trametinib for BRAF-Mutated Stage III Melanoma : Long-term Outcomes Graph • Adjuvant Therapy for Stage III : Unmet Needs. • Key Takeaways : Adjuvant Treatment in Stage 2 & 3 Melanoma. • Neoadjuvant Therapy in Resectable Melanoma – Prognostic Value of Pathologic Response Graph. • SWOG S1801 Study : Adjuvant Pembrolizumab + Neoadjuvant Pembrolizumab in Resectable Stage III-IV Melanoma and Survival Graphs. • SWOG S1801 Study : RFS by Pathologic Response. • NADINA Study : Neoadjuvant Nivolumab + Ipilimumab vs Adjuvant Nivolumab in Macroscopic, Resectable Stage III Melanoma – Randomised Phase III Trial. • NADINA Study : EFS (Primary Endpoint) Graph. • NADINA Study : RFS by Pathologic Response in Patients Receiving Neoadjuvant Therapy. • Key Takeaways : Management of Clinically Detectable Stage III Melanoma. • Two Treatment Options that are approved for these patients are :- i) Pembrolizumab for Stage 3B to 3D or resectable stage 4 skin or mucosal melanomas. ii) Nivolumab in combination with ipilimumab for stage 3 skin or mucosal melanomas. • Currently in the UK, neoadjuvant immunotherapy treatment for melanoma is only available on the NHS in Scotland. • Nivolumab subcut formulation : -		

		i) CheckMate Trial – 67T is the first Phase 3 trial of the subcutaneous formulation of Nivolumab compared to IV in advanced or metastic RCC. ii) Demonstrated non-inferiority in pharmacokinetics and efficacy. iii) FDA approved December 2024 Nivolumab plus Hyaluronidase-nvhy. iv) MHRA approved 30th April 2025. v) Given over 3-5 minutes, less time for patients in hospital.		
6.	**SOP for Melanoma**	**<u>Presentation provided by Anthi Zeniou</u>** • AZ advised that this SOP requires agreement. • The SOP Imaging for Melanoma Presentation provided an overview of the following :- • Active Surveillance + Active Treatment : - i) CT chest/abdomen and pelvis (CT TAP) is recommended for all truncal melanomas. ii) PET CT is recommended for melanomas of the limb. iii) Adaptations can be made according to individual patient factors. iv) I.E. no measurable disease on PET CT can switch to CT. v) I.E. Trunkal melanoma where there is uncertainty on CT can consider PET CT for additional diagnostic information. • Active Surveillance – Stages, Risk Level and Recommended Follow-up Chart. • Active Treatment - Adjuvant i) CT or PET-CT every 3-4 months. ii) MRI Head every 6 months. iii) Can adjust based on patient factors. • Active Treatment - Palliative		**Presentation circulated to the group on Tuesday 27th May**

		i) CT or PET-CT every 3-4 months. ii) MRI Head every 6 months. iii) MRI Head every 3 months if known brain mets. iv) Clinician discretion as long as clearly documented. • Uveal Melanoma i) Clinical Surveillance every 6 months (years 1-5). ii) Clinical Surveillance every 12 months (years 6-10). iii) Baseline MRI Liver. iv) MRI or US Liver 6 monthly. v) Routine CT or PET CT not indicated. vi) Routine Brain Imaging not indicated. • References GE suggested an Oncology discussion needs to be held with Stage 4 Patients. There were no changes to the active surveillance table.		
7.	**PET CT Scanning**	**<u>Presentation provided by Gordan Ellul</u>** • The FDG PET/CT in Melanoma Presentation provided an overview of the following :- • Why is Melanoma "Special"? i) Large proportion of patients are young and many are motivated and informed. ii) Distant visceral metastatic disease is often asymptomatic until advanced. iii) Metastatic spread can be atypical and hard to predict. iv) Surveillance imaging is contentious and based on expert opinion, guidance is not consistent amongst different bodies. v) Background of generational change in how healthcare is practiced, living and dealing with uncertainty in imaging findings. vi) We perform a huge amount of imaging in the region.		**Presentation circulated to the group on Tuesday 27th May**

		• Turn-around Times – the service is under pressure at EKHUFT, scanning 6 days per week and referral numbers are high. • FDG PET/CT in the clinical management of melanoma. • FDG listed the 'The good, the bad and the Ugly'. • FDG PET/CT and real patient outcomes. • FDG PET/CT and Immunotherapy. • Advanced Cutaneous Melanoma. • Why FDG PET/CT? • High False Positive – Depends on the Reporter. • Diagnostic Performance of FDG PET/CT in Disease Recurrence. • Surveillance Imaging. • Guidance on the role of FDG PET/CT in the Clinical Management of Melanoma. • NICE Guidance & Summary Table. • ESMO – Suggested follow-up schedule by disease stage. • RCR/RCP/BNMS/ARSAC – Evidence based indications for the use of PET CT. • Melanoma Focus (UK) Expert Group. • Final Comments & Why/When do we perform imaging in melanoma?		

		GE is keen to obtain a LAFOV PET Scanner at EKHUFT which would be revolutionary for both staff and patients. National PET/CT contract is up for renewal in November 2025. It was agreed that for the first 2 years – PET / CT – in metastatic disease (stage IIID and fully resected stage 4) to be done 4-monthly, then CT. PET/CT is a superior scanning tool for diagnosing melanoma. **ACTION - Oncology to discuss metastatic stage IV imaging.** GE announced that a new Nuclear Medicine Consultant will be commencing at EKHUFT in August 2025. SLNB for Merkel Cell Carcinoma was also discussed. **ACTION - RB will discuss with GE to put together a business plan to try and get if off the ground, though may have to wait until the national guidelines are released before Trusts are compelled to action it.**		**AZ** **RB/GE**
8.	**BRAF/MEK Inhibitors & Echos – Change to local guidelines**	**<u>Presentation provided by Heba Hassan</u>** • The Optimising Cardiac Monitoring in Patient on BRAF/MEK Inhibitors (A Proposal to Update Local Guidelines) presentation provided an overview of the following :- • Background, Aim & Method. • Results – A total of 45 patients were included. 4.4% (n=2) developed BRAF/MEK inhibitors related cardiac dysfunction. Both patients developed moderate CTRCD. No patients developed severed CTRCD. Both patients were on DAB/Tram at metastatic setting. • Results of Patient 1 and 2 Case Study and Conclusions. • Current Burden of Monitoring and ASCO recommendation. • Do you have echo guidelines for BRAF MEK Inhibitors? Recommendation.		**Presentation circulated to the group on Tuesday 27th May**

		• ESC CVD Risk Calculation App. • Expected Benefits. References. SH felt that the guidelines need updating. EKHUFT agreed to use this tool for a year. It was agreed to apply the changes and re-audit in 1 year. The plan is for baseline Echo and then risk stratify the patients, only high risk patients need Echo every 4 months and the rest every 6 months. To assess after 1 year if we still need the 6 monthly Echo for the low risk. It was also noted to document on KOMS or Action Sheet the risk category of the patients to make it easier for the team to follow up.		
9.	**ECT**	**<u>Presentation provided by Siva Kumar</u>** • The Electrochemotherapy presentation provided an overview of the following :- • Electrochemotherapy : a combined treatment. • Electrochemotherapy in Metastatic Melanoma (Palliative Setting). • ECT and Immunotherapy can be given at the same time (it is still safe to do this). SK stated it is a well tolerated treatment that has been carried out for 7 years at QVH which can be delivered locally or intravenously. 80% of patients have a good response and the vast majority of treatment is given to patients under general anaesthetic. Two ECT Nurses will see the patient regularly after the treatment. Referrals can be sent to SK for discussion at the MDT.		**Presentation circulated to the group on Tuesday 27th May**
10.	**AI Teledermatology**	**<u>Presentation provided by Andrew Birnie</u>** • AB advised that AI has received NICE approval for use in the diagnosis of skin cancer in test cases and pilots but feedback is required.		**Presentations circulated to the group on Tuesday 27th May**

		• The AI for Teledermatology Presentation provided an overview of the following :- • Derm – Skin Analytics – Only UK approved AI for Dermatology and claim :- i) Up to 60% of 2WW referrals can be discharged before entering secondary care. ii) Face to Face appointments can be reduced by up to 95% in the remaining cohort via digital teledermatology. iii) Reduction in minor ops and unnecessary biopsies (up to 10%). iv) Earlier diagnosis and treatment for cancer patients, improvement of FDS performance. v) £2 saved for every £1 invested, according to multiple independent NHS service evaluations. • Post Referral Pathway with HCAS. • Costs and Claimed Savings Table listing Pricings and Savings – based on 1250 referrals a month. • Solihull and West Suffolk are two providers that have used this service. AB discussed their experience with their Clinical Leads. • The AI does not give a diagnosis and in Solihull missed 19 MMs and MM in-situ in 18 months. They are not confident to use without a second read by a Dermatologist. Their opinion is that it is just a good telederm platform. • In West Suffolk it has helped them with GIRFT. They do not review what AI thinks is benign (aware of 1 missed MM in-situ 18/12 ago) but do review all others and direct to appropriate clinic/surgical list. 2/3 do not need to be seen in 2ww, thus spreads work out rather than putting pressure on 2ww (but the patients still need to be seen). 20-25% discharged without being seen. • Realistic Costs including Pricings and Savings based on 1250 referrals a month (assuming 20% and not 50% discharge rate) were then presented. • Verdict – If cost could half then it could play an important role in GIRFT. Fewer appointments for		

		patients and faster pathway. SH confirmed EKHUFT are not using teledermatology for 2ww cases due to capacity issues. It would cost £50K to support this service. At the current costing the TSSG agreed not to use this new AI Service.		
11.	**CNS Updates**	**EKHUFT** • The EKHUFT Team are fully staffed, with 2 Cancer Support Workers on board and are looking at setting up a Patient Support Group. **MTW** • MTW have 2 CNS's who have an active role in service development. MTW cover a large area across West Kent and are looking to carry out collaborative work with EKHUFT. A Patient Support Group is being set up. **SCDS & QVH** • No update provided.		
12.	**SCC Stratified Pathway**	**Presentation provided by Denise Burt** • The Personalised Stratified Pathways for cSCC Presentation provided an overview of the following :- • What is a Stratified Pathway? i) It is an NHS England initiative. ii) Aims to improve patient experience and quality of life for people following treatment for cancer. iii) Aims to make services more efficient and cost-effective. iv) Skin is a focus for KMCA.		**Presentation circulated to the group on Tuesday 27th May**

		v) 1 Years funding won for second skin CSW to aid implementation. vi) NHSE Implementing Personalised Stratified Follow-Up (PSFU) services for people with Skin Cancer (published 2022 – updated 2025). • Implementing Personalised Stratified Follow-Up (PSFU) Services for people with skin cancer. • Guidance on :- i) Types of skin cancers to consider – focus should be cSCC. ii) Inclusion and Exclusion Criteria. iii) Risk and mitigating the Risks. Measuring outcomes. • Decisions/Discussion i) Agreements on inclusion of high risk csCC being included for PSFU as per new indications. ii) Agreement on exclusion criteria. • What happens next? i) SOP ii) PSFU Letter to GP, PSFU Leaflet for Patients iii) Develop 'End of Treatment' summary. iv) Review Infoflex templates for data input. v) Create Self-Management Group Forum. vi) Develop Patient Portal vii) Aim to implement pathway by September 2025. DB added that this has been undertaken in Plymouth and has worked for them. Once the pathways go live the data will be reviewed annually. Stratified Pathways will free up clinic capacity. Patients will have open access pathway for 2 years with access to skin cancer CNS team via the cancer care line. **ACTION – DB to review Data after one year.** The TSSG agreed for this to go ahead.		**DB**

13.	**AOB**	• AB raised the following questions on behalf of Jo Jackson (Project Manager for the Early Diagnosis Team). • Waiting times for Dermatology and would a press release and hard launch of the Skin Smart Campaign have an adverse effect on services? • The TSSG agreed for Jo Jackson to go ahead with the Skin Smart Campaign. • Are clinicians aware of any patients that have attended Dermatology clinics who have been prompted to attend after seeing one of the previous Skin Smart Campaigns? No comments were raised by the TSSG. • AB announced that AW was retiring in June 2025 and thanked her personally for all of her support over the years. • Chemo Top Tips were circulated to the group.		
	Next Meeting	Thursday 20th November 2025 – (2.00pm – 5.00pm) – Microsoft Teams		