Kent and Medway Cancer Collaborative

Skin Tumour Site Specific Group meeting
Thursday 6th May 2021
Microsoft Teams
14:00–16:30

Final Meeting Notes

Present	Initials	Title	Organisation
Larry Shall (Chair)	**LS**	Consultant Dermatologist	Sussex Community Dermatology Service
Samantha Collins	**SC**	Service Manager (North Kent)	Sussex Community Dermatology Service
Grace Hancock	**GH**	Service Manager (West Kent)	Sussex Community Dermatology Service
Russell Emerson	**RE**	Consultant Dermatologist & Dermatological Surgeon	Sussex Community Dermatology Service
Andrew Birnie	**ABi**	Consultant Dermatologist	EKHUFT
Wendy Willmore	**WW**	Macmillan Skin Cancer CNS	EKHUFT
Kim Peate	**KPe**	Macmillan Lead Skin Cancer CNS	EKHUFT
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Karen Glass	**KG**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Tracey Ryan	**TR**	Macmillan User Involvement Manager	KMCC
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Ciara O'Hanlon-Brown	**COHB**	Consultant Medical Oncologist	MTW
Susannah Lowe	**SL**	Melanoma CNS	MTW
Ann Fleming	**AF**	Consultant Histopathologist & Clinical Lead for Cellular Pathology	MTW
Chris Singleton	**CS**	Senior Programme Manager – KMCA	NHS Kent & Medway CCG
Bana Haddad	**BH**	Macmillan GP/Clinical Lead – LWBC/PC&S	NHS Kent & Medway CCG
Maggie Curtis	**MCu**	Macmillan Skin Cancer Clinical Nurse Specialist	QVH
Heather Drewery	**HD**	Oncology Booking Team Manager	QVH
Mandy Charles	**MCh**	Macmillan Skin Cancer Clinical Nurse Specialist	QVH
Victoria Worrell	**VW**	Access & Performance Manager	QVH
Abigail Brunning	**ABr**	Staff Nurse	QVH
Karen Carter-Woods	**KCW**	Head of Patient Safety	QVH
Louise De Barra	**LDB**	Skin MDT Coordinator	QVH
Kirstyn Parratt	**KPa**	Admin & Cancer Lead	West Kent Dermatology Service

Sandy Flann	**SF**	Consultant Dermatologist	West Kent Dermatology Service
Cherng Jong	**CJ**	Consultant Dermatologist	West Kent Dermatology Service
Prasad Hunasehally	**PH**	Consultant Dermatologist	West Kent Dermatology Service
Apologies			
Elizabeth Sharp	**ES**	Consultant Surgeon and Clinical Tutor	EKHUFT
Jeremy McKenzie	**JM**	Consultant Head & Neck/Maxillofacial Surgeon	EKHUFT
Nicholas Williams	**NW**	Consultant Breast and General Surgeon	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Sue Drakeley	**SD**	Clinical Trials Practitioner	EKHUFT
Irene Nhandara	**IN**	Programme Lead – Early Diagnosis	KMCA
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Sona Gupta	**SGu**	Macmillan GP	NHS Kent & Medway CCG
Julie Anthony	**JA**	Skin Cancer CNS	QVH
Lekha Chandrasekharan	**LC**	Consultant Radiologist	QVH
Debbie Terry	**DT**	Cancer Data Manager	QVH
Siva Kumar	**SK**	Consultant Plastic Surgeon	QVH
Jennifer O'Neill	**JON**	Consultant Plastic Surgeon	QVH

Item		Discussion	Agreed	Action
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • LS welcomed the members to the meeting and asked them to introduce themselves. **Action log Review** • The action log was reviewed, updated and will be circulated along with the minutes from today's meeting. **Review previous minutes** • The final minutes from the previous meeting were reviewed and agreed as a true and accurate record.		

2	**Early diagnosis of skin cancer: innovating the two week wait skin cancer referral pathway as part of the NHS post Covid-19 targeted intervention recovery plan**	**Presentation provided by Larry Shall** • LS referred to a presentation collated by Dr Julia Schofield (Consultant Dermatologist – United Lincolnshire Hospitals) on behalf of the national cancer programme team, which sets out recommendations on how 2ww skin cancer referrals/models can be developed and implemented. By innovating them they would hope to: - Reduce the number of melanomas missed. - Reduce hospital visits. - Harness digital technology. - Follow on from successful pilots of different models in place across the country. - Develop and implement cancer Rapid Diagnostic Centres. - Reduce the negative impact of 2ww activity on patients with other skin conditions. • LS stated the majority of the recommendations set out in the presentation are already common practice across the patch, including virtual and community-based clinics. He did, however, specify he objects to 'spot' clinics.		
3	**Skin suspected cancer e-referral form**	**Update provided by Larry Shall** • Following the last meeting, LS worked on redesigning the form. He relocated the 'Clinical Information' section to the top of the document and added a free text box in order for GP's to provide supporting information (although he now believes this can be removed). • LS added a number of extra fields, including ones for: - The date when the lesion was first noticed. - Past or family history of cancer. - The site of the lesion. - The size of the lesion. - A description of the lesion and the presumed diagnosis. • The GP should also state whether the patient is on anticoagulants, has a cognitive impairment and how mobile they are. • LS specified he believes the tick boxes under the 'Referral Criteria' section should be removed as he feels this is purely for the GP's information. BH stated it is not an easy process to change the parts of the form needed to ensure NICE NG12 compliance and it could therefore take some time to amend. • PH specified the site of the lesion is the most important piece of information. LS agreed with this and suggested it be put in bold font and relocated to the top of the 'Clinical Information' section. • ABi mentioned at least 20% of the 2ww referrals he sees at EKHUFT have little or no information on the form and therefore emphasised the importance of this being filled		

		out sufficiently. • **<u>Action:</u> BH confirmed the GP Bulletin could be used to highlight to GP's the importance of completing the form sufficiently and stating the site of the lesion.** • RE suggested an additional 2 fields be added in order to determine whether the patient has a pacemaker or implantable defibrillator. • ABi stated a field on whether the patient is immunosuppressed should also be added. • LS agreed with RE and ABi's suggestions and confirmed he would add them to the document. • **<u>Action:</u> LS to update the form based on today's discussions and circulate it for comments with a deadline of 03.06.2021. It will then be sent to Kent & Medway CCG colleagues for them to review.**		**BH** **LS**
4	**Neoadjuvant systemic therapy for metastatic melanoma**	**<u>Update provided by Ciara O'Hanlon-Brown</u>** • Treatment for stage 3 melanoma has rapidly changed over the last few years. • Adjuvant immunotherapy and adjuvant-targeted therapy has resulted in a 20% improvement in recurrence-free survival. • COHB stated stage 3 melanoma patients are being overtreated with the adjuvant approach as only 20% benefit from it. 50% of patients are cured by surgery and 30% relapse despite adjuvant treatment. In order to improve on this, we can: 1. Improve adjuvant treatment by prescribing different drugs. 2. Employ the neoadjuvant approach. 3. Utilise the biomarker-driven patient selection approach. 4. Continue to review new drugs/treatments. • COHB stated melanoma clinical trials now tend to focus mostly on the neoadjuvant approach. • COHB mentioned it is not possible to determine whether adjuvant treatment has worked but it is possible to know when it has not as the stage 3 patient relapses. With the neoadjuvant treatment, however, it is possible to decipher who is and is not responding to treatment. • The neoadjuvant approach can reduce tumours prior to surgery in order to make the operation run smoother. However, it can also have adverse effects which may delay or complicate surgery. • COHB outlined the radiologic and pathologic response to the PRADO study. • COHB referred to a list of ongoing neoadjuvant trials. • COHB mentioned the standard of care for patients with stage 3a melanoma is generally good.		

		• Patients with stages 3b, 3c and 3d melanoma are likely to be offered neoadjuvant treatment at some point in their pathway. • Stage 4 resectable/borderline resectable patients are likely to need to undergo more trials and may be offered stage 2 adjuvant full strength Ipi/Nivo. • COHB stated the utilisation of neoadjuvant treatment will require the multidisciplinary team (including radiology, pathology, surgery and oncology colleagues) to work closer together and make more complicated decisions. In view of this, LS advocated the need for joint clinics.		
5	**Performance**	**<u>EKHUFT – update provided by Andrew Birnie</u>** • They achieved the 2ww standard in January, February and March 2021. • EKHUFT met the 31d target in January, February and March 2021. • The Trust met the 62d standard in January, February and March 2021. • They had no 104d cases in January, February and March 2021. • EKHUFT had 3 62d backlogs in January, 1 in February and 1 in March 2021. • In terms of 28d compliance and completeness, they consistently meet the targets. Dedicated admin support with the 28d piece is in place in order to improve data collection and accuracy, with the pathway navigator supporting with data entry. • Daily calls with the team ensure capacity is managed and engagement with the team ensures compliance as any issues can be addressed quickly. • ABi stated virtual MDT meetings have functioned well and quoracy has not been an issue. • Oncology input has improved. **<u>North & West Kent Dermatology Service – update provided by Russell Emerson and Cherng Jong</u>** • Both services achieved the 2ww target between January and March 2021. They are predicted to also achieve it in April 2021. • They achieved the 31d target between January and March 2021 and are expected to do so again in April 2021. • In relation to the 62d standard, they achieved this between January and March 2021 and are likely to meet it again in April 2021. • They had no 104d+ cases between January and March 2021 and are likely to have none in April 2021 too. • They are running a full cancer service within the community. • Patient-facing staff are required to do lateral flow tests twice a week, with full PPE		

		worn at all times and high level sanitation procedures in place. • All patient appointments require an 11 point questionnaire to be completed regarding COVID-related symptoms. • With regard to theatre capacity, appointments are available within 2 weeks. • In relation to outpatient capacity, most 2ww appointments are offered a date within 1 week. • Both services continue to run an efficient cancer service with no capacity or treatment issues. **QVH – update provided by Victoria Worrell** • They met the 2ww standard in January and February and are predicted to meet it in March 2021 too. The Trust started to see a recovery of 2ww referrals in July 2020 following the first wave, although they dipped in October 2020 and January 2021. In February and March 2021, however, they saw an increase in referrals. • QVH failed to meet the 31d target in January and February and are likely to fail it in March 2021 too. The main challenges have been capacity, patient comorbidities and COVID delays. • In relation to the 62d standard, they achieved this in January and February and are predicted to reach it in March 2021 too. They are focusing on the 24d pathway for late referrals, ensuring there are clear lines of escalation to make sure patients are treated within the timeframe. • They had 12 104d+ cases in January, 8 in February and are likely to have a total of 8 in March 2021. They continue to see delays relating to COVID, with patients waiting to have their first and/or second vaccination. • In terms of 62d backlogs, they had 25 in January, 12 in February and are likely to have a total of 5 in March 2021. • QVH failed to reach the 28d compliance target in January, achieved it in February and are likely to achieve it in March 2021 too. In relation to 28d data completeness, the Trust met the standard in January and February and are likely to do so in March 2021 also. • 62d and 104d+ performance has the potential to be impacted by the inclusion of late referrals from other Trusts. • A number of patients have had to self-isolate due to testing positive for COVID. • QVH are recruiting into an additional locum skin consultant which will support the restoration and recovery of the service.		

		• QVH continue to work through clinical validations, with clinical harm reviews in place for all 104d+ cases. • Breach reasons include: complex pathways, patient choice and consultant theatre capacity. • Consultant theatre capacity is a challenge as more patients now require a higher level of surgery. • There are no escalations for outpatient capacity. QVH are currently providing a mixture of telephone, virtual and face-to-face appointments. 2ww referrals are triaged after a photograph is sent by the patient, with 90% of patients having their first appointment in the See and Treat clinic. • The Trust's Cancer Improvement Plan was approved by their Cancer Board in April 2021, with the first Task and Finish group meeting in May 2021. The plan covers all aspects of cancer care at the Trust, with the key areas of focus on: 1. Ensuring all pathways are in line with rapid diagnostic pathways. 2. Developing a more systematic approach to root cause analysis, formalising feedback and learning. 3. Regularly reviewing cancer theatre capacity and utilisation. 4. Reviewing and updating all cancer SOP's where appropriate.		
6	**SSMDT update**	**<u>Emailed update from Siva Kumar</u>** • The SSMDT meetings now take place on Microsoft Teams and this is working well from an IT perspective, ensuring accessibility to the meetings. • SK is very grateful for the input from all members, especially during the pandemic. • The SSMDT has valuable and consistent dermatology support. • Oncology support was provided for a number of months by Sophie Papa from GSTT. RP then took this over and has provided an excellent service. This has now been bolstered with support from COHB who recently returned to work following maternity leave. • AZ now offers valuable support for non-melanoma oncology and this part of the service is the best it has been over the last few years. • AF from histopathology and the CNS teams have also provided a lot of support. • Radiology support is provided by Guyven from QVH and Sunil Bhargava from MFT. • Challenges include: - Increasing case numbers. - To reduce the burden on the service, many of the low risk SCC cases are now for 'noting only'. Going forward they will need to determine if all radiology for surveillance		

		scans that are N0M0 need formal discussion or can be put on to 'noting only'. - The increasing complexity of cases, especially with adjuvant therapy. There will be a need for surgical and oncology teams to work more closely and seamlessly. - SK stated it is likely they will see a rebound effect post-COVID of skin cancers which have yet to come in to hospital. This will have an impact on the MDT meetings across the patch. • SK highlighted the importance of determining whether the teams across the patch can do anything over and above what they are already doing to improve the meetings and the way they function. • SK also emphasised the need to identify whether the MDT outcomes are adequate and to think about how they can be improved.		
7	**Skin cancer management pathways**	• ABi stated this item had been put on the agenda in error.		
8	**Clinical Pathway Discussion**	**<u>Update provided by Larry Shall</u>** • AW mentioned the HOP and PoC documents still require updating. • **<u>Action:</u> A working group is to be set up in order to update the HOP and PoC documents, with LS to coordinate this by allocating the documents to specific people. It was felt the melanoma PoC requires updating most urgently so the necessary amendments will be made and circulated to the members for comments.** **<u>SCC guidelines – update provided by Larry Shall</u>** • LS stated the BAD guidelines for the management of cutaneous SCC should be adhered to and therefore suggested they be adopted patch-wide. • ABi mentioned at EKHUFT they now perform a PET CT scan on patients with >stage 2c melanoma, with repeat scans bi-annually. Patients with stage 2c melanoma are given the PET CT scan prior to their sentinel lymph node biopsy in case there is a risk of the cancer spreading anywhere else. • ABi believes it would be reasonable to implement a process whereby patients with stage 2b melanoma are given a PET CT instead of a CT scan. Gordon Ellul, Head of Nuclear Medicine at EKHUFT, would be happy to attend the next meeting in order to provide some data on why PET CT is preferable to CT for melanoma follow-up. **<u>Action:</u> LS/AW to invite Gordon Ellul to the next meeting to present on this.**		**LS** **LS/AW**

		• **<u>Action:</u> KPe to conduct an audit on stage 2c melanoma scanning at EKHUFT.**		**KPe**
9	**Research update**	**<u>Update provided by Ciara O'Hanlon-Brown</u>** • COHB stated DANTE is the only study open at present and West Kent are recruiting to this.		
10	**CNS updates**	**<u>EKHUFT – update provided by Kim Peate</u>** • Their CNS team currently comprises of KPe, WW and Nina Hayes. They hope to recruit a 4th CNS by the end of this year. • KPe stated additional surgical and oncology support would be helpful. • They hope to embed a lot more eHNA's and other recovery package elements in to the service. • KPe has been unable to progress with the stratified pathways piece since the last meeting due to workload. They will, however, be adhering to the BAD recommendations when the team start to work on developing stratified pathways. **<u>SCDS – update provided by Susannah Lowe</u>** • From a West Kent perspective, the TVEC service was set up last year by SL and COHB and they successfully treated 2 patients prior to lockdown. They are keen to restart this service when safe to do so. • SL is currently the only CNS in West Kent. • SL is looking in to the recovery package piece and hopes to progress with this in the next few months. • They are now seeing more patients face-to-face at MTW and have used the Attend Anywhere system for virtual appointments. **<u>QVH – update provided by Maggie Curtis</u>** • Virtual clinics have functioned well and they have discovered some useful patient-friendly online links, including ones for: self-checking of lymph nodes, lymphoedema and health and wellbeing. • The Trust hope to be allocated additional CNS hours. **<u>Stratified pathways – update provided by Bana Haddad</u>** • BH encouraged the members to contact her or Claire Mallett should they require any support with the stratified pathways piece.		

11	**Cancer Alliance update**	**<u>Update provided by Tracey Ryan on behalf of Serena Gilbert</u>** The predominant aims of cancer services across the patch are to: • Restore urgent cancer referrals at least to pre-pandemic levels. Between March 2020 and February 2021, 85% of the normal amount of treatments were provided. • Reduce the backlog at least to pre-pandemic levels on 62 day (urgent referral and referral from screening) and 31 day pathways. • Ensure sufficient capacity is in place to manage increased demand moving forward, including follow-up care. • Reduce health inequalities. • Support the 28d FDS piece. • Ensure patients and staff are confident services are COVID-protected. • Ensure the right workforce is in place. • Restart Long Term Plan activity.		
12	**CCG update**	**<u>Update provided by Chris Singleton</u>** • CS and Laura Alton are the new Senior Programme Managers for cancer commissioning in Kent & Medway and are working as part of an integrated CCG and KMCA team. They believe this is a positive change from the previous locality-based commissioning approach, and is in line with the development of the Integrated Care System. It will support delivery of local and national cancer priorities, and brings together the expertise of the KMCA with commissioners under the leadership of Ian Vousden (Programme Director). • CS and Laura Alton are keen to help support the development of clinical pathways which improve access to cancer services for the K&M population, navigating through the new CCG governance processes. The CCG will ensure they work at scale across the patch, whilst also making sure all voices are heard. • They are working closely with their planned care commissioning colleagues in each of the 4 Kent & Medway Integrated Care Partnerships, given the overlap between cancer and planned care pathways. • Cancer is a clear priority in the recently published NHS Planning Guidance, and they will be working with all relevant colleagues to help deliver the priorities, particularly in terms of returning to pre-pandemic levels of cancer treatment. • They are currently focusing on a number of commissioning priorities for cancer, including pilots of a number of rapid diagnostic services including: - The Vague and Indeterminate Symptoms Service at DVH (which they are looking to make a substantive commissioned service there due to the success of the pilot).		

		Discussions are underway to extend the VISS model more widely across the patch. - The rapid lymphadenopathy service at EKHUFT. - The low dose CT piece at EKHUFT. • CS and Laura Alton have also been working with the provider of the K&M prehabiliation programme, which has been presented and discussed at a number of TSSG meetings, in order to extend the pilot of the service for patients and to help them prepare for surgery. • CS encouraged the members to contact him/Laura Alton if they require commissioning support with any cancer pathway developments.		
13	**AOB**	• SL stated she sees a number of patients at MTW who have developed rashes as a result of immunotherapy toxicity and asked if there was a dermatologist in West Kent she could rapidly refer these cases to. LS mentioned he would be happy for her to call him so they can discuss this further.		
	Next Meeting Date	• To be confirmed.		