Kent and Medway Cancer Collaborative

Skin Tumour Site Specific Group meeting
Thursday 25th November 2021
Microsoft Teams
14:00-16:30
Final Meeting Notes

Present	Initials	Title	Organisation
Larry Shall (Chair)	**LS**	Consultant Dermatologist	Sussex Community Dermatology Service
Grace Hancock	**GH**	Acute Services Manager	Sussex Community Dermatology Service
Cherng Jong	**CJ**	Consultant Dermatologist	Sussex Community Dermatology Service
Andrew Morris	**AM**	Consultant Dermatologist & Dermatological Surgeon / Clinical Director	Sussex Community Dermatology Service
Kirstyn Parratt	**KPa**	Admin & Cancer Lead	Sussex Community Dermatology Service
Prasad Hunasehally	**PH**	Consultant Dermatologist	Sussex Community Dermatology Service
Samantha Collins	**SC**	North Kent Service Manager	Sussex Community Dermatology Service
Nina Hayes	**NH**	Macmillan Skin Cancer CNS	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Wendy Willmore	**WW**	Macmillan Skin Cancer CNS	EKHUFT
Sandra Varga	**SV**	Consultant Dermatologist	EKHUFT
Gordon Ellul	**GE**	Consultant Nuclear Physician	EKHUFT
Claire Mallett	**CM**	Programme Lead – Living With and Beyond Cancer	KMCA
Ian Vousden	**IV**	Programme Director	KMCA
Karen Glass	**KG**	Administration & Support Officer	KMCC
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Facilitator	KMCC
Susannah Lowe	**SL**	Melanoma CNS	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway CCG
Holly Groombridge	**HG**	Cancer Commissioning Project Manager	NHS Kent & Medway CCG
Maggie Curtis	**MC**	Macmillan Skin Cancer Clinical Nurse Specialist	QVH
Siva Kumar	**SK**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Heather Drewery	**HD**	Assistant Cancer Manager	QVH
Anne-Marie Kennedy	**AMK**	Consultant Plastic Surgeon	QVH
Karen Carter-Woods	**KCW**	Head of Risk & Clinical Quality	QVH
Abigail Brunning	**ABr**	Skin Cancer CNS	QVH
Sandy Flann	**SF**	Consultant Dermatologist	West Kent Dermatology Service
Apologies			

Andrew Birnie	**ABi**	Consultant Dermatologist & Dermatological Surgeon / Clinical Lead - Dermatology	EKHUFT
Sue Drakeley	**SD**	Oncology (Solid Tumour) Research Team Leader	EKHUFT
Asha Rajeev	**AR**	Consultant Dermatologist	EKHUFT
Elizabeth Sharp	**ES**	Consultant Surgeon	EKHUFT
Kim Peate	**KPe**	Macmillan Lead Skin Cancer CNS	EKHUFT
Danielle Mackenzie	**DM**	Macmillan Skin Cancer CNS	EKHUFT
Serena Gilbert	**SGi**	Cancer Performance Manager	KMCA
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Stefano Santini	**SS**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Sona Gupta	**SGu**	Macmillan GP & Cancer Lead	NHS Kent & Medway CCG
Kusu Orkar	**KO**	Consultant Plastic & Reconstructive Surgeon	QVH
Victoria Worrell	**VW**	Access & Performance Manager	QVH

Item		Discussion	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 to the members with the final minutes from today's meeting. **Review previous minutes** • The minutes from the previous meeting which took place on 06.05.2021 was reviewed and agreed as a true and accurate record.	
2	**Research update**	**Presentation provided by Rosemeen Parkar** • RP provided an overview of: - The RELATIVITY-047 trial, the rationale for RELA + NIVO, the study design and the progression-free survival across sub-groups. - The KEYNOTE-716 trial and the results of an interim analysis. - The MASTERKEY–265 trial. - A Phase II trial of ipilimumab, nivolumab and tocilizumab for unresectable metastatic melanoma.	
3	**National Skin Cancer Pathway**	**Update provided by Larry Shall** • Following a review of the National Skin Cancer Pathway document, LS stated as a region we are ahead of the curve with regard to following the recommendations set out in the guidance.	

		• LS believes the document offers innovative solutions to the challenges posed by increasing skin cancer referral workload. Two models are principally proposed: 1. The harnessing of new technology, in particular tele-dermatology, digital referral platforms and the use of remote consultations to reduce the need for unnecessary hospital attendances. 2. Spot clinics, a successfully piloted cost-effective intervention, offering a quick way for consultant-led dermatology teams to review large numbers of suspected skin cancer 2ww referrals in a community or specialist setting. • LS believes the document was timely given the increasing number of people being referred to the 2 week rapid access clinics and the drive to find ways of increasing the throughput of patients through those clinics. • LS stated the My Skin App is utilised by Kent Integrated Dermatology Service patients. • SH outlined the process in East Kent with regard to the 2ww tele-dermatology service, particularly in relation imaging and clock stops. • SK mentioned QVH are looking to make their 2ww pathway more efficient.	
4	**Skin suspected cancer e-referral form**	**<u>Update provided by Larry Shall</u>** • LS stated he is receiving an increasing number of blank or incomplete e-referral forms. • **<u>Action:</u> Following a review of the updated skin suspected cancer e-referral form, LS outlined which changes had been made since the last meeting and stated a section for the inclusion of a photo will be incorporated in to the document. LS/AW will then circulate the document to the group for them to review and feedback accordingly before it is finalised. Once finalised, the document will be implemented in to the pathway.** • SH highlighted the need for referrals to be vetted prior to being sent in to secondary care as a number of GPs are referring patients in without having seen them face-to-face. He believes if GPs did see more patients in person, they may have decided a referral was not necessary. HG mentioned she would be happy to support getting this message out in order to try and expedite the issue if required.	**LS/AW**
5	**PIFU/Stratified Pathways** **Cancer Alliance update**	**<u>PIFU/Stratified Pathways – presentation provided by Claire Mallett</u>** • CM provided the group with an overview of: personalised models of care, self-management pathways, the digital evolution of the various LWBC-related workstreams and the key features of the InfoFlex web-based system. • CM asked whether there is an appetite to move forward with the supported self-management/remote follow-up workstreams for skin cancer. In response to this: - LS suggested early stage melanomas may be suitable to take forward from a stratified pathway/PIFU perspective. - SK suggested non-melanomas should also be considered. - CM stated the Alliance could be in a position to help support the tracking aspect of the PIFU piece (with PH suggesting SCC may be the tumour type which would benefit most from this). • **<u>Action:</u> In order to move this piece of work forward, LS mentioned it would be advisable to schedule a meeting with skin cancer nurses, dermatologists, surgeons and oncologists. CM to set this up.** **<u>Cancer Alliance update – presentation provided by Claire Mallett</u>** • Please refer to the circulated Cancer Alliance presentation which was circulated post-meeting.	**CM**

6	**Performance**	• Please refer to the performance slide pack which was circulated post-meeting for an overview of the EKHUFT, North Kent, West Kent and QVH performance data.	
7	**SSMDT update from Siva Kumar QVH**	**Update provided by Siva Kumar** • Hosting the SSMDT meetings via Microsoft Teams has been working well and this platform allows members to dial in from their clinic rooms. SK believes, however, attendance could be better and encouraged the leads for both North Kent and West Kent to speak to their respective teams to improve this. • The substantive radiologist QVH appointed has provided valuable input to the meetings and Ian Francis is also able to cover these meetings from a radiology perspective as and when required. • SK stated accessing PET-CT scans has been an issue and obtaining scans from Alliance Medical has proven difficult. The company are happy to send the scan and the report to the referrer but not to the MDT itself (which SK suspects may be due to a GDPR issue). In view of this, the MDT coordinators often spend a lot of time contacting other hospitals to request these be sent to them. In the interim, SK believes it would be sensible to ask Alliance Medical to copy in the QVH Skin Cancer MDT when returning the scans and reports – something he believes may help to circumvent the GDPR issue. • The SSMDT is well supported by pathology, CNS, dermatology and oncology colleagues. • HD believes QVH's main challenge lies with imaging. Authority from the requester that the images can be sent via the IEPD method is required otherwise they cannot be reviewed. Further, HD stated the images need to be sent to their PACS system. **Action: LS stated it would be sensible to add some wording to the form before it is sent to Alliance Medical, specifically relating to what needs to be included on there for access to be granted, which HD agreed to do.** • PH feels the teams are doing a lot more CT scans than is clinically necessary. Currently CT scans are offered to patients with an ulcerated melanoma even if they have had a negative sentinel lymph node biopsy, despite the fact this is not a NICE recommendation. In view of this, he believes the teams should reduce the number of CT scans they perform. SK agreed with this and stated this is often discussed in the SSMDT and MDT meetings. • SK mentioned NICE are expected to publish guidance within the next 12 months to outline updates to follow-up protocols for all melanomas and who should have imaging, when they should have it and what type should be offered. • SK suspects there will be an increase in the number of discussions needing to be had with patients around radiological scans and what to expect from them. • LS and SK agreed scans for <PT3b cases should not be ordered unless there is agreement at the MDT. **SCC guidelines – update provided by Cherng Jong** • Please refer to the presentation circulated post-meeting for a detailed overview of the updated 2020 guidelines for squamous cell carcinoma. The general points CJ wished to convey are: - The new guidelines emphasise that clinicians should take in to account: a patient's clinical history, comorbidities and whether they are immuno-suppressed. - The new guidelines have introduced a very high-risk category for patients who tend to be followed up for 3 years. - There is a push to streamline follow-ups, particularly for the purpose of discussion at MDT meetings. - The measures which can be taken with regard to follow-up for low-risk, high-risk and very high-risk patients.	**HD**

8	**Clinical Pathway Discussion**	**Melanoma PoC – presentation provided by Larry Shall** • LS stated the Melanoma PoC is outdated and proceeded to provide an overview of the slides he had collated. These included (but are not limited to): - The pathway for pigmented lesions when referred to a 2 week rapid access skin cancer clinic. - The recommended clinical information which should be provided to pathologists and the pathological staging of malignant melanoma (especially when to offer a Sentinel Lymph Node Biopsy at time of Wide Local Excision). - Staging of cutaneous melanoma. - Surgical management and surgical margin recommendations for primary cutaneous melanoma. - The role of a Sentinel Lymph Node Biopsy. - NICE pathways for managing melanoma. - Targeted therapy drugs for melanoma. - Immune checkpoint inhibitors, PD-1 inhibitors and the PD-L1 and CTLA-4 inhibitors. - Reasons for follow-up. - Melanoma follow-up by stage. - Pregnancy and melanoma. • LS stated the old proforma will be removed from the website and replaced with the pathway discussed as part of this presentation.	
9	**CNS updates**	**EKHUFT – update provided by Nina Hayes** • The team comprises of 4 CNS'. • A Band 4 has recently been appointed. **QVH – update provided by Maggie Curtis** • A new CNS will be joining the team next week. MC will send the CNS's email address to CC/AW so she can be added to the Skin TSSG mailing list. • MC asked whether a CNS will be appointed for North Kent in order to pick up the patients Stacey Croney used to see. She was informed this is in hand. **Stratified pathways** • It was felt this item had been discussed sufficiently under agenda item 5. **Length of time to receive investigations reported and discussed at MDT** • This item was not discussed.	
10	**CCG update**	**Update provided by Holly Groombridge** • Local ICP teams are working with the relevant Community Diagnostic Centres (of which there will be 6 for Kent & Medway), which can cover populations of up to 300,000. The Alliance is supporting this workstream from a cancer perspective. East Kent and West Kent are taking this forward initially and are currently in phase 1. MFT and DVH will follow suit in phase 2. • From 01.04.2022, the CCG will be replaced by ICPs. Within the ICPs there will be PCN's which is where the GP practices will sit.	

		• The intention is to support system-level working and collaboration which is already in a good position from a cancer perspective.	
11	**Why PET-CT is preferable to CT for melanoma follow-up**	**<u>Presentation provided by Gordon Ellul</u>** • GE provided a presentation on why he believes PET-CT is preferable to CT for melanoma follow-up cases. His slides provided an overview of: - The function of an FDG PET-CT. - The Tracer Principle and Signal Amplification. - A comparison of imaging technologies and radiation doses. - The advantages and disadvantages of an FDG PET-CT. - FDG PET-CT and immunotherapy. - FDG PET-CT biomarkers for survival prediction. - FDG PET-CT tumour parameters and prognosis. - FDG PET-CT and real patient outcomes. - FDG PET-CT and advanced cutaneous melanoma. - The response to anti-PD1 treatment prediction in metastatic melanoma. - Early metabolic progression on immunotherapy. - The safe discontinuation of treatment. • GE presented images of the following: - Metastatic melanoma on 2nd line treatment (ipilumimab). - A review of the brain in melanoma patients. - Postsurgical seroma and lymphatic insufficiency. - Sinonasal melanoma. • GE believes FDG PET-CT is here to stay for melanoma cases. • GE stated a PET-CT scan has higher sensitivity not only for melanoma but other tumours as well. • When GE next meets with Alliance Medical, he will outline to them where he feels there is a geographical gap in terms of PET-CT provision.	
12	**AOB**	• No-one had anything to raise under any other business.	
	Next Meeting Date	• To be confirmed.	