Kent & Medway Cancer Collaborative

Skin Tumour Site Specific Group meeting
Thursday 9th November 2023
Orida Hotel, Maidstone
14:00 - 17:00
Final Meeting Notes

Present	Initials	Title	Organisation
Siva Kumar (Chair)	**SK**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Brian Bisase	**BB**	Consultant Maxillofacial / Head & Neck Surgeon	QVH
Kim Peate	**KP**	Macmillan Lead Skin Cancer CNS	EKHUFT
Nina Hayes	**NH**	Skin Cancer CNS	EKHUFT
Wendy Willmore	**WW**	Skin Cancer CNS	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Andrew Birnie	**ABi**	Consultant Dermatologist & Dermatological Surgeon / Clinical Lead - Dermatology	EKHUFT
Khari Lewis	**KL**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Kemal Tekeli	**KT**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Rhiannon Leppard	**RL**	Skin Cancer Support Worker	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Karen Glass (Minutes)	**KG**	Administration Officer	KMCA & KMCC
Annette Wiltshire	**AWi**	Service Improvement Lead	KMCC
Denise Burt	**DB**	Clinical Nurse Specialist	MTW
Ann Fleming	**AF**	Consultant Histopathologist / Clinical Lead - Cellular Pathology	MTW
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Anthi Zeniou	**AZ**	Consultant Clinical Oncologist	MTW
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	NHS Kent & Medway ICB
Ariane Kempton	**AK**	Clinical Nurse Specialist	SCDS / KIDS
Grace Hancock	**GH**	WK Service Manager	SCDS / KIDS
Samantha Collins	**SC**	NK Service Manager	SCDS / KIDS
Cherng Jong	**CJ**	Consultant Dermatologist	SCDS / KIDS
Alice Hubbard	**AH**	CNS - Dermatology	SCDS / KIDS
Danish Kazmi	**DK**	Consultant Dermatologist	SCDS / KIDS
Apologies			

Asha Rajeev	**AR**	Consultant Dermatologist	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Ian Vousden	**IV**	Programme Director	KMCA
Colin Chamberlain	**CC**	Administration & Support Officer	KMCC
Alison Watkins	**AWa**	Faster Diagnosis Team Leader	MTW
Louise De Barra	**LDB**	Skin Cancer MDT Coordinator	QVH
Heather Drewery	**HD**	Cancer Manager	QVH
Jill Anderson	**JA**	Interim Head of Elective Access, Performance and Health Inequalities	QVH
Jennifer O'Neill	**JON**	Consultant Plastic Surgeon	QVH
Andrew Morris	**AM**	Consultant in Dermatology and Cutaneous Surgery / Clinical Director - SCDS	SCDS / KIDS
Sandra Varga	**SV**	Consultant Dermatologist	Whitstable Medical Practice

Item		**Discussion**	**Action**
1.	**TSSG Meeting**	**Apologies** • The formal apologies are listed above. **Introductions** • SK welcomed the members to today's face to face meeting and confirmed this would be last one he would be chairing. The group introduced themselves. KG explained she would be administrating at today's meeting as her colleague CC was poorly. • If you attended the meeting and have not been captured within the attendance log above please contact karen.glass3@nhs.net directly. **Action Log Review** • The action log was reviewed, updated and will be circulated together with the final minutes from today's meeting. **Review previous minutes**	

		• The minutes from the previous meeting which took place on the 11th May 2023 were reviewed and signed off as a true and accurate record.	
2.	**Introduce new Cancer Alliance Medical Director**	• SK introduced RC as the new Medical Director for Kent & Medway Cancer Alliance. • RC planned to attend this full round of TSSG meetings and will be a familiar face moving forwards. RC introduced JB the Primary Care Clinical Lead for the ICB who she would be working closely alongside. • RC thanked the TSSG Chairs for their support and strong clinical leadership in driving forward their respective TSSG's. • RC mentioned the K&M CA will soon be embedded within the K&M Integrated Care Board (ICB) and as such will function as a bridge between the ICB and the TSSG's. The aim will be to develop an ICB clinical strategy whilst utilising the data, CA funding and to be clinically led by the TSSG experts. The TSSG's are key to driving forward the clinical strategy and shaping their service for the next year, 5-years and 10-years. • RC suggested they focus on what is pertinent to K&M particularly within those areas of deprivation and inequality. • RC is keen for each of the TSSG's to include MDT leadership & specialist clinical roles within pathology, radiology, oncology, surgical & nursing and to encourage their attendance at the TSSG meetings. RC emphasised the importance of the Radiology and Pathology Networks linking in with the Cancer Alliance so they are an integral part of the horizon planning for the next 5-10 years. RC was pleased to see there was pathology support at today's meeting which has not been the case for some of the other TSSG meetings. • JB highlighted the importance of improving the communication link / relationship between Primary & Secondary Care and the quality of referrals coming in. JB suggested other ways to target the GP's / Practices who do not engage in the education sessions. JB raised the point that some patients are still not aware they are being referred on an urgent cancer pathway. They need to have good quality data which will help them achieve fool proof quality care for their patients.	

		• SK referenced the updating of the High-Level Operational Policy document for Skin which has not been updated for 3-4 years. He asked if the ICB could help resource the additional time it takes for their busy clinicians to update these key documents. RC sympathised with SK and emphasised how the NHS runs on the goodwill of their staff. RC agreed to look at the CA / ICB budget to help support additional projects required across the trusts.	
3.	**Impact on radiology of imaging requirements for follow up of melanoma patients and the relationship to treatment options**	**<u>Update by Rosemeen Parkar</u>** • RP outlined the current radiology local practice which they struggle to maintain: i) Adjuvant >2b – 3-monthly PET and 6-monthly MRI brain - discharge to dermatology – 6-monthly PET scans ii) Metastatic – 3-monthly PET and 3-monthly MRI brain – for 2 years at least – then if CMR – 6-monthly for next 2 years – then yearly thereafter. • RP referenced the Melanoma Focus and NICE Guidelines. • RP asked the group the following questions: i) Could we reduce the frequency of PET scans to 4-monthly – for patients having adjuvant treatment? ii) This will reduce a PET scan request by 1 / Patient / Year iii) GSTT are already doing this. • RC suggested they followed what was the best clinical practice and was in the best interests of their patients. In order for them to plan for future services there needs to be consensual guidance in place for every pathway. • It was agreed the importance of having clear, accurate data so they could re-design and plan their pathways for the future. RC confirmed the Cancer Alliance Data Analyst – David Osborne would be very happy to support with any data requests.	**Presentation circulated to the group on the 13th November 2023**

		• The group agreed they would continue to follow NICE and Melanoma Focus guidelines for Dermatology. • Oncology – further guidance required for adjuvant / metastatic patients to follow.	
4.	**Measurements of Vitamin D and scanning frequencies for melanoma patients** **Melanoma Stage 2b 2c adjuvant immunotherapy**	**<u>Update by Rosemeen Parkar</u>** • Having a Vitamin D deficiency can be associated with a worse prognosis for metastatic melanoma patients. ABi explained those patients with a high Vitamin D level at diagnosis often have better outcomes. He suggested everyone should take a Vitamin D supplement. • KP confirmed at diagnosis they do not test Vitamin D levels but she does advise her patients to take a Vitamin D supplement. She added these levels do naturally fluctuate in the winter and summer months. SK agreed he would advise the same – 400IU standard tablet taken daily. • JB explained GP's are advised not to prescribe Vitamin D tablets if they are readily available to buy over the counter at a Pharmacy. • Sentinel Node Biopsies – a safe process for patients where appropriate.	**Presentation circulated to the group on the 13th November 2023**
5.	**Merkel Cell Guidelines**	**<u>Update by Jennifer Turner</u>** • JT outlined the European Guidelines for Merkle Cell Carcinoma which were updated in 2022. • Merkel Cell Carcinoma: i) Highly aggressive cutaneous carcinoma with epithelial and endocrine features. ii) Rare iii) Risk factors including: ○ White Skin type ○ Old Age (median age at diagnosis is 77)	**Presentation circulated to the group on the 13th November 2023**

		○ UV exposure ○ Immunosuppression ○ Merkel Cell Polyoma Virus infection • JT explained there is a higher incidence of MCC in K&M due to an ageing and primarily white population. However, the numbers are small with only approximately 10 patients per year. • JT highlighted at clinical presentation MCC can present as a firm asymptomatic, non-tender flesh-coloured or red nodule or plaque. It can grow rapidly over a number of weeks. The most predominant site would be the Head & Neck or extremities. • The Lymph Node Status is the most important independent prognostic factor. • The Consensus document recommends: i) Preoperative and baseline investigations ii) Surgery iii) Sentinel Lymph Node Biopsy iv) Clinical Lymph Node Dissection – controversial due to the absence of high-quality data. v) Radiotherapy vi) Palliative Radiotherapy vii) Immunotherapy viii) Chemotherapy ix) Follow up • The proposed treatment pathway for Kent & Medway includes: **i) <u>Diagnosis</u>** ○ Primary Biopsy ○ Staging PET ○ SLNB **ii) <u>Treatment</u>**	

		○ Wide Local Excision – if appropriate – MDT decision – agreed on a case by case basis. ○ Adjuvant Radiotherapy ○ Appropriate nodal basin management **iii) <u>Follow up</u>** ○ 3 monthly Ultrasound and clinical examination ○ 3-6 monthly cross-sectional imaging for 3 years, then 6-12 monthly for 2 years. • ABi suggested 6-monthly US and 6-monthly PET – scans to be staggered. **Action – Ritchie agreed to contact Gordon Ellul - gordon.ellul@nhs.net - Lead Clinician & Consultant in Nuclear Medicine at EKHUFT to discuss buy-in for a local service.**	**RC**
6.	**e-referral form** **SSCA referral form**	• The group discussed and compared the K&M CA – Skin Suspected Cancer e-referral form with the Surrey and Sussex CA – Suspected Cancer Referral Form: Melanoma and Non-Melanoma Skin Cancers. • They agreed it was important to make the process as simple as possible so patients could be triaged more appropriately. A common issue is the referral criteria is not completed adequately. To have certain fields as mandatory would definitely help. • RC asked if having a photo attached would help them triage. The group agreed this would not be ideal as the quality of the photo would not be good enough. KP added a history of the lesion would need to accompany the photo as well. • ABi explained they often have to ask the patient why they are in clinic and additionally, have not been seen face to face / examined by the GP. Tidying up the referral process within PC would make a massive difference. • KP referred to patients blocking clinics who come in with skin rashes, which is not an appropriate use of the clinic. They have on average 1500 2ww referrals every month at EKHUFT.	**Both referral forms were circulated to the group on the 13th November 2023**

		• JB emphasised the importance of having an agreed minimum clinical dataset before a referral can be made. • It was suggested a mandatory field is added to confirm the patient has been seen and examined by the GP. There are varying working practices in place across K&M with a higher volume of locums employed particularly within EKHUFT. • SH confirmed they currently have 5 Tele-Dermatology clinics in place in EKHUFT but plan to increase this to 10. These clinics are bookable via ERS and there is a relatively short waiting time. Low risk patients are referred to Tele-Dermatology with high risk patients referred via an urgent 2ww referral. • Comparing the KMCA referral form to the SSCA they agreed the SSCA lesion guidance was simpler and straightforward compared to KMCA. SK emphasised in simple terms they only require the size, site and duration of the lesion.	
7.	**Performance data questions** **Performance data to present** • **EKHUFT** • **SCDS** • **QVH**	• SK confirmed K&M is the highest performing Alliance for their Skin 62-day performance but FDS performance is below the England average. They also have one of the lowest Urgent Suspected Cancer backlogs nationally at 2.8%. **<u>EKHUFT – presentation provided by Andrew Birnie</u>** • **Please refer to the performance slide pack for a full overview of the Trust's data.** • ABi confirmed despite the huge volume of referrals they are doing well at EKHUFT in terms of their performance data. They consistently meet the 75% target for 28-day FDS performance and most patients do not have cancer. • ABi mentioned their 31-day performance has dropped recently due to elective capacity issues. • The main reasons for 28-day breaches are due to punch biopsy capacity and delays with patient letters being sent out.	**Performance data circulated to the group on the 13th November 2023**

		• They have 25 patients waiting over 62-days with 1 patient waiting over 104-days. The main reasons for these delays are due to biopsy capacity, patient choice and histology delays. • ABi acknowledged the rise in number of referrals during the summer months due to people wearing less clothing. He did not necessarily feel the K&M CA Skin Cancer awareness campaign had contributed to this increase. **SCDS – North and West Kent - presentation provided by Danish Kazmi** • **Please refer to the performance slide pack for a full overview of the organisation's data.** • DK referred to the 1800 skin referrals they receive on a monthly basis. Overall their performance across both North and West Kent for all of the national targets are doing well with no particular issues raised. **QVH – presentation provided by Siva Kumar** • **Please refer to the performance slide pack for a full overview of the Trust's data.** • SK raised the issue of space at QVH which is having an impact on their delivery. Additionally, there are staffing issues impacting their 62-day performance, but with the appointment of two new Consultants this will improve their performance.	
8.	**Cemiplimab experience**	**Cemiplimab in cutaneous SCC – presentation provided by Anthi Zeniou** • AZ explained there are no conflicts of interest. Some of the slides are courtesy of Sanofi / Regeneron and there has been no financial incentive for their use. • CSCC is the second most prevalent skin cancer and has increased over the past 30 years. CSCC predominantly affects the older population with a median age of 71 at the time of diagnosis. Patients with advanced CSCC with distant and regional metastasis have an overall survival of between 8 and 13 months. Tumours which develop around the head and neck region have a significant impact on the	**Presentation circulated to the group on the 13th November 2023**

		patient's quality of life. The only treatment they can offer is chemotherapy and radiotherapy. • AZ referred to the EMPOWER trail whereby patients were doing well overall and have a quick response time. They are seen in clinical practice. There is a 6% risk of severe toxicity with Cemiplimab. • Cemiplimab Experience in Kent: i) Data from September 2019 – September 2023. ii) 44 patients – 34 male – 10 females iii) Median age 78 iv) PS 0/1 v) 84% (37 / 44) primary surgery vi) Median time to failure from primary surgery – 6.5 months (0-41) vii) 68% (30 / 44) received Radical or Palliative Radiotherapy at diagnosis of failure viii) Median number of cycles – 5 (1-35 – max number). ix) Response assessment clinical, radiological (CT, MRI, PET-CT) x) Median time to assessing first response – 10 weeks (2.7 – 91.9) xi) Commonest toxicity – fatigue, new rash. xii) 3 / 44 patients developed >/= Grade 3 toxicity xiii) 1 / 44 required hospital admission and all required steroids and discontinued treatment xiv) No drug related mortality. • The median overall survival for these patients was 15 months and 21 out of 40 patients died. • AZ outlined the progress of 3 case studies. • Not licensed to use Cemiplimab neo-adjuvantly. Only licensed for 2 years via the Cancer Drugs Fund. • KP mentioned there are some areas of the Country that are not using Cemiplimab.	
9.	**Update on Clinical Pathways**	**<u>High Operational Policy</u>** • SK to update this document with support from AW.	

	High Operational Policy **Basal Cell Carcinoma** **Melanoma** **Cutaneous Lymphoma** **Squamous Cell Carcinoma**	• SK to locate the Surrey CA HOP document which will aid updating the K&M HOP. **Basal Cell Carcinoma** • ABi will aim to update this document within the next 6 months with support from AW. **Melanoma** • KP and AW to work together to update this document. **Cutaneous Lymphoma** • KP and AW to work together to update this document. **Squamous Cell Carcinoma** • KP and AW to work together to update this document.	
10.	**CNS updates**	**EKHUFT** • RL is new to post. **MTW** • New CNS in post - doing follow up and breaking bad news. **QVH** • 1.5 CNS in post.	
11.	**AOB**	• A request from Tracey Ryan – K&M CA User Involvement Manager to the group asking for their help	**Further details**

	Patients Partners Engagement **Fatigue Management**	to locate ideally two patient representatives for the Skin TSSG meeting. If they have anyone in mind to contact her directly – tracey.ryan1@nhs.net. • AWi highlighted an online 2-hour Fatigue Management Workshop on behalf of Sue Green - Macmillan Project Manager, Personalised Care & Support Programme. This is being run and funded by the Pilgrims Hospice and K&M CA. • SK felt this would be very worthwhile for their CNS's to attend and is an integral part of the Holistic Needs Assessments. • There was no further business raised under AOB. SK thanked the group for their attendance and contribution at today's meeting.	**sent to the group on the 13th November 2023.**
12.	**Next Meeting Date**	• **Thursday 23rd May 2024 – 14:00 – 17:00 – Venue to be confirmed.**	