Kent & Medway Cancer Collaborative

Skin Tumour Site Specific Group meeting
Thursday 11th May 2023
Great Danes (Mercure) Hotel - Maidstone
14:00-16:00

Final Meeting Notes

Present	Initials	Title	Organisation
Siva Kumar (Chair)	**SK**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Julie Anthony	**JA**	Macmillan Skin Cancer CNS	QVH
Jane Meaney	**JM**	Marketing Director	AMLo Biosciences Ltd
Kim Peate	**KP**	Macmillan Lead Skin Cancer CNS	EKHUFT
Gemma Larking	**GL**	Skin Cancer Support Worker	EKHUFT
Nina Hayes	**NH**	Skin Cancer CNS	EKHUFT
Wendy Willmore	**WW**	Skin Cancer CNS	EKHUFT
Saul Halpern	**SHa**	Consultant Dermatologist	EKHUFT
Andrew Birnie	**ABi**	Consultant Dermatologist & Dermatological Surgeon / Clinical Lead - Dermatology	EKHUFT
Kemal Tekeli	**KT**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Abigail Brunning	**ABr**	Macmillan Skin Cancer CNS	KIDS
Colin Chamberlain (Notes)	**CC**	Administration & Support Officer	KMCC
Annette Wiltshire	**AW**	Service Improvement Lead	KMCC
Ann Fleming	**AF**	Consultant Histopathologist / Clinical Lead - Cellular Pathology	MTW
Nellie Kumaralingam	**NK**	Melanoma Nurse Consultant	MTW
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Susannah Lowe	**SL**	Melanoma/Skin Cancer CNS	MTW
Holly Groombridge	**HG**	Cancer Commissioning Project Manager	NHS Kent & Medway ICB
Grace Hancock	**GH**	Regional Operations Manager	SCDS/KIDS
Samantha Collins	**SC**	Service Manager	SCDS/KIDS
Andrew Morris	**AM**	Consultant in Dermatology and Cutaneous Surgery / Clinical Director - SCDS	SCDS/KIDS
Danish Kazmi	**DK**	Consultant Dermatologist	SCDS/KIDS
Apologies			
Nic Goodger	**NG**	Consultant Maxillofacial Surgeon	EKHUFT
Nipin Bagla	**NB**	Consultant Histopathologist	EKHUFT
Sandra Holness	**SHo**	Cancer Pathway Tracker Coordinator	EKHUFT
Sandra Varga	**SV**	Consultant Dermatologist	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT

Karen Glass	**KG**	Administration & Support Officer	KMCC
Elisabet Sanchez	**ES**	Service Manager for Oncology & Haematology	MFT
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	NHS Kent & Medway ICB
Jonathan Bryant	**JB**	Primary Care Cancer Clinical Lead	NHS Kent & Medway ICB
Louise De Barra	**LDB**	Skin Cancer MDT Coordinator	QVH
Heather Drewery	**HD**	Cancer Manager	QVH
Maggie Curtis	**MC**	Macmillan Skin Cancer CNS	QVH
Victoria Worrell	**VW**	Access & Performance Manager	QVH
Brian Bisase	**BB**	Consultant Maxillofacial / Head & Neck Surgeon	QVH
Prasad Hunasehally	**PH**	Consultant Dermatologist	SCDS/KIDS
Cherng Jong	**CJ**	Consultant Dermatologist	SCDS/KIDS

Item		**Discussion**	**Action**
1	**TSSG Meeting**	**Apologies** • The apologies are listed above. **Introductions** • SK welcomed the members to the meeting and asked them to introduce themselves. • If you attended this meeting but your name is not referenced on the attendance list, please notify CC (c.chamberlain3@nhs.net). **Action log Review** • The action log was reviewed, updated and will be circulated to the members following today's meeting. **Review previous minutes** • The minutes from the previous meeting were reviewed and agreed as a true and accurate record.	
2	**Guest Speaker**	**AMBI low risk non-ulcerated early stage melanoma – update provided by Jane Meaney** • AMLo Biosciences has identified two proteins (AMBRA1 and loricrin) in the skin overlying the primary tumour which are lost in melanomas at risk of progression. • AMBLor® is a new test in development based on two protein markers which are normally present in the upper layer of the skin (epidermis). Loss of both of these markers overlying early-AJCC (Stage 1 and 2) melanomas is associated with tumour subsets which are at risk of progression, while one or both are retained in the epidermis overlying low-risk tumours. • The use of AMBLor® biomarkers as a prognostic marker was initially established in 2 independent powered discovery cohorts of over 350 UK patients with AJCC stage I melanoma with known clinical outcomes. This initial discovery cohort established that the test is an accurate prognostic marker for stage 1 melanoma, which is able to stratify patient risk over and above AJCC staging alone. The negative predictive value (NPV) of 98.3% demonstrates the potential for AMBLor® as a rule-out test for patients with truly low-risk melanomas.	

		• The AMBLor® test was subsequently evaluated in two further cohorts of over 400 non-ulcerated AJCC Stage 1 and Stage 2 melanoma from Australia and the USA. • The high NPV (97.14%) of AMBLor® means the test is very effective at identifying melanomas where the biomarkers have been retained and are therefore at low risk of progression. • AMLo has developed a proprietary set of antibodies which can be applied to spare tissue biopsy sections and which accurately identifies patients at genuinely low risk of disease progression. AMBLor® fits easily into the existing histological analysis of specimens and provides the pathologist with highly relevant clinical information. Users of the AMBLor® tests will require no additional equipment and minimal training. • Currently, clinicians are unable to identify low-risk subsets of patients with Stage 1 and 2 melanoma and all patients are treated as having equal risk. • In future, the AMBLor® test will offer the potential for personalised, prognostic information for clinicians and patients over and above AJCC staging alone. If recommended in local and national guidelines, there could be the possibility to step down the consultation burden for patients with melanomas which are at low risk of progression. While, for melanomas with an 'at-risk' AMBLor® result, clinicians will be able to confidently continue to follow the recommended standard of care. • JM stated each test will cost £175. • JM mentioned that UKCA approval is expected in June 2023 at which point the test could be incorporated in to MDTs.	
3	**Update on stage 2b 2c**	**<u>Update on stage 2b 2c provided by Rosemeen Parkar</u>** • RP provided the group with an overview of the current set-up, or lack thereof, in relation to the treatment for adjuvant stage 2b and 2c patients. • West Kent will be ready to start treating these patients when SL's replacement is in post, perhaps in about 3 months' time. • East Kent will be ready to start treating these patients when they have walk-in clinic capacity. • These patients will be discussed during MDM and then highlighted to RP and JT. • It was mentioned that Kent & Medway are one of the only areas not treating these cohorts of patients nationally. • KP stated East Kent would have around 70 2b and 2c patients to treat and she believes this number would be higher for West Kent. • AM highlighted the need to write to the Trust CEOs to highlight the importance of having the staffing and resource in place to treat these cohorts of patients. • RP highlighted the measures being taken by East Kent and West Kent to work towards being in a position to provide treatment to stage 2b and 2c patients and stated that management are discussing options with GSTT and RMH regarding the treatment of these patients in the interim. The Kent Oncology Centre will inform the TSSG before the next meeting of the outcomes pertaining to this. • **<u>Action:</u> RP to formulate a flow chart of how 2b and 2c patients would be treated in Kent & Medway.**	**RP**

	Dream Seq Trial	**Presentation provided by Rosemeen Parkar** • The presentation which RP discussed, as sourced from BMS I-O Academy, provided the group with an overview of: - Determining the most efficacious first-line and second-line treatment sequence in BRAF-mutant metastatic melanoma. Both immunotherapy and targeted therapy are effective in treating BRAF-mutated metastatic melanoma. However, little prospective data existed to guide the choice of either initial therapy or treatment sequence in this population. The DREAMseq trial was conducted to determine which initial treatment or treatment sequence resulted in the best efficacy. - NICE's belief that immunotherapy as first-line treatment is aligned with best practice and guideline recommendations. - The DREAMseq study design. - The 2-year overall survival rate which was 71.8% for patients who started on NIVO/IPI (Arms A/C) and 51.5% for those who started on DAB/TRAM (Arms B/D; p=0.010). The study was closed to accrual after overall survival difference was deemed clinically meaningful by independent DSMC**.** All patients still on Arm B (DAB/TRAM) were given the option to switch to Arm D (NIVO/IPI). - The median Progression Free Survival which for Step 1 therapy was 11.8 months for patients who started on NIVO/IPI (Arm A) and 8.5 months for those who started on DAB/TRAM (Arm B; p=0.054). - The median Duration Of Response among patients who responded to Step 1 therapy which was longer for patients who started on NIVO/IPI (median not reached) than for those who started on DAB/TRAM (12.7 months; p<0.001). - Objective Response Rates which were similar between Step 1 regimens (Arms A and B). NIVO/IPI appeared more effective during first-line than during second-line (after progression on DAB/TRAM). - Both treatment regimens having consistent safety profiles with previous trials. The differences in Grade ≥3 treatment-related adverse effects in Arm A vs. B (Step 1) and C vs. D (Step 2) were not significant, although numerically more Grade 4 toxicities were seen with NIVO/IPI as first-line (Arm A). • In summarising: - All subgroups had numerically (or statistically) favourable 2-year overall survival rates when starting NIVO/IPI vs. DAB/TRAM. - For the majority of patients with unresectable Stage 3 or Stage 4 BRAFV600 metastatic melanoma, NIVO/IPI followed by DAB/TRAM resulted in improved 2-year overall survival compared with the alternate treatment sequence. - DREAMseq addressed the question of treatment sequencing in patients with treatment-naïve BRAFV600 mutant advanced unresectable or metastatic melanoma. - The treatment sequence beginning with NIVO/IPI resulted in a 20% absolute improvement in 2-year overall survival, and also demonstrated Progression Free Survival and Duration Of Response benefits. - Treatment with DAB/TRAM or NIVO/IPI in first-line resulted in similar Objective Response Rates; and NIVO/IPI appeared to be more efficacious when given as first-line treatment rather than second-line (after progression on DAB/TRAM). - Treatment with DAB/TRAM resulted in similar Objective Response Rates regardless of sequence. - The safety profiles for both treatment sequences were consistent with previous reports.	

		- The results of DREAMseq suggest immunotherapy should precede targeted therapy as first-line treatment for the majority of patients with BRAFV600 mutant advanced unresectable or metastatic disease.	
4	**MDT Quoracy issues with MDTs**	• The East Kent MDT is generally quorate, especially since it moved to taking place virtually. Oncology cover, however, can sometimes be an issue. • The West Kent MDT does not tend to experience any problems with regard to quoracy. • ABi highlighted the issue of only having 1 person covering a role within the MDT, particularly when that person is on leave. He believes this should be highlighted as a problem and would be worthy of adding to a risk register should one exist for the TSSG.	
5	**Performance**	**EKHUFT – presentation provided by Andrew Birnie** • Please refer to the performance slide pack for an overview of the Trust's data. • With regard to the FDS, the breaches EKHUFT have are usually due to patient choice (holidays, illness and transport issues). Punch biopsy delays have contributed to some of the breaches but generally performance on this pathway has always been compliant to the standard. • Performance on the 31d pathway has always been compliant until April 2023. The breaches for April 2023 were due to patient choice (declining or cancelling an appointment or treatment). • 62d USC performance for April 2023 was impacted by: outpatient appointment capacity, a complex case and a patient cancelling their surgery on the day it was due to take place. • With regard to backlogs, the volume has dropped since the beginning of 2023 but increased towards the end of April 2023. All cases >62d have treatments booked and an enhanced escalation process has been put in place for consultant reviews, tertiary referrals, surgical dates and diagnostics for patients over day 62. The 1 >104d patient was a complex case. **SCDS – presentation provided by Andrew Morris** • Please refer to the performance slide pack for an overview of the organisation's data. • 2ww referrals continue to rise across the whole of the Kent Integrated Dermatology Service reaching a combined figure of 1038 in March 2023 (455 in West Kent and 583 in North Kent). • The service only breached 18 2ww appointments in total for March 2023 whereas it was 138 for the FDS. • SCDS are doing generally well with regard to the 31d standard with no breaches in West Kent or North Kent. Surgeries continue to be booked within 14 to 21 days. **QVH – presentation provided by Siva Kumar** • Please refer to the performance slide pack for an overview of the Trust's data. • The overall 2ww referral numbers remain above last year, and is 76% above the baseline of 2019/20. • The team continue to report delays in benign letters for skin patients. • The teledermatology pathway has been approved and will be fully operational in August 2023. As of October 2023 teledermatology will move into the CDC at QVH as part of the national programme.	

		• With regard to the 31d standard, there are challenges with the complexity of patients as well as medical delays. SLNB theatre capacity is back on track, however outpatient capacity is challenged. • In relation to 62d performance: - Late referrals are a key challenge for skin, with QVH receiving late referrals from Kent, Surrey and Sussex. - The 24d performance is remaining above 70% for late referrals within skin. - Skin outpatient capacity is challenged with regard to both follow-ups and new appointments (tertiary) due to the volume of referrals coming through. - Breach themes include: unwell patients (those in hospital/those with COVID), follow-up outpatient appointment delays (capacity), and complex pathways (further diagnostics required). • With regard to backlogs: - There is an increase in complex pathways due to patient comorbidities which require input from multiple healthcare professionals, internally and externally (e.g. primary care, community colleagues, safeguarding and CNS'). - A number of patients are choosing to delay at various points along the pathway (at first appointment, diagnostics, follow-up and treatment stages). - There have been a number of late tertiary referrals – 40% of the backlog recorded in April 2023 were late referrals. - The team continue to complete clinical harm reviews on all >104d patients. • SK mentioned that doctors taking industrial action has also impacted on performance.	
6	**Update on lack of non-melanoma oncologist in Kent**	• It was felt this item no longer needed to be discussed.	
7	**Update on Clinical Pathways**	**<u>High Operational Policy</u>** • SK to work on updating this document with support from AW. **<u>Basal Cell Carcinoma</u>** • ABi to work on updating this document with support from GL and AW. **<u>Melanoma</u>** • KP to work on updating this document with support from AW. **<u>Cutaneous Lymphoma</u>** • KP to work on updating this document with support from AW.	

		Squamous Cell Carcinoma • KP to work on updating this document with support from AW.	
8	**Cancer Alliance update**	**Presentation provided by Holly Groombridge** • HG provided the group with an overview of the various projects relating to the following workstreams (please refer to the presentation circulated on 11.05.2023 for a detailed breakdown of what these are): - Faster diagnosis and operational performance. - Early diagnosis. - Treatment and care. - Cross-cutting.	
9	**Skin Awareness Campaign**	**Update provided by Holly Groombridge** • KMCA ran a Skin Awareness Campaign last summer, in line with the national Help Us To Help You campaign. The evaluation of this was brought to the last Skin TSSG meeting. • The Earlier Diagnosis team are campaigning again this summer, starting earlier in June 2023, focusing once again on coastal communities. • There will be similar resources to last year, however there will be an addition of a Z-card which will include a ruler to allow the public to measure their moles. • If anyone would like to support the campaign then please contact the KMCA. Please also let them know if you review any patients who attend due to the campaign.	
10	**CNS updates**	**EKHUFT** • There are 3 CNS' in place for the service. **MTW** • SL will be retiring from her role as Melanoma/Skin Cancer CNS later this year. **QVH** • MC will be retiring later this year. ABr will, however, be joining the team. • The team hope to recruit an additional Skin Cancer CNS. • Nurse-led clinics have commenced. **SCDS** • An advert has gone out for ABr's role given her imminent departure.	
11	**AOB**	• The first round of KMCA Transformational Funding bid meetings has commenced so any organisations who submitted requests for funding to support their services should receive feedback within the next 3-4 weeks. • With regard to the NG12 referral form, KP highlighted a number of forms are still not being completed appropriately - with some being sent in blank. ABi highlighted the importance of referrers including the following information:	

		- The location of the lesion(s). - Whether the patient is taking any anticoagulants. - Whether the patient is taking any immunosuppressants. - The patient's performance status. - What they suspect based on examination of the lesion(s). • KT confirmed he would be happy to take on the role of Research Lead for the Skin TSSG. • **<u>Action</u>: Updated e-referral form to be circulated to the group along with the final minutes from today's meeting and discussed at the next meeting.**	**CC/AW**
	Next Meeting	• Thursday 9th November 2023 (14:00-16:00).	