NHS
Kent & Medway Cancer Collaborative

Skin Tumour Site Specific Group Meeting
Thursday 21st November 2024
Park View Meeting Room, Mercure Great Danes Hotel, Ashford Road, Maidstone. ME17 1RE
14:00-17:00

Final Meeting Minutes

Present	Initials	Title	Organisation
Andrew Morris (Chair)	**AM**	Consultant Dermatologist	SCDS
Alice Hubbard	**AH**	Skin Cancer CNS	SCDS
Arianne Kempton	**AK**	Clinical Nurse Specialist	SCDS
Sam Collins	**SC**	Service Manager	SCDS
Raghuram Boyapati	**RB**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Khari Lewis	**KL**	Consultant Oral & Maxillofacial Surgeon	EKHUFT
Claire Bingham	**CB**	Macmillan Personalised Care Facilitator	EKHUFT
Kim Peate	**KP**	Lead Skin Cancer CNS	EKHUFT
Casey Powell	**CP**	Consultant Histopathologist	EKHUFT
Nick Williams	**NW**	Consultant Breast & General Surgeon	EKHUFT
Andrew Birnie	**AB**	Consultant Dermatologist & Dermatological Surgeon	EKHUFT
Nina Hayes	**NH**	Skin Cancer CNS	EKHUFT
Wendy Willmore	**WW**	Clinical Nurse Specialist	EKHUFT
Annapoorna Pai	**AP**	Consultant – OMFS	EKHUFT
Ann Courtness	**AC**	Macmillan Primary Care Nurse Facilitator	KMCA
Sharon Middleton	**SM**	Workforce Programme Lead	KMCA
Joanne Jackson	**JJ**	Early Diagnosis Project Manager	KMCA
Joanne Bailey	**JB**	Early Diagnosis Programme Manager	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
Mohammad Osman	**MO**	Medical Oncologist SpR	MTW
Erselle Joseph	**EJ**	Support Worker	MTW
Rosemeen Parkar	**RP**	Consultant Medical Oncologist	MTW
Denise Burt	**DB**	Melanoma CNS	MTW
Ann Fleming	**AF**	Consultant Pathologist	MTW

Laura Abdey	**LA**	Clinical Nurse Specialist	MTW
Caspie Graham	**CG**	Macmillan Skin Cancer CNS	QVH
Brian Bisase	**BB**	Consultant Maxillofacial/Head & Neck Surgeon	QVH
Chris Macdonald	**CM**	Consultant Plastic Surgeon	QVH
Kirstyn Parratt	**KPa**	Cancer Service Manager	KIDS
Apologies			
Anna Lamb	**AL**	Cancer Performance Manager	EKHUFT
Sue Drakeley	**SD**	Senior Research Nurse	EKHUFT
Saul Halpern	**SH**	Consultant Dermatologist	EKHUFT
Danielle Mackenzie	**DM**	Macmillan Lead Nurse for Personalised Care	EKHUFT
Nick Goodger	**NG**	Consultant Maxillofacial Surgeon	EKHUFT
Ritchie Chalmers	**RC**	Medical Director	KMCA
Jennifer Turner	**JT**	Consultant Clinical Oncologist	MTW
Sarah Qureshi	**SQ**	Consultant Medical Oncologist	MTW
Jennifer O'Neill	**JF**	Consultant Plastic, Reconstructive & Aesthetic Surgeon	QVH
Sandra Varga	**SV**	Consultant Dermatologist	Whitstable Medical Practice

Item		**Discussion**	**Agreed**	**Action**
1.	**TSSG Meeting**	**<u>Apologies</u>** • The apologies are listed above. **<u>Introductions</u>** • AM welcomed the members to the meeting. **<u>Action Log Review</u>** • 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 23rd May 2024 were reviewed and agreed as a true and accurate record.		
2.	**Clinical Reference Group EOI**	**Update provided by Andrew Morris** • AM felt that the CRG would "have teeth" going forwards and it would be good to incorporate this group into their TSSG. The CRG will consist of Dermatology, Surgery, Oncology, Pathology, Radiology, Nursing and Primary Care roles. The CRG will meet once a month for 1hr and 30minutes it attracts 1PA for the role of Chair and 0.5PA for other members and will be for a duration of one year initially. • The Skin CRG has received some support with Rosemeen Parker (Pathology), Ann Fleming (Oncology), Antony Gough-Palmer (Radiology) and Kim Peate representing Nursing. NHS experienced members are required. • If anyone is interested in the vacant roles in Dermatology, Surgery and Primary Care, please contact AW and AM.		
3.	**Dashboard Performance**	**Presentation provided by Andrew Morris** • AM went through the Data Pack sent by David Osborne. • FDS has improved at Kent & Medway from 87.7% to 92.2% in the last 6 months. 62 day performance is at 89.3% compared with 86.1% six months ago. • FDS Performance at SCDS is at 94.1%, EKHUFT at 88.7% and QVH is at 82.0%. • 62 day Performance at EKHUFT is at 92.5%, QVH at 88.4% and SCDS is at 85.5%. • AB stated that data needs to be recorded correctly. At EKHUFT the FDS Performance target is easy to meet. Waiting times are good – ruling out cancer within 14 days.		**Data Pack circulated to the group on Monday 18th November.**

		• Referrals for Suspected Cancer – AM stated that the Data provided enables them to drill down into the specific areas, individual GP Practices and also see the Cancer Conversion rates. This will ensure that we can all target specific challenged areas using this data and provide further education to GP's. • AM praised David Osborne for the fantastic slides and asked if there is any other data that members would like to see, to please contact him. • AM felt it would be helpful to know the percentage of patients treated with adjuvant therapy. • There is a 21% rise in West Kent in referral numbers. This could be due to the referrals being made by other practitioners than GP's – such as Locums, Paramedics and ACP's etc. • SCDS have an 11% rise on Referrals, but have poor CNS Indicator Data completeness. Primary Care is struggling but Skin is functioning quite well on performance. AB felt that there is a need to target the increase on referral rise at EKHUFT. There are dips in winter and peaks in summer with 1500 referrals a month. • AM asked everyone to use the data that is provided. **ACTION – AW to ask David Osborne for Skin Cancer Conversion Rates and circulate Skin Data Performance on a quarterly basis.**		**AW**
4.	**Cancer in Kent & Medway**	**<u>Presentation provided by Andrew Morris</u>** • The Cancer in Kent and Medway Presentation provided the group with an overview of the geographical variation and key differences by tumour type in cancer across Kent & Medway. • Cancers diagnosed at stage 1 or 2 by Tumour Type - Kent & Medway, 2017-2021 - % diagnosed at Stage 1 or Stage 2. • The number of cancer cases by route of diagnosis and survival - Kent & Medway, 2019-2020 – Two Week Wait Referral, Emergency Presentation and Other Route (including Screening).		**Presentation circulated to the group on Friday 22nd November**

		• Geographical Variation in Cancer Mortality, including Mortality by HCP and LA, Mortality by Deprivation and Mortality in Coastal Areas. • Skin Melanoma Mortality, incidence and % diagnosed at stage 1 or 2 rates in Kent & Medway between 2001 and 2020. Mortality for Kent & Medway is above the England average, incidence is higher in affluent areas and diagnoses at stage 1 or 2 are later in deprived areas. • Cancer in Kent and Medway and key differences from England and Health Inequalities by Tumour Type. • Skin Melanoma, Oesophagogastric Cancer, Liver Cancer, Pancreatic Cancer, Prostrate Cancer, Kidney Cancer and Bladder Cancer. AM added that we are doing well in Melanoma by catching it early and we are seeing patients by the correct 2ww route and not through emergency presentation or via screening. **ACTION – AM to request more data on mortality by deprivation from David Osborne.**		**AM**
5.	**KMCA Clinical Leadership Group**	**<u>Presentation provided by Andrew Morris</u>** • The presentation provided an overview of the following :- • Priorities Data review and differences between acute providers Data additions to the Dashboard • AM highlighted that we are data driven and the data is reliable. It is good to look at the percentage of patients that have metastatic disease and asked everyone to think of any data omissions.		**Presentation circulated to the group on Friday 22nd November**

		Cancer outcomes – Benchmarking and Health Inequalities Horizon scanning: What are the priorities? Some Cancer Alliance funding is provided but this will only be a small amount but would be key for Dermatology. Integrating palliative care into pathways MDT Streamlining • AM added that MDT Streamlining is relatively irrelevant in Skin as they are streamlined already with scans reviewed and documented. Patients with normal surveillance imaging are listed but not discussed in MDT. Around 50 patients are discussed in their specialist MDM at SCDS which is held for 1.5/2hrs. • At EKHUFT AB goes through the MDM list in advance and they discuss all SCC's. MDT is completed in 1/1.5 hrs and 50-55 patients are discussed in this time. • The duration of the MDT at QVH is 30 minutes to 1 hour. • KP added that at MDT it should be noted that the patient's scan has been looked at by a Clinician as their service is nurse led. • EKHUFT are already streamlining their MDT, but holding a Pre-MDM is not feasible.		
6.	**Digital & AI**	**<u>Presentation provided by Andrew Morris</u>** • The presentation provided an overview of the following :- • Pathpoint eDerma – This is being used at EKHUFT and has reduced face to face appointments by 85.8%. 93.6% of patients were diagnosed or given a decision to treat at teledermatology assessment. • Skin Analytics – Since 2020 it has assessed over 120,000 NHS Patients for suspicion of skin cancer, helping Secondary Care organisations remove the need for up to 94% of face to face NHS urgent		**Presentation circulated to the group on Friday 22nd November**

		suspected skin cancer appointments. • Skin Analytics - Clinical Performance Over Time • Edge Health – Evaluating Pathways for AI Dermatology in Skin Cancer Detection – A white paper • NICE slide – AI technologies for assessing and triaging skin lesions within the urgent suspected skin cancer pathway. • AB has experience of Skin Analytics at EKHUFT. Patients attend a Hub in Dover, where 2 Healthcare Assistants take a proforma history and photos of the lesion, this is then looked at by a Registrar or Saul Halpern (Consultant Dermatologist). Patients are advised Straight to Surgery or other options are provided. KP added that patients can also be upgraded to the cancer pathway. • AM highlighted that the Nice Paper is due to be published on 19th December 2024 and will be applied autonomously with full blown AI. Excellent data is coming out of this service and this will be an amazing game changer as the machine will make a diagnosis. AM hopes at the next TSSG meeting (May 2025) the machine might already be deployed. 10-15 NHS trusts are already trialing this service nationally.		
7.	**Melanoma Follow-Up**	**<u>Presentation Slide provided by Andrew Morris</u>** • The presentation provided an overview of the following :- • IB Melanoma – Year 1, Years 2 & 3 & Years 4 & 5 • IIa Melanoma – Years 1 & 2, Year 3 & Years 4 & 5 • AM advised that EKHUFT follow the guidelines and see patients on a yearly basis. They have a good system in place for their patients as there is easy access back to the CNS's if there are any concerns. KP is bringing in a Self-Management Form and holding a Group Forum (quarterly) to teach patients to		**Presentation circulated to the group on Friday 22nd November**

		self-examine and are also creating videos for patients to access.		
8.	**Mohs Surgery**	**<u>Presentation Slide provided by Andrew Morris</u>** • The presentation provided an overview of the following :- • Waiting Times • Appropriate Referrals • East Kent • AB added that EKHUFT are struggling to find re-construction slots.		**Presentation circulated to the group on Friday 22nd November**
9.	**2024 Melanoma Highlights**	**<u>Presentations provided by Rosemeen Parker</u>** • **The 2024 Melanoma Highlights Presentation provided an overview of the following :-** • 2024 Highlights - Checkmate 067-10 year Analysis. No further updates from this trial after 2024. 945 patients recruited and stratified according to their staging. • Overall Survival Graph – 10 year OS Analysis. 12-18 months before they had the 3 treatments. This trial showed really good results. • Melanoma-Specific Survival (MSS) Graph – 10 year MSS Analysis. Statistical survival is also good. • OSS and MSS in Patients with PFS at 3 years Graph • MSS in Patients with a Grade 3 or 4 TRAE Graph • 2024 Highlights		**Presentations circulated to the group on Friday 22nd November**

	Melanoma Stage 3A Risk Stratification	• Neoadjuvant Ipi Nivo and Pembrolizumab – currently at Phase B of commissioning process- outcome Spring 2025 RP stated that NICE has delegated this and an update will be provided at the next meeting once it has been approved. A re-design of the service will be required. • TIL therapy (Lifileucel) has obtained FDA approval • TILVANCE (TILS+/- Pembrolizumab recruiting at RMH) (Phase 3)-First line metastatic • PRISM-MEL-301: A Phase 3 Randomized, Controlled Study of IMC-F106C Plus Nivolumab Versus Nivolumab Regimens in HLA-A*02:01-Positive Participants with Previously Untreated Advanced Melanoma • **The Melanoma Stage 3A Risk Stratification Presentation provided an overview of the following** :- • Melanoma Staging • Clinical Outcomes and Risk Stratification of Early-Stage Melanoma Micrometastases from an International Multicenter Study: Implications for the Management of American Joint Committee on Cancer IIIA Disease • Critique - There was no central review of pathology undertaken. The reliability of the results was therefore questioned • Melanoma-specific survival in patients with positive sentinel lymph nodes: Relevance of sentinel tumor burden • Rotterdam and Dewar Criteria and RDC		

	Real Life Ipililumab Nivolumab Toxicity Data Kent (2023)	• In Conclusion • 3A in general holds better prognostic value • Subset of 3A – much lower risk and we could potentially be overtreating this group • Rotterdam and Dewar criteria most commonly used across centres to risk stratify. • Suggested integrating this criteria formally into pathology reports to aid clinician in decision making • Most tertiary centres using 1mm single deposit with nil other risk features as a standard cut off as this was used in the adjuvant trials. • TSSG to discuss what criteria we need to put into place locally. RP has spoken to the Marsden, UCL and Guys – decisions are made in their MDT based on the trial data. TSSG Members held a discussion around sticking to 1mm Melanoma. KP asked for the detail to be written into a Kent & Medway SOP to include the detail which will cover them in terms of complaining patients. Stage 3A's patients are eligible for treatment but more detailed discussion is needed for younger patients. AB stated that a discussion needs to be held with the Oncologist regarding adjuvant treatment. The TSSG agreed to follow the current pathway. • **The Real Life Ipililumab Nivolumab Toxicity Data Kent (2023) provided an overview of the following :-** • Retrospective analysis of toxicities • 89 patients had Ipililumab Nivolumab across Kent in 2022-2023 • Mean age 61.5 (range 27-80) • Most common histological type was nodular • Most common location – trunk (n=26) and Head Neck (23) • 46% completed all 4 cycles		

		• 13.5 % completed 3 cycles • 16.9% completed 2 cycles • 23.6% completed 1 cycle • Graph showing the grade of immunotherapy toxicities in patients who did not complete four cycles of Ipililumab and Nivolumab treatment Toxicities were outlined – hepatitis, colitis and skin issues being the most prevalent. These patients will be referred to Steroid Clinics and Gastroenterology team.		
10.	**Impact Trial**	**<u>Presentation provided by Kim Peate</u>** • The presentation provided an overview of the following :- • Trial Schema • Study Endpoints – Primary & Secondary • Inclusion Criteria – Surgery & Radiology • Exclusion Criteria • Trial Sites Mount Vernon and Barts are the most local trial sites for referral from Kent & Medway. Patients would need to travel to these sites on a 3-weekly basis. Travelling expenses are often reimbursed for these patients. The future aim is to bring trials to their patients in Kent & Medway but this is not currently possible due to not having the trials team in place. CNS's do not have the capacity to do this currently. **ACTION – AM to discuss with CRG and Ritchie Chalmers to have a future dedicated skin trials team in place for their patients.**		**Presentation circulated to the group on Friday 22nd November** **AM**

11.	**CNS Updates**	**<u>EKHUFT</u>** • The EKHUFT team now have a Nurse Consultant. A Support Worker (funded by Cancer Alliance for 1 year) is commencing next week to set up Stratified Pathways for SCC patients. A Lead CNS is commencing in January 2025. KP's future role is to look at immunology toxicities and to provide better pathways for cancer patients using immunotherapy. **<u>MTW</u>** • Laura Abdey is the new CNS and Erselle Joseph (Support Worker) has joined the MTW team. **<u>SCDS/QVH</u>** • CG (shared CNS for SCDS and QVH) is moving onto a different post and QVH may not replace her. CNS's are difficult to obtain. BB will look into this and hopes that they will advertise the post. This has been raised with the Cancer Board.		
12.	**Validation of Digital Pathology across KMPN**	**<u>Presentation provided by Casey Powell</u>** • The presentation provided an overview of the following :- • The difference between the Analogue and Digital Workflow in Pathology. • Benefits of Digital Pathology. • Efficiencies and Improved Workflow i) Reduced Case Transfer Times between the Laboratory and the Diagnostic Pathologist. ii) Improved workload allocation. iii) Rapid case tracking, archival and retrieval. iv) Clearer diagnostic audit trials. v) Increase diagnostic efficiency.		**Presentation circulated to the group on Friday 22nd November**

- Improved Workforce Factors and Collaboration

  i) Potential for more flexible patterns of work, helping to optimise working hours.
  ii) Recruitment and Retention.
  iii) Ergonomic advantages for Pathologists.
  iv) Improved teaching and mentoring.
  v) Facilitate MDT Teams.

- Improved Patient Safety

  i) Faster diagnosis of urgent cases.
  ii) Faster access to external second opinion.
  iii) Faster access to molecular testing.
  iv) Reduced risk of patient/slide misidentification errors.
  v) Reduced risk of tissue/slide loss or damage.

- Evolving Technology/Research & Development Opportunities

  i) Enabler of emerging technology, such as AI.
  ii) Archive of images will be a valuable resource for research purposes.

- Initial Implementation Impact

  i) System training will be provided by supplier with ongoing support from the Kent and Medway Pathology Network team.
  ii) Each pathologist needs to verify their digital reporting against their analogue reporting to ensure clinical care level continuity.
  iii) This will impact the rate of reporting for the duration of the verification which will vary for each pathologist for an estimated period of 1-3 months.
  iv) This will impact turnaround times further for the duration of validation.
  v) Pathologists will validate in phases, so no more than 5 pathologists at one time will be validating.
  vi) Digital Pathology project has accessible funding to utilise other resources during validation

		phases. vii) Support from clinical colleagues across TSSG to understand and accept limited duration verification impact and to remove patients from cancer pathways when endoscopic findings are normal/benign. CP stated that this process is part of the Steering Group and will be rolled out over the next year. Leeds have been using digital pathology since 2019 – with brilliant results. There is a need to ensure safe reporting. Work from Home can be accommodated using this process and this will improve workload reduction and help facilitate MDT's. At present the IT infrastructure is being delayed because of cables and this is becoming worldwide. Health Heidi is an AI trial, the transcription mode is being used for consultation notes and is currently being used in Guys. It is an incredible service and also provides a dictation service using AI voice recognition.		
12.	**Clinical Pathways Update**	**<u>Update provided by Andrew Morris</u>** • Basal Cell Carcinoma • Melanoma • Cutaneous Lymphoma • Squamous Cell Carcinoma • AM advised that the above Clinical Pathways all need changes as they are outdated. The hope is to get all 4 signed off by the next meeting. AM is presently updating Squamous Cell Carcinoma. **Action - AM to send Squamous Cell Carcinoma (once updated) to the Group for comments.**		**AM**
13.	**AOB**	• No issues raised.		
	Next Meeting	• Thursday 22nd May 2025 – (PM)- Venue TBC.		

		Action - SW has circulated the meeting invite to the group and will advise when venue confirmed.		**SW**