*Somerset, Wiltshire, Avon and Gloucestershire (SWAG) Cancer Alliance*

**Meeting of the SWAG Network Skin Cancer Clinical Advisory Group (CAG)**
***Wednesday 27th February 2019, 09:30-13:30***
**Spire Oncology Centre South West**
**300 Park Avenue, Aztec West, Almondsbury, Bristol, BS32 4SY**

**This meeting was sponsored by AMGEN, BMS, MERCK SERONO & NOVARTIS**

**Chair: Mr Ewan Wilson (EW)**

| | NOTES<br>(To be agreed at the next SSG Meeting) | ACTIONS |
|---|---|---|

**1. Welcome and apologies**

Please see the separate list of attendees and apologies uploaded on to the South West Clinical Network website here.

**2. Review of last meeting's notes and actions**

As there were no amendments or comments following distribution of the minutes from the meeting on the 23rd May 2018, the notes were accepted.

**Actions:**

**Development of online Specialist Multi-Disciplinary Team (MDT) referral proforma:** Development of an online platform for MDT referral forms is currently being investigated as part of the regional MDT reform work. **HD**

**Melanoma Algorithm:** The algorithm will be agreed after the national treatment guidelines have been finalised. **AB**

**Medical Illustration:** Equity of access to a medical illustration service has been raised as an issue by the CAG (formerly SSG) over the past 7 years, and still varies across the region. A follow up letter will be sent to the Senior Management Team in RUH Bath. This will contain information on the clinic time that could be saved if a medical illustration service was available, and detail the risks (non-compliance with NICE guidance, image upload to incorrect patient records, wrong site surgery) and benefits (review of images in MDT, compilation of learning resource) that the service would bring to the organisation. **EW/HD**

Clinical Nurse Specialist (CNS) Elizabeth Metcalfe (EM) will organise a stop-clock audit with assistance from Consultant Dermatologist David de Berker (DdB) to quantify the imaging workload that currently occurs in the CNS clinic. **EM/DdB**

**Community skin cancer service:** A community service for excision of low risk basal cell carcinoma (BCC) has yet to progress in the Bristol, North Somerset, and South Gloucestershire region. There didn't appear to be a cohort of GPs interested in specialising in this area, or any resources available to set up the service.

**Development of a referral information leaflet for ECT:** To be sent to Helen Dunderdale (HD) for circulation to the group. **NBT CNS Team**

**Review of suspected cancer referral processes:** North Bristol Trust are frequently sent referrals for suspected BCC that do not meet the two week wait referral criteria. This creates significant workload pressure at the beginning of the pathway and, as suspected cancer referral forms are not triaged according to skin cancer type, could delay the processing of the referrals sent for suspected melanoma or squamous cell carcinoma. It was recognised that, ultimately, the number of referrals managed by the service would be the same.

Previous versions of the form are also being used, as it was not possible for these to be removed from the EMIS platform where these were saved. This should improve now that BNSSG has uploaded the forms to a separate website called REMEDY.

Wiltshire Community Skin Cancer Practitioner Fiona Armstrong uses ARDENS Healthcare Informatics to make referrals. The referral forms on the system have been developed to meet the needs of General Practitioners; certain data fields populate automatically, streamlining the amount of data inputting required.

The referral form is being used appropriately in the Gloucestershire region.

**Radiology protocol for CNS teams:** A protocol to enable the CNS team in UH Bristol to make radiology requests is still awaiting approval before training and sign off can be arranged. The Taunton CNS team can now make all of the requests required. It was not currently possible for Associate Specialist Katherine Finucane to make certain requests; this will be revisited as CNS teams are being granted approval.

**Pathology SLNB protocol:** A modified protocol has been approved. Action closed.

**Taunton service:** The provision of plastics is stable. Now that the service is not taking two week waits, the workload mainly consists of a complex oncological case mix. New referrals complete the first stage of the pathway in UH Bristol. Referral on to plastics can occur in Bristol or Royal Devon and Exeter according to patient choice.

**Royal College of Pathology 8th Edition Dataset:** To be revisited at a future meeting once available.

**3. Network issues/MDT service**

**3.1 Multi-Disciplinary Team Meetings: National and Local Reforms**

**Please see the presentation uploaded on to the SWCN website**

**Presented by Ewan Wilson (EW)**

Following a review of the Cancer Research UK MDT Effectiveness Report by each SSG, and Professor Martin Gore's appointment by the National Cancer Transformation Board to reform MDTM working arrangements across the UK, an inaugural meeting of the SWAG Cancer Clinical Leads was held on Monday 16th July 2018 to define a loco-regional approach to MDT meeting reforms.

A presentation by Cognitive Scientist Tayana Soukup Ascencao gave details of 3 tools that can be used to improve MDT streamlining. The presentation will be circulated and SSG members will be contacted to see who may be interested in attending a training day on use of the tools. People receiving the training would have to review at least 1 alternative MDT.

It was recommended that a 10 minute break should be introduced in meetings after a period of 1 hour of discussion, or after 20 patient discussions, to prevent cognitive fatigue and the negative effect that this can have on the quality of decision making. It was also recommended that MDT Chairs visit alternative MDT meetings (contact Helen Dunderdale to discuss funding) to compare styles. In addition, it is planned to address the varied quality of triage systems by the development of online referral proformas with mandatory fields like the Bristol Neuro-Oncology Group form. **MDT Leads**

Many of the issues identified did not apply to the SSMDT which was generally completed in under an hour. It would be useful to trial video conferencing facilities in Bristol. This was very effective in Taunton, Yeovil and Oxford MDTs; MDT members could arrange to ring in at allocated time slots. An appropriate room would need to be assigned, and the service development would need to be evaluated to assess the value added. The technology was already available in North Bristol, UH Bristol and RUH Bath and this will be explored further.

The British Association of Dermatologists (BAD) had facilitated a multi-stakeholder workshop to discuss and propose recommendations for changes to the structure and function of Skin Cancer Multidisciplinary Team Meetings (MDTM) as detailed in the presentation. The majority of recommendations were already in place at the SWAG MDTs, with the majority of two week wait referrals listed but not discussed at the MDT. Further development of protocols is underway, for discussion within the meeting today.

National guidance for MDTMs is due to be published in June. South West Cancer Alliance Programme Manager Jon Miller recommended that the Clinical Advisory Group (CAG) agree those cases that can be progressed prior to discussion in the MDT, and agree predetermined standards of care for those patients whose treatment does not need to be discussed at the MDT. These were processes that

the Skin MDT already had in place and were more relevant to other MDTs.

The Cancer Alliance Board can provide support to the CAG by giving permission for the service to be developed as advised by the Clinical Team, for example, asking the provider Trust to ensure videoconferencing facilities are made available, and provide access to ordering scans to all appropriate MDT members. Reducing the workload for radiology and pathology members by rationalising when they need to attend and minimising the need for double reporting would also be supported as agreed by the CAG. A Medical Directory of Diagnostic Services has been produced for this purpose in the Peninsula, and it is hoped to do the same in the SWAG region.

**3.2 Cancer Alliance Update: current service, challenges and initiatives**

**Presented by Jonathan Miller**

Dermatology services have been identified as a priority for commissioning in the coming year due to the significant workload pressures caused by increased referral rates as Somerset had failed to recruit a Dermatologist. Innovative ways of working can be explored, for example, the optimal way for advice and guidance to be provided via Teledermatology, and how extended job roles might be developed with relevant training sessions. The service will be looked at as a whole rather than looking at the cancer service in isolation.

Progress has been made with the development of Teledermatology across the region, and it is now being extended to Bath and North East Somerset (BANES). It was reemphasised that Teledermatology is not a substitute for the two week wait (2WW) referral process, which delivers high quality images and past medical history, provided by the medical illustration service. It is proposed that medical illustration hubs in local areas that link directly with secondary care could be a beneficial service development, providing good quality images and an appropriate structure to safely triage 2WW referrals. Teledermatology can be used to screen out benign pigmented lesions.

A project in Leeds is looking at triaging 2WW referrals based on images taken by GPs sent via Teledermatology systems. Results from a number of previous related projects had not found this to be safe due to training and equipment issues affecting image quality.

Having additional General Practitioners with a Specialist Interest (GPwSI) in Dermatology was also considered to be a beneficial service development, but GP practices required more of an incentive to undertake this work, which was currently not profitable, being time consuming and generating a minimal income. Community Skin Cancer Practitioner Fiona Armstrong could offer a GP Educational Package if this was something that the group wanted to pursue.

A smaller group meeting with key members from each MDT will convene to decide on the priority issues and next steps. **HD/EW/Cancer Alliance Board**

**4. Clinical guidelines**

**4.1 Improving Squamous Cell Carcinoma (SCC) follow up pathways**

**Please see the presentation uploaded on to the SWCN website**

**Presented by Adam Bray (AB)**

In the light of the updated Staging Guidelines (8th Edition), recent key papers, the imminent revision of BAD guidance, increasing demand for follow up and a recent audit of recurrences (as detailed in the presentation), SWAG propose a protocol for the risk stratification of SCC follow up.

The protocol will minimise MDT discussions, focus on high risk SCC, identify patients with a higher need for face to face follow up, improve recording of staging and cancer registration, reduce outpatient appointments, and provide standardised education sessions for patients that could be delivered by non-clinical staff.

The new guidance on measuring thickness from the adjacent epidermis to the base of the tumour, excluding the exophytic measurement was questioned. It was considered preferable to measure both thickness and depth.

The not for profit Staging document, published by the Union for International Cancer Control (UICC), was very similar and considered easier to interpret than the staging document published by the American Joint Committee on Cancer (AJCC).

Follow up should be targeted on cases where tumours are greater than 6.0 mm, which have been found to have a 7 fold risk of metastases and local recurrence, and on those patients with other high risk factors.

Previous guidelines included follow up in primary care, but it had been established that there was no mechanism to ensure that this occurred.

Group education sessions for patients can be delivered by audio presentation, saving 3 to 4 follow up appointments for low risk patients.

Patients who don't have evidence that lymph nodes have been assessed, or any other factors that fall outside the low risk definition will be filtered out to be given an appointment for further assessment.

Recent publications have shown that both Nicotinamide and Acitretin can be used for skin cancer chemoprevention.

**4.2 Adjuvant therapy for melanoma**

**Please see the presentation uploaded on to the SWCN website**

**Presented by Tania Tillett (TT)**

BRAF gene mutations are present within the cells of malignant melanoma, and are not hereditary. Identifying the mutation can allow treatment to be personalised. Approximately 40% of malignant melanomas are BRAF positive, and sensitive to more lines of treatment; 60% are wild type and sensitive to immunotherapy only.

Combined treatment with genomically targeted agents and immune checkpoint therapy has significantly changed survival outcomes, achieving a long term sustained response in the majority of BRAF positive patients, with immunotherapy teaching the body how to attack malignant cells long term. The latest evidence on adjuvant treatments is documented within the presentation along with the eligibility criteria for applying to the Cancer Drug Fund.

For Stage III cases, complete axillary clearance is no longer required, and the presence of a SLN to monitor is a mandatory requirement on the CDF application form; the drugs cannot be accessed without this. Relevant patients should be referred for oncological treatment at the earliest opportunity.

Complete axillary clearance may be appropriate to discuss with those patients who decline adjuvant treatment.

It was noted that side effects of immunotherapy have not been found to be age specific, although 15% of people do get Grade 3 to 4 toxicities.

It is thought that immunotherapy currently costs approximately £70,000 per annum.

**5. Quality indicators, audits and data collection**

**5.1 BRAF mutation rates in primary and metastatic cutaneous melanomas 2016/17**

**Please see the presentation uploaded to the SWCN website**

**Presented by Yuening Zhang (YZ)**

Aims of the audit:

- Determine the frequency of BRAF mutation in primary and metastatic melanomas in Bristol and compare with published studies
- Compare methods of test material preparation (curls versus slides)
- Characterise the clinical and pathological characteristics of BRAF-mutated melanomas in Bristol.

Results:

- 312 patients identified over 2 years
- Age range 31-99 years
- Mean age 69 years, median age 71 years
- 64% male and 36% female.

Further details are documented in the presentation. NBT genetic testing turnaround time is approximately 2 weeks, this can be faster if flagged as urgent. Gloucestershire send samples for immuno-histo-chemistry; testing turnaround time is 24 to 48 hours.

Recommendations:

- Re-audit yearly
- Assess trend for BRAF mutation in paraffin curls vs slides
- If only a small amount of tumour was tested and was BRAF wild-type, consider repeating the test on a different tumour especially if young patient/SSMM.

Criteria for the last recommendation will be drafted. **YZ**

**5.2 Sentinel Lymph Node Biopsy in Malignant Melanoma 2017/18**

**Please see the presentation uploaded onto the SWCN website**

**Presented on behalf of Iraklis Delikonstantinou**

Aims of the audit at NBT:

- Continued Annual Audit of SLNB
- Measure Surgical Outcomes of SLNB
- Comparison of practice against NICE guidance.

Please see further details of the methodology, results and conclusions documented in the presentation.

Recommendations:

- Focus on improving hit rate regarding service time targets – increased surgical capacity and establish a full team.
- Be aware of steadily increasing case load year-on-year and take this into account when planning future provision.

**6. Patient experience / Living With and Beyond Cancer**

**6.1 CNS update: Suspected and diagnosed melanoma guidance / patient survey**

**Please see the presentation uploaded on to the SWCN website**

Repatriation of patients from NBT with all necessary information has been inconsistent, but has improved in response to feedback and because the role of a navigator is now in place.

The CNS team are undertaking an audit of the services provided across the region and looking into standardised Banding, responsibilities and areas where the service can be reconfigured and streamlined. Some centres have had to stop routine follow up due to workforce shortages.

The workload associated with completion of Holistic Needs Assessments has improved due to the appointment of Cancer Support Workers.

**7. Research**

**7.1 NCRI Clinical Studies Group & CM-Path Initiative**

**Please see the presentation uploaded on to the SWCN website**

**Presented by Paul Craig**

UK wide data on non-melanoma skin cancer (NMSC), presented by Brian Diffey at a 3 counties Skin Cancer Network meeting in 2011, had shown a sharp increase in the potential workload of NMSC. This has proven to be correct, with an increase in diagnoses of 41% over the past 8 years due to the aging, sun damaged population. The SWAG Skin Cancer Network will escalate the need to invest in services to manage the rise in incidence to the Cancer Alliance Board. **EW/HD**

Members of the group are recommended to read *Venables et al JAMA Dermatol* (Nov 2018); please see further details documented in the presentation.

**7.2 Clinical trials update**

**Please see the presentation uploaded on to the SWCN website**

**Presented by David Rea**

Recruitment figures (sourced from EDGE), open trials, and trials in set up are documented within the presentation. The national recruitment target for skin cancer is currently 0.5 per 100,000 of the population served. Although this is not recorded in the presentation, which shows recruitment data from April 2018 to January 2019, the target has now been met.

Recruitment to time and target for cancer studies has improved, resulting in a slight increase in income to the network from the National Institute for Health Research (NIHR).

The metrics for measuring performance are being revised. It is thought that these will help recompense research activity according to the burden of disease type.

Principal Investigators are invited to use the research section of the SSG meetings to launch new trials. Information on open trials and those in set-up is available on the SWCN website to view within the MDT here. In addition, there is a list of trials available to open in new sites documented within the presentation. SSG members are to contact Portfolio Facilitator Jessica Bartlett if they are interested

in opening any of these trials, who will make enquiries on your behalf: jessica.bartlett@nihr.ac.uk

It has not been possible to open new NIHR funded clinical trials for skin cancer in NBT due to resources being directed to other research areas. The BHOC trials unit was also short on capacity to open new trials. This was flagged on the NIHR Work Programme as an area that requires improvement.

Consultant Oncologist David Farrugia will be contacted to establish how resources are set up in Gloucestershire. **HD**

**Date of next meeting: To be confirmed**

**-END-**