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

Meeting of the SWAG Network Skin Cancer Clinical Advisory Group (CAG)
Thursday 24th September 2020, 10:00-11:00 via MS Teams

Chair: Mr Ewan Wilson (EW)

NOTES **ACTIONS**

(To be agreed at the next CAG Meeting)

1. Welcome and apologies

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

2. Management of Skin Cancer Services During the COVID-19 Pandemic

Please see the presentation uploaded on to the SWCN website

Presented by Ewan Wilson

CAG meets today to share information on managing services during the pandemic for the purpose of peer support and to see if any local guidelines can be distributed across the network.

The challenges and achievements from RUH, UHBW and GRH teams are documented in the presentation, which will be available on the SWCN website to enable comparison of the problems faced by teams.

Management of the number of suspected cancer referrals for all services across the region has proved challenging.

2.1 RUH:

From an oncology perspective, the main issues are capacity in the oncology department due to the need to social distance, and access to imaging as radiology capacity has been significantly affected. This experience is mirrored across the region.

Clinics were gradually returning to normal, with face to face consultations being encouraged where needed.

There are concerns that Systemic Anti-Cancer Therapies will make patients susceptible to severe COVID-19, which may inform the choice of therapy when considering the most likely toxicities. Provision of T-VEC had been paused in one centre at the beginning of the pandemic to reduce the need for face to face appointments; in the impending second wave, this and all other treatments will continue, including surgical treatments, now that all facilities have been made safe and the clinical teams are appropriately kitted out in Personal Protective Equipment (PPE). **Agreed**

Provision of radiotherapy had been impeded as the majority of patients have been advised to shield and had made the choice to defer treatment; treatments have continued for all patients who are willing to attend sessions.

For Basal Cell Carcinoma 3, it may be appropriate to consider radiotherapy as the primary treatment option rather than opt straight for surgery.

Clear guidance on risk assessments of patients and explanation of risks is required.

Action 001/20: A risk score sheet, developed in NBT, helps define whether a patient is low or high risk. This will be circulated to the group. **H Dunderdale**

All elective surgery is now classified as low risk, but the risk assessment may be helpful in certain cases.

It has not been possible to arrange clinical appointments using videoconferencing technology in RUH as the image resolution is inadequate.

2.2 GRH:

GRH have had a reduction in suspected cancer referral numbers, caught up with surgery during lockdown, and currently do not have a backlog of cases. A rapid access service (RAS) was piloted for GP referrals; this was unsuccessful as GPs are not seeing patients face to face to take dermoscopy images, and the majority had to come for face to face appointments. Assistance from the Cancer Alliance to get GPs to return to providing dermoscopy images would be welcomed; all GP practices in the area have access to dermatoscopes.

The regional MDTs are a mixture of partially social distanced face to face together with virtual dial in options. Radiologists are currently attending remotely. The main issue for Gloucestershire is the need to access paper notes during the meetings.

NBT MDT now has a system where the MDT Lead and Coordinator have planning time to pre-fill the data required prior to the meeting. Consultant Dermatologist James Milne is invited to attend the NBT MDT to share practice.

There is better attendance at MDTs now that there is the remote option. Initial technological issues have mostly been resolved; it is understood that MS Teams will be upgraded in the near future.

2.3 UHBW:

In UHBW, the majority of suspected cancer clinic appointments are arranged by telephone, with one face to face clinic being held for those triaged as requiring further investigation and high risk surveillance.

Patients had been advised to send photos of skin lesions via email. This resulted in wasted slots and caused a backlog of referrals as it was not possible to interpret many of the photos. Further work has now been undertaken with Medical Illustration to resolve this.

Fifty three percent of patients can be directed straight to surgery or discharged after submission of photographs taken by a medical photographer; the medical photography hubs are available in remote clinics across the region. It is hoped to expand the service to Bridgewater and Weston-Super-Mare.

The limited workspace in UHBW Dermatology Department makes it difficult to comply with the social distancing policy.

The CNS team is currently reduced from 4 to 2.

Low risk patients on follow up with a new lesion are advised to initially visit their GP for assessment, while the team prioritises follow up of any changes to the original site of disease.

Consultant Dermatologist Adam Bray is stepping down from the role of Skin Cancer Lead to take on the role of Departmental Lead. Consultant Dermatologist Pawel Bogucki will undertake the role from Thursday 1st October 2020. After an initial strategy meeting, he will share potential initiatives with regional colleagues, attend the Specialist MDT once a month, and is keen to discuss service development ideas for management of rare tumours.

Action 002/20: Consultant Plastic Surgeon Ewan Wilson will gather information via email for the purpose of defining the rare tumour types and convene a separate meeting of the Cancer Leads to discuss management. **E Wilson**

Action 003/20: Consultant Maxillofacial Surgeon Mark Singh has a role that will forge stronger links between the Skin Cancer and Head and Neck Cancer Teams, and will liaise with Ewan Wilson to discuss the governance of managing patients across the patch. **M Singh**

2.4 NBT:

NBT have set up My Skin Selfie, which most patients seem able to use. Clinics are running smoothly as the size of the atrium at Southmead Hospital easily enables social distancing. However, the majority of patients do not want to be seen face to face. All melanoma follow up has continued face to face according to clinical guidelines throughout the pandemic.

The Fast Track office is struggling with the workload associated with explaining to patients how to take photographs; ideally this should be managed by the patient's GP at the point of referral.

2.5 Pathology:

Consultant Pathologist Paul Craig is involved in the creation of a rare skin cancer database as part of his role working with the National Cancer Research Institute, and requests that CAG contribute to the data collection. **Potential future agenda item**

It is a national priority to digitise pathology across the network, as discussed at a meeting held yesterday, with significant funding available to the South West region from NHS E/I to drive this forward. There are currently 10 different suppliers that are being considered. Three pathology departments in the country are fully digitised to date. In SWAG, analogue cameras still predominate, so it will take a long time to implement. Artificial Intelligence (AI) may well help with the process. This is being explored by John Hopkins University, USA.

2.6 Support required from Cancer Alliance:

CAG requested continued support for GP training in the provision of adequate information for patients and training in dermatoscopy from the Cancer Alliance, rather than roll out any AI solutions in the current situation which would be a huge undertaking.

Action 004/20: To escalate need for GP training to Cancer Alliance **H Dunderdale**

3. Management of Metastatic Skin Cancer Lesions: Head and Neck Region

The local and specialist MDT will look into how skin cancer metastases in the head and neck region are managed in collaboration with the maxillofacial surgeons. The pathway for skin metastases is multidimensional and requires a unified, standardised approach.

The Head and Neck Clinical Nurse Specialists (CNSs) team currently provide support for those patients receiving adjuvant radiotherapy for skin metastases, as this is the same specialised care, with managing the cutaneous and intraoral toxicities and nutrition needs etc. that they provide on a regular basis, albeit in a slightly older, frailer cohort of skin cancer patients.

Action 005/20: Unifying support across CNS teams would be helpful and will be explored. **E Wilson/CNS Team**

The Maxillofacial team in GRH are part of the MDT.

4. Any Other Business

Amar Challapalli is the UK Chief Investigator for the C-POST randomised controlled trial for adjuvant immunotherapy (Cemiplimab) in Cutaneous Squamous Cell Cancer post-surgery and radiotherapy. The trial has now reopened in UHBW. C-POST needs teams to identify eligible patients shortly after surgery to facilitate enrolment. Patients can be treated for radiotherapy at their local centre, but would need to travel to receive the trial drug.

Action 006/20: Details of the C-POST eligibility criteria will be circulated **H Dunderdale**

All CAG members were thanked for their continued hard work running services during the pandemic.

Date of next meeting: To be confirmed

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