



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

**Meeting of the SWAG Network Skin Cancer Clinical Advisory Group (CAG, formerly SSG)**

**Wednesday 6<sup>th</sup> November 2019, 09:30-13:30**

**Engineers' House, The Promenade, Clifton Down, Bristol BS8 3NB**

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

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

**NOTES**

**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 27<sup>th</sup> February 2019, the notes were accepted.

**Actions:**

Development of an electronic MDT referral form, similar to the Bristol Neuro-Oncology Group (BNOG) form, remains an open agenda item. The format has been drafted by Daniel Keith (DK), and access to an online platform is currently being investigated as part of the wider MDT reform work.

The introduction of video-conferencing was previously discussed as a potential service improvement. There are very good links and information pathways with UH Bristol, Gloucestershire and RUH Bath; this is not considered an urgent priority but something that could be developed over a period of time. Yeovil and Taunton have a long-standing arrangement to remote dial in to each other's MDT meetings, which works well.

The melanoma staging and follow up algorithm has been developed, with thanks to Adam Bray, and circulated to all.

Follow up of pT2a patients for 5 years could be adapted according to individual cases if there is confidence that the patient will self-examine and contact the service with any concerns. This could be documented as 'patient initiated follow up by local arrangement'. The guidance will remain useful for those patients who would be unlikely to self-examine. Education is provided at the end of treatment to empower patients with low risk disease to self-manage, while still being able to access the service rapidly when required, freeing up out-patient capacity where safe to do so. Patients with metastatic disease or positive nodes should continue to get regular follow-up appointments.

Examples of follow up guidance will be sought from the Skin Cancer Teams in Sydney, Australia and Houston, USA to compare with the SWAG algorithm.

**EW**

It was noted that pathological staging should be recorded for medical insurance purposes rather than clinical staging.



### 3. Service development

#### 3.1 Genomic Laboratory Hub

Please see the presentation uploaded on to the SWCN website

Presented by Laura Yarram-Smith (L Y-S)

The provision of genetic and genomic test panels is now transitioning from a project to a standard NHS service. The number of laboratories has been consolidated from 25 to a network of 7 Genomic Laboratory Hubs (GLHs), all processing a core set of samples according to the same standards. North Bristol Trust (NBT) was successful in the bidding process to become one of the GLHs in partnership with Royal Devon and Exeter Trust. Each hub has been given the responsibility for processing a number of additional specialist tests, which are divided so it is clear who is doing what for each indication / disease; all cancer samples will be processed in NBT. The Director of the laboratory is Genetic Scientist Rachel Butler (RB).

National genomic test directories for rare diseases and cancer have been published [here](#) to give equity of access across the country. These define the tests that will be made available via NHS England at some point in the near future (potentially April 2020); directories will be reviewed by a panel of experts on an annual basis. This includes access to tests for inherited cancer, whole genome testing for all patients with sarcoma, leukaemia and paediatric cancers (which will include patients up to 24-years-old), and genetic panels for other tumours. Whole genome sequencing is currently not available for skin cancer, but the plan will be to include all cancers in the future.

The tests available to patients with melanoma (all tests have an individual code) are listed in the presentation. The South West GLH is proposing a gene panel that includes 500 genes in the hope that further relevant gene alterations and targeted therapies can be identified in the future; many biomarkers are emerging that could be eligible for Neurotropic Tyrosine Receptor Kinase (NTRK) gene alteration inhibitor drugs.

Transport methods are in the process of being clarified to ensure timely receipt of samples to the laboratory.

Tests will be requested on a paper referral form until an online requesting system has been developed.

Consent is required as results are stored on a research database and will be facilitated by a standardised record of discussion forms.

A list of agreed variants will be discussed by the Genomic Tumour Assessment Boards before reporting back to the requesting MDT; patients with germline variants will be referred to the genetic counselling service and guidance for delivering initial results will be provided by GLH representatives to the clinical team.

Discussion ensued around the most appropriate clinician to deliver results of genetic abnormalities. Ideally it was felt that it should be the responsibility of Genetic Counsellors. Processes will evolve over time after review of the services for which this is more immediately relevant, for example, BRCA results and



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breast/ovarian cancer discussions.

National guidelines are being developed on the reporting of relevant variants.

A Genomic Medicine Service Cancer Education Event will be held in Taunton on the 29<sup>th</sup> January 2020.

### **3.2 Genetic testing (including BRAF) of melanoma samples from April 2020**

**Presented by Paul Craig**

Arnaud de la Fouchardière provided a presentation at the National Histopathology External Quality Assessment (2017) that emphasised the importance of immunohistochemistry (IHC) staining to inform diagnosis and prevent over treatment. In Gloucestershire, BRAF result turnaround is achieved within 4 hours, using the rapid PCR machine. The testing equipment is due to be removed in April 2020 and all such tests moved to the GLH, increasing turnaround time to 10 days/2 weeks.

There is a call for the GLH team to work closely with the regional histopathology teams, given the increased workload due to extra samples for gene panels, existing workforce shortages and the considerable workload pressures.

Histopathology needs to evolve into a networked service with access to view other departments' reports, and there should be an integrated approach with genetics and pathology; this message will be escalated on behalf of the Skin Cancer CAG.

EW

Representatives from the GLH are liaising with the Clinical Advisory Groups and will continue to contact all specialties to facilitate the integration.

## **4. Patient Experience/Living With and Beyond Cancer**

### **4.1 Good News Feedback: Developing a nurse-led skin cancer pathway**

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

**Presented by Louise Pound/Clinical Nurse Specialist (CNS) Team**

The Gloucestershire CNS Skin Cancer Team (funded by Macmillan) are finalists for a Macmillan Quality Improvement award.

Due to the rapidly increasing number of suspected skin cancer referrals, and in recognition of the CNS skill set (which has been continually audited with excellent results) Managers and Consultants supported changing CNS job plans for the purpose of restructuring management of the skin cancer pathway.

Same day, nurse-led clinics have been arranged for 24 patient 20 minute appointments referred via the suspected cancer process. Patients are sent a letter to confirm that they would be seen in a specialist nurse clinic and may be offered surgery. Certain patients considered high risk are seen by the Consultant.

The clinics consist of history taking and dermatoscopic examination, resulting in



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referral to surgery or on to the medical team, or discharge with lifestyle and monitoring advice.

Audit of lesion management has been found to be 100% accurate, and patient experience feedback was 100% positive. Time to diagnosis has improved, with the team now offering 6 'super' clinics a month in collaboration with the medical team. Further benefits of the service are documented within the presentation.

The CNS team in RUH have been running a results clinic for the last 2 years; breaking bad news requires a longer clinic slot to discuss the impact of a cancer diagnosis with the patient, and 45 minutes is routinely allocated.

To meet clinical governance requirements, the Gloucestershire CNS team has completed the same dermatoscopic competency training as the Consultants, and all clinics are supported by the consultants should it be necessary to seek further advice; a rolling audit of lesion management is required. From an insurance perspective, personal indemnity for the practice is covered in the CNS job description.

The Taunton team have achieved improvements to their service with assistance from the Gloucestershire team. A recent visit from the Getting it Right First Time (GIRFT) team was very helpful and positive. The CNS team also run breaking bad news clinics, working closely with the oncology team.

The North Bristol Team has had some workforce changes, but is now back up to full complement plus one excellent Cancer Support Worker. The clinic model differs from other Trusts as the majority of patients have received their diagnosis elsewhere, and patients generally see one of the Consultants then the CNS straight after; patient feedback is positive.

The UH Bristol Oncology Team's adjuvant clinics are running well. A Band 6 CNS is due to be appointed to provide assistance, including phone clinics and links with the wards.

In addition to Health and Wellbeing events, the team now run an event for patients with a poor prognosis, called Adjust, Adapt and Plan, which cover topics such as dietary psychological advice, and how to maintain work, make financial arrangements, and Will Writing.

The Gloucestershire model could be shared with Cancer Managers and could be adapted to suit the needs of other services, given the scale of the suspected cancer workload and workforce crisis. Significant investment in nursing roles would be required; this has been recognised in other areas with the development of Advanced Nursing Practitioner roles. Teams would need to be flexible in the management of their resources. The importance of having protected time to provide sufficient key worker support for patients was recognised.

**CAG Team**



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#### 4.2 Provision of CNS support for private patients

Please see the presentation uploaded on to the SWCN website

Presented by Carol Chapman (CC)

There is a need to ensure that private patients have access to CNS support. Private patients do not displace NHS patients, but are treated in parallel. Many of these patients have private insurance as part of a work contract, and should not be disadvantaged in comparison with NHS patients. Clear guidance must be developed to address this; existing guidelines from other regions will be sought, and discussed further by the Lead Cancer Nurses in each Trust.

CC/Lead Cancer  
Nurses

While some Trusts recruit to CNS roles specifically for managing private patients, other CNS teams have specifically been told not to provide support to private patients. There was also a safety aspect in doing so, as results from interventions would not be accessible. The private sector is buying CNS time where possible, but does not have the resources to deliver a comparable service. Ideally, arrangements need to be made between NHS and private providers.

Consultants will evaluate the private patient workload over the next three months, and CNSs are to keep track of any related workload.

CAG  
Consultants/CNS  
team

#### 4.3 National Cancer Patient Experience Survey (NCPES) Results 2018 / Treatment summaries

Please see presentation uploaded on to the SWCN website

Presented by Carol Chapman (CC)

Historically, the survey had been provided by Quality Health; PICKER will be providing the service from now on, and plan to feedback results in time to action findings before the next survey is distributed.

The 2018 responses, based on all adult admissions / day cases between April and June 2018, have only been published for UH Bristol and NBT due to the low number of responses (results from less than 20 respondents are not published). It is hoped that this will improve when PICKER include outpatients in the cohort of patients receiving the survey, which will be included in a future iteration of the survey, but not the 2019 version.

Results are within the national average as a region and some are significantly above the national average. There has been some deterioration in the score relating to waiting times. Details on areas where there may be room for improvement are documented in the presentation.

CC

The patient comments make a really positive read, and will be circulated.

Treatment Summaries, drafted and circulated to the group for comments, require paring back and integrating into an automated electronic system that simplifies the process of completing them as much as possible. The summaries were initially designed to meet the needs of GPs, but recent GP feedback indicates that this needs to be revisited. RUH have developed alternative versions. Now that the post holder who was developing the summaries (LWBC



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Lead Catherine Neck) has changed posts, a replacement will be sought to lead on the project.

CC

## 5. Clinical guidelines

### 5.1 Adjuvant follow-up pathways

The practice in North Bristol for adjuvant follow up of melanoma is 3 monthly skin checks by the Plastics Consultant, with all imaging completed by oncology, for four years; some patients may be followed up by dermatology at local hospitals for convenience the first year and, if all goes well, returning to dermatology follow up for the next 2-5 years. This is also the practice in Gloucestershire and Yeovil. RUH Bath patients are followed up every 6 months unless the Consultant specifies 3 monthly checks.

**Comment [DH1]:** Amended as advised by Katherine Finucane

There is a need to be aware of patients' follow up schedules at other centres to avoid surplus appointments.

## 6. Network issues/MDT service

### 6.1 MDT reforms: low risk group session feedback

Please see the presentation uploaded on to the SWCN website

Presented by Lois Baldry (LB)

In response to the increased number of new patients, capacity pressures, and the aim to standardise patient information, the team in UH Bristol have implemented group education sessions for patients with low risk squamous cell carcinoma (SCC) as an alternative to individual outpatient appointments. The sessions are 45 minutes long and usually attended by up to 10 patients; this is restricted due to room size, but works well as a small group. The information provided (via pre-recorded power point presentations), and patient feedback (which is very positive) is documented in the presentation. Initial organisational problems have been identified and resolved. The team filter out patients that would be more appropriate for a one to one appointment, for example, patients with dementia or hearing impairments.

It is hoped that the pre-recorded presentation will allow Cancer Support Workers (CSWs) to run the sessions in the future with the CNS attending for a question and answer session at the end. The next plan is to hold sessions in Weston to reduce the need for patients to travel.

Patients requiring lymph node assessments are still seen in clinic.

An invite to the group meeting, held once per month at present, is sent with the Consultant clinic letter 4-6 weeks after the biopsy result. Non-attenders are contacted to see why it was not possible to attend and are sent an information pack. Patients are invited to bring someone with them. A sticker on the information provided is added to the patient's medical notes, and a template end of treatment summary is completed; it takes approximately 30-40 minutes to complete the administration for all 10 patients.



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It could be possible to develop a video for those patients that do not attend.

## **7. Coordination of Patient Care Pathways: Appraisal of evidence on management of two week wait pathways**

### **7.1 Introduction: to agree investment in skin cancer early diagnosis**

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

**Presented by Patricia McLarnon (PM)**

The Skin Cancer Service has been identified as requiring investment to improve the diagnostic pathway due to the significant workload. A new 28 day faster diagnostic cancer waiting times standard will be introduced in April 2020. The aim of this is for all patients who are referred for the investigation of suspected cancer to find out if they do or do not have a cancer diagnosis within 28 days. The information is gathered from clinic letters by the performance teams. Further national guidance is due to be published soon; it stems from patient feedback of the stress caused by waiting and not knowing.

There is a need to look at alternative ways to manage services, make the best use of the technology available, and upskill the workforce where possible.

Funding is available (£100,000) from the Cancer Alliance via the National Cancer Board that can be used to make sustainable improvements to the cancer pathway. A review of potential ways to spend the funds is the purpose of the rest of this meeting, but CAG members are invited to send any other ideas to Cancer Alliance Programme Manager Patricia McLarnon (PM).

The 28 day diagnostic standard was felt to be unachievable with existing resources in secondary care; any workforce expansion needs to be channelled through recurrent funds.

Clinical Commissioning Groups (CCGs) in the region want to use the funding in primary care to reduce referrals to the acute sector.

### **7.2 Wiltshire and BANES Teledermatology Pilot**

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

**Presented by Andy Jennings (AJ)**

The Teledermatology pilot, run by Bath, Swindon and Wiltshire CCGs (which are currently merging into one organisation), is based on the Leeds model for all two week wait (TWW) referrals to be made via the Consultant Connect system. Details are documented within the presentation. It is possible to discharge approximately 28% of referrals using the system, but there are issues with information transfer, Consultant job-planned time, and image quality. All referrals sent with no or poor images (50%) are booked into a two week wait clinic.

Wider roll-out is subject to job planning changes.

The pilot will now be revised and used as an Advice and Guidance service prior to referring as a TWW. Template response letters have been developed that can be



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shared.

HD

Cancer Alliance funding could be used to buy additional iPods, Dermatoscopes and connection kits for more GP practices across the region.

It was noted that the process does not reduce the number of TWW referrals, but does reduce the number of face to face clinics. Advice and Guidance via Teledermatology can (if the IT system is fit for purpose) be given faster than face to face clinics; in Gloucestershire this takes approximately 3 minutes in comparison with 7 minutes in RUH due to the software system.

### **7.3 Gloucestershire Advice and Guidance/future Rapid Access Service**

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

**Presented by James Milne (JM)**

An Advice and Guidance Service via Teledermatology, using the Synapse system, has been available in Gloucestershire since 2016. All but 2 GP Practices have access to Dermatoscopes and there is a rolling education programme for GPs, a major part of which is 'how to take good quality photos'. Quality images are key to making this work; as with the BSW pilot, poor quality images result in a TWW clinic appointment.

A new Rapid Access Service is due to commence in the near future to manage TWW referrals via Teledermatology as well, which would be considered successful if it is possible to triage 30-40% of patients; this will be facilitated by GPs' accurate completion of the suspected cancer referral form.

The team had previously trialled a medical photography service, but this was discontinued due to mistakes made by external photographers and issues with some referrals. Feedback on the Rapid Access Service will be provided at a future meeting after a year's pilot to assess if it is worthwhile.

JM

### **7.4 Somerset CCG plans for dermatology services**

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

**Presented by Carmen Chadwick-Cox (C-C)**

An overarching project for Dermatology is underway in Somerset since Taunton stopped providing a service for new patients in 2017. Currently, patients are managed between Bristol, Yeovil and Exeter, with the majority of TWW referrals going to the Bristol Royal Infirmary. The community service is limited with 4 GPs with a specialist interest in place in 2 practices.

Key deliverables:

- Reduction in 2WW demand
- Increase in Telederm referrals/number of GP's using Telederm
- GP confidence in managing patients within Primary Care
- Equitable provision of Community Dermatology across the county
- Robust provision in place for training, accrediting and supporting GPwER
- Rolling Programme of Primary Care education on recognition of skin





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Lesions and pathway management

- Patient feedback on confidence to self-manage.

Somerset will continue to liaise with the CAG to align, where possible, regional work.

### **7.5 Medical illustration and Fotofinder hubs**

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

**Presented by David de Berker (DdB)**

Three videos are available on YouTube, produced by the Skin Cancer Team in Leeds, that are useful teaching aides for referring GPs. Provision of quality images is key; Teledermatology systems require proper investment. The system currently used in Somerset generates integrated reports that enable quick review of service activity. This is no longer available in Bristol due to the associated cost.

Results of a UK survey on Teledermatology, organised by the British Association of Dermatology, are documented in the presentation. There were 90 respondents; 21 are currently using the system for management of suspected cancer referrals. A range of different software solutions exist, which are either standalone systems or work with ERS; ERS alone is not easy to use.

Use of professional medical photographers is increasing, and is used in rural Wales, where photographers are available in the community. Portsmouth also have community hubs with medical photography, which generates a tariff of £65.00 per case. A higher percentage of patients can be discharged after review of professional images; 50% in a previous pilot, and 30% were booked straight to surgery. A pilot will be run in Bristol for 4 months. Patients will be phoned prior to the appointment to ensure that attendance at the community hub is appropriate. Evidence from the pilot will be reviewed at a future CAG meeting.

### **8. Any other business**

The West of England Research Network has appointed Consultant Oncologist Helen Winter (HW) to the role of Clinical Research Specialty Lead, and is currently investigating ideas for translational research. There is a drive to find non-medical staff that would like to express an interest in the Principal Investigator role.

**DdB**

CAG had the advantage of being a close knit network that can liaise about clinical trials and promote cross-referrals.

Novel therapies are on the horizon. A new trial of a tumour-infiltrating lymphocyte therapy for metastatic melanoma (which involves sending a biopsy to the Netherlands) is looking for their first patient. CAG members are to contact HW or Chris Herbert if a relevant case is identified.

### **9. Break-out meeting for Provider Trusts/CCG representatives**



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

**-END-**