**Meeting of the SWAG Network Skin Cancer Clinical Advisory Group**

**Wednesday 18th June 2025, 09:30-13:30**

**Berwick Lodge, Berwick Drive, Bristol, BS107TD / MS Teams**

**Chair: Mr Ewan Wilson**

| **REPORT** (To be agreed at the next CAG Meeting) | **ACTIONS** |
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**1. Welcome and apologies**

Please see the separate list of attendees and apologies uploaded on to the SWAG website here.

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

As there were no amendments or comments following distribution of the report from the meeting on Wednesday 13th November 2024, the report was accepted as finalised.

From the Work Programme:

**2.1. Clinical Nurse Specialist (CNS) equity of access to request imaging modalities:**

Following completion of many hours of online training, the NBT CNS team can now order all relevant imaging aside from PET-CT.

SFT can also order any imaging, including PET-CT, following a long process to gain permission.

UHBW CNS team can order CT only but are investigating getting permission to order ultrasound.

Protocols could be shared in the CNS break-out meeting following the meeting today. These should clearly state the governance process for acting on the reported results and requesting of imaging should be added to CNS job descriptions.

SWAG Cancer Alliance want to help ensure equity of access to requests to streamline patient pathways and it may be possible for ACCEND Lead Liina Haythornthwaite to help with organising training requirements.

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| **Action: To ensure equity of access to request imaging modalities across the region.** | **CNS Teams/Radiology** |

The decision for requesting a PET-CT would have been approved via the MDT and so no additional countersignature should be required.

**2.2 MDT Meeting Reforms**

It had been hoped to develop an online referral system for referrals to the SSMDT, similar to the system used by Bristol Neuro-Oncology Group (BNOG), but it has not been possible to arrange this with the IT department. A digitised referral process with mandatory data fields would still be preferred if this becomes possible in the future; it is hoped that this would reduce the need to go back to referrers for missing information. **Daniel Keith**

**Action: To revisit the action to look into digital MDT referral systems.**

**2.3 To explore IT solutions to optimise the histology report export process**

No progress has been made to date as the IT department has been focused on digitising pathology services, which is an NHS England mandatory target. Improving the histology report export process will need to be revisited once this has been completed.

**2.4 Regional Melanoma Pathway: To streamline the pre SLNB pathway by arranging multiple steps in parallel and audit the impact**

NICE criteria is being followed for the SLNB referrals, and it is felt that all relevant patients are being referred appropriately. To remain a rolling agenda item for ongoing review.

All other relevant items on the Work Programme are on the agenda today.

**3. Teledermatology Update**

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

**Presented by Senior Project Manager Chris Ashdown**

Chris Ashdown has been tasked with facilitating roll out of Teledermatology in the Bath and North East Somerset, Salisbury and Wiltshire (BSW) Integrated Care System.

Swindon is overseen by Thames Valley Cancer Alliance. Telederm commenced last month and have already increased sessions from one time to three times a week and are now processing approximately 250 patients per week.

For RUH Bath, there is a go live date of 7th July 2025 for image taking hubs to open, initially in 4 GP practices, eventually increasing to 17 practices, with trained health care assistants using specialist dermascopic cameras. The Cynapsis telederm system is going to be adopted, which will be configured to import ERS referrals and images for review by the Consultant Dermatologists.

A dedicated telederm administrator will be required to support the service development, and negotiations are underway to ensure that the post holder is appropriately banded.

For Salisbury, clinical engagement and support has been established. There are internal issues with the ERS system in regard to being able to view the referral and associated images in one place. A Robot Process Automation (RPA) project is underway to try and resolve the connectivity problems.

The other challenge is setting up image taking hubs in the sprawling geography of Wiltshire.

RUH Bath also has forthcoming challenges with the Consultant workforce.

For Somerset, although there is an existing teledermatology service, further work is underway to set up community image taking hubs.

Some cross-border issues exist, for example, although Frome is a Somerset town, RUH receives approximately 300 referrals per year from the local GP practices. Once ICBs have merged, it may be that cross border negotiations are easier to navigate.

For Gloucestershire, telederm has been established for some time, although image quality has been a limiting factor for proving it to be cost effective for the ongoing business case to be agreed. Medical Illustration are now working on developing community imaging hubs to improve diagnostic quality. The SWAG Cancer Alliance are providing funding to keep the service afloat in the interim.

A dedicated clinic has now been established which will help as previously the triaging Consultants were having to fit in telederm assessments around existing in person clinics.

For BNSSG, 15 out of the 20 Primary Care Networks are referring via telederm to the two Bristol hospitals, and the other 5 PCNs will be piloting telederm in the next quarter.

There has been some variation across the region in the way that images were being captured, but it is now planned to roll out the Casio cameras, which take exceptionally good quality images.

Compliance with the 28 day Faster Diagnostic Standard (FDS) has improved over the last two quarters which may be due to the increased roll out of telederm.

The York Economic Health Consortium have been tasked with providing SWAG with economic benchmarking which will compare each telederm system to see which model is the most efficient, and provide evidence to support business cases. It will also be able to look at the resources required according to different future scenarios.

**Discussion:**

The main barrier for telederm triage of two week wait referrals in YDH is Consultant Dermatologist workforce, with only two triaging Consultants in post to manage a population of 600,000 patients. This is the same barrier in RUH.

It was noted that training of image taking needs to be continuously provided to capture any new staff members appointed to the imaging hubs and provide refresher training as and when required.

Contracts are being drawn up with Medical Illustration in UHBW and Gloucestershire to provide ongoing training.

It is hoped that diagnostic imaging quality can be raised to 90% with the correct use of the Casio cameras.

Although telederm is likely to increase the number of patient cases that can be processed in each session, it is not thought likely to create a huge surge for pathology services as the number of surgical lists have not been increased. It is likely that more benign work will be triaged appropriately.

The community image taking appointment is approximately 10-15 minutes, reduces foot fall in the Secondary Care site and the burden of travel and parking for patients. It does not reduce the workload for the triaging dermatologist who will still either be seeing 20-30 patients in person in clinic or 30-40 online referrals, depending on how many can be processed prior to the onset of cognitive fatigue.

Another challenge is the work outsourced to external providers who run weekend clinics and then bombard pathology with samples.

Only three images need to be uploaded with the referrals, one of the location, one close up and one dermascopic.

Management of skin lesions in Primary Care is often delegated to paramedics or other non-medical health professionals with no triaging experience, and this has resulted in Advice and Guidance telederm being flooded with referrals.

**Action: An update on telederm roll out will be provided at the next Skin CAG meeting. Chris Ashdown**

**4. Intermediate Care Service (ICS)**

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

**Presented by General Practitioner with a Specialist Interest (GPwSI) in Skin Cancer, Jon Upton**

Radical IT driven solutions are required to deliver sustainable skin cancer services.

The background and current provision of the ICS, including IT solutions, audit methodology, challenges and future plans are documented in the presentation.

Following closure of the dermatology two week wait service in Taunton in 2015, patients had to be repatriated to Bristol and Exeter. This became increasingly untenable to manage, and so the ICBs incentivised development of the ICS, training 6 GPwSI to manage referrals for low risk Basal Cell Carcinoma (BCC), and a further 10 who will complete training in the next year; clinics are available across Somerset.

It has been essential to have integrated IT systems to enable the service to work and, when a GP refers in to the service, the team have sight of all relevant medical records. This has also enabled the ICS to immediately share back results from the patient's assessment and outcomes to the referring GPs.

The IT system uses templates which makes it easy to make standardised assessments and automate clinical audits. With the huge case load that Primary Care have to manage – the practice of Jon Upton totals 19,000 patients - where it is necessary to demonstrate successful management of diabetes, heart disease and hypertension for example to secure funding, seamless IT systems are vital to ensure services are appropriately safe for patients and recompensed for their activity.

Although the system being used has been available in Primary Care for over 20 years, it is not available in Provider Trusts.

The ICS wish to emphasise that the need for integrated IT systems across all healthcare providers.

If this was enabled, advice and guidance could be provided across both the ICS and Secondary Care. Cynapsis are working on responding to this challenge.

ICS are now using an NHS approved version of Co Pilot to automate transcriptions of clinic outcomes into an action plan.

Artificial Intelligence system Ambient AI was piloted for two months to transcribe advice and guidance.

The Tortoise system was also used to transcribe consultations into patient notes and create letters before the patient even leaves the room. This reduced triaging time for 12 patients from 2 hours to 30 minutes due to the reduced administrative burden.

Agreeing to the use of new technologies needs to be collaborative, and understanding the impact of small optimisations is key.

Ideally, AI triage should be at the beginning of the referral pathway, for example with implementation of Skin Analytics.

**Discussion:**

Ambient AI can filter out general discussions you have with patients that are not clinically relevant.

GP training on skin cancer is generally 2 weeks and it was recommended that the training should be extended as it is the fastest growing cancer. This is challenging because every medical specialty recommends the same but has been addressed in part in Somerset by training the GPwSI's that are distributed across the region.

An argument against the time saving element of transcribing consultations is the importance of having a moment in between consultations to regroup.

Supervisors are currently available in every single ICD clinic to assess competence of the GPwSI team.

The importance of retaining the human element of the working day in terms of ensuring that proper break times are adhered to was

emphasised.

It is hoped that AI will remove the administrative burden to allow this and improve the amount of time that can actually be spent with the patient.

**5. Genomic Medicine Service Alliance (GMSA) update**

**Presented by GMSA Managing Director Jonathan Miller**

The South West GMSA is drafting guidance for all clinical specialties on the priority genomic tests for cancer in light of the reduced funding allocation in the next financial year.

Volunteers were requested from pathology, oncology and dermatology to help construct the guidance and, in particular, where a wider genomic panel would be considered beneficial for certain patient groups.

This will hopefully include a section on sebaceous neoplasms and MMR testing as recommended by Skin CAG.

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| **Action: Consultant Pathologist Naomi Carson and Consultant Dermatologist Kim Lin volunteer to help draft the guidance.** | **Naomi Carson/Kim Lim/Jon Miller** |

**6. Oncology update, Clinical Trials and Neoadjuvant Treatments**

**Presented by Study Support Manager Claire Matthews**

National clinical trial recruitment from April 2025 to June 2025 shows that 329 patients have been recruited to 26 skin cancer trials across 14 research networks.

The majority of trials were non-commercial and interventional. It may be too early to tell but it appears that recruitment may be lower in comparison with the previous year.

The list of clinical trials that are open and in set-up across the region are documented within the presentation. The data is sourced from the EDGE database and is not always accurate or complete. CAG are encouraged to inform the research team if any trial information is missing.

The SCOPE cancer vaccine trial has joined forces with the Cancer Vaccine Launch Pad (CVLP) service to facilitate recruitment.

A bidding process is open for delivering Tumour Infiltrating Lymphocyte (TIL) therapy centres. It is expected that 8 centres will be chosen across the UK. UHBW would be well placed to offer the service as it is already a centre for CAR-T so has many of the required tissue licences already in place. **Future agenda item**

Only a small number of patient's will be eligible for this inpatient treatment, which does make patients very sick, but can have really positive oncological outcomes. It will not have an impact on pathology as samples are sent directly to the USA.

Neoadjuvant trials are showing positive outcomes, and an update will be provided at a future meeting.

The SSMDT now has a research nurse who attends the meeting which has greatly improved screening for trials.

A website is available where everyone can proactively register their interest in participating in research: https://bepartofresearch.nihr.ac.uk Posters and leaflets are available to display in waiting areas to encourage people to sign up.

There is concern for healthy participants who have an incidental finding, for example, a germline alteration, and how they can then access support.

**Action: To establish if a support mechanism exists for participants in research when incidental findings are reported.** **Helen Winter**

The free NIHR 6-month Associate Principal Investigator (PI) scheme is still open to any interested clinician who doesn't have research in their current role. It allows associates to work alongside current PIs on studies (as documented in the presentation) signed up to the scheme.

The free 18 month Principal Investigator Pipeline Programme (PIPP) is also available for research delivery nurses or midwives. The next cohort will open to applications later in the year.

NIHR website links and team contact details are available within the presentation.

**Discussion:**

The DETECTION trial is for Stage 2B, 2C or 3A melanoma, and is investigating the use of adjuvant treatment.

As only a small benefit is seen following one year of adjuvant treatment in this patient cohort, which comes with significant toxicity risks, further evidence is required to establish if the treatment is doing more harm than good.

The trial will compare standard immunotherapy treatment versus close surveillance with circulating tumour (ct)DNA detection to see if relapses can be picked up early and the outcomes if treated at that point. If the trial is successful it could spare many patients from the toxicity of adjuvant immunotherapy.

Skin CAG are encouraged to refer relevant patients directly to RUH Bath where they will be rapidly assessed for eligibility.

**Action: To circulate DETECTION trial eligibility criteria to Skin CAG.** **Helen Dunderdale**

**7. SWAG Melanoma Staging and Follow Up Guidance**

The melanoma flowchart provides a sensible structure for follow up guidance and surveillance according to disease stage.

Following review of the flow chart, the Year 4 and 5 follow up for Stage 2B melanoma will be updated to an annual follow up with CT.

Follow up schedules can become less rigid when there is confidence that Patient Initiated Follow Up (PIFU) is appropriate for certain patients who will regularly check themselves and contact the service with any concerns. This is not appropriate for all individuals, for example, if someone lives on their own and can't check their back.

There are some capacity problems with the ultrasound schedule in UHBW.

**Action: To contact Consultant Radiologist Mandy Williams for assistance with booking the follow up ultrasounds.** **UHBW CNS Team**

YDH Radiology Department used the melanoma follow up guidance as a lever to get additional resources and this now works well, although the local challenge is ordering surveillance tests in the right time frame and keeping track of results and next actions for those patients who are managed remotely. A Cancer Navigator role is required. **Workforce shortage**

SFT have access to a remote monitoring system (RMS) built into the Somerset Cancer Register which tracks all the intervals for the scans.

A traffic light flagging system indicates when a scan needs to be requested and a list of the surveillance scans that require review by the MDT can be created.

Any other requirements along the patient pathway can be tracked using the system. For example, if a patient is attending an oncology appointment, it can remind the team to check on the outcome.

Administrative support has been secured to facilitate the tracking process.

A skin cancer navigator is also available who works specifically on coordinating the patient pathway up until first treatment.

The system for booking surveillance scans in YDH does not have an alert to flag that the patient is on an urgent cancer pathway.

**Action: To raise that YDH Radiology department is an outlier for not providing urgent reporting of surveillance scans.**

**Mihaela Savu**

Outsourcing of surveillance scans has also raised concerns, with incidences where scans have been incorrectly reported as normal; this has been mitigated by MDT members double checking the scans.

Sentinel Lymph Node Biopsies are arranged in accordance with the latest evidence on probability risk.

**Action: To collect data on SLNB positivity rates for a regional audit.**

**Ahmed Basiouni**

Australia have a melanoma risk calculator; this has yet to be completely validated but is gradually improving.

A project underway in Newcastle is looking at AMBRA1 and Loricrin expression testing as a prognostic indicator to identify tumour subsets at low risk of metastases.

**Future agenda item**

**8. Skin Cancer Research Fund (SCaRF) Charity Update**

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

**Presented by Consultant Plastic Surgeon, Trustee and Deputy Chair of SCaRF, John Pleat**

SCaRF has been running since 1979 and was originally based at the Frenchay site and now is hosted by North Bristol Trust.

The charity promotes research, offers grants to look at the cause and prevention of skin cancer, and also provides an educational role, with the ultimate aim to reduce the number of cases and burden of disease.

The complete list of Trustees is documented in the presentation who all contribute to scientific supervisory roles

Many charity events were held over the years to raise funds to conduct research and SCaRF supports national projects. Grants are awarded twice a year following an independent assessment process. These may be smaller pump-priming grants of £1-5K or larger project grants up to £20K.

Many of the projects supported have produced successful initial results that have resulted in larger project grants authorised by the NIHR, Wellcome Trust and MRC etc.

Details of past research projects, SCaRFs educational role, and fund raising activities are documented within the presentation.

Volunteers from Skin CAG to fund raise or become a Trustee and scientific advisor would be welcomed, as would applications for research projects for the grants.

**Discussion:**

Grant applications are welcomed from anywhere in the nation. Historically there have not been many applications made from the South West region.

Research relating to immunotherapy induced toxicities would definitely be considered.

**9. CNS update: Cancer Navigator (CN) and Cancer Support Worker (CSW) roles**

NBT have excellent support from the current CSW and MDT Coordinator.

The NBT team have worked hard to build a business case to increase numbers to a team of 10 CNSs, navigators and secretaries. This works well when the full complement of staff are available; further resilience is required to cover annual leave or sickness.

Clear communication pathways have been established to ensure the most efficient use of time by clear handover between staff members.

It is important to protect non-clinical administrative staff from any overlap with clinical work.

YDH Cancer Navigator tracks patients throughout the cancer pathway rather than only focused on the two week wait pathway. An additional Skin Cancer Administrator is also in post. A generic group of Cancer Support Workers is available who work across the different cancer sites.

At UHBW, the funds for Cancer Navigator roles has been used to fund Cancer Support Workers.

SFT team were the first to secure a permanent Cancer Navigator, the majority of which are on fixed term temporary funding.

Free online training is available for Cancer Administrative staff. Detail can be sourced from the Cancer Alliance team, who can also be sent any other ideas for training opportunities: swagca@nbt.nhs.uk

**10. Data from the National Cancer Registration Service and SACT dataset**

**Presented by Data Liaison Manager for the National Disease Registration Service, James Withers**

A live demonstration was provided of the Cancer Stats website. Any NHS member of staff is welcome to register to access the website, which contains the most up to date Cancer Outcomes and Services Dataset (COSD) submissions. The data is not published as it then undergoes a data quality improvement process.

The data was filtered to show staging completeness for melanomas.

The target is for 80% of melanomas discussed at MDT to have staging data completed.

Over the past 12 months, the overall percentage of staging completeness in SWAG is 82.7%, which is fantastic.

As only one version of Somerset Cancer Register is owned across the two Bristol Trusts, the data from each is combined, which has an effect on data completeness.

Once the data has been through the cancer registration process and cross referenced with all relevant reports, the data can be separated into patients managed at either NBT and UHBW.

On occasions, staging is documented in the body of the free text at NBT rather than in the set data fields; attempts are being made to ensure this is rectified whenever possible.

The National Cancer Registry guidelines is for TNM staging or a stage group to be completed within 4 months of diagnosis.

Partial staging is accepted if the patient has distant metastases at diagnosis.

SWAG Skin Cancer staging is of very good quality in comparison with other cancer sites. Staging is verbally announced for the benefit of the MDT Coordinator in the MDT meeting after discussion of each patient.

It is possible for the data to be refreshed and updated retrospectively.

It is also possible to view data from each trust on the patient with melanoma receiving SACT.

**11. SWAG Cancer Waiting Times Performance Data**

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

**Presented by Data Manager Funmi Oladipo**

A Peer Review analysis of Cancer Waiting Time performance data for skin cancer, in relation to the 28 day Faster Diagnostic Target, shows how the SWAG region compares with other Trusts and the percentage improvements made in performance in each Trust between Quarter 3 and Quarter 4.

Looking at SWAG as a whole, between April 2024-April 2025, FDS improved from 78% to 93.1% and 62 day performance improved from 87.5% to 95.5%.

Performance according to ruling out or diagnosing with cancer was also available in the presentation as was the two week wait conversion rate to cancer.

The same Peer Review analysis of the 62 day target in each trust between Quarter 3 and Quarter 4 also showed improvements in each centre and in particular for RUH Bath.

**Discussion:**

Overall, the data was a testament to the hard work undertaken by skin cancer services throughout the year, despite the continued exponential increase in referrals.

RUH has appointed an extra locum which was in part how the recovery has been achieved.

NBT had made improvements by outsourcing some activity, which also came with problems as previously discussed.

Current solutions are always short term and involve asking teams to undertake extra clinics and theatre lists and, when this is not possible, provide funding to outsource activity which creates additional downstream work.

Ideally, long term sustainable changes need to be made to increase in-house resources.

Any ideas for service improvements can be shared with the Cancer Alliance.

The focus on the targets at front of the pathway do not reflect the capacity issues at other points in the pathway, and improvements need to be made at every step.

Once available, it is the ambition to start sub-cut immunotherapy within a week of a patient's diagnosis.

It is only possible to progress the pathway in parallel while awaiting the next test result.

**12. MDT Operational Policy**

It has recently come to light that the majority of MDT Operational Policies need to be updated. In response, Cancer Manager Hannah Marder has drafted a template that is hopefully easier to populate and more useful than the previous Peer Review style documents.

It also incorporates a section on the appropriate cases to streamline to protocolised care, wherever appropriate.

If it is agreed to adopt the template, this will help fulfil Terms of Reference governance for the regional MDT meetings.

Feeback from regional Cancer Managers is for individual MDTs to decide what is safe quoracy and to have ownership of how your own MDT meetings are managed.

The template will be adapted to comply with the British Association of Dermatology (BAD) Service Specification.

**Action: The MDT Operational Policy will be circulated to the MDT Leads for comments.** **Helen Dunderdale**

**Date of next meeting: Wednesday 3rd December 2025, 09:30-13:30 Berwick Lodge / MS Teams.**

**-END-**