Peninsula Cancer Alliance

Meeting of the Skin Site Specific Group

Thursday 23rd July 2020

2pm-3pm

MS Teams Conference

FREEDOM OF INFORMATION

This group will observe the requirements of the Freedom of Information Act (2000) which allows a general right of access to recorded information including minutes of meetings, subject to specific exemptions. No one present today had any objections to their names being distributed in the minutes.

SSG Chair: Dr Emily McGrath
Consultant Dermatologist- Royal Devon and Exeter NHS Foundation Trust

Attendees:

PCA	Beth Kingshott	PCA SSG Support Manager
NGCCG	Bev parker	Head of Planned Commissioning
RDEFT	Chris Bower	Consultant Dermatologist
RDEFT	Claire Murray	Consultant Histopathologist
GP	Duncan Mckenzie	GP
RDEFT	Emily McGrath	Consultant Dermatologist
UHP	Jill Daniels	Clinical Nurse Specialist
PCA	John Renninson	PCA Clinical Director
NDHT	Laura Beer	Clinical Nurse Specialist
UHP	Melody Frankland	Developmental Nurse Specialist
TSDFT	Mihaela Costache	Consultant Dermatologist
RDEFT	Rebecca Batchelor	Consultant Dermatologist
RCHT	Samantha Hann	Consultant Dermatologist
UHP	Toby Nelson	Consultant Dermatologist

Apologies

PCA	Amy Noonan	Project Manager
TAUNTON	Clare Barlow	
PCA	Jonathan Miller	Network Manager
RDEFT	Kate Scatchard	Oncologist
RCHT	Magdalena Ionesou	Surgeon
NDHT	Vicky Ford	Oncologist

Draft Notes

Reference	Notes
1.0	**Welcome and Introductions**
2.0	**Stage 1A Malignant Melanoma Follow Up – Toby Nelson**
2.1	Currently stage 1a melanoma is followed up every three months for a year. Historically this has been for educational purposes i.e. for checking lymph nodes.
2.2	No recent guidance has been produced, and the current BAD Guidelines are very outdated.
2.3	TN explained that AJJCC classification of stage 1a melanoma has a 1% mortality rate in 5 years and a 2% mortality rate in 10 years.
2.4	The group discussed how these patients could be managed differently across the peninsula.
2.5	All patients are offered a Health and Wellbeing following their diagnosis where education can be delivered.
2.6	JR explained that the SSG can agree a form of words as a team and use this as an opportunity for PIFU whereby the patient is given the right information, and re access to the team should they have concerns. A safe way to manage these patients could be agreed and incorporated into the SSG guidelines in lieu of updated national guidelines.
2.6.1	ACTION: TN to send JR a written summary of the above, which JR can take to the medical directors for approval.
2.7	Following a recent presentation from TN regarding low risk cSCC's the SSG would like to consider reducing the number of FU's for these patients in order to effectively use their resources.
2.8.1	ACTION: CNS teams to ensure that they are confident that they can provide a similar level of education for SCC. BK to email each lead CNS.

2.8.2	UHP were due to start educational sessions for patients but due to lockdown this was paused. The team are offering a 2 year re access via the CNS team. During Covid the CNS teams have continued with FU appointments via telephone and signposted to the BAD website which has been working well.
3.0	**Service/ Trust Updates**
3.1	RCHT • Continuing with F2F 2ww clinics and restarted all skin cancer surgical work including low risk BCC and high risk facial work. • MOHs has picked up again. • FU is still remote unless there is concern, in which case the consultation will be converted to F2F.
3.2	NDHT • 2ww continuing as normal and the team are trying to triage with photographs where possible. • More Surgery is beginning and the numbers of patients on MDT is increasing.
3.3	UHP • Similarly to other centres, 2ww have remained. • Teams have been doing telephone FU and bringing the patient where there is concern. • The team is beginning to look at reopening surveillance work but due to social distancing there is less availability in clinics.
3.4	TSDFT • 2ww have continued to be seen F2F and surgery has also continued.

	• 2ww are seen F2F
3.5	EM confirmed with each centre that covid tests are available to patients prior to facial surgery. Torbay do not have access to this but have access to FFP3 marks for surgical procedures.
3.6	<u>Exeter</u> • 2ww referral numbers are back to how they were prior to lockdown. • 2ww patients are being offered F2F appointments, but where they choose not to come to F2f appointments, photos are being emailed where possible. • Surgery is back to where it was prior to lockdown in terms of activity. • MDTs are almost up to the level it was prior to lockdown • Nurses are beginning to see more patients F2f for Fu but capacity issues remain due to social distancing measures, with only 25% of patients able to have F2F appointments. • RT and Immunotherapy is running as normal. • TVEC and ECT have reopened in Exeter.
3.7	Cornwall thanked Exeter and Plymouth for their help whilst MOHs was unavailable at their trust.
3.7.1	The trusts and the alliance is considering the use of a single list of patients for MOHs surgery in order to offer this to patients at whichever centre can perform it sooner.
3.7.2	MOH consultants have agreed this in principle at Exeter but are unsure of how to proceed.
3.7.3	ACTION: JR to send an email requesting information to each trust to understand the demand.

4.0	**Clinical Guidelines**
4.1	The group discussed the best place to host the clinical guidelines so that they would be accessed.
4.1.1	ACTION: Once guidelines agreed BK to arrange for them to be uploaded onto the formulary as well as the PCA website.
4.2	EM would like the guidelines to be shorter and to direct to other guidance which is updated more frequently.
4.3	ACTION: EM to shorten the current draft of the guidelines. BK to format and send round to each centre for feedback and final approval.
5.0	**MDT Streamlining**
5.1	Since moving the MDTs to virtual the quality of MDT discussions have improved and are more focused.
5.2	Each SSG needs to identify those cases that do not require MDT discussion as they follow a SOC pathway. These can then be listed within the guidelines.
6.0	**Dermatoscopes within GP Surgeries**
6.1	The Exeter team trialled dermatoscopes amongst the dermatology team and GPs, and the procurement process has begun for Delta 1 dermatoscopes.
6.2	BP explained that the order had been placed and GPs have been sent expressions of interest, with a GP champion to support. Along with the order, training material has also been included.
6.3	The Exeter team could provide in-house training for GPs to provide an intensive introduction to dermatoscopes with monthly updates to GPs where they can bring their own cases.
6.4	JR confirmed that this is part of the PCA work plan and they are able to support training to GPs across the peninsula.

7.0	**SCC AFTER trial of AdRT for completely excised high-risk primary cSCC**
7.1	UK Dermatology Clinical Trials Network are recruiting centres to investigate adjuvant radiotherapy in treating high-risk SCC patients in the UK.
7.2	EM explained that the Exeter Oncology department does not have capacity to be a recruiting centre for this trial but asked if another centre in the peninsula would be able to consider.
7.2.1	No Oncologists present at the meeting to discuss further. ACTION: EM to email Toby Talbot with information about the trial.
8.0	**AOB**
8.1	Next meeting due October 2020 but needs to avoid the school holidays
8.1.1	ACTION: BK to arrange the next meeting for the 22nd October via MS Teams. **END**

Summary of Actions

REFERENCE	ACTION	OWNER
2.7	TN to send JR a written summary re Stage 1a MM FU	Toby Nelson
2.8.1	CNS teams to ensure that they are confident that they can provide a similar level of education for SCC.	CNS Teams/ BK
3.7.3	JR to send an email requesting information to each trusts to understand the demand.	John Renninson
4.1.1	Once guidelines agreed BK to arrange for them to be uploaded onto the formulary as well as the PCA website.	BK
4.3	EM to shorten the current draft of the guidelines. BK to format and send round to each centre for feedback and final approval.	EM/BK
7.2.1	Email TT regarding trial	EM