GMCA GREATER MANCHESTER COMBINED AUTHORITY

NHS in Greater Manchester

Greater Manchester Cancer

Skin Pathway Board

Skin Pathway Board

Minutes and Actions

Friday 14th September 2018

2:00pm-4:00pm

Meeting Room 6, 3rd Floor, The Christie, Wilmslow Road, Withington, M20 4BX

Members present

Name	Role
John Lear (JL) – Chair	**Consultant Dermatologist, Salford Royal Foundation Trust and Clinical Director of the GM Skin Pathway Board**
Rachel Allen (RA)	Pathway Manager, GM Cancer
Agata Rembielak (AR)	Consultant Oncologists with special interest in skin malignancies, The Christie NHS Foundation Trust
Avinash Gupta (AG)	Consultant Medical Oncologist, The Christie NHS Foundation Trust
Chris Duff (CD)	Consultant Plastic, Reconstructive and Aesthetic Surgeon, Manchester University Foundation NHS Trust
Deemish Oudit (DO)	Consultant Plastic and Reconstructive Surgeon, The Christie NHS Foundation Trust
Gavin Wong (GW)	Consultant Dermatologist, Manchester University Foundation NHS Trust
Julie Collins (JC)	Skin Cancer Nurse Specialist, MFT, Chair of the Skin Cancer Nursing Forum
Loma Gardner (LG)	Consultant Dermatologist, Tameside & Glossop Integrated Care NHS Foundation Trust
Luisa Motta (LM)	Dermatopathologist, Salford Royal Foundation Trust
Lorraine Burgess (LB)	Patient Representative
Natasha Smith (NS)	Macmillan User Involvement Manager, GM Cancer
Neil Cutler (NC)	Patient Representative
Stephanie Ogden (SO)	Dermatology Consultant, Salford Royal and Stockport
Tim Kingston (TK)	Consultant Dermatologist, Manchester University Foundation NHS Trust
Wayne Maxwell (WM)	Specialty Doctor, Dermatology

Apologies

Coral Higgins (CH)	Cancer Commissioning Manager, Manchester Clinical Commissioning Group
Prof Tim Woolford (TW)	Consultant ENT Surgeon, Central Manchester Foundation Trust
Alexander Marsland (AM)	Consultant Dermatologist and Urticaria Specialist, Honorary Lecturer University of Manchester, Salford Royal Foundation Trust

David Mowatt (MW)	Consultant Plastic Surgeon, The Christie Foundation Trust
Eileen Parry (EP)	Consultant Dermatologist at Tameside Hospital NHS Foundation Trust, Manchester
Rebecca Brooke (RB)	Salford Royal Foundation Trust

1. Welcome and introductions

JL opened the Board and welcomed attendees, including AR who was dialling in.

2. Board review

Discussion summary	JL explained that the Board membership has been revised. JL expressed his apologies for how chaotic the Board has operated previously and emphasised that going forward the Board will significantly improve. JL welcomed Rachel Allen (RA), the new Pathway Manager from GM Cancer and thanked her for her hard work to date since commencing in post at the end of August. JL highlighted the new start, new group and new work programme in place to achieve the objectives set out by GM Cancer and make a difference to patients in GM. RA was invited to give the Board an overview of her background prior to her new role with the GM Cancer team. RA informed the Board of her previous role with the GM Health and Social Care Partnership (GMHSCP) in the Population Health team around prevention of ill-health. RA explained that the GMHSCP is the body which oversees the devolution of health and social care in GM and that GM Cancer is the cancer arm of the GMHSCP. RA expressed that she was excited by the challenge ahead and is looking forward to working with the Board to improve skin cancer outcomes in GM. There are several areas that the Trust boards are very keen on. The three objectives that the Board must focus on this year are: 1. Implementation of the recovery package 2. MDT reform 3. 62 day target 4. A new approach to the two week wait JL explained that the 62 day target is being met for skin cancer. There are massive numbers and at the moment, the GM system tends to meet them. Despite this, it remains a focus for the Board to maintain the position. JL described the proposed new structure of the Board and the plans to create three new subgroups, including: a recovery package subgroup; MDT reform subgroup and two week wait subgroup. JL highlighted that the three quarterly board meetings will continue on the second Friday of the month and the subgroups will sit in the interim of these. JL invited members to indicate which subgroup they would like to participate in or lead. JL highlighted that as long as the Board focused on those three areas, there is scope to develop other areas of work and innovation. Board members were encouraged to bring ideas forward. RA requested Board members to resend their preferences in terms of

	subgroups as RP did not hand this information over. JL highlighted that the first meeting of the MDT reform subgroup was scheduled for that same afternoon (Friday 14th September). JL noted that there is a lot of work that can be undertaken quickly around MDT reform.
Actions and responsibility	**a) RA to email Board members inviting them to select a subgroup to be part of** **b) Board members to respond indicating which subgroup they wish to be part of**

3. GM Cancer Plan

3.1. Delivering the recovery package / ERAS +

Discussion summary	JL provided an overview of the recovery package for the benefit of new members. AG noted that his knowledge of the recovery package was from the Transformation Fund investment paper shared in advance of the meeting. JL invited JC to broadly describe the recovery package. JC described the programme as Macmillan-led, incorporating follow-up, stratified follow-up, support, holistic needs assessments (HNAs) and health and wellbeing events. JC informed the Board of the pathway mapping event taking place on the 17th October with Lindsey Wilby (LW) which all skin cancer nurses in the region are invited to work out how HNAs and health and wellbeing clinics can be best set up. There is variation across the conurbation. The intention is for the HNAs to be transferable across Trusts. JC informed the Board that MFT began undertaking HNAs last week. Some patients feel that they don't need one yet it is something that needs to be demonstrated as being offered. NS mentioned that the mapping work which LW has been delivering has been crucial for other pathways. JL noted that at the moment the Board suspect that not all patients are being offered a HNA, the full recovery package or even any of it. For skin, there is a such a vast volume of patients. SO highlighted that the HNAs are long appointments and which go into a lot of detail and aren't available for everyone. As long as they are offered a HNA, that's the main thing. JL mentioned that the Board can outline what they feel is best for patients. GM Cancer is being a little more lenient about how the recovery package is implemented – a one size fits all approach will not work. The Board now has leeway in terms of how patients are stratified. A tiered recovery package may be appropriate and something that could be implemented. JL invited JC to lead the recovery package subgroup with the support of JL and RA given her involvement in co-ordinating the recovery package to date. JL informed the Board that GM Cancer are aware of the huge population size and the limited capacity available which means that stratifying will be important. AR questioned whether there was an opportunity to include patients with non-melanoma because those patients who have developed metastatic disease don't have any active anti-cancer treatment available for them

	because of age and co-morbidity. These patients really need support in how to live with cancer and about quality of life is important. Sometimes they are in far more difficult situations than metastatic melanoma patients because no treatment exists for them. JL clarified that the recovery package is for squamous cell carcinoma (SCC) and melanoma patients. In essence it is anything that can go through the two week wait. JL highlighted that there isn't much work that can be undertaken until the mapping exercise takes place in October. JL noted that following the October mapping event, JL, RA and JC will meet to discuss the outcome of the mapping and then the first recovery package subgroup will follow. Board members queried whether the recovery package included ERAS+ too. NS responded that they are connected and a dedicated project manager is in place to lead the work. TK spoke of his experience in Australia where patients indicated that the fear of reoccurrence is incredible and the psychology of cancer is extremely important. JL suggested that for those patients with lower stage disease more time can be focused and recurrence and less time on drugs. JL highlighted that it's an evolving process; different things are relevant for the patient at different points of the patient pathway. JL asked NC's thoughts the approach. NS highlighted that NC will be attending the mapping event. NC commented that it seemed a sensible approach. WM highlighted that skin cancer care has come a long way, no skin cancer nurses existed 20/30 years ago and patients received no support.
Actions and responsibility	**a) JC to lead recovery package subgroup** **b) JL, RA, JC to meet after the 17th October mapping event to discuss the outcome of the session** **c) RA to organise first recovery package subgroup for early November to discuss the gaps that exist, how we can do things differently particularly around a stratified follow-up**

3.2. MDT reform

Discussion summary	JL explained that the MDT reform group was scheduled for immediately after the Board meeting therefore suggested that little time was spent discussing it in the meeting. JL informed the Board of Martin Gore's work on MDT reform and the draft paper in existence. Martin Gore was tasked by NHS England to produce the MDT reform document. Martin has spent 18 months socialising the paper. JL met Martin at the British Association of Dermatologists (BAD) conference this year and Martin commented that the most receptive audience to the approach has been in skin. The idea is not about stripping away MDTs or reducing time but about using the time as efficiently as possible for those patients that need the discussion. The idea would be to look at MDTs and see if we can improve them. JL suggested that the two documents that would be helpful to the Board are Martin Gore's paper and the consultation exercise that the BAD undertook which is in draft. JL proposes to look at the BAD paper and consider how we wish to reform MDTs in GM. JL clarified

	that the Board does not need to wait for national guidance as long as it is audited and is safe. JL highlighted that the Skin Pathway Board could be one of the first areas in the country to innovate in this area. JL invited delegates to stay behind for the MDT reform meeting. LM suggested that Lynne Jamieson (LJ) would be a helpful addition to the subgroup. LJ has many innovative ideas to improve the approach to MDTs.
Conclusion	
Actions and responsibility	**a) RA to include LJ in the MDT reform subgroup**

3.3. Two week wait / 62 day reform

Discussion summary	JL informed the group that a subgroup for the two week wait/62 day reform was scheduled for Friday 7th September but was cancelled due to low attendance although subsequently individuals have complained to JL that they could have attended the meeting. RP advised to cancel. JL discussed the intended approach to this work. JL explained that dermascopic imaging is progressing in many parts of the world and in the UK and was showcased at the World Congress of Dermoscopy. JL spoke of a proposed pilot to trial looking at existing two week wait referrals, seeing the patients as normal but run a trial in parallel with a photograph and dermascopic image. JL suggested looking at those independently and exploring how consultants would action them based on the image alone, and compare to what was actioned in reality. JL proposed to explore how this would work for the GM conurbation. What works in other areas may not work for GM. JL highlighted that he would like the two week wait subgroup to explore running a trial of that nature. The specifics can be discussed going forward. JL highlighted that it would require dedicated project management support so would look to identify explicit funding for the project and dermatoscopes for the practices that do not have them currently. DO queried the prevalence of dermascopy in GP practices. JL explained that it didn't really matter, as long as GPs can take a picture of the lesion and take a dermascopic image and send alongside the two week referral. There are many ways to build on that such as AI. WM expressed his interest in this area. GP practices see many benign lesions. There is a need to seek out the patients that can stay in primary care which will lower the two week wait cohort. JL highlighted that the intention would be to include 600-1,000 patients in the trial. WM described how dermatoscopes can be attached to iPhones with ease and images sent securely from the GP practice to the Trust. SO highlighted that all Stockport GPs have dermatoscopes in their practices already. SO spoke of another trial underway in Stockport with MDSAS where images are never stored, an established network within the NHS is already in place. A QR code is scanned initially, then the image is taken, so the images are never stored on the phone. The system allows the GP to write a blurb as required. JL asked whether the Board were supportive of the general idea. JL spoke of the potential for publications.

	LM spoke of the broad ambitions of Theme 3. Workforce is an issue. The need to look at technology such as AI to improve resources is the way forward. JL mentioned potential approaches to follow-up that could develop on the back of these e.g. standard follow-ups versus MEDOPAD follow-ups. There is a lot of exciting opportunities to come of this and MEDOPAD seem to want to help us secure funding. SO commented on the audit of incidental findings on the full skin check and it was 30% of patients so quite high. SO noted that they weren't all malignant. CD noted that if the index lesion could be excluded as an area of concern then the patient can go into routine dermatology as opposed to using up space on the two week wait pathway. Often there is something more important than the symptom the patient is referred with (SO). JL highlighted that in some two week wait services, consultants do not examine the rest of the patient's skin due to time constraints. JL need to future proof our service; reducing referrals by 30% would present a massive benefit. CD highlighted that the Board need to consider what they are prepared to have as the false negative rate. GW commented that in general it is a great concept. JL informed the Board that conversations are underway in Salford in relation to MEDOPAD. There may be funding to recruit a dedicated project manager for this pilot. RA can support in areas but we will need dedicated statistical analysis and co-ordination across all eight sites as it will be a large project. Undertaking the pilot across multiple sites will be much more powerful than a single Trust. JL commented that funding is being sought for a project manager and dermatoscopes across multiple localities. JL explained that originally the funding source may have been JDE but that hasn't been successful so JL is meeting with John Derwellin soon at Salford. Stockport CCG funded all of Stockport's dermatoscopes. JL commented that he is meeting with Coral Higgins (CH) and the GP cancer leads soon so there is potential to discuss funding with them. LM highlighted that the proposal and technology is market ready so would be compliant with InnovateUK. JL spoke of the potential for developing our own AI in GM. MEDOPAD have great links with China who are interested in pushing the boundaries. The work that is underway in other countries such as Australia may not be relevant to the GM population. JL suggested the need to meet to get the project moving before funding is secured, rather than waiting. RA agreed to help support, capacity allowing. AG suggested the need for GP representation on the subgroup. JL highlighted that WM is a former GP (now dermatologist) and that the Board has struggled to identify a GP rep with capacity to join the Board on a Friday afternoon. JL suggested that a GP representative could join the subgroup, as opposed to the full Board which takes place on a Friday afternoon. JL requested all Board members to consider GP colleagues who may wish to join the Board, preferably with a handle on commissioning.

	JL informed the Board that RA and JL are planning to meet with CH, Denis Colligan (DC) and Sarah Taylor (ST) in October, two of the GP cancer leads. RA noted that CH has sent apologies for the December Board but is hoping to attend future Board meetings. AR queried whether the GP should be a dermatology specialist. AG commented that a GP without a specialist dermatology background would be good because if they have a specialist interest in this area, they will already be engaged. SO commented that she may have colleagues who would be interested. JL we are keen to identify somebody with ideas who can influence and help us.
Actions and responsibility	**a) JL to continue to explore funding opportunities for project management support to support the pilot** **b) RA to organise subgroup meeting without delay** **c) All Board members to consider GP colleagues who may wish to join the Board, preferably with an interest in commissioning. Board members to share contact details with JL/RA who will make contact and invite to the Board**

3.4. Transformation Fund update

Discussion summary	RA updated the Board on Transformation Funds. RA informed the Board that in 2016 £6 billion was devolved to GM as health and social care spend, with an additional £450 million health and social care transformation fund. Of this, £10 million has been assigned to GM Cancer. RA explained that the paper shared in advance of the meeting describes the priority one projects that will be funded through the £10m, including: • Accelerated pathways for lung, prostate and colorectal • CURE smoking programme in secondary care • ERAS+ and recovery package / stratified follow-up • I-Can shared decision making JL asked RA to explain more about ERAS+. RA clarified that ERAS+ is part of the recovery package which offers cancer patients in GM a bespoke package of care to prepare them for surgery, chemotherapy and radiotherapy. RA explained that the prehabilitation project has begun with a dedicated project manager in post Zoe Merchant (ZM). NS confirmed that it is about equipping patients with the knowledge and tools to get fit and healthy prior to surgery. ERAS+ has been piloted already and is now being rolled out across GM with Transformation Funding. The clinical lead for the work is Dr John Moore. RA informed the Board that ZM and JM are intending to attend a future Skin Pathway Board to explore how the ERAS+ and recovery package can be implemented for skin cancer patients in GM. RA referenced that JL, RA, JM, ZM are planning to meet with LW in November to discuss further. JL suggested for JC to also join the discussion. RA informed the Board that the Cancer Board had agreed the allocation of the £10m and that final drafts of PIDs for each project are being worked through ready for sign of. RA is able to share the final PIDs with Board

	members once they are ratified. RA invited the Board for questions. JL highlighted that so far the Board haven't discussed prevention of skin cancer. The immediate priority would be the aforementioned objectives of the Board however prevention of skin cancer remains very important. JL invited the Board to consider ideas around prevention and perhaps identify areas of good practice in existence already that we could look to scale up. JL highlighted that we have direct access to Trust boards so if board members have ideas; they are welcome to share to take forward. DO highlighted that Rob Bristow (RB) views skin cancer research as a big priority and is encouraging research teams to get together. JL noted that he is due to meet RB soon so can discuss further. AG commented that Richard Moray is also keen to look at campaigns such as banning sunbeds. SO queried whether there was on anything on the national curriculum around skin care education. JC noted that it would be good to access school PHSE classes. JL spoke of the need to include prevention in the pathway work programme. RA spoke of plans for a GM public health campaign around skin cancer care in 2019 through the GM pharmacies so offered to explore this further. WM spoke of roadshow work in Cheshire which was well received. NS highlighted that prevention is one of the top three priorities of GM Cancer service users. DO noted that Richard Moray would be a good person to speak to around prevention. LB highlighted that patient education is important e.g. around UVA protection and Vitamin D.
Actions and responsibility	**a) RA to invite JC to November meeting with JL, RA, JM, ZM** **b) RA to explore 2019 plans for a GM public health pharmacy campaign focusing on skin cancer** **c) JL to make contact with Richard Moray to explore current work underway around prevention of skin cancer**

3.5. GM Cancer Team structure

Discussion summary	RA informed the Board of the new GM Cancer Team structure which was shared electronically in advance of the meeting. RA explained that there have been changes to the GM Cancer leadership team with Prof. Dave Shackley (DS) as Medical Director, Susi Penney (SP) as Associate Medical Director and Claire O'Rourke (COR) as Associate Director. JL commented that COR has visited the Skin Cancer Pathway Board previously. RA explained that the 19 Clinical Pathway Directors will report to SP. RA informed the Board that Alison Armstrong will commence in role soon. There are three Pathway Managers managing the 19 pathways – RA is the

	dedicated Pathway Manager for skin cancer. RA highlighted that a number of projects have dedicated project leads such as Freya Howle (FH) for the CURE programme and ZM for ERAS+/prehabilitation. RA explained that LW is the lead for the Living with and Beyond programme. ST is the GP lead. Adrian Hackney is director of cancer commissioning and CH, commissioning representative for the Skin Board belongs to Adrian's team. RA described the user involvement team structure. RA also referenced the GM Cancer analyst team which isn't listed on the team structure shared. JL highlighted that the Board will require data analyst support so this is helpful. RA to connect with Morris Tomlinson (MT), GM Cancer Data Analyst to clarify what support is available.
Actions and responsibility	**a) RA to connect with Morris Tomlinson (MT), GM Cancer Data Analyst to clarify what support is available from the data team**

4. GM Cancer Skin Board Educational Meeting – 22nd November 2018

Discussion summary	JL explained that a couple of education meetings have been delivered previously over the years. JL confirmed that the 22nd November is confirmed. RA clarified that RP did not hand anything over in relation to the GM Cancer Skin Board Educational Meeting prior to her leaving. JL explained that in the past, a three hour meeting has been arranged. Refreshments have been offered previously and it has been broken down into a local MDT hour; specialist MDT hour and then GM Cancer hour. We've had different speakers in different sections of the event. Rebecca Brooke (RB) tends to organise the speakers for the first hour (the local MDT section). RB is the lead for local MDT at Salford. The specialist MDT hour is led by Nick Telfer (NT), a dermatologist from Salford. JL organises the last hour – the GM Cancer section. JL highlighted the need to identify speakers for the event. For the GM Cancer section, JL asked whether AG would like to present on latest advances in melanoma. AG highlighted that the event clashes with an NCRI meeting in London. RA questioned the audience for the event. JL clarified that it is for professionals. Previously the event has been shared with Board members for them to cascade. There is a big distribution list for the local MDT and specialised MDT distribution lists which combined with the GM Cancer distribution list gives a broad coverage of approximately 150 individuals. JL advised to continue with this approach for now. For next year (2019), the Board could look at cascading the invitation more widely e.g. covering GPs. Board members confirmed that a room at Salford had been booked. RA to clarify. JL Board members for their suggestions for other presentations as part of

	the GM Cancer section. DO suggested a presentation on giant basal cell carcinomas (BCCs). It was also suggested to cover the recovery package. It was suggested that LW may be able to talk. LW could tailor her talk to the mapping event on the 17th November and explain what is involved in a HNA. DO confirmed that he can speak on the 22nd November. A presentation on the MSLT-II trial was suggested with Paul Lorigan (PL) or David Mowatt (DM) suggested as a potential speaker. There was a suggestion for adjuvant treatments to be covered under the specialist MDT hour. Specialist registrars should be invited. RA clarified whether refreshments should be included. JL noted that drinks and a light snack would be good. JL clarified that a room should be booked already for 2-5pm with lunch a 1pm. LB queried patient involvement in the event. JL explained that patients have presented previously for 30 minutes and encouraged NC and LB to be involved as much as they would like to. TK noted that in future it may be good to have a psychologist speaking about fear of cancer. JL invited LB to share a presentation with LW to talk about the patient experience. LW could talk about the recovery package and LB could talk about her experience of cancer. LW could support in a joint presentation.
Conclusion	Speakers agreed as follows: • **First hour:** RB to organise • **Second hour: specialist MDT –** to be discussed with NT • **Third hour: GM Cancer –** DO presenting on giant basal cell carcinomas (BCCs) (20 mins); potentially LW on the recovery package with particular reference to skin cancer. LB to join this presentation sharing her experiences from a patient perspective (20-30 mins); and the MSLT-II trial with PL or DM (10-20 mins).
Actions and responsibility	**a) RA to clarify that a room has been booked at Salford for the education event** **b) RA to clarify arrangements with Board members** **c) RA to invite LW to present at the education event under the GM Cancer section (the 3rd hour)** **d) RA to share the event invitation out again to all Board members for them to cascade** **e) RA to contact speakers in relation to the GM Cancer** **f) RA to contact RB to inform her of the Board discussion and agreed actions** **g) JL/RA to discuss specialist MDT presentation with NT**

5. Nursing Forum

Discussion summary	JC informed the Board of recent meetings including a recent presentation on radiography and a presentation by Changing Faces covering scar tissue.

	The November meeting has been cancelled as it clashes with the British Association of Skin Cancer Nurses in Birmingham. The meeting takes place on the 5th Thursday of the month – whenever there are five Thursdays in the month, the next one being January. A speaker is still to be confirmed for the January meeting. JL highlighted that Board members are happy to help if necessary. JC referenced that much of the agenda is spent on the recovery package.
Conclusion	
Actions and responsibility	**a) JC to contact Board members to seek potential speakers for the January Nursing Forum meeting**

6. Macmillan User Involvement Team update

Discussion summary	NS referenced that she has been out of office for the past few weeks and has recently returned to work therefore there is no update. NS introduced LB as the new patient representative and highlighted that it was her first board meeting.
Actions and responsibility	**No actions.**

7. Cancer Board update – 2nd November 2018

Discussion summary	JL informed the Board that he will be presenting to Cancer Board on the 2nd November which will be the first opportunity to showcase the pathway. JL highlighted that it would be an opportunity to secure the Cancer Board's help in the work programme and with any specific issues. JL noted that the intention is to cover the Board's priorities for the next 12 months and what the main issues are that the Board is facing. JL invited Board members to contribute suggested items to cover at the Board such as in skin cancer and pathology, particularly around any big issues that we face in GM as a Pathway Board. JL advised members to contact RA with any suggested points to cover. RA referenced that standard agenda items are 10-20 minutes.
Actions and responsibility	**a) Board members to contact RA by 12th October with any suggested areas to present to Cancer Board on 2nd November**

8. Upcoming events: GM Cancer Conference – 26th November 2018

Discussion summary	RA informed the Board of the upcoming GM Cancer Conference on Monday 26th November at the Emirates Old Trafford stadium. RA explained that the event is an opportunity to showcase the work of the Board. There is room for the Board to have a stand or poster presentation to showcase work to date, raise the profile of skin cancer, inform delegates of the skin cancer prevalence in GM, share the priority workstreams. This would be similar coverage to what is presented at Cancer Board but will be shared in a much more succinct fashion. The stand does not need to be manned. RA highlighted that the Board's ideas and suggestions of what to

	include would be useful. All 19 clinical pathways will be invited to showcase. The audience will be professionals. Andy Burnham is confirmed to speak and potentially Chris Boardman too. There are 300 spaces for delegates although places are being booked fast. RA will share the event invitation to all Board members. 30 patients will be involved. JL invited Board members for their thoughts and suggested that a poster presentation would be a good idea. JL suggested the following: • Skin cancer prevalence • Risk factors • Visual summaries of prevalence e.g. graphs • Research (melanoma and non-melanoma skin cancer) RA to find out how much space is available. RA explained that DS is keen for all pathways to be represented. JL clarified that it's all day and free and would be a great opportunity to network. RA noted that it is being run by the School of Oncology at The Christie, not the GM Cancer Team. JL encouraged the Board to contact RA with suggestions around potential coverage for the poster. JL asked DO and AG to produce a short summary of current practice around melanoma research from the basic science. JL asked RA to format the content from Board members into a poster. LM advised that local skin cancer statistics should be available from the GM Cancer analyst team. JL suggested information from commissioners on referral rates would be a good idea. There was a suggestion for TK to share year on year progression data. JL suggested a paragraph on the structure of MDTs and how the service is run. JL suggested a section on prevention work underway. SO explained the Stockport work underway is rashes and lesions. LB queried whether there was any data around age. LB commented that she is seeing a bigger increase in older people with skin cancer. JL indicated that this information would be available. DO highlight the connection with dementia. LB informed the Board that she is a dementia nurse at The Christie. It was noted that DO has demographic data that may be helpful. AG referenced The Christie clinical outcomes team that look at trends and have produced a helpful factsheet. AG to share with RA. LM commented on the newsletter that she receives from the GM Cancer analysts which
Conclusion	Agreed content for the poster includes: • **Research** • **General skin cancer statistics in GM**

	• **Risk factors** • **Referral rates from commissioners** • **A paragraph on the structure of MDTs and how the service is run** • **A section on the prevention work underway and the work programmes** It would be good to showcase the clinical problem, the research and the pathway board and what we are trying to achieve.
Actions and responsibility	**a) RA to share the GM Cancer Conference event invitation with all Board members** **b) RA to clarify how much space is available and that JL is registered** **c) Board members to contact RA with suggestions around potential coverage for the poster** **d) DO and AG to produce a short summary of current practice around melanoma research from the basic science** **e) RA to format the content from Board members into a poster** **f) RA to contact the data analyst team for general skin cancer prevalence data/trends in GM** **g) TK to share the year on year progression data with a short paragraph to explain what it means** **h) RA to contact GM commissioners for data on referral rates** **i) DO to share the demographic data/visual representation in existence around skin cancer prevalence and age** **j) AG to share The Christie clinical outcomes team factsheet with RA** **k) LM to share a copy of the newsletter that she receives from GM Cancer analysts with RA (for info)**

9. AOB

Discussion summary	RA asked all members to sign the sign in sheet. CD current direction of travel is getting it right first time. Ken Dunn (KD) is the national lead for surgery in terms of getting it right first time so we will have local extra knowledge and experience to bring to the table over time but there is an impetus for exactly what we have been talking about. Two week wait clinics are one example of this, not delaying patients who quite clearly will need proper surgical input. This will require negotiation at the highest level between dermatology and plastic surgery. CD informed that Board that this work is currently starting and may have implications for GM. Its intention is to provide help to get us to the patient to the right person as quickly as possible. This is across the board. It started in hip replacement. KD was appointed in May but effectively has only just started. JL suggested that KD is invited to the next Board. RA to invite him. LM spoke of work around pathology services for GM. The focus so far has been around consolidation due to financial reasons. There are several projects underway around technology including laboratory information management systems in order to be able to share all results across GM with ease. The digital pathology work underway to enable specialists and new ways of organising the work in GM is essentially about getting it right first time. Change presents numerous barriers and natural resistance so it is very important that for dermatology and plastic surgery there is an emphasis that

	getting it right first time is translated into diagnostics, radiology and histopathology. LM explained that there is significant work underway in GM to improve the digital network in the health service. Storing of large files/images is a problem. Discussion ensued on the benefits of technology of dermascopy and image quality were discussed. LG queried the Board's approach to HNAs. JL explained that the Board spent some time discussing the proposed approach at the start of the meeting. The mapping exercise is planned for the 17th October, this will from that a gap analysis can be undertaken. On the basis of this a recovery package subgroup will be formed to look at how the recovery package can be stratified. There is no way it can be implemented in all patients and may not be a good idea for all patients to have a HNA. JL invited AG to present an update at the next Board on work underway around the rationalisation of surveillance and follow-up. JL commented that the Board were looking at a project around insitu melanoma where patients would all be discharged with a care package and then perhaps an app-based approach for intermediate patients. JL advised AG to link with CD to explore further. WM also expressed his interest in joining the conversation. DO spoke about the melanoma database in existence and the data being collected which could be used for stratifying follow-up. Funding has been secured for a post to input further data for the next 6 months to develop a further comprehensive database to share numbers. Ethical approval is being sought. DO highlighted that statistical support is a stumbling block at the moment. JL suggested that the GM Cancer analyst team may be able to help given its links to stratified follow up looking at where patients are and what the follow-up options may be. RA to explore with GM Cancer analysts. DO confirmed that he is happy for the database to be listed as an area of work underway within the Pathway Board.
Actions and responsibility	**a) RA to invite KD to the next Pathway Board in December** **b) AG to present an update at the next Board on work underway around the rationalisation of surveillance and follow-up** **c) AG to link with CD to explore surveillance and follow-up further. WM to also join** **d) RA to explore whether GM Cancer analyst team can help with statistical analysis of melanoma database which could be used for stratified follow-up**

10. Date and time of next meeting

RA highlighted that the November meeting has been cancelled. An email has been communicated to all members. RA is unable to physically cancel the calendar invite as has no access to RP's account.

The next meeting is scheduled for Friday 14th December 2pm. All meetings for the next 12 months have been shared. RA asked for anybody who hasn't received the invitations to get in touch with RA directly.