Scotland Against Cancer
Conference 2012
Surgeons’ Hall, Edinburgh
Monday 30th April 2012

Conference Report

Together we will beat cancer
Conference Report

The 2012 Scotland Against Cancer conference, held in Edinburgh on 30 April, attracted 180 delegates from across the cancer community in Scotland for a day of lively discussion and debate.

Scotland Against Cancer affords delegates the opportunity to hear from others working in cancer prevention, treatment, care and research, but crucially, to feed in their own experience and expertise through the discussion groups.

We are particularly grateful to Malcolm Chisholm MSP and Nanette Milne MSP, Co-conveners of the Cross Party Group on Cancer in the Scottish Parliament, for chairing the day, and encouraging wide ranging debate on a number of issues. We are also grateful to other Scottish Parliamentarians, speakers and cancer charity representatives who supported the conference.

Recommendations from Scotland Against Cancer play an important part in influencing discussion on cancer policy in the Scottish Parliament. A number of recommendations were made which we hope the Cross Party Group on Cancer in the Scottish Parliament will take forward over the next session.

The conference was organised by Cancer Research UK. We are grateful to the Scottish Cancer Industry Group of the ABPI, Novartis Oncology, Janssen and Genomic Health for their generous sponsorship of the event.

Sarah Woolnough
Director of Policy
Cancer Research UK
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Key recommendations and insights

The key issues to emerge from this year’s conference related to evidence – the need for evidence to prove that certain treatments, procedures or models of care are effective, efficient and produce good outcomes. In a time of tight budgets and challenging demographics, it was felt to be even more vital that funds are spend in the most appropriate way.

From the Cabinet Secretary’s discussion of the importance of the NHS Quality Strategy in setting a strategic vision for a person centred, safe and effective health service, to Professor Cameron’s consideration of the importance of research in demonstrating how best to improve outcomes, to the various discussion regarding informed consent in screening, access to cancer treatment, or proposed changes to follow-up and care after treatment, the focus was firmly on balancing cost effective with improving outcomes.

Through the discussion groups, the conference identified some key recommendations for consideration by the Cross Party Group on Cancer, and for submission to Ministers.

Cancer screening
• The importance of clear information to aid informed consent.
• The need to better engage GPs in screening.
• The need to better understand the relationship between screening and symptom awareness.
• The need to invest more in developing screening techniques for hard to detect cancers.

New approaches to prevention
• Addressing issues in communicating prevention messages – the challenge of explaining the concept of risk to people in a meaningful way; the need to challenge misinformation about lifestyle factors and cancer risk; and the need to frame messages in a more positive manner.
• Prevention messages were often negative and more could be done to highlight the benefits of a healthier lifestyle to people, both in terms of cancer prevention, but also general wellbeing.
• The NHS could better mainstream prevention, using every healthcare contact as an opportunity to discuss lifestyle changes - cancer screening is an important opportunity for this.
• Action on obesity offered a real opportunity to reduce the risk of large numbers of people in Scotland, and would benefit from more attention.

Providing world class treatment
• SMC declines more cancer drugs than it approves – we need to understand and address this.
• The need for a debate about how we assess value.
• The challenge of stratified medicines for diagnostic services and measures of clinical effectiveness.
• The importance of evaluating surgical outcomes and the potential impact on models of service delivery.
Delivering patient centred care
• Lessons should be learned from the Edinburgh decision support study – recording consultations was viewed very positively.
• There is a need for more and better ‘soft’ research.
• Time management is often a key barrier to quality care.
• Answer is straightforward – respect and good communication.

Balancing benefit and cost
• Look more closely at disinvestment – there are some routinely used treatments of processes which haven’t been assessed for clinical and cost effectiveness.
• Need to systematically and swiftly adopt evidence into practice – UK good at innovation, less good at adoption).
• Savings must be appropriate and not compromise patient care (especially in light of increased incidence).
• The need to look more broadly at societal benefit (and ensure this is taken into account in the development of Value Based Pricing).

Detect cancer early
• The complex interplay between prevention and early detection – does health promotion (e.g. advice on smoking cessation) put people off going to their GP with a symptom?
• The need for more positive messaging around treatment and outcomes to combat fear.
• The need to learn within practices e.g. patterns of patients returning with same symptoms (this could particularly help with rarer cancers or those with vague symptoms).
• Endoscopy capacity is a major limiting factor.

Transforming care after treatment
• The need for better support for workplaces for return to work.
• Moving to a more self management/ enablement requires a fast route back in for support and professional care.
• Risk stratified follow up is ideal, but there is clinical resistance to change, and some public concerns about it being a cost cutting exercise.
• Holistic needs assessment would help to stratify follow-up.

Where next for cancer research?
• The need for access to latest medicines so they can provide standard care to encourage new drug research to be located in Scotland.
• The need to improve communication about benefits of clinical trials.
• Research needs to be better ingrained within the NHS.
• The administrative burden often prevents clinicians getting involved in research.
Introduction

Malcolm Chisholm MSP
Co-convener, Cross Party Group on Cancer in the Scottish Parliament

Malcolm Chisholm MSP introduced the Scotland Against Cancer Conference and welcomed all delegates, noting the large attendance and variety of delegates, including researchers, clinicians, patients, pharmaceutical companies and politicians. Mr Chisholm thanked the conference sponsors, without whom it would not be possible to hold the conference, and the steering group members for putting together a full and interesting programme. Mr Chisholm also thanked Cancer Research UK for planning the conference and providing the secretariat for the Cross Party Group on Cancer, and invited anyone interested in joining the group to contact the secretariat. Mr Chisholm thanked delegates for their willingness to participate in the conference and wished them a productive day.

Health Secretary Address and Questions

Nicola Sturgeon MSP
Deputy First Minister and Cabinet Secretary for Health, Wellbeing & Cities Strategy

Ms Sturgeon opened by thanking the Cross Party Group and Cancer Research UK for the invitation to update the conference on the various strands of work being undertaken by the Scottish Government. She assured delegates that the report from the conference would be considered by Government, and has an impact on future policy.

She stated that she believed that a great deal has been achieved, but there is still much to do. Ms Sturgeon went on to discuss the NHS Quality Strategy, which sets out a strategic vision for the delivery of health services in Scotland. The strategy has three quality ambitions: to deliver care that is person centred, safe and effective. She noted the financial and demographic challenges which mean that demand for healthcare, and the circumstances in which it will be operating, will be radically different from the past decade. Ms Sturgeon thanked those working in the health service for their effort and dedication and underlined the need to treat staff with respect and to understand that job satisfaction and wellness are key to improving patient experience and outcomes. Ms Sturgeon outlined the meaning of the quality strategy’s ambitions for cancer: that people must feel that their cancer experience is about them; that they have the opportunity to be active partners in their care; that their needs, wishes and values are respected at every stage of the journey; and that they are assured that the care and treatment offered to them is safe and effective so it will achieve the best possible outcome.

Ms Sturgeon moved on to talk about cancer prevention and acknowledged that while the evidence on the link between smoking and lung cancer was well known, there is now a growing body of evidence that suggests that many other cancers are linked to lifestyle choices, and that this should encourage government to act – including in relation to diet, physical activity, sun awareness and alcohol consumption. She highlighted a ‘small steps’ approach, where supporting people to make healthily choices and relatively small changes to their lifestyle will help them to see great benefits to their health and wellbeing and do a great deal to cut their risk of developing cancer. Ms Sturgeon outlined recent achievements in tobacco control, sunbed legislation and action on alcohol. However, she stated that recent statistics on skin cancer – a 62% increase over the past ten years – should serve as a “wake-up call” that more needs to be done.

Turning to early diagnosis, the Cabinet Secretary outlined the work of the Detect Cancer Early initiative, which is now a central part of the cancer strategy. She noted that cancer is being detected and treated successfully thanks to improvements in treatment, staff and equipment and that cancer waiting times have been met and sustained, but that Scotland continues to lag behind other parts of Europe for cancer survival rates. She stated that by diagnosing cancer earlier patients can be treated when their general health is better and when less aggressive treatment might be required, improving survival and patient outcomes. Ms Sturgeon outlined the focus of the social marketing campaign to reduce the pessimism that still exists around a cancer diagnosis, to improve public awareness of improving survival rates and to maximise the potential for the success of the symptom awareness
campaigns to follow. The campaign is also using an extensive fieldwork component specifically to target those communities where advanced stage disease at presentation is more common and where information about the balance of risk and advantages of cancer screening needs to be provided much more widely and more strongly. In that way the potential of the campaign to widen the gap in cancer survival across the socio-economic gradient will hopefully be minimised.

She acknowledged that the social marketing campaign is only one part of the initiative and that the contribution of primary care professionals in the prompt referral of people with suspicious signs and symptoms is crucial, as well as the need to address the capacity of our screening and diagnostic services, and the importance of accurate data gathering to underpin the entire programme.

Turning to treatment, Ms Sturgeon noted that as part of its workplan the Scottish Cancer Taskforce is driving forward surgical oncology improvement work, and stated that enhanced recovery pathways, based on solid evidence, have been transforming cancer care pathways right across the NHS. They use less invasive surgical techniques, smarter anaesthetics, and targeted new nutritional interventions so patients can get better sooner, have a reduced length of stay, fewer complications and reduced readmissions rates. She noted a significant amount of success in colorectal and short stay breast surgery, and the next steps are to provide national support to share and build on that progress within other specialities as well.

Ms Sturgeon stated that radiotherapy is a very important modality for treating cancer but one that doesn’t always get the recognition it deserves, and that teams across Scotland are working together to ensure an equitable service for all those who could benefit from these treatments, and to introduce new more targeted techniques to improve efficacy and improve outcomes.

On access to medicines, the Cabinet Secretary acknowledged that the topic is of great interest and of ongoing discussion in the wider public. She stated that she believes progress has been made, but that we should always be looking at how to further improve the process for accessing new sophisticated medicines as they come on-stream. She stated that the SMC and HIS both have arrangements in place for assessing new medicines which are widely regarded as being robust, transparent and responsive, and that these arrangements work completely independently of government, which she believes is appropriate on an issue as important and sensitive as this.

In terms of measuring progress, Ms Sturgeon outlined the work on developing quality performance indicators, which are proxy measures for quality. She noted the involvement of clinicians, third sector and patient representatives in their development. To support implementation a CMO letter has been issued to boards to help them to prioritise improvements.

Ms Sturgeon highlighted the Transforming Care After Treatment programme, which is in the early stages of development, and is a partnership between the Scottish Government and Macmillan Cancer Support. It is designed to support recovery of function and confidence following anti-cancer treatment, reduce the need for hospital-based follow-up and empower patients to self-manage. She welcomed support form Macmillan in funding this work.

The Cabinet Secretary closed by stating that she hoped delegates would enjoy the conference and that she looked forward to hearing the outcomes. She noted her commitment to continuing to work in partnership with all of those involved in Better Cancer Care.
Questions

Questions were raised on a range of issues, including:

- The need for greater emphasis on skin cancers – The Cabinet Secretary welcomed suggestions for new approaches as there are particular challenges in skin cancer incidence and around getting the message across about sun awareness.

- The recent trial of consultation recording in Edinburgh to aid informed decision making – Ms Sturgeon agreed that this had been a very encouraging innovation and one she thought may be rolled out across the country in future.

- Access to the prostate cancer drug Abiraterone – Ms Sturgeon stated that she had received a lot of correspondence about this, but that she believes that it is right that politicians don’t make these decisions based on who was making the most emotive case at any one time or who was being most vocal towards a particular drug and that there is a robust and independent procedure in place. She noted that SMC will look at resubmissions on any treatment. She also noted that IPTRs are available to patients in some cases. She stated that the Government is not minded to introduce a cancer drugs fund as it distorts treatment priorities within cancer, and creates inequity in terms of other conditions.

- Plans to extend the Detect Cancer Early initiative across other cancer types – Ms Sturgeon explained that the initial three cancer types were chosen based on incidence levels. She stated that it is in the early stages, and lessons will be learned for how to apply it to other cancers in future, but that the generic messaging will also be helpful for all cancers.

Malcolm Chisholm thanked the Cabinet Secretary for addressing the conference and introduced Professor David Cameron, Professor of Oncology at Edinburgh University and Director of Cancer Services at NHS Lothian.

Keynote Address

Professor David Cameron
Professor of Oncology at Edinburgh University and Director of Cancer Services at NHS Lothian

Professor Cameron opened by stating that he hoped to convince delegates that we should be doing more research into cancer, not just in the lab, but to underpin the evidence of how treatment and care is delivered to patients. Setting the scene, Professor Cameron referred to improving survival rates, but also increasing incidence, and that Scotland does still lag behind other countries in terms of outcomes. He noted the importance of all different healthcare professionals in supporting early diagnosis and successful treatment of cancer. He acknowledged that most clinical trials are of drugs, although surgery and radiotherapy make a larger contribution to the number of cancers cured, which is an anomaly. He outlined the various phases of clinical trials for new therapies, and noted that for new surgical techniques there is not an approval process and that is perhaps why there are fewer surgical trials - a surgeon can introduce a new technique without having to prove its efficacy to a regulatory authority. Professor Cameron noted the continued high public and political profile of health economic appraisal of drugs through SMC. Professor Cameron stated that we should only fund and prescribe evidence based medicine, including drugs, surgery, radiotherapy, and utilise evidence based clinical structures.

In examining the benefits which research brings to the NHS, Professor Cameron noted that it not only delivers the evidence case for future treatments, but that there is good evidence that the overall healthcare delivery model has improved by doing research. It’s not just about the individual patient who chooses to go into a trial, who then happens to get the new and better treatments; but the whole service benefits from the process of research. He discussed why this might be – the need for a standardisation of treatment in all hospitals taking part in the trial, so the research can easily compare the new and existing treatments; there is also some evidence that from a staff point of view that being part of the research can improve morale and finally, there may be a placebo effect which we don’t fully understand. He outlined trial evidence which showed improved outcomes for those patients treated in hospitals undertaking research, regardless of whether the individual patient took part, and that part of this was due
to a higher standard of care, including those things not included in the trial, such as surgery, but which required to be of a high standard for the trial to take place. Professor Cameron surmised that the whole healthcare model ‘ups its game’ when it takes part in research, driving up standards so that everybody benefits. So, research is good for patients, not just at the individual level, but there is evidence of wider service benefits.

Professor Cameron noted that importance of ECMCs, which are a partnership between Cancer Research UK and healthcare funders; including the CSO in Scotland. This is a partnership to do more early phase cancer work; bringing earlier phase ideas through to the clinic to hopefully lead to more later phase trials and ultimately improve patient outcomes.

He noted the anomaly that most research focuses on drugs, but they are a small part of the cancer budget, and we have one of the lowest drug spends in Europe. Professor Cameron stated his belief that more research should be done into other areas, including changes in working practices, which are often subject to change without any evaluation of efficacy or analysis of effect. The bulk of what we spend our money on is the model of the healthcare delivery, including staffing, is much less well studied. He outlined examples including the introduction of multi disciplinary meeting involving a range of staff groups to discuss each patient’s treatment plan. It is believed to have improved healthcare, but there was no evidence that it was the right model when it was introduced. Similarly, there is a debate ongoing about who should deliver follow-up for cancer patients, but no trials to compare new methods with existing practice. He noted the challenges in undertaking this kind of research, but the irony that the most costly areas of care are often less well scrutinised. We change the model of healthcare in hospitals without any health economic evaluation; whether it’s the right thing to do or not.

Professor Cameron closed by stating that it’s the process of doing research into cancer care, not just the individual trials, which benefit patients by improving the overall service, and the challenge is if we can do that for drugs, and sometimes other interventions, we should start to do it for the model of healthcare delivery. We could achieve more by researching properly the changes we make to service delivery, and the evident huge public support to invest in research may indicate that the taxpayer may be willing to spend more on research in our healthcare services.

Questions

Questions were raised on a range of issues, including:

• The number of clinical trials undertaken in Scotland, and the impact of that on our outcomes – Professor Cameron noted that while there had been a very high rate of recruitment in Scotland previously, he didn’t think this was the case anymore, and there has been significant investment in England, although the data is slightly distorted by the fact that many of the trials that get counted are observational, rather than randomised interventional ones and it’s not clear whether Scotland has lost ground there as it has in the other areas, but we have slipped our position compared to ten years ago.

• The lack of long term research into survivors of cancer and their long term effects – Professor Cameron noted that there is research ongoing in certain areas of cancer survivorship, but noted the difficulties in this kind of research, as people move and are lost to the trial, so it’s hard to collect the data. Long term studies are also a huge investment, which may not show any return on investment for the funder, so it’s difficult to demonstrate impact. He stated that it’s an important area of research, particularly as we get more survivors, but it is one of those areas that is more challenging than it sounds.
Discussion Groups

Key points from each discussion group:

Cancer screening

- Importance of clear information to aid informed consent.
- Challenge of dealing with false positives and unnecessary treatments – do we need to talk more about the possible consequences further through the process?
- Should we treat non participation as passive non compliance or informed non consent?
- GPs currently don’t get feedback on bowel screening uptake by their patients - this would help them to support increased uptake.
- Need for a more pro-active approach by GPs e.g. get patients more engaged with their health/ offer more general health checks, particularly for men who are less used to routine screening.
- We need more consistent evidence about the benefits of screening against both the cost and the risks.
- We need to better understand the relationship between screening and symptom awareness – raised awareness or complacency?
- Do we need to invest more in developing screening techniques for hard to detect cancers such as ovarian?

New approaches to prevention

- Strong evidence base for the need for action on prevention, and for some interventions, but this needs to be put into practice.
- Prevention work doesn’t feature strongly in the Scottish Cancer Taskforce’s agenda; but there is a need for a real and tangible programme of work.
- Other areas of prevention could benefit from the experience of those working on tobacco control in counteracting industry lobbying.
- There are complex issues of fault and blame relating to lifestyle, and the challenge of talking about lifestyle changes without stigmatising individuals.
- Three key issues in communicating prevention messages – the challenge of explaining the concept of risk to people in a meaningful way; the need to challenge misinformation about lifestyle factors and cancer risk; and the need to frame messages in a more positive manner.
- Prevention messages were often negative and more could be done to highlight the benefits of a healthier lifestyle to people, both in terms of cancer prevention, but also general wellbeing.
- More use could be made of both community networks, both locally and online, to distribute prevention messages
- The NHS could better mainstream prevention, using every healthcare contact as an opportunity to discuss lifestyle changes - cancer screening is an important opportunity for this.
- People would likely be more or less susceptible to change at different life stages, and that this should be explored further in order to best target interventions.
- Key role for pharmacists in promoting good health, and the need to better integrate their work with that of GPs and other primary care health professionals.
- Action on obesity offered a real opportunity to reduce the risk of large numbers of people in Scotland, and would benefit from more attention.
Providing world class treatment
• SMC declines more cancer drugs than it approves – we need to understand and address this.
• Small populations for targeted therapies may increase risk of non approval.
• Is the QALY appropriate for end of life treatments?
• Increase SMC threshold to be equal to NICE (£30k v £50k end of life).
• What factors contribute to assessing value?
  • IPTRs - patient must be likely to benefit vs whole population so the vast majority of patients aren’t eligible – not a substitute/ equivalent of England’s cancer drugs fund – variations in processes in different jurisdictions.
• Will stratified medicine lead to better evidence of clinical effectiveness or add to the challenge with small patient populations?
• Diagnostic services are not ready for stratified medicine.
• Lack of data on treatment costs in Scotland.
• Single procurement plan for radiotherapy services has led to standardised treatments.
• Surgical outcomes are being evaluated, but resources are scarce – political will would be required to make best use of available data.
• Best outcomes possible should be aim, even if patients have to travel to receive care.

Delivering patient centred care
• Do patients want to be involved?
• Do we need to challenge the NHS ‘office hours’ work culture?
• Lessons should be learned from the Edinburgh decision support study – recording consultations was viewed very positively.
• The voluntary sector has an important role to play here.
• Information and support centres should be better integrated into the NHS.
• There is a need for more and better soft research.
• Time management is often a key barrier to quality care.
• Value of patient experience in training health care professionals.
• How do we measure success here?
• The role of the CNS is seen as vital, but hard evidence needed to demonstrate benefits and impact.
• Answer is straightforward – respect and good communication.
Discussion Groups (contd.)

Balancing benefit and cost

- There are many things which don’t cost much but would improve services.
- Look more closely at disinvestment – there are some routinely used treatments of processes which haven’t been assessed for clinical and cost effectiveness.
- Need to systematically and swiftly adopt evidence into practice – UK good at innovation, less good at adoption).
- Savings must be appropriate and not compromise patient care (especially in light of increased incidence).
- Majority of costs in NHS are staff – difficult to address.
- NICE accepted QALY not fit for purpose in some cases, as with SMC modifiers.
- Drugs have one price for all indications - cancer first used in end of life setting then used earlier/ curative – process doesn’t appreciate aspects particular to cancer.
- Targeted therapies turned some incurable diseases into conditions patients live with – adds complexity to economic models.
- Models don’t take social impact into account e.g. carers, ability to work – how do you do this?
- It’s hoped Value Based Pricing will look more broadly at societal benefit.

Detect cancer early

- Long appointment waiting times can put people off, especially if they want to see a particular GP.
- Complex interplay between prevention and early detection – does health promotion (e.g. advice on smoking cessation) put people off going to their GP with a symptom?
- More positive messaging around treatment and outcomes to combat fear.
- Need to learn within practices e.g. patterns of patients returning with same symptoms.
- Are red flag/ three strikes systems helpful for GPs?
- Lack of communication between primary and secondary care often leads to patients taking their own action.
- Need to join up IT systems.
- Endoscopy capacity is a major limiting factor.
- We should expand direct access to tests/ diagnostics.
- What criteria will be used to determine future Detect Cancer Early campaigns?
- What can the Detect Cancer Early Programme do to support diagnosis of rarer cancers?
**Transforming care after treatment**

- Better support for workplaces for return to work.
- Psychological impact – people don’t know how to treat you.
- Feelings of abandonment at the end of treatment.
- Issues with family about returning to ‘normality’ – altered normality.
- Follow up tailored to patients’ needs/disease.
- Significant groups of long term survivors do move on – lack of research in how they move forward.
- Moving to a more self management/enablement requires a fast route back in for support and professional care.
- Patient education for follow up and information and support.
- Data collection/evidence based follow-up – information prevalence, QoL, side effects etc.
- Risk stratified follow up is ideal, but there is clinical resistance to change, and some public concerns about it being a cost cutting exercise.
- Duty of care vs self management model.
- Holistic needs assessment would help to stratify follow-up.

**Where next for cancer research?**

- Patients should be involved in research design and to identify areas of unmet need.
- Findings from the EPIC study showed the benefit of patient involvement in improving recruitment.
- Need access to latest medicines so they can provide standard care to encourage new drug research to be located in Scotland.
- Patients are willing to accept certain risks for research – need to look to clinicians and ethicists for reason for risk aversion.
- Research follow-up needs to be longer term to affect clinical decisions.
- There is a gap in measures of quality of life – can inform better treatment options.
- CSO looking at training research clinicians – a better pathway is needed.
- Need to improve communication about benefits of clinical trials.
- We should recognise the altruism of patients in early phase trials.
- Research needs to be better ingrained within the NHS.
- Administrative burden often prevents clinicians getting involved in research.
Expert Panel questions and answers

The expert panel was introduced and chaired by Nanette Milne MSP and included:

**Dr Robert J Jones**  
Senior Lecturer and Hon Consultant in Medical Oncology, Beatson West of Scotland Cancer Centre

**Dr Paul Baughan**  
GP, Dollar Health Centre, Clackmannanshire and Chair, Scottish Primary Care Cancer Group

**Dr Hilary Dobson**  
Regional Cancer Lead Clinician, West of Scotland Cancer Network

**Karen Bell**  
Acting Cancer Research UK Senior Research Nurse and Acting Scottish Cancer Research Network (West) Manager

Questions were raised on a range of issues, including:

- **The potential use of aspirin in cancer prevention and treatment** — the panel noted that there are several trials ongoing in this area, and hope that speedy results might be available. However, they cautioned about potential later effects. They supported an expert group to look at the evidence.

- **Complementary therapies** — the panel agreed that there could be benefits for patients when done in conjunction with standard treatment, but felt there was a need for more research, applying the same rules of evidence as used for clinical techniques before they are recommended by clinicians. The panel noted the need to deal with the psychological impact as well as the physiological impact of cancer.

- **The impact of the financial situation on cancer treatment** — the panel agreed that we need to be cleverer about how we use the available resource, but also that there is an opportunity to rethink how things are done and challenge some existing models of care. They noted the frustration of clinicians when a treatment with better outcomes and fewer side effects comes along, but is too expensive to be made available on the NHS.

- **The importance of clinical nurse specialists and pressure for them to return to wards** — the panel agreed about the importance of CNSs but noted that there was a wide disparity in roles and that there may well be scope for streamlining people better into the role. They also agreed that while it is difficult to determine their value, it’s not impossible to develop surrogates.

- **The importance of patient and public involvement and ways in which it could be more co-ordinated** — the panel agreed that PPI is needed at the beginning of service reconfiguration, for evaluation once the service is running, and to review things when they go wrong. They were open to suggestions about whether there should be a single centralised pool created.

- **What patient centred care looks like** — the panel agreed that all aspects of a patient’s life should be considered and taken into account.

- **Information for children and young people** — the panel felt that young people should be taught about the benefits of a healthy lifestyle, and that the age profile of various cancer should be considered when thinking about what to focus on.

- **What support should be available for GPs in diagnosing cancer** — the panel felt that GPs need evidence based guidelines, good communication skills and the ability to safety net and advise patients to return with unrelenting symptoms. They also supported the need for significant event analysis.

- **The impact of targets on waiting times** — it was felt this has been positive as patients are being seen more quickly, but sometimes secondary care gives out a message that it is overstretched. They endorsed increased GP access to diagnostic tests.
• Return to work for cancer patients – the panel felt that this must be judged on the individual – some people may want to return; others may be too ill and shouldn’t feel pressurised.

• The one thing they would like to see politicians do to make a difference to cancer care – to not be seen as just a medical problem; to look at socio-economic solutions to encourage healthy lifestyles; to make sure there is an evidence base for any service changes and reconfigurations and to measure the impact of change; to ensure that recruitment to clinical trials is maintained/improved; to support a holistic approach to prevention and follow-up.

Nanette Milne closed the session and thanked the panel and those who asked questions for an interesting and lively debate.

Closing Remarks

Nanette Milne MSP
Co-convener, Cross Party Group on Cancer in the Scottish Parliament

Nanette Milne thanked the expert panel members, and all delegates for a very lively debate.

She thanked all the speakers for motivating speeches and all those who took part in, facilitated and took notes at the discussion groups, which were very worthwhile and stimulated interesting debates.

Ms Milne thanked all those involved in the organisation and support of the conference, which provides a useful forum for sharing information and co-ordinating work.

She noted that a report of the conference would go to the Cross Party Group on Cancer for discussion, and will be sent on to Government. She reiterated that the aim of the conference is to generate ideas about how to improve services for cancer patients and that in previous years there have been positive outcomes from the issues raised by delegates, and she hoped that will continue this year.

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Cancer Research UK would like to thank the following organisations for their support, without which the Scotland Against Cancer conference would not be possible. All Gold and Silver sponsors have a medical expertise and a common interest in cancer, but have not been involved in the content of this conference.

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