

# Scotland Against Cancer Conference 2010

Stirling Management Centre  
Monday 28th June 2010



## Conference Report

*Together we will beat cancer*

## Conference Report

The 2010 Scotland Against Cancer conference, held in Stirling on 28 June, attracted 140 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.

This year the theme of the conference was 'Putting Policy into Practice'; looking at how we can turn our knowledge into action, whether that's in cancer prevention, treatment or care.

We are particularly grateful to Ken Macintosh MSP and Nanette Milne MSP, Members 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 by facilitating the discussion forums.

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 would like to thank the members of the steering group: Macmillan Cancer Support, Myeloma UK and the Scottish Cancer Foundation for providing advice on the agenda, and in supporting the conference. We are grateful to the Scottish Cancer Industry Group of the ABPI and Novartis Oncology for their generous sponsorship of the event.

### **Aisling Burnand**

*Executive Director of Policy and Public Affairs  
Cancer Research UK*

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## Key recommendations and insights

### Two phrases featured strongly at this year's conference – 'collaboration' and 'economic climate'.

Delegates wanted to see greater collaboration across cancer services – between primary and secondary care, between the health and social care sectors, between statutory, voluntary and private sectors, and, perhaps most resoundingly, real collaboration between patients and those providing treatment, care and support services. It was felt that better collaboration could have significant benefits in delivering a more joined up service to patients, and might reduce duplication.

In addition, the conference was conscious of the impact the changing economic climate could have on cancer services, and the difficult choices which lie ahead. There was a recognition that services needed to be re-examined and assessed to ensure they are providing high quality care in the most efficient manner possible. However, delegates were determined not to see recent gains undermined, and to reiterate the importance of high quality services, and the need for sufficient funding to maintain them.

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

### Prevention

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- We need to capitalise on 'teachable moments' to give prevention messages, and all health professionals should be empowered to deliver these.
- We should identify those who can influence behaviour e.g. family/ community.

### Early detection

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- We need to address people's fear of cancer (and their subsequent delay in reporting symptoms) by getting the message across about survivorship – we could use real life examples that will have resonance.
- People need to be encouraged to know what's normal for them and report any changes (and doctors need to acknowledge this expertise).
- There should be a system to support GP decision making (e.g. linking symptoms to referral guidelines, flagging multiple attendances for a single symptom).

### Access to treatment

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- The balance between local treatment and the expertise in centres of excellence needs to be debated honestly and treatment delivered in the most appropriate setting (e.g. this might mean complex treatment in a centre, but follow-up locally).

- Patient access schemes have made some treatments available which wouldn't be otherwise but some are complex and have significant associated admin costs.
- The Scottish Medicines Consortium should encourage and support patient group submissions e.g. through clear guidance and best practice examples.
- We need to disinvest in outdated practices to free up investment for new technologies.

### Support for patients during and post treatment

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- The role of the Clinical Nurse Specialist is vital and should be protected.
- A patient advocate/ co-ordinator role could help to ensure all aspects of care and support are integrated.
- Communication with GPs is important post-treatment – patients need to feel they can contact them to discuss any issues.
- Follow-up could happen much more in the community with GPs rather than returning to acute care, but there needs to be rapid re-access to services if patients are symptomatic.

### Patient experience

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- We need to show examples of where patient experience has been translated into changes in delivery (these are often simple things and not necessarily expensive).
- The increase in 'softer' research into patient experience is to be welcomed and encouraged.
- We need to think about how to take patient experience and make it measurable.

### Rarer cancers

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- A nationwide 'pot' for the cost of treatment for rarer cancers could be created, with each health board contributing, then applying for funding if they have a patient to treat.
- Co-ordination by an expert body (e.g. national MDT) is essential.

### Research

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- The protected space for non-clinical work (including participation in research activity) is not the same in reality as it is on paper.
- The UK is a good place for carrying out translational research – we need to better capitalise on this.
- Infrastructure support funding is vital for charity funded research in universities.
- Primary care could be better involved in research e.g. in relation to end of life care.
- NHS Research Scotland should streamline the process for multi-centre trials, but 'clock-stopping' in the approval process means it may be taking longer than it may seem.
- We should work to raise public awareness of research and trials and encourage involvement.
- The radiotherapy community would like to undertake more trials but capacity is an issue.

## Introduction

### Ken Macintosh MSP

*Member, Cross Party Group on Cancer in the Scottish Parliament*

Ken Macintosh MSP (standing in for Malcolm Chisholm MSP) introduced the Scotland Against Cancer Conference and welcomed all delegates. Mr Macintosh 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 Macintosh also thanked Cancer Research UK for planning the conference and providing the secretariat for the Cross Party Group on Cancer.

Mr Macintosh noted that ideas and suggestions expressed during the conference would be included in a report to be sent to the Cross Party Group on Cancer, and considered in the forming of future policy. He highlighted the case of sunbed regulation, first suggested at a previous conference, which has now passed into law in Scotland, as an example of the impact delegates' suggestions can make.

Mr Macintosh thanked delegates for their willingness to participate in the conference and wished them a productive day.

## Health Secretary Address and Questions

### Nicola Sturgeon MSP

*Cabinet Secretary for Health and Wellbeing*

Ms Sturgeon opened by commenting on the level of enthusiasm shown by the Scotland Against Cancer Conference to bring together different experiences and perspectives to bear on the shared ambition of improving cancer care in Scotland.

She noted that it is often clear what people want from cancer services, and where there is scope for improvement, but that we need to be much better at translating that knowledge into action and putting policy into practice.

The Cabinet Secretary then went on to outline the context in which Better Cancer Care is being delivered - the new health care quality strategy. She highlighted the strategy's aim to make the NHS in Scotland a world leader in terms of the health care services that it delivers. She noted that people with a cancer diagnosis want speedy treatment and that there had been significant improvements in this area, but that they also want a health service that is compassionate and respectful, and which fosters a genuine partnership between clinicians, patients and carers.

Ms Sturgeon then outlined her thoughts on some of the topics on the conference agenda. She stated her pride that the Scottish Government is building on the work done by previous administrations in implementing a comprehensive and wide ranging programme of action to encourage healthy lifestyle

choices. She noted the ongoing work to raise awareness of the small everyday changes that people can make to their lifestyle to bring about the health benefits, for example, through the Take Life On campaign. She also highlighted the need to take advantage of 'teachable moments' when a person can be given appropriate information on how to improve their health and wellbeing.

She went on to discuss the need to pick up on the signs and symptoms of cancer at an earlier stage, and the work that the Scottish Cancer Taskforce is undertaking to improve awareness amongst both medical professionals and the public. She noted the significant success of the cancer screening programmes and paid particular credit to those involved in rolling out the bowel cancer screening programme.

Moving onto access to treatment, Ms Sturgeon highlighted the improvement in waiting times for treatment, and she paid tribute to the recent parliamentary inquiry into access to cancer treatment for highlighting issues for improvement, and the updated guidance that has been produced in response to those findings.

In relation to patient experience, Ms Sturgeon outlined the two national surveys currently underway through the Better Together programme to ask people about their priorities - one about their experiences of being in hospital and the second about using GP services. The next phase will focus on the experience of people living with long term conditions, including cancer, and three cancer specific pilots are already underway, looking at the experience of teenage and young adult patients during the transition from children to adult services; the experience of people with learning disabilities who are living with cancer; and people's experience of day case chemotherapy and bowel screening and colorectal cancer.

Turning to the topic of living with cancer, Ms Sturgeon stated that she is very supportive of the work being undertaken on this issue, and mentioned a recent workshop where psychological, spiritual, social, physical and financial issues were all discussed in some depth.

Finally, Ms Sturgeon outlined the role of the Scottish Government in supporting cancer research in Scotland. She particularly highlighted the Scottish Academic Health Sciences Collaboration which will support activities that are critical to cancer research, like tissue banking and imaging.

She reiterated the importance of research in Scotland both in terms of the health benefits, but also in the economic benefits that research, and having Scotland at the leading edge of some of that research, brings to us.

Ms Sturgeon concluded by alluding to the financial climate and the commitment made by the Scottish Government to protect the NHS. However, she acknowledged that the cost of delivering health care increases on an ongoing basis as new drugs and technologies open up new opportunities. She closed in saying that this made it vital that we work in collaboration to focus on those things that really matter – of which the fight against cancer is undoubtedly one.

## Questions

### Questions were raised on a range of issues, including:

- The scope for individual health boards to make either a Scottish Medicines Consortium (SMC) approved medicine or its equivalent available to patients, and the need for greater transparency in these decisions – The Cabinet Secretary noted that the SMC is a very robust way of assessing new drugs and that although their decisions are not statutory binding the Scottish Government does consider them to be binding on health boards. But she stated that where there are different drugs available that do the same thing there has to be flexibility for local health boards to decide what goes onto the formulary and what does not. She stated that the focus of recent work had been to create equity as well as a better understanding of how the system works from one end to the other, and that significant progress has been made.
- The avoidance of environmental pollution and the recommendations of the President's Cancer Panel report – The Cabinet Secretary was not familiar with the recommendations, but reiterated her commitment to looking at all the ways to prevent cancer.
- The importance of sun awareness – Ms Sturgeon agreed that there is a need to continue to educate and raise awareness of how to avoid the risks of melanoma.
- A plea for protection of the research budget and to shorten the time between research findings and the difference it makes to patients – The Cabinet Secretary stated that research should be given the priority it deserves, not just in the health department in Scotland but through the Government recognising the economic benefits and to make sure we stay at the leading edge of research and other life science initiatives.
- The continuation of waiting time targets – Ms Sturgeon stated her intention to retain waiting time guarantees, and her view that speed of treatment is of the essence in terms of outcomes, but also in terms of reducing the stress and anxiety that comes with a diagnosis.
- The variation in the availability of certain treatments across Scotland – Ms Sturgeon highlighted the status of the SMC as independent of Ministers and the importance of this in reaching equitable decisions.
- The impact of budget constraints on the introduction of a new generation of diagnostics and targeted therapy based on our molecular understanding of disease – Ms Sturgeon stated that there is a need to keep the focus on those kinds of developments and that the development of drugs that are much more targeted, reduce side effects, and are much more tailored to individual needs, is very important.

## Keynote Address (sponsored by Scottish Cancer Foundation)

### Professor Graham Watt

*Professor of General Practice, University of Glasgow*

Professor Watt addressed the topic of 'Putting Policy into Practice' and the importance of 'generalists' in cancer care. Professor Watt discussed the inverse care law, where the availability of good medical care tends to vary inversely with the need for it in the population served. He also addressed the issue of fragmentation: when care focuses on the cancer and not the person; when care focuses on some of the patient's problems but not all of them; when care isn't joined up; and when care is provided for some but not for others. He stated that "the challenge for health services around the world facing problems of ageing populations, spiralling costs and inequity is to imagine and deliver integrated systems in which nobody falls through the cracks".

Professor Watt highlighted the fact that patients taking part in a clinical trial as part of their treatment are more likely to do better than patients receiving conventional care in the usual way, even if they're in the control group and not getting the benefit of a new treatment. In addition to the highly co-ordinated care they will receive, this is because patients in clinical trials are generally healthier and have better survival prospects to begin with; and so there is little evidence from those patients who weren't included because trials systematically exclude complicated people with co-morbidities. He suggested that studies which look at patient records can help here and referenced a study which investigated why although breast cancer is commoner in affluent women survival is worse in deprived women. It showed that the NHS was equitable in the provision of the major treatments, but that women from deprived areas tended to present later, reported poorer communication, and had more GP consultations and admissions in the year after diagnosis for reasons than other breast cancer. Professor Watt stated that these are the kinds of patients who most need co-ordinated care. In relation to this, Professor Watt discussed the issue of consent for this sort of research, and the impact that asking for consent might have in skewing the demographics of those who take part. He made the case that the task of primary care is to integrate research into the context of consultations with individuals, addressing all their problems.

Discussing the restructuring of services, Professor Watt made the case that this was often counterproductive since nothing would happen for several years as organisations defending their starting positions. He stated that what is important in reducing fragmentation is encouraging communication, integration and collaboration.

In addressing the Keep Well initiative, he noted that over 65,000 people had been given health checks involving a forty minute initial encounter followed by referrals to general practice on a range of health improvement programs, but that the best response rates are about two thirds to the target population. Professor Watt considered that those not participating in Keep Well are precisely those people most often not engaged with health services. He also noted that many practices working in the most deprived communities in Scotland are not participating.

## Keynote Address (contd.)

Professor Watt then highlighted the Deep End project which involves the 100 most deprived practices in Scotland, supported by the Scottish Government, RCGP and the Glasgow Centre for Population Health. He went on to highlight the key issues affecting those practices, including insufficient time to deal with all the problems that patients bring - their multiple morbidity and complexity (psychological and social); lower expectations, sometimes by both patients and professionals; lower levels of patient enablement; a greater degree of practitioner stress, particularly after long consultations with psychological co-morbidity; and a relative lack of GP training.

Discussing the recent inquiry undertaken by the Health Committee into health inequalities, Professor Watt stated that its conclusions were more suited to those patients who are articulate, in employment, keen to self manage, with single problems, and wanting to use the service outside working hours and are not typical of patients in very deprived areas. He contested that patients with complex problems are not so articulate, less health literate, and who do not expect to be asked what they think or want need more time, not just once, but serially, to make a difference.

Moving on to referral to other services, Professor Watt agreed that it is necessary but much more likely to be taken up if it can happen promptly and nearby. He stated that rather than referring on, GPs at the deep end want attached workers who can help to provide a service close at hand, providing an integrated service for the patient.

In his closing remarks, Professor Watt stated that "if we didn't already have general practice it might be necessary to invent it". He contested that "when you already have a system that provides contact, coverage, continuity, coordination, flexibility and long term relationships based on trust, which is what Keep Well needs to keep going, and what the NHS needs to avoid fragmentation, you should build on it".

His key message was that in deprived areas, general practice is the obvious hub around which to build an integrated service and that to avoid the problems and inefficiencies of fragmentation, especially for patients with multiple and complex problems, we need services that provide contact, coverage, coordination and continuity. He stated that there should be a focus on 100% of people, studying medical records so that the health service can learn what is happening to all patients – and that this would be a challenge for mutuality and trust. He highlighted the need for more research on the horizontal issues of integration within consultation, clinic, practices, and communities. And, finally, that the NHS should be seen at its best where it is most needed – and Scotland could lead the world in showing what integrated equitable services could deliver if that was something it wished to do.

## Discussion Groups

### Making lifestyle change a reality

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#### Key points:

- There are opportunities for all health care professionals to deliver prevention messages
- Messages need to be individualised, meaningful and relevant
- We need to capitalise on teachable moments
- Family-based approaches can be useful
- Identify those who can influence behaviour e.g. family/ community (e.g. the breast screening campaign sought to capitalise on this by promoting to husbands, daughters of target group)
- We should consider risk reduction approaches
- Social marketing approaches can make a real impact
- The media can be a challenge

### Diagnosing cancer earlier

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#### Key points:

- GPs see so few of some cancers – how realistic is it to expect them to recognise symptoms?
- Not all GPs have access to diagnostic tests
- Acknowledge the difficulty of GPs assessing what should be an urgent referral
- People sometimes do not acknowledge or take action on symptoms
- People need to be encouraged to know their own body and report any changes (and doctors need to acknowledge this expertise)
- Fear can be a delaying factor – people don't want to accept they have cancer
- We need to get the message across about survivorship – can we use survivors (real life examples that will have resonance) to do this?
- There should be a system to support GP decision making (e.g. linking symptoms to referral guidelines, flagging multiple attendances for a single symptom)
- Can also capitalise on family/ friends here – encouraging attendance at screening or to visit GP with symptoms

## Discussion Groups (contd.)

### Access to treatment

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#### Key points:

- Patients' expectations with regard to medicines need to be managed (e.g. balance of benefit and side effects)
- Patient advocates/ co-ordinators would help to support patients through the system
- More targeted therapies may mean better efficacy but also greater expense
- The media want 'tears, fears and cheers' – not interested in more complex stories – this can make managing people's expectations of new treatments difficult
- The balance between local treatment and the expertise in centres of excellence needs to be debated honestly and treatment delivered in the most appropriate setting (e.g. this might mean complex treatment in a centre, but follow-up locally)
- Patient access schemes have made some treatments available which wouldn't be otherwise but some are complex and have significant associated admin costs
- SMC should encourage and support patient group submissions e.g. through clear guidance and best practice examples
- We need to disinvest in outdated practices to free up investment for new technologies
- The role of the CNS is vital and should be protected

### Valuing patient experience

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#### Key points:

- Peer support models can help patients to negotiate the system
- Dedicated specialist nurses have a role to play in helping the patient identify and articulate their needs
- There has been a limited cultural shift to learning from patient experience – it is now seen as important but still limited in success
- We need to show examples of where patient experience has been translated into changes in delivery (these are often simple things and not necessarily expensive)
- A cultural shift is needed from complaint forms to feedback forms – a more rounded model
- In an evidence-based climate it can be hard for the patient voice to be heard and acknowledged
- The increase in 'softer' research into patient experience is to be welcomed and encouraged
- We need to think about how to take patient experience and make it measurable
- Are there times when we can undertake research with patients e.g. while they're having chemo?
- Patients need to be supported to be involved

### Do we provide equitable services for those with rarer cancers?

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#### Key points:

- People need to be more aware of what's normal for them and encouraged to report any changes
- Repeat visits to the GP for any symptom need to be taken seriously
- People often have to travel for expertise, but the improved outcomes make it worth it
- Co-ordination by an expert body (e.g. national MDT) is essential
- Patient advocates to co-ordinate care would be very helpful
- The affordability of drugs is a real issue and rarer cancers need a flexible system of appraisal
- A nationwide 'pot' for the cost of treatment for rarer cancers could be created, with each health board contributing, then applying for funding if they have a patient to treat
- Research is difficult – often targets for recruitment are difficult to reach because of small numbers

### World class research

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#### Key points:

- The protected space for non-clinical work (including participation in research activity) is not the same in reality as it is on paper
- Trials units need to be engaged earlier to help untie protocols and should be more proactive
- A standardised approach to providing info to ethics committees, R&D etc. would help speed up the process
- Research was not given sufficient focus in the cancer action plan
- The UK is a good place for carrying out translational research – we need to better capitalise on this
- Infrastructure support funding is vital for charity funded research in universities
- Primary care could be better involved in research e.g. in relation to end of life care

## Discussion Groups (contd.)

### From bench to bedside

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#### Key points:

- NHS Research Scotland should help to streamline the process for multi-centre trials, but it's not yet clear what the requirements are
- 'clock-stopping' in the approval process means it may be taking longer than it may seem
- We should work to raise public awareness of research and trials and encourage involvement
- There is a role for patient groups in being more vocal to ensure research happens
- We need to tackle the issue of patient consent
- Where NHS care is not in line with what is being trialled it is difficult to attract trials to Scotland
- We need to ensure that the need to meet other targets within the NHS isn't detrimental to conducting research
- There are still some groups under-represented in clinical trials and this needs to be addressed
- The radiotherapy community would like to undertake more trials but capacity is an issue

### Living with and beyond cancer

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#### Key points:

- People often feel abandoned post-treatment
- The impact on family, friends and carers needs to be acknowledged and support offered
- There is a vast amount of information available to people, and it's sometimes difficult to distinguish quality, so NHS Inform is welcome
- The NHS quality strategy aims to be person centred and this is very welcome
- A co-ordinator role could help to ensure all aspects of care and support are integrated
- Communication with GPs is important post-treatment – patients need to feel they can contact them to discuss any issues
- Follow-up could happen much more in the community, with GPs rather than returning to acute care, but there needs to be rapid re-access to services if patients are symptomatic
- We should learn from the survivorship initiative taking place in England

## Expert Panel questions and answers

The expert panel was introduced and chaired by Nanette Milne MSP and included Ann Muir, a patient representative; Dr John Davies, Consultant Haematologist at the Western General Hospital, Edinburgh and Clinical Director of the South East Scotland Cancer Network; Professor Bob Steele, Professor of Surgery at the University of Dundee and Director of the Scottish Colorectal Cancer Screening Programme; and Dr Gill Hubbard, Co-Director of the Cancer Care Research Centre at the University of Stirling.

### Questions were raised on a range of issues, including:

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- Cancer as an election issue – the panel were hopeful that equity would be a key issue on the agenda.
- What Scotland can learn from Australia's 'slip, slap, slop' sun awareness campaign – this was felt to be a very successful campaign, and the issue of adapting this to suit the Scottish climate and population was discussed. The work of the Scottish Cancer Prevention Network was also highlighted.
- The possible impact of budget cuts on waiting times – the panel acknowledged the importance of timely treatment and the will within the political and medical communities to maintain this.
- How to improve uptake of screening services – it was acknowledged that the bowel cancer screening programme is currently running at about 60% uptake, and that research into techniques such as pre-notification letters have shown an impact. Evidence from the breast screening programme showed the importance of also focusing on family and peer groups in order to encourage uptake.
- How to improve awareness of prostate cancer among men – the panel acknowledged the complexity of the issues surrounding PSA testing and the need for continued debate and research.
- The appetite for joint working initiatives with the pharmaceutical industry – it was felt that where there is mutual interest and areas of real need and concern, then there is a genuine appetite for collaboration between the clinical community and industry.
- The need for more tailored approaches to screening and prevention – there was agreement that a distinction should be made between population screening for people of average risk and more tailored approaches for people at high risk, and that this is currently the case for both breast and bowel screening.
- Concerns about the changing role of clinical nurse specialists – it was agreed that there is a need to resist any changes that directly affected patient care. It was noted that there are plans to look at the job descriptions of CNSs to maximise their direct patient contact. It was also noted that research had shown the value and benefit of CNSs to patients' experiences of care.

## Expert Panel Q&A (contd.)

- The impact of patient involvement and patient representatives in service planning – it was felt this could sometimes be tokenistic, and that patients should be given the opportunity to be consulted in a meaningful way.
- What could be learned from the advances in leukaemia treatment – it was noted that there are some benefits peculiar to blood cancers (e.g. easy to biopsy, particularly chemo-sensitive) which have benefited treatment, but that international collaboration in trials and research have also played a significant role.
- The relatively low spend on lung cancer research – it was acknowledged that this is the case, that it is often easier to raise funds for research into other areas, and that due to the nature of the cancer, there isn't the same lobbying strength from patients, and some stigma attached.
- The impact of the financial climate on decisions about rationing treatment and services – a suggestion was made that better use could be made of volunteers to support and buddy with patients.
- The impact of increasing complexity of treatment – it was noted that there were significant time and resource implications associated with increasing complexities in terms of diagnosis, staging, imaging, PET scanning and around complexities of treatment where both radiotherapy and chemotherapy regimes are increasingly intense and complex.

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-convenor, Cross Party Group on Cancer in the Scottish Parliament*

Nanette Milne said she thought it had been a very good conference with a wide spectrum of people with interests in cancer attending.

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.

She thanked the MSPs who had attended and particularly Ken Macintosh, for chairing the meeting in the morning.

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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# Scotland Against Cancer Conference 2010

Stirling Management Centre

Monday 28th June 2010

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.

**Gold Sponsor:**



**Silver Sponsor:**



**Steering Group:**

Breast Cancer Care Scotland  
Macmillan Cancer Support  
Myeloma UK  
Scottish Cancer Foundation

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