

## Scottish Parliament Cross Party Group on Cancer

Tuesday 16<sup>th</sup> December 2014 17.30-19.00

### Minutes

Attendees and apologies noted in appendices. **Bold underlined text indicates actions/ agreements**

#### 1) Welcome

Malcolm Chisholm MSP (“the Chair”) opened the meeting, welcoming all attendees and speakers.

#### 2) **The minutes from the last meeting were approved, with one amendment to the list of attendees.**

#### 3) Annual General Meeting

**The draft annual return, circulated in advance of the meeting, was approved.**

**Malcolm Chisholm MSP and Nanette Milne MSP were re-elected by the group as the conveners of the CPG for the coming year.**

**Cancer Research UK was approved by the group to retain the post of Secretariat.**

#### 4) Speaker, Professor Anthony Chalmers of the University of Glasgow.

The Chair introduced Professor Anthony Chalmers (AC) to discuss the topic of Intensity Modulated Radiotherapy (IMRT), which has been one of the most significant developments in cancer treatment in the last ten years.

AC noted that the ability to cure cancer by radiotherapy is not determined by the size or type of the tumour itself, but by the surrounding tissues. Some tissues, especially those of the vital organs, are unable to tolerate the strong beams of radiation necessary for curative radiotherapy, and this limits the scope for radiotherapy for a number of cancers which are located close to vital organs and structures.

IMRT has been an important development as it allows the radiotherapy beam to be much more precise than in traditional radiotherapy (RT). Instead of a ‘box shaped’ beam of radiation, in IMRT the beam can be shaped much more closely to the shape of the tumour meaning that more healthy tissue can be avoided. This means a strong beam can be directed at the tumour, without damaging neighbouring organs.

AC went on to outline the benefits of IMRT over standard RT. As it can be given at a stronger dose to the affected area, patients generally require fewer sessions. AC noted that a curative dose of IMRT could be given in 3-5 sessions rather than every day for eight weeks as is normal for some RT. This has great benefits for patients, who are able to maintain a more normal life and spend much less time in hospital. IMRT also provides more treatment options for elderly and infirm patients who would not be fit to have surgery, as well as patients with cancers in difficult to treat areas such as the lungs, the brain and around the eyes. Because of the ability to tailor the dose to different areas and minimise damage to healthy tissues, many more patients can now be treated to a curative extent.

AC then went on to discuss how the full potential of IMRT is sadly not being reached in practice. Although all RT centres in Scotland have been equipped with linear accelerators capable of delivering IMRT, only two are presently using them for this on a regular basis. This is primarily as a result of staffing issues, due to a lack of clinical oncologists and RT physicists with the necessary skills to perform IMRT. It was noted that this is especially a problem in the north of Scotland cancer network.

AC finished by urging more investment in IMRT and the necessary staff, pointing to large variations in access to the most advanced treatments across Scotland, meaning patients who would benefit from these treatments are missing out. He noted that relatively small additional investment to attract more high quality staff in key areas would have huge impacts into the longer term.

#### **5) Question and Answer Session led by AC**

A number of issues were raised, including the difference between Glasgow, where SABr- another advanced and focussed form of RT- is now routinely offered, and Edinburgh, which is just beginning to do so. When asked what level of staffing he would like to see, AC responded that ideally there should be one or two RT physicists and a handful of RT oncologists to each centre.

The effectiveness of IMRT compared to other RT techniques such as proton beam therapy was also raised, with AC noting that in most cases IMRT was more effective and a better investment, with the exception of childhood cancers for which proton beam therapy is usually more effective. Colon cancer was also noted as a difficult cancer for IMRT to treat because the colon moves.

It was noted that although IMRT takes more time to plan than standard RT, as the beam needs to be tailored to fit the tumour, its shorter programmes of treatment mean that more patients can receive far less treatments than standard RT.

Other attendees questioned whether the shortage of specialised expertise was a purely Scottish problem. AC remarked that it was a global problem, but one that was particularly pronounced in Scotland, as in his view Scotland has not been looking ahead enough. He felt more investment was needed in the training of RT physicists, and that Scotland should also look more at recruiting

better from outside Scotland. AC also felt that current working structures did not provide enough time for oncologists' ongoing personal development and research, unlike in England.

Finally, it was noted that a bigger focus on IMRT by politicians and the media might be beneficial in increasing provision of IMRT with the contrast made to cancer drugs which, overall, cure less cancers but inequalities of access command high political and media profile.

## **6) Speaker, Deborah Alsina, Chief Executive of Bowel Cancer UK**

The Chair introduced Deborah Alsina (DA) to speak on the subject of screening and endoscopy services for bowel cancer. DA began by noting that while bowel cancer mortality has been declining significantly in the last 25 years, it is still the UK's second biggest cancer killer. She also noted that Scotland has both the highest incidence of bowel cancer and the highest mortality in the UK. 95% of cases are among the over 50s.

DA discussed some of the different routes to diagnosis and the different stages of the disease. Like most cancers, bowel cancer can be treated most effectively if it is detected at the early stages. Of those diagnosed at the 1<sup>st</sup> stage of bowel cancer 93% survive more than five years, while of those diagnosed at stage 4 of the disease 93% do not survive five years. She noted, however, that bowel cancer is rarely caught in its earliest, most treatable stage (only 9% of patients are diagnosed at stage 1).

One of the best means of detecting bowel cancer at the early stages is through bowel screening. DA noted that Scotland is a leader within the UK in this regard, as bowel screening is offered routinely on the NHS to everyone over 50, while in England and Wales it is not offered until the age of 60. This allows more early stage bowel cancers to be detected. However DA explained that there are inequalities in uptake as people from deprived areas are less likely to take part in screening, and so are more likely to be diagnosed at a later stage when survival rates are lower.

The Scottish Government's Detect Cancer Early programme has led to a 9% rise in bowel screening following the latest campaign, however DA insisted that this must be sustained and built upon. Screening is especially important for bowel cancer as the symptoms can be very vague, and some people may experience no symptoms at all.

She went on to note that while bowel cancer is most commonly a disease of the over 50s, many patients do develop it at a much younger age. This is especially the case for those with a family history of the disease or with a genetic condition such as Lynch Syndrome. People with long term Irritable Bowel Syndrome are also more likely to develop bowel cancer at a young age, and DA argued much more must be done to understand these links and to identify at-risk groups, so that bowel cancer can be detected early or even prevented all together.

DA discussed different types of screening, noting that the new Faecal Immunochemical Test (FIT) is much more accurate than the currently used Faecal Occult Blood Test (FOBT).

She went on to discuss the need to increase screening capacity to meet a rising demand. Too many patients are already waiting too long, and with uptake expected to rise, it must be ensured that the system can cope and that services are of the highest standard.

She concluded by laying out Bowel Cancer UK's priorities; for GPs to refer more patients for bowel screening; for the new more accurate FIT Test to be introduced; the surveillance of high risk groups to detect bowel cancer early; genetic testing for Lynch Syndrome of all bowel cancer patients; and for Scottish Centres to invest in JAG accreditation to ensure they offer the highest quality service.

**7) Question and Answer Session led by DA.**

A number of issues were raised, including the difficult nature of bowel cancer symptoms as they can be vague. It was noted that changing bowel habits and abdominal pain are common symptoms which could be the result of many different conditions. Links between GPs and pharmacists were raised, as it was noted that many patients go to their local pharmacy with symptoms rather than their GP, and that better referrals between pharmacies and GP's surgeries could help improve early detection. Members also discussed the risky nature of colonoscopy, and it was hoped that the introduction of FIT would reduce the number of unnecessary colonoscopies. Capacity issues as a result of increased screening were also raised as a challenge.

**8) Close**

The meeting closed with the next meeting confirmed as 17<sup>th</sup> March 2015, 17.30-19.00. Dates of subsequent meetings would be sent alongside the draft minute of the meeting.

## Appendix 1: Attendees

Deborah	Alsina	Bowel Cancer UK
Emma	Anderson	Bowel Cancer UK
Phil	Atkinson	Health Policy Scotland
Lynne	Barty	Brain Tumour Action
Aileen	Bryson	MASSCOT & Royal Pharmaceutical Society
Christine	Campbell	University of Edinburgh
Anthony	Chalmers	University of Glasgow
Malcolm	Chisholm	MSP
Jeannie	Erskine	Cancer Patient
Zohreen	Farzad	SCAN
Tonks	Fawcett	University of Edinburgh
Heather	Goodare	Edinburgh Health Forum
Peter	Hastie	Macmillan Cancer Support
Alistair	Haw	Prostate Cancer UK
Peter	Hutchinson	Scottish Primary Care Group
Christina	Lilley	South East Scotland Cancer Network
Kate	Macdonald	South East Scotland Cancer Network
Gregor	McNie	Cancer Research UK
Nanette	Milne	MSP
Angus	Ogilvy	SCAN
Rachel	Pont	Cancer Research UK
Katie	Robb	University of Glasgow
Kate	Robertson	NHS Forth Valley
Lesley	Shannon	Bowel Cancer UK
Ewan	Shannon	Bowel Cancer UK
Bob	Steele	Scottish Cancer Foundation
Helen	Stevens	Scottish Government
Greg	Stevenson	Roche Products

## Appendix 2: Apologies

Stuart	Barber	Beating Bowel Cancer
Karen	Bell	SCRN
Lorna	Bruce	SCAN
Frank	Buckley	Pancreatic Cancer Scotland
Alison	Campbell	NHS Greater Glasgow & Clyde
Christine	Campbell	Cancer Research UK
Ian	Campbell	NHS
Lindsay	Campbell	WoSCAN
Maggie	Clark	Novartis
Emilia	Crighton	NHS Greater Glasgow & Clyde
Dawn	Crosby	Teenage Cancer Trust
Kate	Cunningham	OCHRE
Val	Docherty	SCAN
Sheena	Dryden	NHS Lothian
David	Dunlop	NHS Greater Glasgow & Clyde
Mary	Dunlop	Cancer Research UK
Ellen	Finlayson	Clic Sargent
Liz	Forbat	Cancer Care Research Centre
Robert	Hill	NHS National Services Scotland
Alex	Holme	SCAN
James	Jopling	Breakthrough Breast Cancer
Lesley	Kidd	SCAN
David	Linden	Scottish Government
Janice	Malone	Macmillan Programme Manager
Marie	Mathers	NHS Lothian
Alison	McInnes	MSP
Kaz	Molloy	Womb Cancer Support UK
Elizabeth	Preston	NHS Lothian
Heather	Rankine	Boehringer Ingelheim
Helen	Reilly	BMA Scotland
Alan	Rodger	Radiotherapy Expert
Colin	Selby	SCAN
Mhairi	Simpson	NHS Lanarkshire
John	Sleith	Royal Environmental Health Institute for Scotland
Morag	Stocks	Cancer Research UK
Vanessa	Taylor	Scottish Health Action on Alcohol Problems
Ali	Walker	SCAN