Cross-Party Group on Cancer

Tuesday 3 November 2026,18:30-20:30, Hybrid Meeting

Minutes

Present

MSPs

Kayleigh Kinross-O'Neill MSP
Jackie Baillie MSP

Invited Guests

Florence Young (Campaign for Science and Engineering)

Samantha Harrison (Cancer Research UK)

Maree Todd MSP

Dr Douglas Rigg (Scottish Primary Care Cancer Group)

Carey Lunan (Scottish Deep End Project)

Non-MSP Group Members

Andrew Reynolds (Young Lives vs Cancer)

Anna Campbell

Carey Lunan

Clair Thorsten-Well (The Brain Tumour Charity)

Claire Headspeath (ABPI Scotland)

Claire Seaman (Individual Member)

Christine Campbell (University of Edinburgh)

Dawn Crosby (Pancreatic Cancer UK)

Fiona Brown (Pancreatic Cancer Scotland)

Florence Young (CaSE)

Frances Logan (Breast Cancer Now)

Genevieve Mincher (Blood Cancer UK)

Helen Fleming (Individual Member)

Jennifer Bisset

Jennifer Cameron (Royal College of Occupational Therapists)

Jessica Cuddy (Cancer Research UK)

Jo Williamson (Individual Member, CRUK Ambassador)

Julie Wardrop (Dundee Cancer Support Network)

Jyoti Chand (Cancer Research UK)

Lauren Ng (University of Edinburgh)

Laura Conaghan

Lorna May (Lilly UK)

Lorraine Dallas (Cancer Card)

Lornie Blake (AstraZeneca)

Michelle Conway (ABPI Scotland)

Norman Pratt (Target Ovarian Cancer)

Sal Peterson (Scottish Primary Care Group)

Samantha Harrison (Cancer Research UK)

Sian James (Teenage Cancer Trust)

Sorcha Hume (Cancer Research UK)

Tom Steiner (Pancreatic Cancer UK)

Vicky Reid

Apologies

MSPs

Colin Beattie MSP

Finlay Carson MSP

Helen McDade MSP

Miles Briggs MSP

Non-MSP Group Members

Edwin J.R. Van Beek

Greg Stevenson (Greg Stevenson Consulting Ltd.)

Heather McVicars (NRS South East Cancer Research Network)

Joe Woollcott (Prostate Cancer UK)

Marianne van-de-l'Isle (CLL Support Association (CLLSA))

Mhairi Simpson (NHS Lanarkshire)

Michael Clancy (Law Society of Scotland)

Sally Clive (Edinburgh Cancer Research Centre)

Sandra Auld (Healthcare Public Affairs)

Agenda Item 1 - Welcome & Previous Minutes

The group met for the first time since its re-establishment in the seventh parliamentary session. The minutes of the previous meeting, held on 2 December 2025, were approved as circulated, with no amendments requested.

Agenda Item 2 - Campaign for Science and Engineering

Florence Young presented Campaign for Science and Engineering (CaSE) polling on attitudes to R&D in Scotland and Wales. CASE described its advocacy as evidence-led and non-partisan and explained that involving the public in a two-way conversation can make R&D more relevant and visible, build trust and strengthen its social licence. The research found broad in-principal support for public investment, despite a generally pessimistic public mood and limited awareness of research and its benefits. Around 87% of respondents said they knew little or nothing about R&D taking place in Scotland, while more than half wanted to hear about it ahead of the elections. Around two-thirds said they would be proud if their area became known for R&D. Medical research, NHS improvement and clinical trials attracted particularly broad support across political groups; health-related R&D was among the public's highest priorities for additional investment.

The most supported actions for MSPs were campaigning for R&D to improve NHS experience, diagnosis and treatment, and for more clinical trials at local hospitals; opposition to these proposals was very low and support was broad across constituencies. CaSE prepared constituency packs combining public-opinion findings with local examples. More than a third featured a Cancer Research UK example,

including a full-page case study on the CRUK Scotland Centre's pancreatic cancer research in Miles Briggs MSP's pack, which was used as an example. Packs for every constituency and the underlying open-access data are available from CaSE; the slides, packs and research links are to be circulated to members.

Agenda Item 3 - Update from the Minister for Mental Wellbeing, Public Health, Sport, Alcohol and Drugs

Marie Todd MSP updated the group on the 10-year Cancer Strategy, launched in 2023 alongside its first Action Plan, and development of the second three-year Cancer Action Plan. She described partnership across government, NHS Scotland, local authorities, charities, researchers, clinicians and patients as central to delivery. The 2026–27 health and social care budget is £22.5 billion. More than £14 million in additional funding supports the most challenged cancer waiting-time pathways, and systemic anti-cancer therapy funding has risen to £10.5 million; both are now long-term commitments.

The Detect Cancer Earlier programme includes public campaigns, professional education and the Gateway C platform. Rapid Cancer Diagnostic Services for people with non-specific symptoms operate in six NHS boards; national guidance has been published, and Healthcare Improvement Scotland has been commissioned to assess expansion. Optimal pathways are being implemented for colorectal, lung, and head-and-neck cancers, with prostate and hepato-pancreato-biliary pathways in development. Latest figures showed 94.8% of patients began treatment within 31 days of a decision to treat, with a median wait of two days, jointly the lowest on record. The Minister acknowledged more work is needed to meet the 62-day standard, although more patients are treated within both standards than before the pandemic or a decade ago.

The first phase of a national targeted lung cancer screening programme is planned for 2027–28, targeting people at highest risk. Breast and cervical screening modernisation continue, including an HPV sampling pilot in higher-deprivation areas and work to increase participation among underserved groups. Whole-person support includes single points of contact, the £27 million Improving the Cancer Journey partnership with Macmillan Cancer Support, psychological support, rehabilitation and patient-reported outcome measures embedded in care.

Questions and Discussion with the Minister

Screening data: The Minister confirmed she knew of data-quality issues affecting Public Health Scotland breast-screening uptake publications and would raise them with the screening team and report back to the group.

Children and young people: The recently announced new cancer strategy for children and young people remained in development, with publication expected in

early 2027 but no firm date. The Minister stressed the need for a meaningful strategy and said she would keep Andrew Reynolds (Young Lives versus Cancer) updated; members offered to contribute.

Travel support: The funding pot is demand-led, but existing schemes are not well aligned, and people can fall through gaps. Members raised accommodation and visitor-levy costs, outpatient journeys that are not always covered, delays in reimbursement, and the difficulty of paying costs before claiming. Young Lives versus Cancer modelling suggested extending eligibility to 18–25-year-olds could fit within the existing budget envelope. The Minister said she would support the change if the evidence confirmed no additional cost, and agreed to clarify the Young Patients Trust Fund review commitment.

NHS reform and the oncology Target Operating Model (TOM): In discussion of the proposed shift from 14 territorial health boards to two strategic boards, members asked what safeguards would protect Cancer Strategy delivery and how reform would be assessed for its effect on inequalities. The Minister said treatment should follow clinical need rather than local availability, with patients able to consider their options, and argued that reform could improve access across board boundaries. Maree Todd described a Highland patient's positive experience of a one-stop breast service delivered by Forth Valley, while noting the hotel stay and travel required; members stressed that people want equal treatment choices and travel that is manageable. The Minister acknowledged the psychological and practical costs of prolonged treatment away from home and pointed to suitable accommodation or care closer to home.

No specific safeguards or inequality measures were set out in the discussion; members were encouraged to feed evidence and patient stories into the reform process. Some CPG members had been approached about the oncology TOM, while others had not. The Minister agreed to include an engagement link in her written response. Members were urged not to wait to be asked; the Scottish Cancer Collaborative and Scottish Cancer Coalition are arranging a December workshop to hear third-sector perspectives. The Minister indicated that three cancer networks were expected to remain.

Genomic medicine and clinical trials: Members asked about the promised annual genomic-medicine progress reports, which did not appear to be publicly available, and how testing capacity is being measured. For one Scottish Medicines Consortium (SMC)-approved medicine requiring genomic testing, capacity was being sourced from England while Scotland develops its own; the Minister agreed to ask about the missing reports. Blood Cancer UK described its Trial Treat Beat campaign and reported that only 21% of people with blood cancer in Scotland had research opportunities discussed at diagnosis. The Minister said it is important to unpick the individual barriers to clinical trials and work out whether each is easy to overcome. For the prostate screening trial, which requires focal therapy, the barrier should be

relatively easy to solve: focal therapy is already offered in Edinburgh as part of a clinical trial, so availability somewhere in Scotland would be enough to participate. For genomic testing, the Minister suggested using capacity elsewhere, such as in England, or setting up one lab to serve several signed-up centres. She also suggested considering routine trial offers in pathways for under-researched cancers. These were potential approaches discussed, not decisions made at the meeting.

Access to medicines: Members linked variation in access to SMC-accepted medicines to staffing and infrastructure, including genomic testing, and noted that medicine horizon-scanning may not capture the wider readiness required across health boards. The Minister cited PharmaScan 2.0, earlier planning with industry and a “Once for Scotland” approach to identify workforce and service capacity needs. She pointed to a national onboarding capacity for diabetes technology, such as hybrid closed loop systems, as an example outside cancer of how nationally commissioned provision can remove the local capacity barriers that caused unwarranted variation.

Secondary breast cancer data: Public Health Scotland intended to begin public reporting by the end of 2027, following a long-standing commitment.

Waiting times and inequalities: The Centre for Sustainable Delivery’s (CfSD) commissioned waiting-times review includes inequalities in its brief, and the Minister agreed to follow up in writing. Members asked whether waiting-time experience and missed appointments would be routinely analysed by deprivation. They warned that opt-in and patient-focused booking can inadvertently increase “missingness” and suggested accessible-language communications, transport and link-worker support. Whether adequate data are available (with postcode as a possible proxy) remained an open question.

Agenda Item 4 – Tackling Cancer Inequalities in Primary Care

Dr Douglas Rigg, Dr Carey Lunan and Samantha Harrison presented recommendations from an August 2025 roundtable, framing them against cancer inequalities as an overarching ambition of Scotland’s Cancer Strategy and asking who is responsible for delivering and monitoring progress towards that ambition. Scotland has the widest deprivation-related cancer mortality gap of the four UK nations: cancer death rates are around 80% higher in the most deprived areas; with about 4,300 cancer deaths a year associated with deprivation. Bowel- and breast-screening participation is lower in deprived communities, and around four in ten cancers are preventable, while key risk factors are socially patterned.

Presenters described how lower screening and vaccination uptake, later presentation, transport and appointment barriers, language and health-literacy needs, and limited continuity compound inequalities. They also highlighted

commercial and social determinants of health, including greater exposure to health-harming products and the cost of healthier choices. Practices serving areas of greatest need often have smaller workforces despite higher morbidity, demand and consultation rates, with shorter appointments and greater pressure on staff - the inverse care law in practice. Risk tools based on chronological age may miss people who develop age-related illness 10-15 years earlier, as is often the case in areas of high socioeconomic deprivation. General practice is uniquely placed to respond through population reach, long-term relationships, coordination and advocacy. However, earlier practical guidance was valued but practices had little capacity to implement it; a short-term, enhanced service to increase bowel-screening uptake produced gains, particularly in more deprived practices, but was not sustained. A practical guide for GP practices, suggesting small quality improvement projects they could take on if capacity allowed, was described as very useful, but practices' capacity to take on additional work was extremely limited, particularly in practices in areas with higher levels of deprivation. A short, enhanced service to increase bowel screening uptake, which ran for about a year or possibly two, brought improvements, especially in the most deprived practices, but was not long enough or sustained enough to maintain them.

The presenters emphasised that repeated missed appointments should be treated as "missingness": an opportunity to understand how systems can better keep people connected to care, rather than as patient failure. Suggested practice responses included link workers and welfare advisers, screening champions, culturally and linguistically accessible communications, continuity of care, proactive follow-up, referral tracking and community outreach. The presenters said relational continuity can improve safety, outcomes and equity, while reducing avoidable urgent care.

The report's four recommendations were: (1) a direct enhanced service (DES) for cancer; (2) improved GP IT for cancer care, safety-netting and follow-up; (3) learning networks and a shared resource repository; and (4) more flexible use of the Screening Inequalities Fund. The proposed DES would be available to all practices but weighted by deprivation ("proportionate universalism"), with protected time, robust evaluation and the ability to adapt as evidence develops. Possible activity included improving screening and referral, appointing practice cancer leads, supporting continuity and quality improvement; the presenters said detailed design would need negotiation with the Scottish Government and the Scottish General Practice Committee (SGPC). They stressed that implementation also depends on sustainable GP and district nursing, expansion of Inclusion Health beyond NHS Greater Glasgow and Clyde, and continued link-worker and welfare-advice provision. CRUK's UK-wide estimate of up to £11.6 billion in productivity losses and premature death was cited as part of the case for the cost of inaction.

The report had been shared with the previous Cabinet Secretary, the cancer policy team, the Chief Medical Officer and SGPC/British Medical Association (BMA) representatives. Presenters said there was support in principle, but no clear

mechanism to propose a new enhanced service through the live national review; the cancer policy team considered inclusion in the Cancer Action Plan necessary to progress it. They warned the review could conclude before the proposal found a route forward. Presenters were willing to meet the BMA and SGPC. No decision to establish the service or add it to the Action Plan was made. MSP members suggested a letter to the Cabinet Secretary or Minister and parliamentary questions and offered to liaise with the presenters after the meeting on concise advocacy points.

Discussion also noted that 30% of blood-cancer diagnoses occur in A&E. Members asked whether this was associated with deprivation, but no breakdown was available; participants said the relationship should not be assumed without data. They discussed how non-specific symptoms, health literacy, difficulty navigating care and barriers to persevering may delay diagnosis, alongside language needs and limited translation capacity in primary care. A Blood Cancer UK awareness measure was collecting data on symptom recognition and access barriers and may provide useful demographic insight.

Agenda Item 5 - Any Other Business

No further business was raised.

Close of Meeting

The next meeting is scheduled for Tuesday 2 February 2027, 6–8pm, focusing on children and young people; a joint meeting was also being organised with the CPG on Brain Tumours.