

COMBATING CANCER

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COMBATING CANCER

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CORONAVIRUS

Don't let COVID-19 distract from the Big C

From staff capacity to fears surrounding infection, coronavirus has made treating people for cancer harder than ever, but a resilient healthcare workforce is finding new ways to cope

Danny Buckland

Cancer is a big enough foe on its own, but the pandemic has pitched its malignancy onto unmapped territory where even entering a hospital or clinic has become fraught with danger.

Delivering cancer care, when resources are stretched and coronavirus infection stalks contacts and procedures, has stretched healthcare providers' ability to cope with heavy workloads and complex logistics.

Around 2.5 million people in the UK are living with a diagnosis, but staff shortages, delays caused by heightened safety protocols and the need to distance cancer patients from COVID-19 wards has caused widespread disruption across cancer care.

A study published during the summer forecast the UK could experience an extra 350,000 cancer deaths over the next year from postponed operations, delayed treatments and patients ignoring symptoms or delaying diagnostic appointments for fear of exposing themselves to infection risks in the health system.

Although the arm wrestle with resources and public confidence will continue for some time, healthcare providers have adapted swiftly to ensure patients receive cancer care and emotional support no matter where they are on the treatment spectrum.

Private hospitals, free from COVID-19 patients, were brought on stream, 19 regional cancer hubs were established to deliver urgent surgery, physical appointments were switched to digital platforms, medication regimes were delivered to patients' homes and mobile wards were deployed to meet local needs.

The NHS introduced drug "swaps" to provide alternatives that could be taken at home, rather than in hospital settings, with a reduced impact on patients' immune systems to minimise the risk of infections.

"The pandemic has had a fairly devastating impact on cancer services and people with cancer," says Sara Bainbridge, head of policy at Macmillan Cancer Support, which offers high-impact support to 1.9 million people annually. "But we have seen an incredible response from staff and support services."

Dr Layla McCay, director at the NHS Confederation, which represents NHS organisations and its leaders, adds: "The pressure has been intense. It is not that people have stopped getting cancer, but the



Christopher Furion/Getty Images

impact has been at every stage from diagnostics through to care. Staff have been working amazingly hard, but that intensity is not sustainable."

The workforce strain – healthcare staff also have to contend with a heightened risk of contracting COVID-19 – is playing out across an NHS staff shortage of 84,000 with the government-pledged cohort of 50,000 extra nurses still some distance away from the frontline.

But the response has been full of ingenuity that ranges from national alliance with private healthcare providers to run and staff the cancer hubs, to using mobile "cancer buses" that have been used as safe spaces to deliver chemotherapy to

four patients at a time, achieving 60 sessions a day safely.

Home care has been ramped up at Clatterbridge Cancer Centre, on Merseyside, as the number of people receiving care at home from specialist chemotherapy nurses has increased by 15 per cent during the outbreak, with 285 patients in the area having oral chemotherapy delivered to their door by local volunteers.

Bristol Haematology and Oncology Centre believes it has developed a blueprint to cope with COVID-19 during the second surge. It switched from face-to-face outpatient clinic appointments to an almost entirely telephone-based outpatient service, increased the prescription length

for some oral medications, and sent some treatments to patients' homes to avoid compromising shielding, while patients established on immunotherapy were changed to longer regimens.

"It has been fluid and has heavily relied on the dedication and goodwill of staff who have sacrificed holidays or time with their families and put themselves on the frontline to not only treat patients with coronavirus, but also to ensure oncology services have been able to continue," according to a report from the centre.

An NHS Confederation survey revealed that 50 per cent of NHS leaders were not confident that cancer care services could recover swiftly. "Cancer services, like all other services, need to learn the lessons from COVID-19," says McCay. "Digital innovation and new, integrated ways of working will have raised new opportunities to improve the efficiency and the effectiveness of diagnosis and treatment. But, with a second surge coming, it is vital that we have the investment to ensure it has the workforce and the physical capacity it needs.

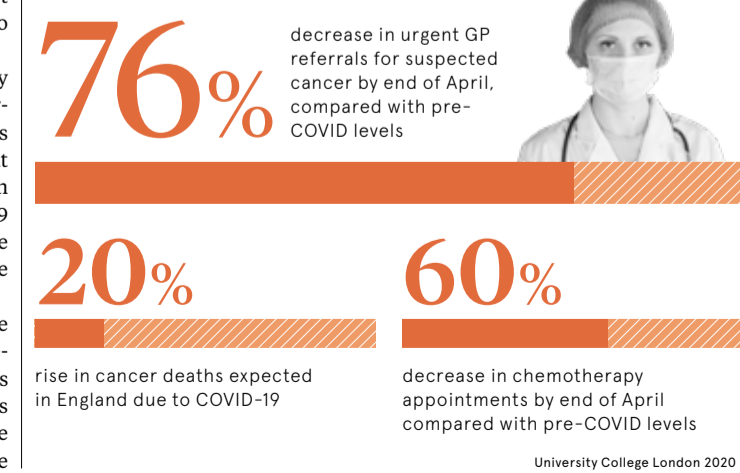
"We also need to think creatively about how we can make the very most of what we have to give patients the best service. We need to be practical in understanding what can be achieved across what timescales to restore these services because it's not just a matter of turning a switch and everything's back to normal.

"This is very complex stuff and COVID-19 has really shone a light on inequalities with data showing that people who are poor or from BAME [Black, Asian and minority ethnic] communities have been disproportionately affected."

Clear communication about changes to treatment plans or locations has been one of the most important elements of cancer care during the pandemic, Macmillan Cancer Support's Bainbridge adds, and although virtual consultations are effective, they may not be appropriate for sensitive conversations.

The charity has launched The Forgotten C campaign to ensure the government tackles backlogs in diagnosis, treatment and care, and that future services will be based on personalised needs.

"At the start of the pandemic, the NHS was promised what it needs and it still needs that commitment because the challenge for cancer certainly isn't finished. We need to make sure that progress made on cancer over the last few decades is not lost," Bainbridge concludes. ●



Advanced therapy platforms have the potential to fight cancer in novel ways

Advanced therapy platforms are an exciting field of innovative treatment approaches. Cell, gene and tissue-based products, as well as novel treatments such as radioligand therapy, have the potential to fight diseases in different ways and may reduce time in hospital for patients

Unlike conventional medicines, advanced therapy platforms treat diseases in unique ways, such as precisely targeting cancers, modulating the immune system or targeting the fundamental cause of genetic diseases. The treatments address the underlying mechanisms of the disease, rather than just managing symptoms. These platforms have the potential to bring innovative treatments to patients.

With one of the largest research and development programmes in the industry, Novartis is making significant investments in this area, specifically AAV-based gene therapy, CAR-T cell therapy, radioligand therapy (RLT) and CRISPR-based therapy. Of these, CAR-T cell therapy and RLT have already shown promise in treating certain cancers and are being explored in others.

"Novartis recognises that advanced therapy platforms have the potential to reimagine medicine. Their transformative power is only just beginning to be understood as our understanding of cell biology and genetic engineering advances. With the

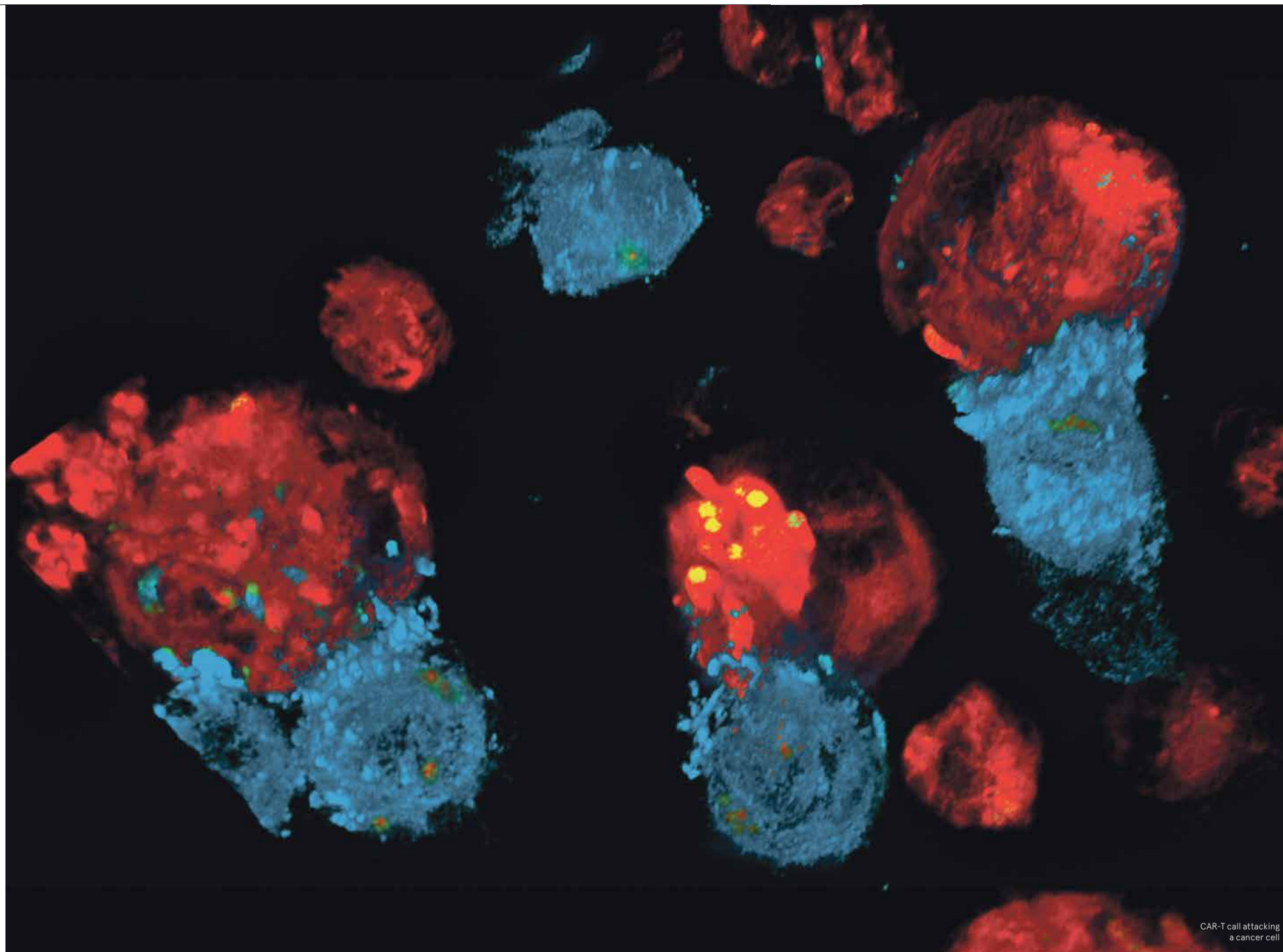
right systems in place they have the potential to deliver promising results for the NHS in the future," says Mari Scheffele, general manager, UK and Ireland, at Novartis Oncology.

Promising treatments

CAR-T cell therapy, or chimeric antigen receptor T-cell therapy, involves genetically modifying a patient's own immune cells to recognise and destroy cancer cells. This personalised treatment can help some patients whose disease has resisted all other forms of medication.

Research has also shown that CAR-T cells remain in the body and continue to be active for long periods of time. Therefore, unlike many other cancer drugs, CAR-T cell therapy is designed to be a one-time treatment, helping the individual continue to fight the disease throughout their life.

"While current medicines have enabled substantial improvements in cancer patient outcomes over recent years, in many cancer types there's still a need for novel treatment options. CAR-T cell therapy



CAR-T cell attacking a cancer cell



We're keen to continue working with the NHS to increase capacity to offer our advances in cancer therapies, so every eligible patient in the UK can benefit

has the potential to offer long-term remission and improve quality of life. Novartis was the first company to offer a licensed CAR-T product in the UK and is investigating multiple cancer types for this platform," says Ed Jenkins, franchise head of Cell and Gene Therapy at Novartis UK. RLT is also growing in importance for cancer care. This form of nuclear medicine delivers radiation directly to

cancer cells via the bloodstream, leaving healthy cells largely unaffected. Targeted isotopes cause DNA strands to break, disrupting the cells' ability to replicate and subsequently trigger cell death. The use of RLT has expanded significantly in recent years.

Ecosystem approach needed

Key in the delivery of these advanced therapy platforms is collaboration. Unlike conventional therapies, these platforms often require specific clinical expertise and unique facilities for administration. They can also require specialised manufacturing processes and a strong skills base. Certain treatments are manufactured individually for each patient. In the example of CAR-T cell therapy, the hospital becomes a key player in the manufacturing process as it is responsible for collecting the patient's T-cells and sending them to Novartis.

"We cannot deliver these highly complex and innovative treatments alone. We need an ecosystem approach. That's why we are collaborating with UK government officials, Health Technology Assessment bodies, the NHS, hospital networks, academia, doctors, commissioners, industry partners, as well as

patients and patient groups, to support improvements in diagnostics and therapeutics," says Jeevan Virk, general manager of AAA UK, Ireland, Nordics and Baltics.

In the case of RLT, due to the nature of the medicine, patients who receive this treatment must do so in isolation rooms. Many of these rooms were repurposed to prioritise patients with COVID-19. Working with the NHS and the private hospital networks, Advanced Accelerator Applications (AAA), the Novartis-affiliated company that makes RLT, was able to ensure cancer patients could still receive their treatment.

The UK has the potential to be a leader in the development, discovery and adoption of advanced therapy platforms. There is an opportunity to work with industry partners

to fast-track promising treatments into clinical trials, develop integrated data systems and harness real-world evidence to identify areas that are of greatest patient benefit.

"Advanced therapy platforms have the potential to extend and increase the quality of life. We're keen to continue working with the NHS to increase capacity to offer our advances in cancer therapies, so every eligible patient in the UK can benefit," Scheffele concludes.

Looking ahead

In the last decade, there has been a tremendous effort by researchers, clinicians, scientists and doctors in academic and industry settings to develop this class of therapies, which are now resulting in real outcomes. For instance, the number of patients to be treated with advanced therapy platforms is predicted to rise to 10,000 every year over the next decade, from roughly 200 patients in 2018.

Industry is keen to target major unmet needs in a wide array of cancers using these innovative therapies and the NHS is looking to play a leading role in the development of cutting-edge technology in a new era of personalised medicine.

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For more on advanced therapy platforms please go to www.novartis.co.uk



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Q&A

Radioligand therapy has a promising future for cancer treatment

Radiopharmaceuticals are increasingly used for diagnosing cancer, as well as treating the disease. For one company, born at CERN, targeted radioligand therapies are showing promise in cancer management. **Jeevan Virk**, Advanced Accelerator Applications, UK and Ireland General Manager, talks about this exciting advanced therapy platform



Q What is targeted radioligand therapy?

A Radioligand therapy (RLT) and radioligand imaging involve a precision medicine approach combining a radioisotope or radionuclide with a targeting molecule or "ligand" that binds to specific markers or receptors on cancer cells. Both the radioisotope and the ligand can be changed, depending on the specific type of cancer a patient has and whether it's being used for diagnosis or therapy.

For diagnosis, a radionuclide emitting a type of energy that's detected with special cameras can be used to visualise the location of the cancer using a PET-CT scan. These scans can also identify the right patients for treatment.

When used as a treatment, a radionuclide that emits therapeutic radiation can be used with the same ligand. After infusion into the bloodstream, RLT targets the cancer cells, releasing radiation and causing breaks in the cancer cells' DNA and cell damage. This either kills the cancer cells or prevents them from replicating. The most common form of therapeutic radiation used (beta) only travels a few millimetres, which minimises damage to surrounding healthy tissues.

Q What can this type of nuclear medicine achieve?

A You normally associate radiotherapy or chemotherapy with patients feeling sick while they receive treatment. RLT, in contrast, is well tolerated. For people with cancer, this therapy can provide them with an option that can slow the progression of their disease for a significant period

of time, allowing patients to go about their everyday lives.

Q How are you embracing new technology?

A We're using data and digital processes to drive RLT, whether it's the screening of new radioactive isotopes or new targeting molecules, monitoring patients' responses or informing them about the innovative therapies they're taking. Every therapeutic treatment is personalised, so data is very much part of this process. Shortening supply chain timeframes and production schedules requires careful data management to ensure patients receive their treatment on time.

Q What are the challenges with deploying these therapies?

A We activate the radioisotope in a nuclear reactor in the Netherlands. It's then shipped to RLT manufacturing sites, where the isotope is combined with the targeting molecule through specialised chemical synthesis. From there, it's sent to hospitals around the world for delivery to patients within 72 hours, otherwise the radioactivity degrades to a level where the dose isn't effective.

It's a logistical challenge, yet we were successful, even during the height of the COVID-19 pandemic, in delivering medicines to patients every day around the globe, despite travel restrictions. This puts us in good stead for the end of the Brexit transition period on December 31. We've been working with the Department of Health medical supplies team to make sure our treatments are not

disrupted because of the UK leaving the European Union.

Q Is the UK a good place to develop this type of cancer therapy?

A The UK and the NHS have taken a leadership position in clinical trials research for RLT. We hope patients here will have access to these cutting-edge treatments far earlier than other nations. An ecosystem approach thrives in the UK, bringing patients, patient advocacy groups, researchers and universities, as well as industry and the NHS together. COVID-19 has also shown how important patient outcomes are.

Q What does the future hold for RLT?

A The possibilities for this advanced therapy platform in cancer are exciting and in some ways we are at the start of this journey. At the moment, it's only being used to tackle rare forms of cancer, but we want to use this form of nuclear medicine to treat more common cancers, bringing targeted RLT to many more patients.

This is why we are researching new isotopes with different energy levels, as well as different targeting molecules that can target different kinds of solid tumours. The amount of basic research that is happening each year is remarkable, with an exponential growth in new publications. It means our understanding is gathering momentum too. These are exciting times. Watch this space.

For more on Advanced Accelerator Applications, a Novartis company, please go to www.adacap.co.uk

DIET

Dietary advice for colorectal cancer patients must improve

Colorectal cancer patients are not getting enough information about how diet can affect their condition. So, what is being done to put this right?

Julie Penfold

New research from the University of Sheffield has highlighted nutritional support must be improved for patients living with bowel, colon and rectal cancer. Some 69 per cent of people surveyed said they had not received any diet and cancer advice or support from their healthcare team at any stage of their care, throughout diagnosis, and during and after treatment.

Treatment for colorectal cancer can involve a partial resection, or a temporary or permanent stoma, all of which affects bowel function. Consequently, most patients will encounter a number of nutritional difficulties, including being unsure what to eat and experiencing diarrhoea, constipation, appetite loss as well as changes to taste and smell.

Research findings come as no surprise to charity Bowel Cancer UK. "Within our online community, there's always a lot of discussion about nutrition and what to eat, and we know there is a gap in the provision of this advice," says Lauren Wiggins, director of services at Bowel Cancer UK.

"Around 268,000 people in the UK are living with bowel cancer and that's a lot of lives to be affected by the long-term consequences of treatment. When your bowel is affected by disease, nutrition has

a huge role to play. It's a part of the treatment and care package that is so important."

National Institute for Health and Care Excellence guidance concurs. Its guidelines recommend colorectal cancer patients should be offered comprehensive advice on managing the effects of treatment on their bowel function. This includes information on diet, foods that can cause or contribute to bowel problems, alongside advice on weight management, physical activity and healthy lifestyle choices, such as quitting smoking and reducing alcohol consumption.

When patients are unsure what to eat, they tend to go online to seek advice. Bowel Cancer UK and Macmillan Cancer Support were the main sources accessed by the Sheffield University study's respondents. Bowel Cancer UK has an *Eating Well with Bowel Cancer* guide and Macmillan has *Eating Problems with Cancer* guidance. Both are popular with people looking for evidence-based general information about diet and cancer.

"When patients look online for diet and colorectal cancer advice, the worry is they risk coming across inaccurate information," says Dr Bernard Corfe, lead author of the study and senior lecturer in oncology at Sheffield University. "If we



“They may need to include food that you wouldn't describe as nutritious, but it's good for them

could introduce a kitemark or an evidence-based standard to online information, this could help people to access only reliable nutritional advice sources."

There is an obvious need for individual advice about diet and cancer because what someone is able to eat at different stages of their treatment

will change. Also, everyone is different and experiences will vary from one person to the next. For example, a young patient living with a stoma will require very different diet and lifestyle advice to an older person who has been treated for advanced bowel cancer.

Anyone living with a long-term condition that affects the digestive system will most likely find out what foods work best for them via a process of trial and error. A food diary can help people to keep track of how they react to certain exclusions and reintroductions in their diet.

"People will ask what they should be eating and when I check whether they've received any advice from their healthcare team, almost everyone will say they haven't been told anything

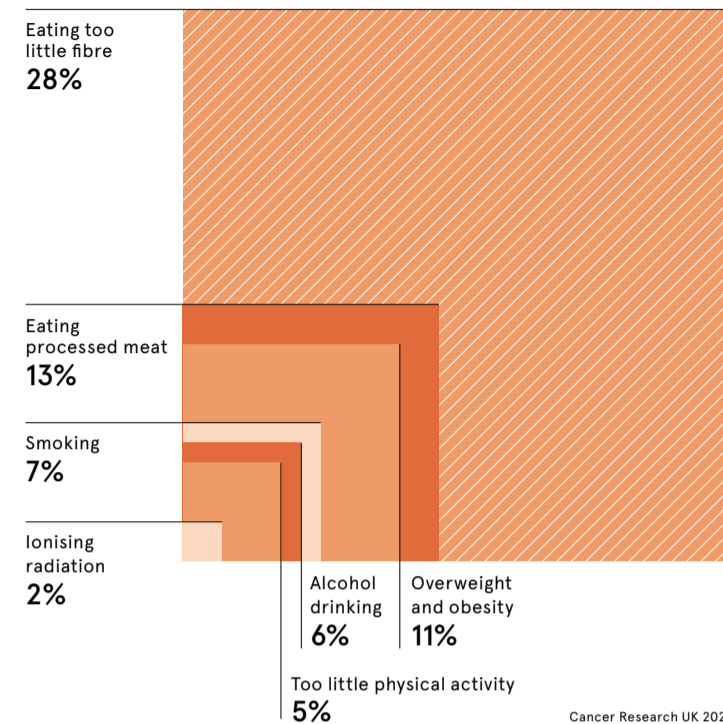
specific," says Kellie Anderson, nutritional adviser at Maggie's cancer care centres. "They are just advised to eat what they fancy. For a limited number of people that might be OK. But for the vast majority, particularly when they have had colorectal surgery, they will have issues."

While eating a balanced diet that includes lean protein, limited red meat, wholegrains and plenty of fruit and vegetables is important for our general wellbeing, and as part of cancer prevention, healthy eating can look quite different for people having treatment for colorectal cancer.

"They may need to include food in their diet that you wouldn't describe as nutritious or as nutrient filled, but it's good for them especially when they are recovering from surgery,"

EXPLORING COLORECTAL CANCER'S RISK FACTORS

54 per cent of bowel cancer cases in the UK are preventable, with diet-related factors responsible for a significant proportion of cases.



says Anderson. "This includes having white bread and rice instead of brown, ensuring the peel is removed from vegetables, excluding high-fibre foods for a short period and avoiding anything that's spicy or too greasy."

"That's why a low-fibre diet is often recommended by someone like myself and I would hope a bowel team might advise this too. The earlier the intervention is, as far as when nutritional advice is given, the better a person's recovery is generally."

Understanding why there is disparity between the nutritional support that people receive could help to ensure it's offered more equitably going forward.

"You may find the reasons differ depending on geographical area, the availability of local dietician services or it may be the resources are just not there," says Wiggins at Bowel Cancer UK. "Another issue could be the resources are there, but patients don't know about them and aren't aware they can ask for a referral to a dietician, for example."

Corfe feels part of the problem is that nutrition is sometimes seen as a bolt-on to care. "Training and paying for enough dieticians to offer this advice to patients isn't probably something that's feasible within the NHS at the moment. But offering basic nutrition training through continuing professional development courses could help to improve the dietary advice provided to patients by GPs."

"There's also a concern that there is insufficient nutrition in the medical curriculum at all stages. I think the bottom line is there needs to be more training offered to better inform GPs."

In addition, GPs could benefit from support to enable them to provide information about diet to patients living with cancer.

"We need to be giving GPs the tools to be able to have these conversations and signpost the right places where patients can get expert support," says Wiggins. "Bringing GPs into the care pathway for colorectal cancer is important because they will be seeing those patients a lot more regularly than their hospital teams."

"The impact of treatment on the bowel is one of the longer-term consequences of treatment for this type of cancer and it can have a significant impact on a person's quality of life. It's vital that nutrition is addressed as part of the care pathway."

Alternatively, general practices could create a list of evidence-based resources to provide to patients, such as information on diet and cancer from Bowel Cancer UK, Macmillan Cancer Support and Maggie's. This would help to prevent patients coming across online diet and cancer advice from unreliable sources. Anderson also offers nutrition and cancer advice via her website *Food to Glow* and this resource is used by a number of hospital teams.

However, evidence-based online advice is not a substitute for a more personalised approach to how diet and nutrition advice is provided.

"The Bowel Cancer UK website has lots of information about diet, but this general information should be viewed only as a good starting point for a conversation," says Wiggins. "It should not be considered as the end of the conversation. Tailored information is really important."

69%

of people said they had not received any diet and cancer advice or support from their healthcare team at any stage of their care

University of Sheffield 2020

Commercial feature

Technology supporting patients and clinicians

How a digital solution is enabling patients to feel in control of their treatment and transforming cancer care

Navigating cancer through the fog of treatment, side-effects, complex medication regimes and personal upheaval can be as challenging as the physical storm created by the condition itself.

Patients struggle with adhering to daily drugs, managing side-effects and staying in touch with medical appointments, often plunging their health into further danger.

But a new brand of "thoughtful technology" is supporting patients and their families through the complexities of diagnosis, treatment and recovery.

Careology, an app that can work with NHS and private healthcare services, is pioneering digital cancer care that puts users in control and gives them confidence at one of the most vulnerable periods of their lives.

It is designed to improve health outcomes for patients by helping keep on top of the complexity of life with cancer. For medical professionals, Careology enables scalable, virtual outpatient care and creates better-informed consultations. The combination of patient self-management and proactive intervention could improve safety, reduce costs and free up clinical capacity.

The platform, which integrates with popular health-tracking devices, was devised by Paul Landau, an experienced technology entrepreneur when his wife Lucy, was diagnosed with Hodgkin lymphoma.

"I watched Lucy go through gruelling treatment and was shocked by how little technology was available to support people going through such a complex diagnosis," says Landau, the founder of wearable technology business Fitbug.

"Cancer is daunting both physically and mentally, from the trauma of diagnosis to all the things that need managing effectively. I saw the opportunity

Up to **500k** people will be diagnosed with cancer in England each year by 2035. An increase of 40% since 2015

Up to **50%** of people do not take their medication as prescribed

More than **£500m** a year is spent by the NHS on emergency inpatient care for people diagnosed with one of the top four cancers

Although **70-80%** of the time it is non-intentional

for consumerised technology to make living with cancer less complicated."

Life becomes dominated by remembering medications, managing side-effects and keeping on top of consultations. Often without wanting to be, or to feel like, a nuisance, it can be hard for people to gauge when to contact the hospital for help.

Careology's intuitive design enables people to improve self-management and log the cumulative effects of treatment. From monitoring vital signs, to mood, symptoms and side-effects, Careology ensures these key pieces of information, often forgotten between consultations, are now available to clinicians.

Careology can highlight potential problems, such as a temperature spike that could indicate an infection, before they become critical, ultimately reducing clinical risk and leading to better outcomes for patients.

The app provides reminders to help minimise the risk of missing medication, improving adherence rates.

"This is incredibly important, as many patients experience 'chemo brain' where it is difficult to remember things, so anything that helps effectively stay on top of medication is vital to their health," says Landau.

The need for this technology has been emphasised by coronavirus, which has restricted contact with individuals' usual support networks and reduced face-to-face hospital appointments.

The NHS is investing in tech to improve cancer treatments and outcomes, to

meet an ambition that by 2028 an extra 55,000 people each year will survive for five years or more following diagnosis. The digital approach will be vital as the numbers of people in the UK living with cancer is forecast to rise from 2.5 million to four million by 2030, according to Macmillan Cancer Support.

The app, which can be downloaded via iOS or Android, has been developed to integrate with healthcare providers to enable medical teams to monitor previously unavailable patient data and devise effective, efficient and personalised care plans for patients. It has been recommended by Macmillan as a useful tool for people living with cancer.

"We have received very positive feedback from the patients and caregivers who are using Careology. It's helping them feel far more secure, organised and connected during treatment. For clinicians and healthcare providers, it represents an opportunity to drive efficient and cost-effective cancer services," says Landau.

"Living with cancer can feel very lonely and place a huge burden on your shoulders, but Careology can give you the confidence that you are not alone. We will lift that weight and help you feel connected to your medical teams and supported by those around you."

For more information please visit www.careology.health/care

Careology

Make more of the

UP
DAYS



Digital technology that transforms your cancer care

Careology will help you feel safe and better equipped to manage your cancer treatment. It supports and connects you to your healthcare provider, enabling remote care that transforms the way people live and deal with cancer. Careology's here to help make the down days more manageable and the up days come more often.

Visit careology.health

Careology



IF YOU LIVE IN ONE OF THE MOST SOCIO-ECONOMICALLY DEPRIVED AREAS IN ENGLAND YOU...

are **20%** more likely to have your cancer diagnosed at a late stage

receive only **50%** of the referrals to early stage clinical trials

face almost **25%** more emergency admissions in the last year of life

could be among **47%** of low-income cancer patients suffering with cancer-related loneliness or isolation

Macmillan 2019

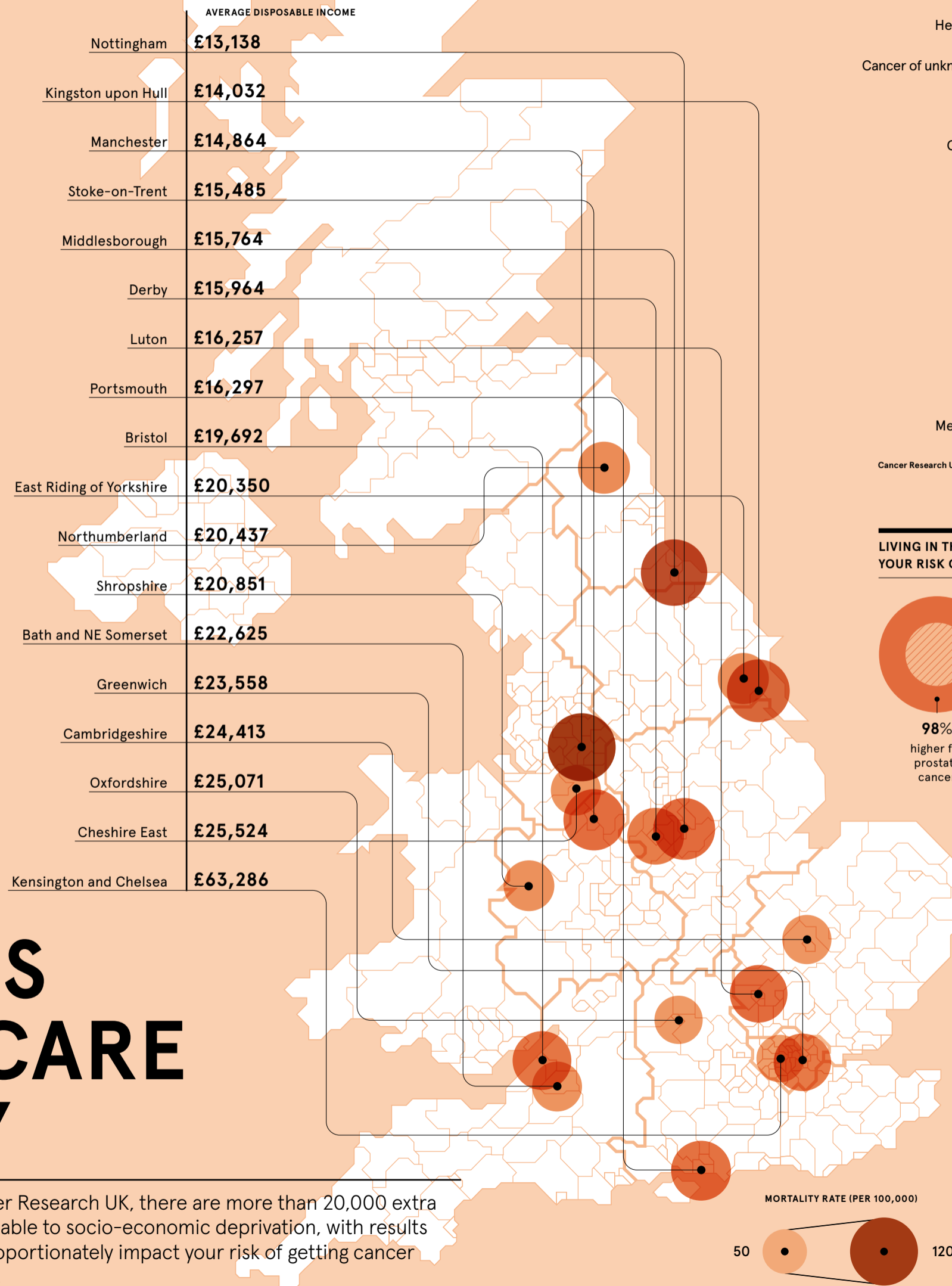
BRITAIN'S HEALTHCARE LOTTERY

According to a recent report by Cancer Research UK, there are more than 20,000 extra cancer cases a year which are attributable to socio-economic deprivation, with results showing that where you live can disproportionately impact your risk of getting cancer and the care you can expect if you do.

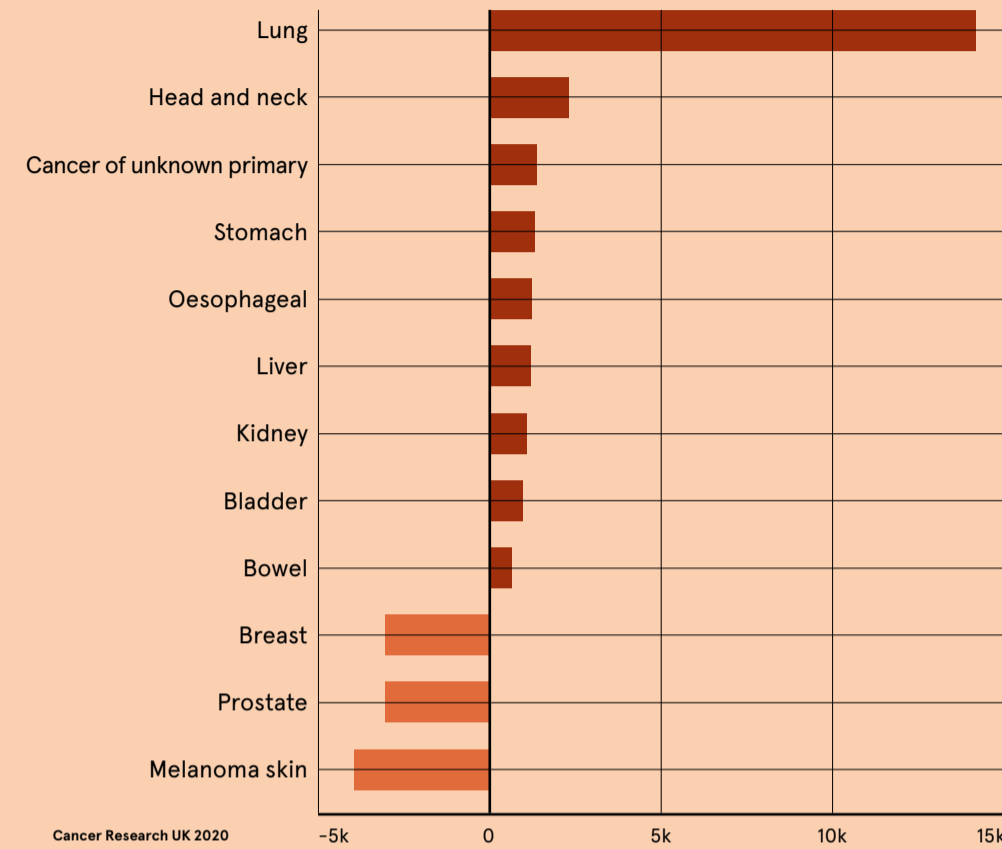
AS INCOME GOES UP, MORTALITY RATES GO DOWN

Examining the link between the mortality rate from cancer considered preventable in people under 75 years old and the average disposable household income across England.

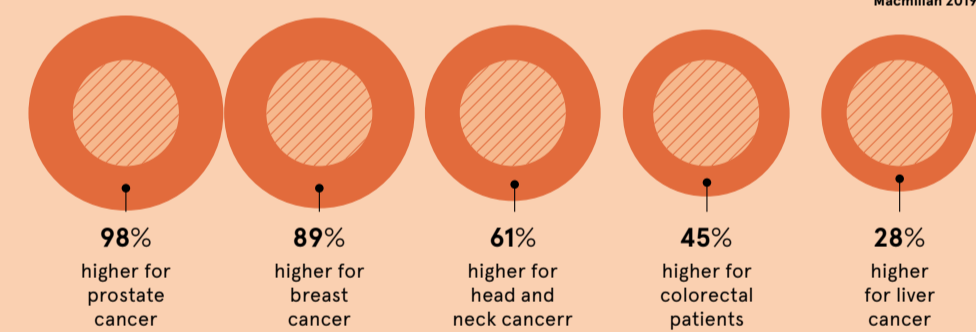
Public Health England and Office of National Statistics 2018



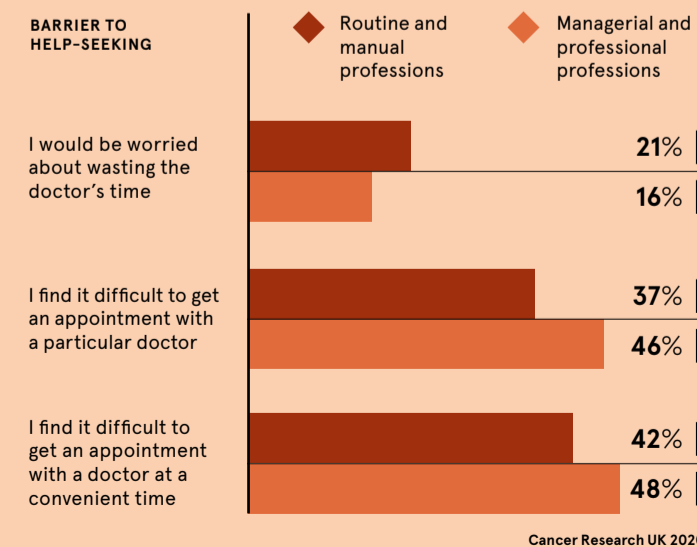
AVERAGE ANNUAL EXTRA CASES DUE TO DEPRIVATION GAP, ENGLAND, 2013-2017



LIVING IN THE MOST SOCIO-ECONOMICALLY DEPRIVED AREAS IN SCOTLAND, YOUR RISK OF MORTALITY IS...



ACROSS THE UK, THOSE WHO WORK IN "ROUTINE AND MANUAL" OCCUPATIONS (WHO ARE MORE LIKELY TO BE FROM MORE DEPRIVED AREAS) ARE ACCESSING BARRIERS TO SEEKING HELP NOT PRESENT IN THEIR COUNTERPARTS FROM LESS DEPRIVED AREAS.



FOUR IN TEN UK CANCER CASES ARE AVOIDABLE

Share of UK cancers that have a preventable cause by risk factor, many of which are a larger problem or more common behaviour in more deprived areas of the UK.



IN NORTHERN IRELAND, SMOKING PREVALENCE IS

30% for the most deprived areas

10% for the least deprived

And the picture is similar all across the UK

Cancer Research UK 2020

Cancer Research UK 2020

INEQUALITY

Tackling inequalities in cancer care

People from the UK's most deprived communities are more likely to get cancer, but the problem of health inequality is more difficult to solve than it might seem

Natalie Healey

It matters where you live when cancer comes knocking. There are around 20,000 extra cancer cases in more deprived areas of Britain every year, according to Cancer Research UK. That's almost 60 additional diagnoses a day and an "unacceptable reality in 2020", the charity says.

The 20,000 figure may be sobering, but for many health experts, it's not surprising. We've known for decades that significant health inequalities exist in the UK. And it's not just cancer that's affected; life expectancy also strongly correlates with wealth.

In 2010, a University College London (UCL) Institute of Health Equity report, led by epidemiologist Professor Sir Michael Marmot, found people living in the poorest neighbourhoods in England will die seven years earlier on average than people in the richest parts of the country. The reasons are multi-faceted, from poor access to healthcare services and housing to more dangerous jobs and food insecurity.

People in poorer areas are not only more likely to get cancer, they're also more likely to die from it, says Cancer Research UK. Compared to the richest regions, people in the most deprived areas are 50 per cent more likely to have their cancer diagnosed through emergency routes, when the disease is often

at a late stage and therefore harder to treat. At every step of the cancer care pathway, poorer people are at a disadvantage.

"It's stark and it's not fair, but it's also changeable," says the charity's science information officer Dr Rachel Orritt.

Researchers have found the most evident socio-economic differences are in cancers linked to smoking, such as lung and throat cancer. Rates of smoking-related cancers are three times higher for the poorest populations compared to the richest.

But it's hard to stub out the habit without sufficient support. Cancer Research UK believes protected funding, raised through a levy on the tobacco industry, to pay for more support programmes that combine expert behavioural support with quit-smoking aids, such as tablets or nicotine-replacement therapy, could help.

Research in January from Cancer Research UK and Action on Smoking and Health found that almost a third of local authorities have axed their specialist stop smoking services in the last five years.

Obesity is another issue and the second-largest preventable cancer risk factor after smoking, accounting for around 23,000 cases in the UK each year. Children from the poorest areas are twice as likely to be obese compared to those in the least deprived. And obese children are around five times more likely to be obese in adulthood when the risk of cancer increases.

Cancer Research UK wants more public health efforts to reduce obesity and is calling on the government to implement measures outlined in its July obesity strategy, which include restricting advertising and price promotion offers on junk food.

Whether these proposals go far enough remains to be seen. "I think a lot of what we do sometimes feels as though we're just tinkering around the edges," says Dr Sara Macdonald, sociologist in primary care at the University of Glasgow. She worries that policies urging people to make better lifestyle choices may not take into account the underlying reasons behind unhealthy behaviours.



Marko Gaber via Gettyimages

“It's stark and it's not fair, but it's also changeable”

“These kinds of things may just not be top priorities if your life is more challenging,” says Macdonald. “The circumstances for people living in areas of deprivation are not always conducive to stopping the behaviours we are encouraging people to stop. Life is harder and we should probably acknowledge that.”

What makes tackling health inequalities so challenging is that every new policy requires patience, says Professor Georgios Lyraopoulos, cancer epidemiologist at UCL. As factors that lead to the development of cancer take many years to show up, it could be decades before efforts to reduce the risk look as if they've worked. “This isn't like preventing people from being injured in a car accident, where if we started with no seatbelts, but introduced them tomorrow, the prevention would happen straightaway,” he says.

But targeted efforts relying on the expertise of local services that understand the unique challenges of their residents could be

important. Plus, in cancer care, we need to understand better the barriers to seeking help at an earlier stage; why someone might skip their screening appointment or put off going to the doctor if they're experiencing symptoms such as a cough that lasts for longer than three weeks, which might suggest lung cancer.

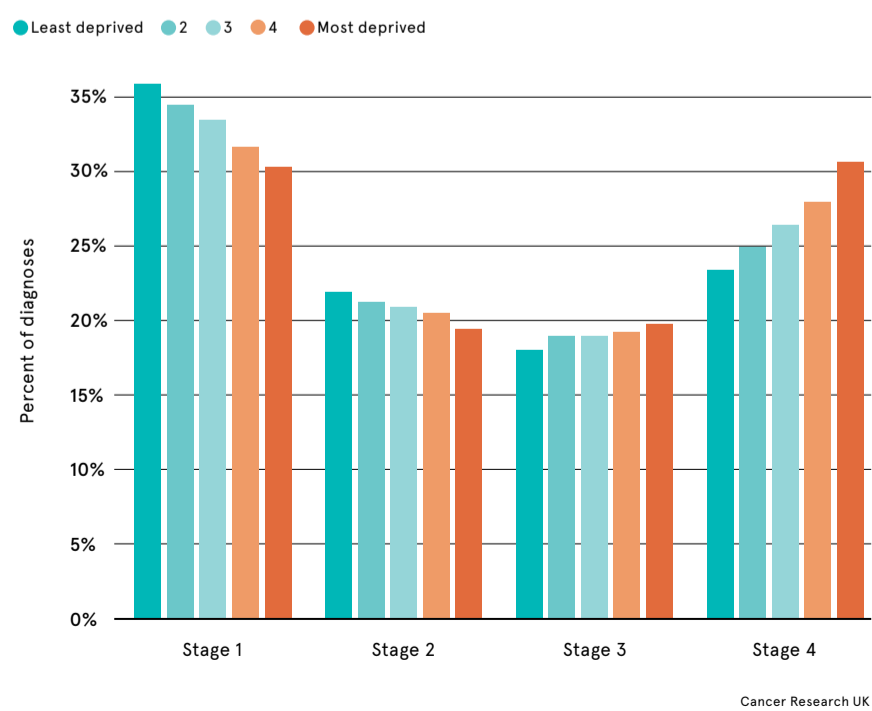
“If you live in a more deprived community and the outcomes are poorer, then your attitude towards cancer may be more fatalistic,” says Macdonald. “Whereas if you live in a more affluent community, you will probably know people who have survived cancer. All these things come into play and affect how we think about our health.”

The Marmot review suggested health inequalities are largely preventable, but a successful strategy must take into account all the social determinants of health, such as education, jobs, housing and community. This is hard to achieve without sufficient funding for support services and local government. Ten years on from the original report, the authors say the health gap has grown between wealthy and deprived areas. They note: “If health has stopped improving, it is a sign that society has stopped improving.”

As the country continues to endure the challenges of the coronavirus pandemic, there are many question marks over how the NHS can adapt and recover from months of disruption. Cancer care in particular has been heavily impacted by the crisis. But COVID-19 could also be a catalyst for change, says Macdonald. “If there's been one benefit of COVID, it has been that people have started to acknowledge the health inequalities in our society. We need to take this seriously.”

DEPRIVATION CAN IMPACT WHEN CANCER IS DIAGNOSED

Proportion of patients diagnosed at each stage of cancer by deprivation quintile.



Cancer Research UK 2020

FOCUS ON CUTANEOUS T-CELL LYMPHOMA (CTCL): A RARE AND DEBILITATING BLOOD CANCER

01

CTCL is a rare disease that affects

0.7 per 100,000³

patients across the UK



02



Mycosis² Fungoides

is the most common form of CTCL, accounting for around half of all skin lymphomas

03

Sézary syndrome accounts for around

3 in every 100⁴

cases of CTCL

04

People with advanced stage of CTCL have a poor¹ prognosis on average: Less than

40% survival rate overall for people with advanced MF or SS, at 10 years

20% of people with very advanced MF/SS have a progression-free survival at 10 years

¹ BAD and U.K. CLG guidelines for primary cutaneous lymphomas 2018, D. Gilson et - ² https://lymphoma-action.org.uk/typeslymphoma-skin-lymphoma/skincutaneous-t-cell-lymphoma - ³ British Association of Dermatologists and U.K. Cutaneous Lymphoma Group, Guidelines for the management of primary cutaneous lymphomas, 2018 - ⁴ https://lymphoma-action.org.uk/typeslymphoma-skin-lymphoma/skincutaneous-t-cell-lymphoma - ⁵ BAD and U.K. CLG guidelines for primary cutaneous lymphomas 2018, D. Gilson et

Bringing hope for people living with rare diseases

Treating rare diseases is one of the greatest challenges faced by the healthcare community

The coronavirus pandemic is continuing to have a significant impact on healthcare systems and the industry's ability to provide timely access to therapies for patients who need them.

Limited patient populations, lag in diagnosis and complex genetic tangles make drug discovery and provision an article of faith, as well as a scientific mission, in the rare disease area.

Kyowa Kirin, the Japanese innovative biotechnology and pharmaceutical company, follows a focused discovery pathway based on excellence in clinical analysis, genetic engineering and manufacturing technology. For more than 30 years, they have pursued scientific discoveries that help address unmet medical needs.

Kyowa Kirin, which is headquartered in Japan but has a strong UK and European presence, has five research facilities around the world that have created more than 50 therapeutic products for people living with a range of rare and more common conditions. Kyowa Kirin has 18 drugs in development and will be launching three global products across its northern cluster, including the UK, Ireland, the Nordics and Baltics, over the next year.

With cutting-edge technologies and systemic therapies, the company is providing hope to people living with rare diseases, including rare cancers.

Although a rare disease is classed as affecting fewer than one in 2,000 people, there are 6,000 different types impacting around 3.5 million people in the UK and 30 million in Europe.⁶

"The rare disease area is particularly challenging, but commitment to life is our founding principle and it flows through everything we do. We never lose sight of patients, their families, carers and healthcare professionals, not to forget our teams," says Richard Johnson, Kyowa Kirin's northern cluster general manager.

"By definition, each rare disease affects very few patients but everyone of them is important to us. We aim to make a difference to their lives. We seek to understand the impact these conditions have on them through our engagement with the clinical and patient advocacy communities. We are constantly thinking about what they are experiencing and doing our best to meet their needs."

Kyowa Kirin's attention to the needs of people living with rare diseases is characterised by its holistic approach, which includes providing nurse home-care services, along with education and advocacy programme. The company's objective is to optimise patients' access to the right healthcare support and to increase patient groups' voice in the health policy debate.

On average, it takes more than four years to receive an accurate diagnosis

of a rare disease and Kyowa Kirin is committed to reducing this distressing time lag.⁶

"Our innovation is focused around unmet needs and improving the outlook for patients, and bolstering the ability of healthcare providers and professionals to offer effective treatments," says Johnson. "We involve patient groups early in the process. They are the best placed to provide us with insights as to what will work best for patients."

"On the immediate horizon, we will be launching three global products across the northern cluster and have more products coming through clinical trials. It enthruses all of us to know we can make a difference to people's lives and these are exciting times for us and people living with rare diseases."

The company has four key pillars to its drug development programme:

“The satisfaction of helping people living with often lifelong and debilitating conditions to have a better quality life is hugely motivating and rewarding”

next-generation therapeutic antibodies, new small molecule drugs, nucleic acid drugs and regenerative medicine. It collaborates strongly with biotech to advance innovative products.

A prime example of its approach has been recently gaining an expanded licence for a treatment for adults with a rare metabolic bone disorder, which previously had no systemic approved therapy.

Dr Robert Chipperfield, the company's northern cluster medical lead, believes Kyowa Kirin's corporate culture is symptomatically tuned to improving the lives of people living with rare diseases.

"You have to be dedicated to develop a drug for a rare disease as you are not going to be producing a blockbuster because the patient populations are small. But the unmet need is there. The satisfaction of helping people living with often lifelong and debilitating conditions to have a better quality life, to be able to enjoy their families, play with their grandkids, is hugely motivating and rewarding," he says.

"We make more than medicines. Our culture is to bring a smile to the faces of patients and that is very refreshing. We have ambition across rare diseases and oncology, and I'm excited about what the future holds for people affected by those conditions we are researching treatment for, for the company and our teams."

Maintaining its core qualities and patient engagement has presented challenges during the pandemic, but Kyowa Kirin has adapted its processes to stay connected to all its stakeholders, including patient groups, clinicians, payers and healthcare providers, while continuing its fast-paced growth and innovation. Objective: discover medicines that have the potential to change lives.

Rare disease focus: Cutaneous T-Cell Lymphoma (CTCL)

Rare diseases are often chronic and life threatening, and all exact an extreme toll on a patient's mental health as, on average, each will receive three misdiagnoses, visit five doctors and wait four years before receiving an accurate diagnosis.⁷

Cutaneous T-cell lymphoma (CTCL) is a rare blood cancer that manifests on the skin with symptoms similar to psoriasis and eczema, which makes it difficult to spot and condemns patients to long periods of severe discomfort and distress.

"CTCL takes away all my energy; it eats me from the inside," one patient says. "I no longer slept, my skin itched constantly. I was incapable of doing professional or intellectual work. It impacted our relationship as a couple."

The condition is treatable, though not curable, but a key component in easing the burden is raising awareness and improving medical education so diagnoses can be delivered swiftly.

"A GP may only see one patient in their lifetime and, because it appears as skin lesions, patients can get stuck in dermatology conditions until someone puts two and two together," says Chipperfield. "That delay in diagnosis can have a massive impact on quality of life, both for people living with the condition and their carer or carers, and on life expectancy. Only around half of patients (52%) with advanced MF/SS survive for 5 years.⁸ This is something that we and the healthcare community should tackle.

"We are committed to raising awareness and enhancing medical knowledge across the clinical journey so we can put the disease into remission and improve quality of life."

Further information on CTCL can be found at lymphoma-action.org.uk and lymphomacoalition.org/Europe_cifoundation.org

⁶ https://www.raredisease.org.uk/what-is-a-rare-disease/
⁷ https://www.raredisease.org.uk/our-work/illuminating-the-rare-reality-2019/
⁸ Scarisbrick JJ, Prince M, Vermeer MH, et al. Cutaneous Lymphoma International Consortium Study of Outcome in Advanced Stages of Mycosis Fungoides and Sézary Syndrome: Effect of Specific Prognostic Markers on Survival and Development of a Prognostic Model. J Clin Oncol. 2016;33(32):3766-3773

DIAGNOSIS

Disruption in diagnosis could have dire consequences

Rapid diagnostic centres were hailed as the great hope pre-coronavirus, but healthcare professionals are in two minds over whether they are still fit for purpose

Nick Easen

If you take notice of the news headlines, you would think coronavirus is the only major threat to mortality and morbidity. Yet postponing the early screening of cancer also kills. Up to 3,600 lives in the UK could be lost to four main cancers over the next five years due to delays in diagnosis caused by the pandemic, according to research published in *The Lancet Oncology*, while almost one million women have missed vital breast screening.

Since the start of the pandemic, a perfect storm has occurred for cancer diagnosis in the UK. People have been frightened to attend early scans. There's also been interruptions in cancer screening services for breast, bowel and cervical cancer, as well as reduced capacity at doctor's surgeries and a shift in healthcare resources to deal with COVID-19.

"The messaging to the public has been beyond extreme and stopped people presenting themselves. Yet a few weeks' delay has a huge impact on patient outcomes. We've seen significant stage shifts across all types of cancers. People who had symptoms in February are only now going for tests. Our data from *The Lancet Oncology* paper is now likely to be an underestimate," says Professor Richard Sullivan from the Institute of Cancer Policy at King's College London.

"The impact on screening, especially colorectal, has been highly



significant. As friction rises in the pathways to early diagnosis, more people are missed. None of this is rocket science and the UK government and SAGE, the Scientific Advisory Group for Emergencies, have either wilfully ignored this or, unbelievably, not taken this into consideration."

There are now calls for renewed public health campaigns to encourage more suspected cancer patients to come forward for screening, with a focus on presenting the NHS as a safe environment for testing, since delays in cancer surgery can make cases non-operable.

"If we don't resolve this we'll see more patients diagnosed with advanced disease and fewer diagnosed with early stages of cancer. This will impact survival rates. There will be real consequences for some patients in terms of their chances of surviving cancer," warns Dr Jodie Moffat, head of early diagnosis, Cancer Research UK.

Investment in rapid diagnostic centres, or RDCs, could help with

A woman attends a mobile breast cancer screening unit. According to recent estimates, almost one million women have missed vital breast screening appointments due to COVID-19.

the backlog. They were designed by the NHS to speed up cancer diagnoses. Pre-pandemic, NHS England committed to rolling out these centres, with the aim of covering the country's entire population, but this is not expected for several years.

"It is not yet clear what impact COVID-19 will have on this rollout. During the peak of the pandemic, some RDCs remained operational, but others paused, when staff moved to other areas. Concerns remain that progress and expansion of centres will be limited due to the availability of workers," says Moffat.

3,600

lives in the UK could be lost to four main cancers over the next five years due to delays in diagnosis caused by COVID-19

The Lancet 2020

The NHS sees RDCs as pivotal to restoring cancer screening services, but some are sceptical of their potential. "These centres are a red herring. The implicit assumption is that these would improve early diagnosis and shift staging. Yet the vast majority of diagnoses are made through standard routes from primary care to local hospital networks," says Sullivan.

Despite the gloom during the pandemic, there have been some unforeseen bright spots aside from highlighting the need to push for more screening. "Interestingly, with the increased number of hospitalised patients because of COVID-19, the number of chest CT or computed tomography scans has been growing and, with this rise, the number of incidental cancer diagnoses is also on the up," says Ade Adeyemi, who heads the global health fellowship at thinktank Chatham House.

Costs have been overlooked in the COVID-cancer paradigm. The fact is cancers in the latter stages

of development are much more costly to treat. "The earlier a cancer is diagnosed, the more treatment options are available including less invasive interventions, which are less expensive to the NHS. Later diagnoses also trigger longer periods of hospitalisation affecting the allocation of in-patient resources," says Dr Sabrina Germain, senior lecturer in medical law at City, University of London.

The plummet in funding for medical charities also impacts early diagnosis. There's been a shortfall of up to £167 million in cancer research spending from this sector. "Charitable funders support the majority of non-commercial early-detection research in the UK and there's a danger that it could be even more greatly affected," says Dr Ian Lewis, head of strategy at the National Cancer Research Institute.

Sara Bainbridge, head of policy at Macmillan Cancer Support, sums it all up: "Cancer must not become the 'forgotten C' during this pandemic." ●

Education Images/Universal Images Group via Getty Images

OPINION

'The cancer workforce needs to be supported; happy doctors deliver safer care to more satisfied patients'

Health budgets are under increasing strain and cancer incidence is increasing. NHS cancer services have big constraints to manage, without the added stress of a novel virus.

But the UK cancer community remains optimistic. The future of non-surgical cancer care is exciting and will be defined by early disease detection, technological advances, including artificial intelligence (AI), and an increasingly personalised approach to all aspects of care. This includes follow-up shaped directly by patients through patient-reported outcome measures.

Screening will be tailored, eventually including individualised genetic risk factors, identified by "reading" our genetic code. Widened screening, coupled with new pathways to diagnosis, including dedicated "one-stop shop" community diagnostic hubs, have the very real potential to boost patient outcomes and survival by detecting more cancers at an earlier stage. Better, less damaging treatment options exist for early-stage cancer, so we will see a shift towards those treatments, improving cure rates.

People, and not just older people, have other illnesses which impact their cancer therapies. Individualised "prehabilitation" for patients will ensure the quickest recovery, both mental and physical. Simple signposting to advice on nutrition, exercise and smoking cessation will become a routine part of the cancer treatment package. More intensive prehabilitation for patients with lung cancer, for example, might include respiratory physiotherapy and exercise classes.

Currently, clinicians are able to segment some patients based on the characteristics displayed by their tumours. For example, there are now four different routine tests that enable clinicians to recommend the best drugs to fit every person's individual genetic make-up, giving the best chance of cancer control to all patients.

We are already starting to see the benefits of research, leading to shorter, less intense courses of treatment for certain cancers, most notably shorter radiotherapy regimes for women with particular breast cancers. Many multinational trials have proven reducing chemotherapy and

radiotherapy in lymphoma treatment doesn't reduce cure rates.

UK cancer teams are also pioneering new radiotherapy technology that aims to make treatment even more precise. Magnetic resonance linear accelerators, first trialled at The Christie and Royal Marsden cancer centres, can map tumours and adapt treatment in real time. It is hoped they will improve targeting of tumours that are mobile or difficult to see using standard techniques.

AI programmes have huge potential to augment care, with uses ranging from helping clinicians provide tailored information for patients, as well as providing back-up to clinical judgment in radiotherapy planning and the interpretation of imaging tests.

The ability to roll out these innovations rests on the resourcing, adaptability and stamina of the multidisciplinary cancer care team, comprised of oncologists, nurses, radiographers, pharmacists, physiotherapists and many others, all working together for the benefit of each patient.

To give the best care, health professionals will need time to assimilate the newest treatment technologies. However, having clinicians work at the top of their licence to improve outcomes will be as exhausting as it will be exciting.

The cancer workforce needs to be supported; happy doctors deliver safer care to more satisfied patients.

To safeguard the future of cancer care, there must be investment in the future of our cancer staff, which means growing the cancer workforce, bolstering clinical leadership and realising the vision of NHS England's *People Plan* in making the NHS the best place to work.



Dr Jeanette Dickson
President of The Royal College of Radiologists and practising lung oncologist

In it together at a time of need

Claire Smith, chief executive officer of HCA Healthcare UK Joint Ventures, describes how cancer care has continued during the coronavirus pandemic and stresses the importance of seeking help if you need it

On March 21, the NHS announced an unprecedented deal with the independent sector, taking over capacity to ensure that vital care could continue for those patients who needed it most. For HCA Healthcare UK that meant making available more than 800 beds, 1,600 employed nurses, healthcare professionals and theatre practitioners, 77 intensive therapy unit (ITU) beds, 33 high dependency unit (HDU) beds and 38 theatres.

As a long-time partner of individual NHS trusts, HCA Healthcare UK has been privileged to work more closely with NHS England during the pandemic, to make a significant contribution at a time of national crisis.

When the UK went into lockdown, our only focus was supporting the national effort to ensure we were able to continue care for patients with time-critical healthcare needs. This included NHS, private medically insured and self-pay patients, who were all triaged strictly according to clinical need via NHS hubs.

We were also able to support NHS trusts with additional equipment needs, as well as through the expertise of our teams, some of whom were seconded to support NHS services. It was truly inspiring to see the healthcare sector come together and deliver this level of unprecedented care.

An urgent focus for us was ensuring cancer patients could continue to receive the care they needed.

At HCA Healthcare UK we took immediate action, putting additional safety measures into place meant that we could use our existing infrastructure to provide the right environment, for even the most complex cancer care to continue safely



At HCA Healthcare UK we took immediate action. Putting additional safety measures into place meant we could use our existing infrastructure to provide the right environment for even the most complex cancer care to continue safely. These measures have now become part of our daily practice, ensuring that since the start of the pandemic, we have managed to both continue care while keeping our hospitals COVID-safe spaces.

As well as additional safety measures within our hospitals, we have taken steps to reduce in-hospital interactions. This has meant adapting treatment plans without compromising on quality of care. For example, some of our most vulnerable blood cancer patients have been treated in the community through oral drug therapies in line with extended NICE (National Institute for Health and Care Excellence) guidance, while our holistic services, such as patient support groups and vital physical therapy, have been provided remotely.

Thinking differently about how patients access our services has been key to continuing care. Virtual consultations either by video or telephone are no longer confined to GP practices. These consultations are enabling us to limit face-to-face interactions while still providing a route into diagnosis and onward care, which when it comes to cancer can be lifesaving in many cases.

Take 32-year-old patient Robert as an example of how effective this has been. Concerned about a lump, he was seen virtually by a consultant and within three

days of his diagnosis, he was having surgery at London Bridge Hospital to remove a cancerous tumour.

We have also seen a shift in how we plan patient care. Our expert consultants and clinical teams have embraced virtual multidisciplinary team meetings, which means we can maintain truly personalised cancer care for each patient.

It is thanks to all these measures that we have cared for patients safely throughout the pandemic and now, as we return our focus to delivering wholly private care, how this care will continue even as we face a second peak.

Though we are seeing more and more patients, we know many people are still not coming forward with symptoms. A recent NHS survey that suggested one in ten people would not contact their GP even if they had a lump is particularly worrying. We know early diagnosis can make all the difference to treating cancer successfully, so we need patients to know we are open, we are safe and we want you to seek care if you have a concern. Suspected cancer symptoms really do have to be investigated, it could make all the difference to your diagnosis and long-term treatment outcome.

Cancer is still here and we will continue to be here to care for our patients safely.

For more information please visit www.hcahealthcare.co.uk/cancercare

HCAHealthcare UK

NCRI Virtual Showcase

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COMMUNICATIONS

Keeping cancer research in the public eye

Cancer charities rely on public support for their lifesaving research, but with the pandemic decimating budgets, preventing fundraising and publicity events, they must find new ways of getting their message across

Celia Jones

Half of us will develop cancer in our lifetime. There is no avoiding this terrible, uncomfortable truth. Hundreds of charities in the UK support people affected by the disease and these charities accounted for more than 50 per cent of publicly funded cancer research in the last year. The role of communications is of critical importance as cancer research marketing helps to increase awareness, protect public health and encourage people to donate.

This is no simple task. Public relations, marketing and advertising teams have to contend with the ever-changing media landscape and the way people engage with information is constantly evolving. The boom of TikTok and seemingly unstoppable rise of podcasts are just two channels that must be considered by any communications department. Everything must be evaluated for relevance: will it help a charity reach its target audience?

Although we are increasingly on our smartphones and digital devices – we spend an average of 3 hours 29 minutes online each day, up 17 minutes compared to last year – the voluntary or third sector is renowned for face-to-face fundraising. Large-scale events like Cancer Research UK's Race For Life and the bobbing rainbow of charity-coloured clothing at the London Marathon are

“It's incredibly important to share the impact of our lifesaving work

essential parts of a charity's public-facing communication strategy. The pandemic and necessary social distancing razed most events' financial potential in 2020.

Even before coronavirus came along, cancer charities' marketing and communications teams had to try to cut through the vast amount of information already out there.

We are a nation of Googlers: on average, UK adults spent 47 minutes a day on Google in 2019. Alison Day, director of communications at Prostate Cancer UK, says access to instant health information online is positive as it can educate people on cancer's associated risks. However, she warns: “This can also bring misinformation and misunderstanding. Charities have moments, if not seconds, to get their brand messages across and for the right information to land.”

When Prostate Cancer UK comes up with ideas, Day considers how cancer research marketing messages will land among a sea of others: “What will make our story jump off a Facebook timeline or catch your eye during an ad break?” She says it is essential to show the public the truth of the number-one cancer affecting men and now the most commonly diagnosed cancer. “You can't talk about prostate cancer without showing the reality of the disease and the gut-wrenching injustice it causes,” says Day.

Jo's Trust, the UK's leading cervical cancer charity, believes it's crucial to have a dynamic communication strategy that spans many channels. “We're very aware that one medium doesn't reach every person,” says Kate Sanger, head of communications and public affairs. Its outdoor advertising speaks to a different audience than its social media support forums for women living with the disease.

Coronavirus meant Jo's Trust lost 60 per cent of its fundraising income almost overnight. It had to

reconsider plans to best supplement the NHS and keep communicating how cervical cancer is largely preventable. The challenge is getting the tone right when so many people are experiencing heightened anxiety, Sanger says: “We didn't want to overburden and criticise the NHS, and at the same time we never want to make anyone feel like they are to blame if they can't attend a smear test.”

Ovarian cancer is one of many versions of the disease that does not have a reliable screening programme. It means knowing the signs and taking action is of vital importance. Annwen Jones, chief executive of Target Ovarian Cancer, says: “We have to make our communications work hard to combat low awareness and to help more people understand how the situation with ovarian cancer is so challenging.”

The charity features women with ovarian cancer in its media and social media campaigns, sharing their experiences. Every day, 11 women die in the UK from ovarian cancer and treating it early makes all the difference. “When diagnosed at the earliest stage, 93 per cent of women survive for five years or more,” says Jones.

Target Ovarian Cancer hopes that if people know the symptoms, they will feel empowered to go to their GP. However, research shows just one in five women could name bloating as a key symptom.

Cancer survival in the UK has doubled in the last 40 years. Cancer Research UK's funding of scientists, doctors and nurses has been at the heart of the progress, according to

director of communications Laura Peters. “It's incredibly important to share the impact of our lifesaving work and achievements of our researchers,” she says.

The charity ensures cancer research marketing is tailored to the bespoke audience of each channel. The reader of a regional newspaper will be interested in different insights than the research community and social channels feature bite-sized information compared to the deep-dives on the science blog, which has seen record visits during the pandemic.

Peters doesn't believe people have become desensitised to cancer research marketing messages, even

amid the shock of COVID-19. “They are craving information and on-the-ground intelligence from a trusted source. It's our responsibility to provide that for them,” she says.

Normally, Race for Life series raises £30 million towards Cancer Research UK's work in the prevention, diagnosis and treatment of cancer. During lockdown, the Race for Life at Home initiative encouraged supporters to keep fit and active indoors with regular Facebook live streams. At the end of September, thousands of people across the country took part in socially distanced 5-kilometre runs, raising vital funds in the process. After all, cancer does not stop for coronavirus. ●

Runners starting Cancer Research's annual Race for Life event in Southampton in 2013



How will COVID impact future cancer research?

Coronavirus has hit cancer charities' fundraising and ability to support vital research hard. According to the National Cancer Research Institute, charities' research spending could drop by 46 per cent, or £167 million, as a result of the pandemic.

Cancer Research UK is projecting a 30 per cent drop in income of £160 million this year and £300 million over the next three years. “We could be forced to reduce the amount of research we fund annually,” says Laura Peters, director of communications. The charity currently spends £400 million on research and, over the next four to five years, it may reduce this by some £150 million a year.

COVID-19 has caused enormous disruption to cancer services across the UK, including

delays to cancer screening, diagnosis and treatment. GPs made a quarter of a million fewer urgent cancer referrals in England between April and June, and the Institute of Public Policy Research says this is likely to wipe out almost a decade of lifesaving progress.

Annwen Jones, chief executive of Target Ovarian Cancer, says: “The impact of the pandemic on women with ovarian cancer cannot be underestimated.” The financial upheaval means it has had to postpone its next round of ovarian cancer research grants, investigating potentially life-changing projects.

“When there are already too few effective treatment options for ovarian cancer, this is of huge concern,” says Jones.

To find out more, click here

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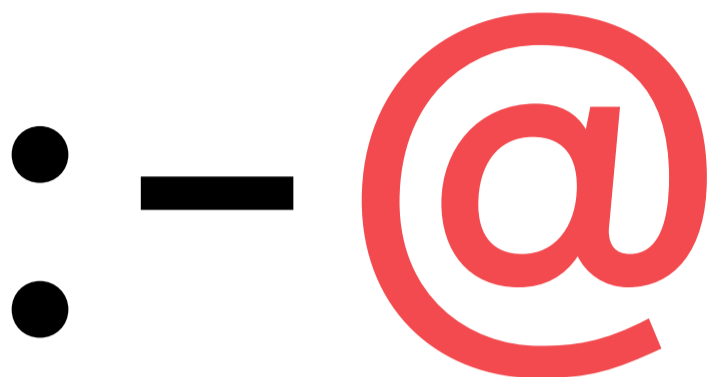


*Costs reviewed annually

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for bad content?**

Your prospects do.

So many lead gen campaigns fail because the content behind the data capture offers no value, causing frustration and negative brand sentiment. The lead gen campaigns we run for brands are based around high-quality content that answers a need.

**Find out how we can help you
make the most of your leads.**

raconteur.net/lead-generation

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