Cancer52 Response to Health and Select Committee Inquiry into Cancer Care

About Cancer52

Cancer52 is a charity which represents nearly 100 charities working to support the 150,000 people diagnosed with rare and less common cancers every year. Cancer52 members represent over £220 million of charitable spend and range in size from tiny, volunteer run charities with incomes of only thousands, to large million-pound organisations, which invest heavily in research and support services.

Summary

Rare and less common cancers are all cancers except the four most common cancers (breast, prostate, bowel and lung). Rare cancers have an incidence of less than 6 per 100,000 population and include cancers such as bone, liver, gallbladder and eye. Less common cancers have an incidence greater than 6 per 100,000 but do not include the four most common. Less common cancers include uterus, melanoma, pancreatic, ovarian and Non-Hodgkin lymphoma. There are hundreds of rare and less common cancers.

In 2017, there were 366,457 new cancer cases in the UK. Of these 53% were breast, prostate, lung and bowel cancers, and 47% were rare and less common cancers, as defined by Cancer52. Deaths from rare or less common cancers in England are more common than the four most common cancers combined.\(^1\) The percentage of deaths from rare or less common cancers has risen from 53% in 2001 to 55% in 2017.\(^2\) The total number of people living with a rare or less common cancer in England was estimated to grow to around 1.25 million people in 2020, 1.63 million in 2030, and 2.06 million in 2040.\(^3\)


Figure 1: Graph showing Age-standardised 1-year and 5-year net survival for females (aged 15 to 99 years) diagnosed with cancer in 2014 to 2018

Key issues

- The NHS Long Term Plan contained a commitment for 75% of all cancers to be diagnosed at stage 1 or stage 2 by 2028. This commitment can only be achieved by efforts to improve early diagnosis across all types of cancer, including rare and less common cancers.
- There is variation in one- and five-year survival rates for rare and less common cancers. Available data shows that the UK also lags behind other European countries for survival in a range of less common cancers.
- There is a lack of awareness of the signs and symptoms of rare and less common cancers among the general public and no regular measure of the extent of awareness and attitudes to inform awareness campaigns.
- Data is not always fully disaggregated for all rare and less common cancers, which stymies the efforts of cancer charities to support people with rare and less common cancers.
- The pandemic has had a negative impact on people with rare and less common cancers and cancer charities supporting people and research into rare and less common cancers have been required to increase their support to people living with rare and less common cancers while facing a more difficult fundraising environment.

Key recommendations

- We recommend that NHS England establishes a Rare and Less Common Cancer Taskforce to continue to provide a focus for Rare and Less Common Cancers until at least 2028. This is needed to make as much progress as possible to meet the NHS Long term Plan target of 75% of cancers diagnosed at an early stage and to save more lives.
- Published cancer data must be fully disaggregated for all cancer types.
- DHSC and the Office for Health Promotion to invest in regular awareness campaigns for signs and symptoms of rare and less common cancers and to measure public awareness and attitudes to cancer.
- The recommendations of NHS England’s Task and Finish Group on Psychosocial Support should be implemented in full.
- The Government should invest in a £500m community fund to support charities, including Cancer52’s members, to build back better after the pandemic. Our members should also be invited to take part in work to develop measures to calculate the social value of charities.
Introduction

Rare and less common cancers are all cancers except the four most common cancers (breast, prostate, bowel and lung). Rare cancers have an incidence of less than 6 per 100,000 population and include cancers such as bone, liver, gallbladder and eye. Less common cancers have an incidence greater than 6 per 100,000 but do not include the four most common. Less common cancers include uterus, melanoma, pancreatic, ovarian and Non-Hodgkin lymphoma. There are hundreds of rare and less common cancers.

In 2017, there were 366,457 new cancer cases in the UK. Of these 53% were breast, prostate, lung and bowel cancers, and 47% were rare and less common cancers, as defined by Cancer52. Deaths from rare or less common cancers in England are more common than the four most common cancers combined. The percentage of deaths from rare or less common cancers has risen from 53% in 2001 to 55% in 2017.5

There is variation in one- and five-year survival rates for rare and less common cancers. Some less common cancers have high one and five year survival rates, such as melanoma. However, some have significantly low survival rates, such as pancreatic and liver. The graphs below show one and five year survival rates for 31 rare and less common cancers.

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Figure 1: Graph showing Age-standardised 1-year and 5-year net survival for females (aged 15 to 99 years) diagnosed with cancer in 2014 to 2018
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Source: National Cancer Registration and Analysis Service, Public Health England
Closing the gap in outcomes

Available data shows that the UK also lags behind other European countries for survival in a range of less common cancers. According to the International Benchmarking Study, England lags behind Europe for mortality and survival for pancreas, stomach, oesophagus and rectal cancer. There is no comparable data for other rare and less common cancers.

Work by the European Federation of Pharmaceutical Industries and Associations shows that the UK is behind on survival for three less common cancers: lymphoid or blood cancer, ovarian and melanoma.

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cancer, as Figures 3-5 demonstrate.

Figure 3: Lymphoid 5 year age standardised survival rate in selected countries

Lymphoid 5 year age standardised survival rate in adults (15-99 years) 1995-2014

Spain Italy United Kingdom Germany France

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7 Lymphoid cancers include leukaemia, myeloma and lymphoma.
England can only match outcomes in other countries if more attention is paid to rare and less common cancers. Too often, rare and less common cancers are considered under the ‘all cancer’ umbrella and new pilots and initiatives are piloted in the four most common cancers first, with the

result that people with rare and less common cancers are consistently left behind. For example, stratified pathways of follow-up have been rolled out first in breast, prostate and colorectal cancer with cancer alliances. Although the latest NHS planning guidance for 2021 states that cancer alliances should agree three new additional cancer types for stratified follow-up and implement one by 2022, this illustrates how rare and less common cancers usually follow behind the more common cancers. Similarly, the new Quality of Life Metric is also being rolled out to patients with breast, prostate or colorectal cancers first although all cancers should be included by autumn 2021.

We recommend that NHS England establishes a Rare and Less Common Cancer Taskforce to continue to provide a focus for Rare and Less Common Cancers until at least 2028. This is needed to make as much progress as possible to meet the NHS Long term Plan target of 75% of cancers diagnosed at an early stage and to save more lives. Cancer52 called in 2018 for such a Taskforce in our report, Getting a Better Deal for Rare and Less Common Cancers: The next ten years, and we also recommended that cancer alliances should have someone with clear responsibility for rare and less common cancers, either in their job description or job title.

Cancer52 was pleased to participate in the Cancer Improvement Collaborative on Rare and Less Common Cancers during autumn/winter 2020/2021. Nine NHS trusts took part in a process that aimed to improve the patient experience of people with rare and less common cancers. Cancer52 sat on the steering group and is now working to provide ongoing links between Alliances and the rare and less common cancer charities who provide vital support for people with rare and less common cancers.

This type of focused attention and action, embedding knowledge and signposting within NHSE to the charities working in this field to support people with rare and less common cancers, is required if we are to close the gap, not only internationally, but between the cancers in this country.

Impact of the pandemic

The pandemic has had a negative impact on people with rare and less common cancers. Cancer52 ran two surveys of people living with rare and less common cancers over the pandemic, one in summer 2020 and another over the winter months of December 2020 and January 2021.

The surveys found that

- People diagnosed since the pandemic faced delays - either because they were concerned about contacting their GP or test and scans had been delayed
- One in ten people who had received treatment since the pandemic began had not had the type of treatment they were expecting to receive
- One in ten people had not been able to access their GP during the pandemic. 20% had been able to see their GP in person and 70% had been able to have a virtual or telephone appointment
- People with rare and less common cancers need access to support, given the impact of the pandemic on all aspects of their lives. In particular, people need emotional or psychological support to manage the mental health impact issues like shielding and delays have caused.

We are also aware that there are a substantial number of people missing from the system who have not presented to the health service with symptoms of cancer. It is essential that these people are persuaded to come forward so that cancer can be ruled in or out.

## Awareness of rare and less common cancers

It is imperative that people have good awareness of the signs and symptoms of rare and less common cancers so that they present to their GP if they notice anything untoward. This would help to ensure that people are diagnosed with cancer at an earlier stage, with better hope of successful treatment.

Lack of awareness of rare and less common cancers, coupled sometimes with vague and non-specific symptoms, means patients do not always recognise that they may have cancer and they therefore present late. It can also mean that GPs or other health professionals fail to recognise symptoms that may be cancer and do not refer to secondary care. For those patients with cancer where symptoms are less well-known, or they relate to organs which cannot be easily palpated or inspected, they report visiting their GP three or more times before hospital referral.\(^\text{13}\) Our 2018 survey of patients confirmed this, with patients relating tales of frequent visits to the GP and long delays before they were diagnosed.\(^\text{14}\) One patient had been told by their GP that their symptoms were ‘in their head’. Another had been accused by their GP of wanting

\(^{14}\) Cancer52 Patient Survey 2018
time off work. One patient had seen their GP 52 times in the 11 months before their diagnosis.

Fewer people have come forward for diagnosis and treatment since the pandemic began. NHS England has responded to this by regularly running campaigns under the banner ‘Help Us Help You’. These follow on from the ‘Be Clear on Cancer’ campaigns that were run prior to the pandemic. However, the NHS Long Term Plan did not state whether the ‘Be Clear on Cancer’ campaign would continue. Cancer52 recommends that long-term and multi-year investment is provided so that these campaigns continue to be run regularly and were pleased to hear recently of the renewed investment in a new abdominal/urological campaign.

Cancer52 has separately undertaken a campaign in partnership with Pfizer UK, Do You C Us?, to raise awareness of rare and less common cancers.\(^{15}\) Cancer52 is willing to work in partnership with the NHS to raise awareness in any way possible and already support campaigns like the abdominal/urological Help Us Help You campaign through bringing together member charities into briefings and updates.

That people in England present later than those in other countries in Europe has regularly been cited as a reason for England and the UK lagging behind other countries in survival and mortality outcomes. There is no regular tracker of awareness of rare and less common cancer symptoms in the UK or England, so whether low awareness of signs and symptoms is a driver of later presentation is not clear. A study in 2012 found that UK attitudes of not wishing to bother their doctor was another factor in people not presenting.\(^ {16}\) Such attitudes likely increased during the pandemic when there was clear messaging to stay at home. It is unclear how this will have impacted attitudes longer term and therefore people’s willingness to come forward with symptoms.

Cancer Research UK runs a cancer awareness tracker on a semi-regular basis though the last one was in 2017. Further regularly updated data is required to understand awareness of rare and less common cancers and their symptoms among the public and health professionals and the DHSC should commit to this. This would help to evaluate whether awareness raising campaigns are making sufficient impact.

### Diagnosis and Meeting Long Term Plan Ambition

\(^{15}\) [www.doyouCus.org.uk](http://www.doyouCus.org.uk)

\(^{16}\) [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3566814/#bib25](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3566814/#bib25)
Diagnosis of rare and less common cancers can be complicated because some symptoms of rare and less common cancers can be vague. People with rare or less common cancers can have a more complicated route to diagnosis and are more likely to be diagnosed through emergency routes.\(^\text{17}\)

The NHS Long Term Plan contained a commitment for 75% of all cancers to be diagnosed at stage 1 or stage 2 by 2028. This commitment can only be achieved by efforts to improve early diagnosis across all types of cancer, including rare and less common cancers. Though some rare and less common cancers are more likely to be diagnosed at stage 1 and stage 2, some rare and less common cancers are not. These include cancers such as pancreas and ovarian.\(^\text{18}\)

Proxy measures must be found to allow those cancers which cannot be staged, such as blood and brain cancers, to be included in the stage 1 and stage 2 target, and data collection must be improved so that cancers are not excluded on the grounds of having minimal staging data. These proxy measures could include reductions in numbers of diagnoses made via emergency presentation and numbers of GP visits before referral to secondary care.

We welcome the development of rapid diagnostic centres (RDC) to provide a pathway for people with vague symptoms to have a diagnosis of cancer ruled in or out. Evaluation of the CRUK ACE programme on MDCs has shown promising results for people presenting with non-specific symptoms.\(^\text{19}\) It is important that RDC data outputs are transparent and accessible to all in the cancer community, including cancer charities. Data must be scrutinised to ensure RDCs are meeting the needs of patients with rare and less common cancers, and action taken if this is not the case. Any RDC review should look at enabling patients to self-refer for diagnostic tests at RDCs and how this could be and implemented.

Diagnostics capacity remains a critical issue in this country, hampering progress in earlier diagnosis of cancers. Diagnostics were also hit during the pandemic and it is known that endoscopy services reduced their activity substantially during the earlier wave. This certainly contributed to the delays in diagnosis and treatment. It is crucial that diagnostic capacity receives the investment required both in


\(^\text{19}\) https://www.nature.com/articles/s41416-020-0947-y#Sec8
kit (estimated to require £1.3 bn over the next three years) and workforce, and that diagnostic activity is protected in any future healthcare crisis.\textsuperscript{20} Earlier diagnosis ambitions cannot be met without this.

**Access to medicines and treatment**

While ensuring people with rare and less common cancers are diagnosed quickly is an important priority, people must have access to the best possible treatment once they are diagnosed. In evidence to the Health Select Committee on 14th July 2021, John Butler, Clinical Lead at the International Cancer Benchmarking Partnership, noted that even when cancers were diagnosed at similar stages, England still lagged behind other countries on survival outcomes and that this was due to treatment.

People with rare and less common cancers must be seen by specialists with the knowledge and experience to treat them. Research has shown that outcomes for people with cancer are improved when their treatment and care is overseen by a specialist - for example, clinics dedicated to people with inoperable pancreatic cancer have better disease outcomes than clinics where oncologists are not pancreatic cancer specialists.\textsuperscript{21} National cancer pathways have so far focused on lung, bowel, prostate and breast. A service specification has recently been developed for sarcoma and a service specification for Teenage and Young People has recently finished a consultation. Some of our member charities have already undertaken work to determine what such pathways could look like for example for pancreatic cancer (Pancreatic Cancer UK), and for teenagers and young people (Teenage Cancer Trust).\textsuperscript{22,23} Cancer52 would like to see the creation of more specialist treatment pathways and service specifications to ensure that the treatment and care provided to people with rare or less common cancers is overseen by a specialist.

**Support services for people with rare and less common cancers**

People with rare and less common cancers can struggle to access support services. The Cancer Patient Experience Survey (CPES) shows that people with rare or less common cancers can find it more difficult to access support and information; for example, they are less likely to be given easy to

\textsuperscript{20}https://policyexchange.org.uk/publication/a-wait-on-your-mind/


\textsuperscript{23}https://www.teenagecancertrust.org/sites/default/files/BlueprintOfCare_2ndEdition.pdf
understand written information about the type of cancer they have and less likely to be given enough support from health and social services.\textsuperscript{24}

This is supported by Cancer52’s 2018 patient survey and by what patient groups have told us. The knock-on effect of lower awareness and smaller populations of patients is that support services such as accurate information, support groups and psychosocial services are not widespread and therefore more difficult to access. This is because there is less funding available (particularly from the third sector which is often made up of small patient groups for these cancers) and fewer healthcare professionals within these specialties. Cancer52 members also tell us that health professionals are often less aware of the patient support offered by the rare and less common voluntary sector. One patient responding to the 2018 patient survey described the range of holistic support available to them as a bowel cancer patient but said that this was not available to them when they were later diagnosed with a less common cancer.\textsuperscript{25}

The support needs of people with rare and less common cancers have heightened during the pandemic. Respondents to our survey about the impact of the pandemic on people with rare and less common cancer told us that their cancer had caused additional burdens to them during the pandemic. A quarter said their finances had been impacted. Three in five said their mental health had been impacted.\textsuperscript{26}

\textbf{We welcome NHS England’s establishment of a Task and Finish Group on Psychosocial Support and believe that the recommendations of this group should be implemented. However, support for patients is not just provided by the NHS.}

The Government should take a wide-ranging approach to supporting the cancer community and recognise that rare and less common cancer charities stepped up their support for people with cancer during the pandemic whilst their income went down. We would like to see further financial support for rare and less common cancer charities - see section ‘Support for cancer charities’ below.

\textsuperscript{24} NHS England Cancer Patient Experience Survey, 2016, Quality Health
\textsuperscript{25} Cancer52, \textit{Getting a better deal for people with rare and less common cancers; what patients told us}, 2019
\textsuperscript{26} https://www.cancer52.org.uk/single-post/cancer52-publishes-england-results-of-its-second-patient-survey
Accessing timely, comprehensive data

Good data is imperative to understand outcomes for people with rare and less common cancers. We are grateful for the PHE Get Data Out Programme, which provides detailed analyses of data for a variety of cancer types, including many rare and less common cancers.\(^\text{27}\) However, too often cancer data is not fully disaggregated for all cancers. For example, the Cancer Dashboard, where CCGs can access their statistics and compare to national data, shows data for breast, lung, bowel and prostate and all cancers, but not any more individual tumour sites than the four most common cancers.

The cancer community consists of the NHS as well as a myriad of cancer charities, which provide vital patient support and invest in research. Yet for rare and less common cancers these charities are stymied because data is usually not disaggregated by cancer type. For example, cancer data sets often include ‘Upper GI’ or ‘gynaecological’, yet the former comprises a range of cancers including stomach, oesophageal and pancreatic as does the latter which includes ovarian, cervical and vulval. This has been particularly true of data shared during the pandemic. Cancer52 recommends that the NHS adopts the principle of always disaggregating datasets by all tumour types to allow the NHS and charities to better plan services and support their community of patients.

There also needs to be investment in analysts so that data is produced more quickly. Staging data for 2019 will not be available until October 2021, nearly two years after the event. It is important that staging data for 2020 and 2021 is released much more quickly, so that the impact of the pandemic can be identified and mitigation steps put in place as soon as possible. Registration of all cancer sites must also be encouraged; all cancers report missing stage data in the final statistics and sometimes this is a significant percentage of all cancer cases.\(^\text{28}\) For example, 17% of bladder cancer cases in 2018 and 28% of all cervical cancers in 2018 were not registered, compared to only 8% of breast cancer cases.

In addition, we recommend that there is further investment in routes to diagnosis data, to understand the impact on different ways people with rare and less common cancers receive a diagnosis and whether that has changed since the pandemic.

Governance

Cancer52 is proud to be a member of the National Cancer Board, part of the governance of the NHS Cancer programme. Cancer52 and our member charities highly valued the regular two-way communication and

\(^{27}\) https://www.cancerdata.nhs.uk/getdataout
\(^{28}\) https://www.cancerdata.nhs.uk/stage_at_diagnosis
sharing of information and data that NHS England facilitated during the pandemic. Sharing data and information allows rare and less common cancers to support people with rare and less common cancers better, which could help to improve outcomes. We recommend that all parts of the NHS strive to be as transparent and open as possible with data and information, publishing it in open forums wherever possible.

Clinical research

For some rare and less common cancers there are few, poor or no treatment options and as a consequence, poor outcomes and survival rates. For example, surgery is the only potential curative treatment for cholangiocarcinoma, a rare cancer of the bile duct, and often the cancer is too advanced for surgery. Pharmaceutical companies may be disincentivised from developing medicines for rare or less common cancers because small population sizes mean a lower return on investment. Recruiting patients for clinical trials for rare and less common cancers is harder because of smaller population sizes so trials require multi-centre site or international trials which are more expensive and complicated. Our members tell us that people with rare and less common cancers find it hard to access clinical trials because there are few available.

We were pleased that treatment-focused clinical trials were kept running during the pandemic, so patients who were benefiting from treatment continued to do so, and that regulatory approval for trials can now be accelerated when prioritised. It has, however, been difficult to get new, non-COVID-19 studies open due to regulatory and local R&D office issues. This has highlighted the key issues in clinical trials about how thinly capacity and infrastructure was stretched pre-pandemic. The UK is the only country which has had to put in a managed programme to restart trials. This makes the country less attractive as a place to undertake trials, and could lead to trials moving to other countries with the consequent negative impacts on patients and UK life sciences.

For research and clinical trial efforts to continue to be a priority for patients with rare and less common cancers, we need a new policy focus on investment in trials and studies, a review of the MHRA processes and approval framework to facilitate rapid approval, and a longer term review of how we make effective decisions on research priorities, including equal access to clinical trial sites across the UK.

Funding and workforce investment

Improvements in cancer treatment, care and experience for people with rare and less common

29 https://ammf.org.uk/treatment-options/
cancers cannot be achieved without the right workforce in place. Workforce capacity issues will impact the successful delivery of the NHS Long Term Plan and our ability to match outcomes in Europe. The 62 day wait Cancer Target across England has not been met since 2013 in the last five and half years, because of the increasing number of referrals as well as workforce pressures and the pandemic.\(^{30}\)

Prior to the pandemic, capacity issues already existed across the workforce and have only been exacerbated. Issues are particularly problematic in the diagnostic and specialist nursing workforce. Short- and long-term action must be taken. We welcome the commitment in the 2020 Spending Review to invest in recruiting and training more staff to diagnose cancer, though further funding is needed in future years in order to meet the Cancer Workforce Plan target for 45% growth in the cancer workforce by 2029.\(^{31}\)

Cancer52 members were surveyed in 2018 about workforce issues and they identified problems with recruitment and retention of staff, as well as ensuring staff have access to continuing professional development.\(^{32}\) For example, despite the clear benefits to patients, healthcare professionals find it challenging to implement the fast tracking of surgery for pancreatic cancer, partly because of lack of workforce capacity.

There is a lack of Clinical Nurse Specialists (CNS) for people with rare and less common cancers. The 2018 National Cancer Patient Experience Survey (CPES) showed that there was a significant difference in patient experience between people with more common cancers who had contact with a CNS compared to people with rare and less common cancers. People with a rare and less common cancer were significantly more likely to find it difficult to get in touch with a CNS compared to people with one of the four more common cancers. They were also less likely to be given a named CNS.

Recruiting CNSs for rare and less common cancers can be difficult because the workforce is less exposed to people with these cancers. Therefore, professionals may not be aware it is an option, or may be unsure about the route to become a rare and less common cancer specialist. Continuing Professional Development (CPD) is not always funded and staff sometimes use annual leave to attend courses.

\(^{30}\) https://www.nuffieldtrust.org.uk/resource/cancer-waiting-time-targets
\(^{31}\) https://www.cancerresearchuk.org/get-involved/campaign-for-us/shoulder-to-shoulder
\(^{32}\) Cancer52, Getting a Better Deal for Rare and Less Common Cancers: The next ten years, 2018 https://docs.wixstatic.com/udg/e22361_9f08a0fe505243dca319f72fae51795f.pdf
Support for cancer charities

The Covid-19 pandemic has adversely affected Cancer52’s charity members. Many types of fundraising activities have been affected. Income is significantly down, with many charities reporting income loss of up to 50%. A survey of Cancer52 members, of which a fifth took part, found that incomes across all respondents had fallen from £120 million in 2019-20 to £40 million in 2020-21.\textsuperscript{33}

Cancer52 members provide cancer patients with support and knowledge, and fund research. They are adept at building communities across dispersed geographies. This includes online patient support groups, helplines and websites as well as face-to-face support groups and services such as counselling or advice. They’re embedded in, and dedicated to, the NHS and people living with rare and less common cancers.

Cancer52 members have worked with the NHS throughout the pandemic to support people with rare and less common cancers. Unfortunately, some Cancer52 members have had to take steps to reduce charitable activities because their income has decreased. Yet there has been little support from the Government.

Support to date from the Government has focused on local charities, rather than charities, like Cancer52’s members, which support communities of people nationwide. Without such charities people with rare and less common cancers would be left with little support.

We want the Government to recognise the value of charities that support geographically dispersed communities, bound together by a common cause, such as cancer. The Government should invest in a £500m community fund to support charities, including Cancer52’s members, to build back better after the pandemic. Our members should also be invited to take part in work to develop measures to calculate the social value of charities.

Importance of alliances

\textsuperscript{33} January 2021. 21 Members responded. Cancer52 members have an approximate total income of £220 million.
There are 21 cancer alliances in England, working to drive improvements in cancer care across their geographical area. Cancer52 believes cancer alliances are a crucial part of the cancer care eco system and should be retained in the future NHS. Cancer52 members are keen to work closely with cancer alliances to ensure better outcomes for people with rare and less common cancers and would welcome opportunities to do so.

**Health Inequalities**

Although 47% of cancer diagnoses in England are rare or less common cancers, 55% of deaths from cancer are from rare or less common cancers. People with rare or less common cancers already face difficulties in diagnosis, treatment and care contributing to the gap between incidence and mortality. This in part can be attributed to the smaller numbers of people with these cancers, which means there is lower awareness in the health system and among the wider public, there are fewer health professionals with knowledge and expertise, and fewer other patients who can provide mutual support or information. Third sector organisations, which may provide support and information to people with rare and less common cancers, are often smaller charities with fewer funds and resources. The nature of treatment and care itself can be more complex with the need to travel further for treatment or be treated over several sites. This all combines to create a perfect storm and means when the health system works less efficiently these patients feel the consequences more acutely. Inequalities across age, sex, gender, ethnicity and disability will only exacerbate this issue.

Cancer52 members are working to reduce health inequalities and we are also pleased that NCRAS and CADEAS have developed statistics delving into inequalities in more detail.\(^\text{34}\)

\[^{34}\text{http://www.ncin.org.uk/local_cancer_intelligence/cadeas#support}\]