WE FUND NURSES
WE CLIMB MOUNTAINS
WE FIGHT INEQUALITY
WE GIVE OUR TIME
WE SUPPORT FAMILIES
WE PROVIDE GRANTS
WE MAKE COFFEE
WE CHANGE LIVES

The importance of evidence for design and delivery of services and interventions

Fran Woodard

Executive Director of Policy and Impact, Macmillan Cancer Support

BPOS and NCRI Psychosocial Oncology and Survivorship CSG Conference

8th March 2018

WE ARE MACMILLAN. CANCER SUPPORT

Outline

1. Evidence drives our work at Macmillan

2. Development, collection and use of evidence is embedded in our ways of working

3. Challenges to building the evidence base

4. Questions and discussion

Evidence validates and guides our direction

Revealing the scale of the problem…..

Cancer prevalence in the United Kingdom: estimates for 2008

J Maddams*,1, D Brewster2, A Gavin3, J Steward4, J Elliott5, M Utley6 and H Møller1

1Kings College London, Thames Cancer Registry, 1st Floor Capital House, 42 Weston St, London SE1 3QD, UK; 2Scottish Cancer Registry, Area 155, Gyle Square, 1 South Gyle Crescent, Edinburgh EH12 9EB, UK; 3Northern Ireland Cancer Registry, Queen's University Belfast, School of Medicine Dentistry and Biomedical Sciences, Mulhouse Building, Grosvenor Road, Belfast BT12 6BJ, UK; 4Welsh Cancer Intelligence and Surveillance Unit, Floor 13, Brunel House, 2 Fitzalan Road, Cardiff CF24 0HA; 5Macmillan Cancer Support, 89 Albert Embankment, London SE1 7UQ, UK; 6University College London, Clinical Operational Research Unit, 4 Taviton Street, London WC1H 0BT, UK

BACKGROUND: Identifying and addressing the requirements of cancer survivors is currently a high priority for the NHS, yet little is known about the population of cancer survivors in the United Kingdom.
METHODS: Data from cancer registries in England, Northern Ireland, Scotland and Wales were analysed to provide limited-duration prevalence estimates for 2004. Log-linear regression models were used to extend these to complete prevalence estimates. Trends in prevalence from 2000 to 2004 were used to project complete prevalence estimates forward from 2004 to 2008.
RESULTS: We estimated that in total, there were 2 million cancer survivors in the United Kingdom at the end of 2008, ~3% of the population overall and 1 in 8 of those aged 65 years and more. Prostate and female breast cancers were the most prevalent. The number of cancer survivors is increasing by ~3% each year. Estimates are also provided by time since diagnosis.
CONCLUSION: These estimates are the most up-to-date available, and as such will be useful for statutory and voluntary sector organisations that are responsible for planning and providing treatment and support to cancer survivors in the United Kingdom.

Projections of cancer prevalence in the United Kingdom, 2010–2040

J Maddams*,1, M Utley2 and H Møller1

1King's College London, Thames Cancer Registry, 1st Floor, Capital House, 42 Weston Street, London SE1 3QD, UK; 2Clinical Operational Research Unit, University College London, 4 Taviton Street, London WC1H 0BT, UK

BACKGROUND: There are currently two million cancer survivors in the United Kingdom, and in recent years this number has grown by 3% per annum. The aim of this paper is to provide long-term projections of cancer prevalence in the United Kingdom.
METHODS: National cancer registry data for England were used to estimate cancer prevalence in the United Kingdom in 2009. Using a model of prevalence as a function of incidence, survival and population demographics, projections were made to 2040. Different scenarios of future incidence and survival, and their effects on cancer prevalence, were also considered. Colorectal, lung, prostate, female breast and all cancers combined (excluding non-melanoma skin cancer) were analysed separately.
RESULTS: Assuming that existing trends in incidence and survival continue, the number of cancer survivors in the United Kingdom is projected to increase by approximately one million per decade from 2010 to 2040. Particularly large increases are anticipated in the oldest age groups, and in the number of long-term survivors. By 2040, almost a quarter of people aged at least 65 will be cancer survivors.
CONCLUSION: Increasing cancer survival and the growing/ageing population of the United Kingdom mean that the population of survivors is likely to grow substantially in the coming decades, as are the related demands upon the health service. Plans must, therefore, be laid to ensure that the varied needs of cancer survivors can be met in the future.

Rise in cancer cases

The number has grown by this extra **400,000 people** in just five years[2].

There are now **2.5 million people** living with cancer in the UK[1].

2010
2 million

2015
2.5 million

2020
3 million

2030
4 million

1 Macmillan Cancer Support. Estimate for 2015 based on extrapolation of data in: Maddams J et al. Projections of cancer prevalence in the United Kingdom, 2010-2040. Br J Cancer 2012; 107: 1195-1202. (Projections scenario 1)
2 'Five years' refers to 2010-2015

JOURNAL OF CLINICAL ONCOLOGY

ORIGINAL REPORT

Patients' Supportive Care Needs Beyond the End of Cancer Treatment: A Prospective, Longitudinal Survey

Jo Armes, Maggie Crowe, Lynne Colbourne, Helen Morgan, Trevor Murrells, Catherine Oakley, Nigel Palmer, Emma Ream, Annie Young, and Alison Richardson

A B S T R A C T

Purpose
To estimate prevalence and severity of patients' self-perceived supportive care needs in the immediate post-treatment phase and identify predictors of unmet need.

Patients and Methods
A multicenter, prospective, longitudinal survey was conducted. Sixty-six centers recruited patients for 12 weeks. Patients receiving treatment for the following cancers were recruited: breast, prostate, colorectal, and gynecologic cancer and non-Hodgkin's lymphoma. Measures of supportive care needs, anxiety and depression, fear of recurrence, and positive and negative affect were completed at the end of treatment (T0) and 6 months later (T1).

Results
Of 1,850 patients given questionnaire packs, 1,425 (79%) returned questionnaires at T0, and 1,152 (62%) returned questionnaires at T1. Mean age was 61 years; and most respondents were female (69%) and had breast cancer (57%). Most patients had no or few moderate or severe unmet supportive care needs. However, 30% reported more than five unmet needs at baseline, and for 60% of these patients, the situation did not improve. At both assessments, the most frequently endorsed unmet needs were psychological needs and fear of recurrence. Logistic regression revealed several statistically significant predictors of unmet need, including receipt of hormone treatment, negative affect, and experiencing an unrelated significant event between assessments.

Conclusion
Most patients do not express unmet needs for supportive care after treatment. Thirty percent reported more than five moderate or severe unmet needs at both assessments. Unmet needs were predicted by hormone treatment, negative mood, and experiencing a significant event. Our results suggest that there is a proportion of survivors with unmet needs who might benefit from the targeted application of psychosocial resources.

J Clin Oncol 27:6172-6179. © 2009 by American Society of Clinical Oncology

INTRODUCTION

As more people survive cancer, there is growing recognition that they need support during the survival phase of their illness.[1-3] Although completion of treatment is eagerly anticipated,[4,5] few studies focus on the transition period between end of treatment and long-term survivorship (> 5 years).[6] Limited evidence suggests that patients are dissatisfied with care received at this time, as support from oncology professionals tails off with little concomitant increase in alternative support.[7,8]

Estimating quality of life (QoL) is the most common method for ascertaining sequelae in the post-treatment phase, with studies revealing the most frequently reported concerns to be psychological and social.[2-3,9] However, QoL measures were developed to assess patients newly diagnosed and/or receiving treatment and so may not capture issues pertinent to survivors[3] such as fear of cancer recurrence,[10,11] early menopause,[12] fears about genetic inheritability of cancer,[13] and concerns about sexual function and fertility.[14,15] QoL measures can also be criticized because participants rate presence and/or severity of an item, rather than whether it is a problem for which they need help.

Needs assessment tools explicitly assess the gap between patients' experiences of services they receive and those they perceive they need.[16] Several cancer-specific supportive care needs assessment tools have recently been developed for use with survivors.[17-21] Studies using these report that approximately 30% to 50% of survivors have unmet needs, mainly for psychological support and coping with fear of recurrence. Predictors of unmet supportive care needs include younger age, advanced

Revealing unmet needs in this population

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To estimate prevalence and severity of patients' self-perceived supportive care needs in the immediate post-treatment phase and identify predictors of unmet need.

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A multicenter, prospective, longitudinal survey was conducted. Sixty-six centers recruited patients

(62%) returned questionnaires at T1. Mean age was 61 years; and most respondents were female (69%) and had breast cancer (57%). Most patients had no or few moderate or severe unmet supportive care needs. However, 30% reported more than five unmet needs at baseline, and for 60% of these patients, the situation did not improve. At both assessments, the most frequently endorsed unmet needs were psychological needs and fear of recurrence. Logistic regression revealed several statistically significant predictors of unmet need, including receipt of hormone treatment, negative affect, and experiencing an unrelated significant event between assessments.

Conclusion
Most patients do not express unmet needs for supportive care after treatment. Thirty percent

From the Florence Nightingale School of Nursing and Midwifery, King's College London; Cancer Services, Guy's and St Thomas' NHS Foundation Trust; National Cancer Research Institute, Psycho-Social Oncology Clinical Studies Group, London; Cancer Services, Royal United Hospital Bath National Health Service (NHS) Trust, Bath; Oncology Centre, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire; Division of Specialised Services, University Hospitals Bristol NHS Foundation Trust, Bristol; and the 3 Counties Cancer Network.

INTRODUCTION

As more people survive cancer, there is growing recognition that they need support during the survival phase of their illness.[1-3] Although completion of treatment is eagerly anticipated,[4,5] few studies focus on the transition period between end of treatment and long-term survivorship (> 5 years).[6] Limited evidence suggests that patients are dissatisfied with care received at this time, as support from oncology professionals tails off with little concomitant increase in alternative support.[7,8]

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Revealing needs that were significant and specific to cancer and its treatment

BJC OPEN

Full Paper

The health and well-being of cancer survivors in the UK: findings from a population-based survey

J Elliott[1], A Fallows[2], L Staetsky[3], PWF Smith[3], CL Foster[4], EJ Maher[1] and J Corner*[,1,4,5]

[1]Macmillan Cancer Support, London SE1 7UQ, UK; [2]Erda Ltd, Norfolk IP21 4PD, UK; [3]Southampton Statistical Sciences Research Institute, University of Southampton, Southampton SO17 1BJ, UK; [4]Southampton Macmillan Survivorship Research Group, Faculty of Health Sciences, University of Southampton, Building 67, Highfield Campus, Southampton SO17 1BJ, UK; [5]Faculty of Health Sciences, University of Southampton, Building 67, Highfield Campus, Southampton SO17 1BJ, UK

BACKGROUND: To compare self-reported health and well-being in a sample of cancer survivors with individuals who have not had cancer and with individuals who have a serious chronic condition other than cancer.
PATIENTS AND METHODS: A cross-sectional survey drawn from an online panel of 400 000 UK citizens supplemented with other online recruitment and telephone recruitment. The participants were 4892 individuals 30 years of age or above, including 780 individuals with a previous cancer diagnosis, 1372 individuals with one or more of 10 chronic conditions but not cancer and 2740 individuals without a previous cancer diagnosis or chronic condition. Thirteen measures of health and well-being were constructed from answers to 25 survey items covering physical, psychological and social dimensions of health and well-being.
RESULTS: Cancer survivors were significantly more likely to report poor health outcomes across all 13 measures than those with no history of cancer or a chronic condition. The adjusted odds ratios for cancer survivors with no chronic conditions compared with healthy participants ranged from 1.37 (95% confidence interval (CI): 1.31 – 1.96) for emotional well-being to 3.34 (95% CI: 2.74 – 4.08) for number of health professionals consulted in the last 12 months. The health profile of cancer survivors was similar to those with a history of a serious chronic health condition.
CONCLUSIONS: A substantial number of individuals who have had a diagnosis of cancer experience ongoing poor health and well-being following cancer and cancer treatment. The results of this study provide an initial basis for the development of specific help and support for cancer survivors.
British Journal of Cancer (2011) 105, S11 – S20; doi:10.1038/bjc.2011.418   www.bjcancer.com
© 2011 Cancer Research UK

Keywords: neoplasms; cancer survivors; quality of life; health outcomes

…providing the case for support in the cancer survivorship agenda

BJC OPEN

Full Paper

The health and well-being of cancer survivors in the UK: findings from a population-based survey

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CONCLUSIONS: A substantial number of individuals who have had a diagnosis of cancer experience ongoing poor health and well-being following cancer and cancer treatment. The results of this study provide an initial basis for the development of specific help and support for cancer survivors.

For this broad group of people and needs, we need evidence from diverse sources to guide decisions on:

- Where improvements should be targeted

- Specific patient groups with specific needs

- What new services might be needed

Evidence from patient surveys

The National Cancer Patient Experience (CPES) Survey

- Developed by Quality Health for the English Department of Health in 2010 and run almost every year since then

- Full census of all cancer patients in treatment during a three-month window (around 120,000 patients every year)

- High response rates: typically 65% to 70%

- All data and documentation is publicly available at www.ncpes.co.uk

CPES in England is widely acknowledged to have driven significant improvement in cancer care over the last seven years:

Respondents from London Trusts report a worse experience than non-London respondents:

	2015 Survey	2016 Survey
Number of scored questions	50	52
London scores **significantly lower than** non-London	**39**	**43**

Macmillan cancer Support. Mind the Gap – Cancer Inequalities in London. Available from: https://www.macmillan.org.uk/_images/4057%20MAC%20Report%202017_tcm9-319858.pdf [Accessed 21 February 2018]

Further analysis reveals stark inequalities in London

Felt they got enough care and support from health or social services during treatment:

Least deprived	51.8%
Most deprived	40%

↓ 11.8%

Felt they were given answers they could understand from their Clinical Nurse Specialist:

Least deprived	89.3%
Most deprived	81%

↓ 8.3%

Felt the GPs and nurses did everything they could to support them during treatment:

Least deprived	61.2%
Most deprived	53.1%

↓ 8.1%

People from the most deprived areas report worse experience on almost **90% of the questions.**

London has a higher proportion of people in poverty (after housing costs) than the rest of England **- 27% compared to 21%**

Looking at breakdowns by ethnicity, there are **32 questions** in London that have statistically significant differences.

Minority ethnic groups account for over **40%** of all people living in London.

Patients felt groups of doctors and nurses talked in front of them as if they weren't there:

White patients	19.2%*
Mixed ethnic background	42.4%

↑ 23.2%
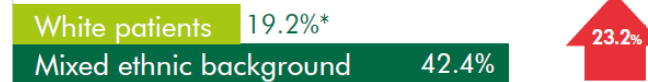
Patients felt they were seen as soon as necessary by their GP before going to the hospital:

White patients	77%
Black patients	61.2%

↓ 15.8%

Patients felt positive about the length of time they had to wait for their test:

White patients	88.4%
Asian patients	75.8%

↓ 12.6%

Ways we are acting on this evidence:

1. Partnerships in Tower Hamlets

2. Primary and community care projects across London

3. London Cancer Community; Representing London's diversity

4. Holding Trusts accountable

TOWER HAMLETS

Cancer touches the lives of millions of Londoners.

0:00 / 0:55

Evidence from Cancer Registry data

Macmillan has an analytical partnership with the cancer registries in each nation.

Incidence and outcome data linked to health, social care, socio-economic and environmental data

Provides a comprehensive picture of the cancer pathway

Started July 2015
Scottish Cancer Registry, Information Services Division (ISD) in the Public Health & Intelligence Unit of NHS National Services Scotland

Started April 2016
Northern Ireland Cancer Registry, Queen's University Belfast

Started 2012
National Cancer Registration and Analysis Service (NCRAS), Public Health England

Started April 2017
Welsh Cancer Intelligence and Surveillance Unit (WCISU), Health Intelligence Division, Public Health Wales

Different cancers have different 'shapes'

Breast
- Diagnosis & treatment (0–1 years) 50,000
- Recovery & readjustment (1–2 years) 47,000
- Initial monitoring (2–5 years) 103,000
- Ongoing monitoring (5≥10 years) 127,000
- Ongoing monitoring (10+ years) 235,000
- Progressive care 23,000
- End of life 5,000 (2,000 year1)

Prostate
- Diagnosis & treatment (0–1 years) 29,000
- Recovery & readjustment (1–2 years) 27,000
- Watch & wait (0–2 years) 18,000
- Active surveillance (0–2 years) 7,000
- Active surveillance (2+ years) 9,000
- Initial monitoring (2–5 years) 63,000
- Ongoing monitoring (5≥10 years) 62,000
- Ongoing monitoring (10+ years) 29,000
- Progressive care 32,000
- End of life 11,000 (2,000 year1)

Colorectal
- Diagnosis & treatment (0–1 years) 42,000
- Recovery & readjustment (1–2 years) 31,000
- Initial monitoring (2–5 years) 48,000
- Ongoing monitoring (5≥10 years) 51,000
- Ongoing monitoring (10+ years) 73,000
- Progressive care 24,000
- End of life 16,000 (11,000 year1)

Lung
- Diagnosis & treatment (0–1 years) 43,000
- Recovery & readjustment (1–2 years) 13,000
- Initial monitoring (2–5 years) 9,000
- Ongoing monitoring (5≥10 years) 6,000
- Ongoing monitoring (10+ years) 21,000
- Progressive care (not estimated)
- End of life 35,000 (29,000 year1)

K. Yip, H. McConnell, R. Alonzi, J. Maher. Using routinely collected data to stratify prostate cancer patients into phases of care in the UK: implications for resource allocation and cancer survivorship. Br J Cancer 2015.

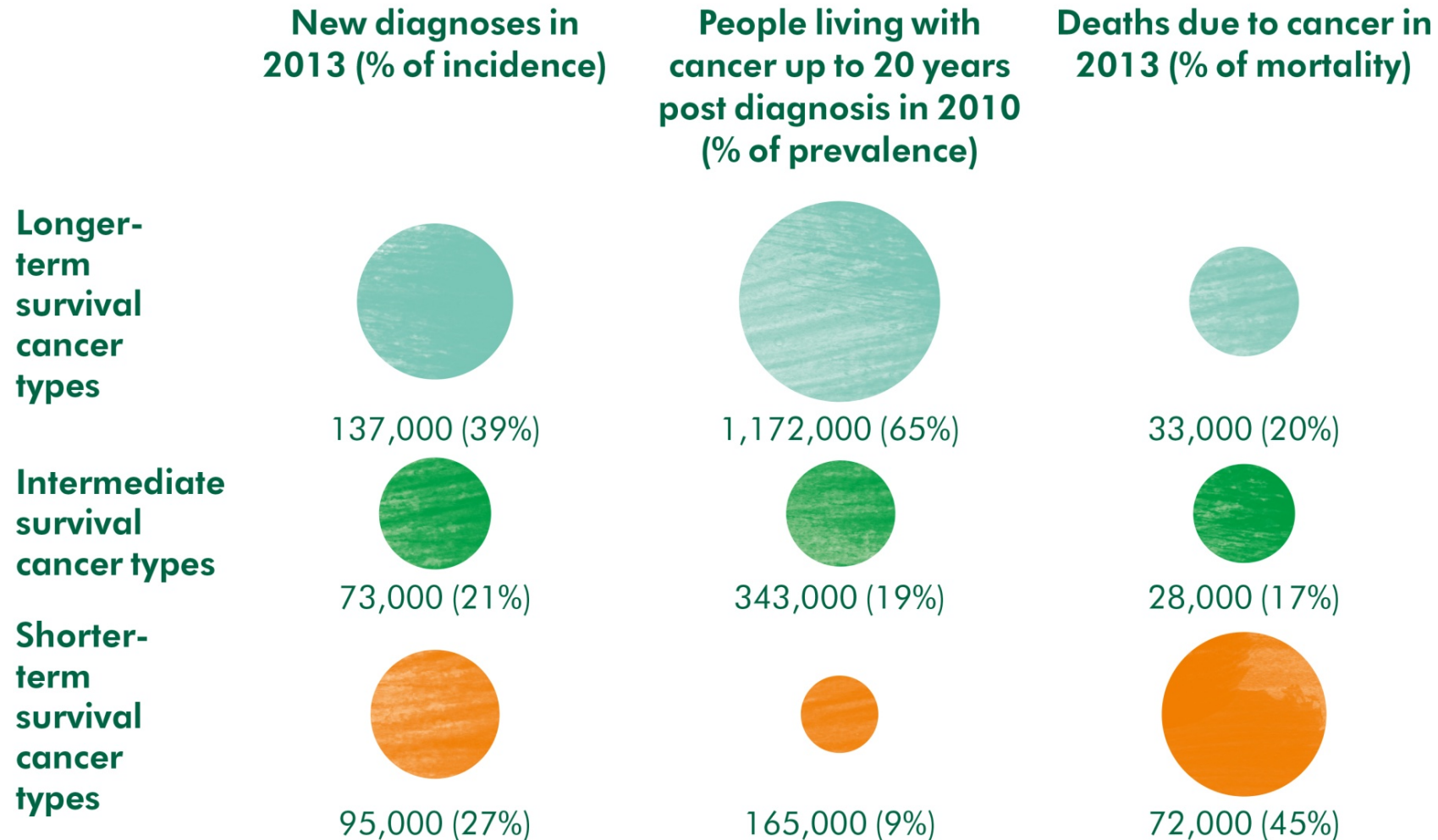Variation in survival rates between the three cancer groups
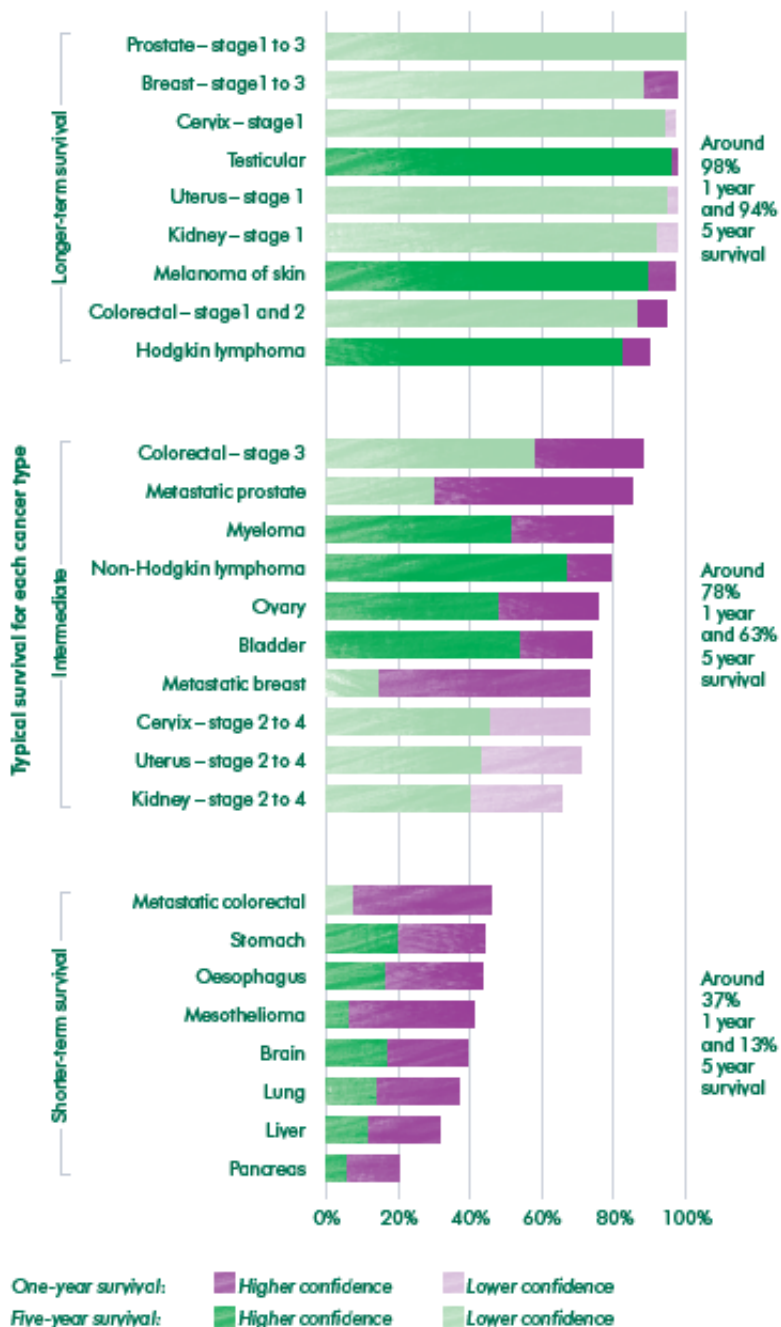
Longer-term survival
- Prostate – stage 1 to 3
- Breast – stage 1 to 3
- Cervix – stage 1
- Testicular
- Uterus – stage 1
- Kidney – stage 1
- Melanoma of skin
- Colorectal – stage 1 and 2
- Hodgkin lymphoma

Around 98% 1 year and 94% 5 year survival

Typical survival for each cancer type — Intermediate
- Colorectal – stage 3
- Metastatic prostate
- Myeloma
- Non-Hodgkin lymphoma
- Ovary
- Bladder
- Metastatic breast
- Cervix – stage 2 to 4
- Uterus – stage 2 to 4
- Kidney – stage 2 to 4

Around 78% 1 year and 63% 5 year survival

Shorter-term survival
- Metastatic colorectal
- Stomach
- Oesophagus
- Mesothelioma
- Brain
- Lung
- Liver
- Pancreas

Around 37% 1 year and 13% 5 year survival

0% 20% 40% 60% 80% 100%

One-year survival: ■ Higher confidence ▫ Lower confidence
Five-year survival: ■ Higher confidence ▫ Lower confidence

❖ Longer term survival

❖ Intermediate

❖ Shorter term survival

Three cancer groups in numbers

	New diagnoses in 2013 (% of incidence)	People living with cancer up to 20 years post diagnosis in 2010 (% of prevalence)	Deaths due to cancer in 2013 (% of mortality)
Longer-term survival cancer types	137,000 (39%)	1,172,000 (65%)	33,000 (20%)
Intermediate survival cancer types	73,000 (21%)	343,000 (19%)	28,000 (17%)
Shorter-term survival cancer types	95,000 (27%)	165,000 (9%)	72,000 (45%)

Pathways are different

Group 1:
Many live for more than a decade

Group 2:
Most similar to a long term condition

Group 3:
Survival for the majority is short term

McConnell H, White R, Maher J. *Understanding variations: Outcomes for people diagnosed with cancer and implications for service provision*. 2014. European Network of Cancer Registries Scientific Meeting and General Assembly

Focus for intervention will differ for people in each group

Group 1: Reduce overtreatment, focus on recovery

Group 2: Balance acute intervention and chronic illness management

Group 3: Diagnose earlier; manage comorbidity early; palliative care for most

McConnell H, White R, Maher J. *Understanding variations: Outcomes for people diagnosed with cancer and implications for service provision*. 2014. European Network of Cancer Registries Scientific Meeting and General Assembly
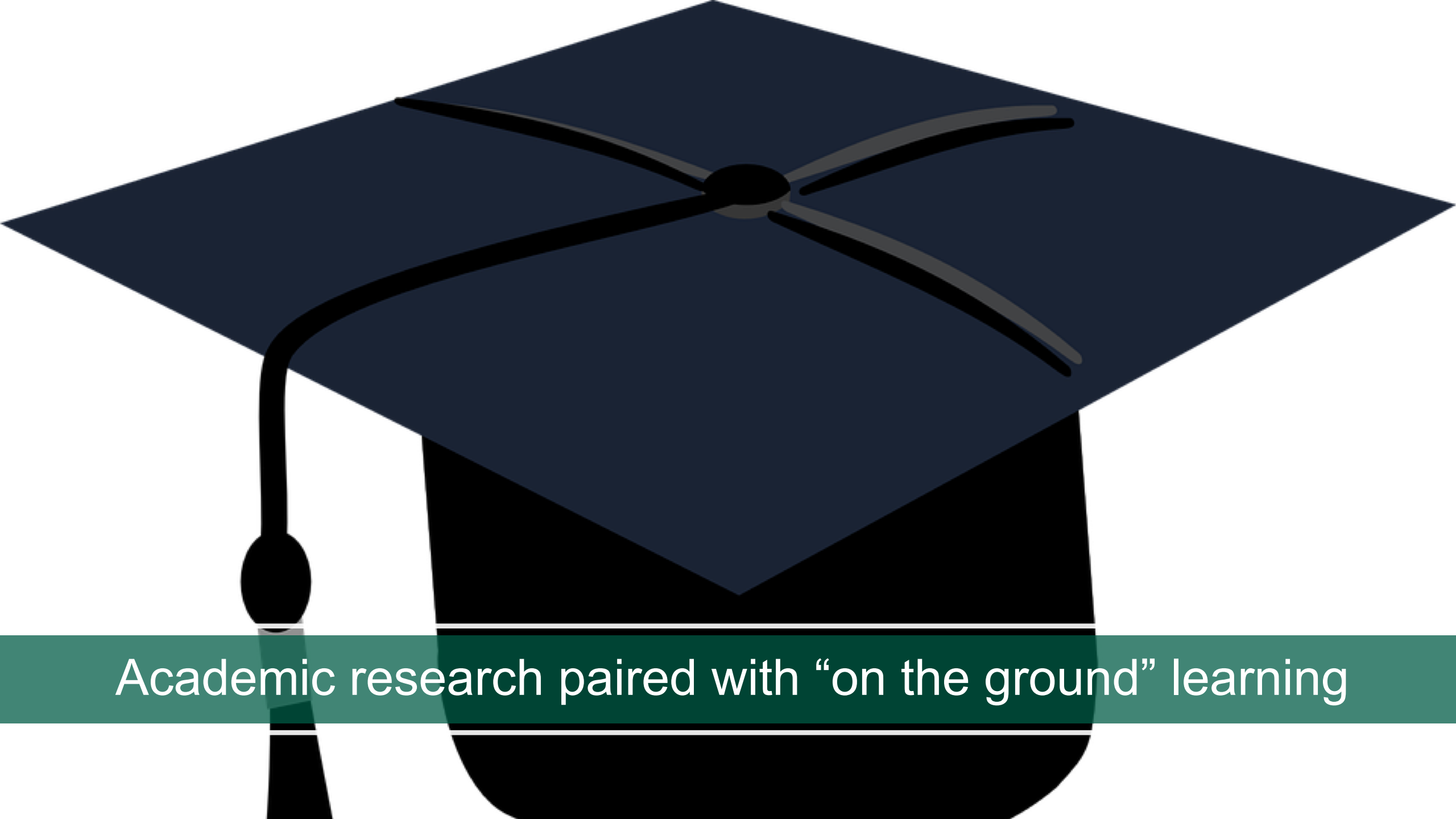
Academic research paired with "on the ground" learning

"Real-world" pilot studies based on academic findings provide more actionable findings

- The real world setting is different to a study.

- We combine academic learnings with what people on the ground tell us.

- Develop pilots that learn and improve as they go.

- Some things don't work but eventually, some things will.

https://commons.wikimedia.org/wiki/File:Florida_State_College_for_Women_students_experimenting_in_the_chemical_lab-_Tallahassee,_Florida_(6859458328).jpg

The case for early introduction of palliative care services

The case for early introduction of palliative care services

The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Early Palliative Care for Patients with Metastatic Non–Small-Cell Lung Cancer

Jennifer S. Temel, M.D., Joseph A. Greer, Ph.D., Alona Muzikansky, M.A., Emily R. Gallagher, R.N., Sonal Admane, M.B., B.S., M.P.H., Vicki A. Jackson, M.D., M.P.H., Constance M. Dahlin, A.P.N., Craig D. Blinderman, M.D., Juliet Jacobsen, M.D., William F. Pirl, M.D., M.P.H., J. Andrew Billings, M.D., and Thomas J. Lynch, M.D.
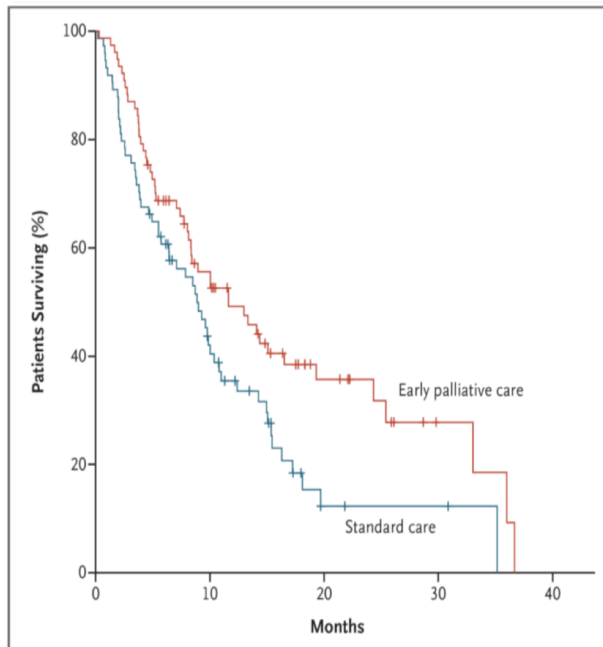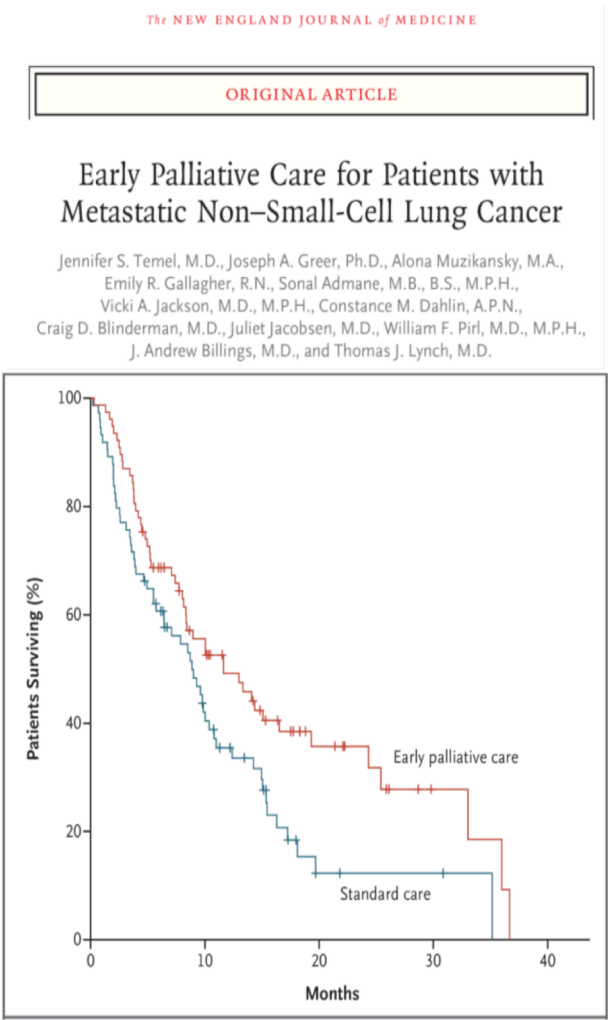
Early palliative care	2.7 months (Temel NEJ 2010)	$6,000
Bevacizumab	2 months (ECOG 4599)	$115,000
Nivolumab	3.3 months (J. Brahmer, NEJM 2015)	$140,000

Early introduction of palliative care

OUR RESULTS AND FINDINGS IN MIDHURST

84% of people died in their preferred place of care in 2012/13, which is significantly up on the national average.

If the service was replicated elsewhere, the total **cost of care could be reduced by 20%**

The service has resulted in **fewer A&E visits and nights in hospital** from the people who use it.

By using their different specialisms, team members ensure **a person-centred approach and optimum use of time**

Volunteers fulfil many important roles and are a key part of the service.

Developing, collecting and using evidence is embedded in our work

Our approach to monitoring, evaluation and learning (MEL)

Understanding and evaluating the difference our services and interventions make
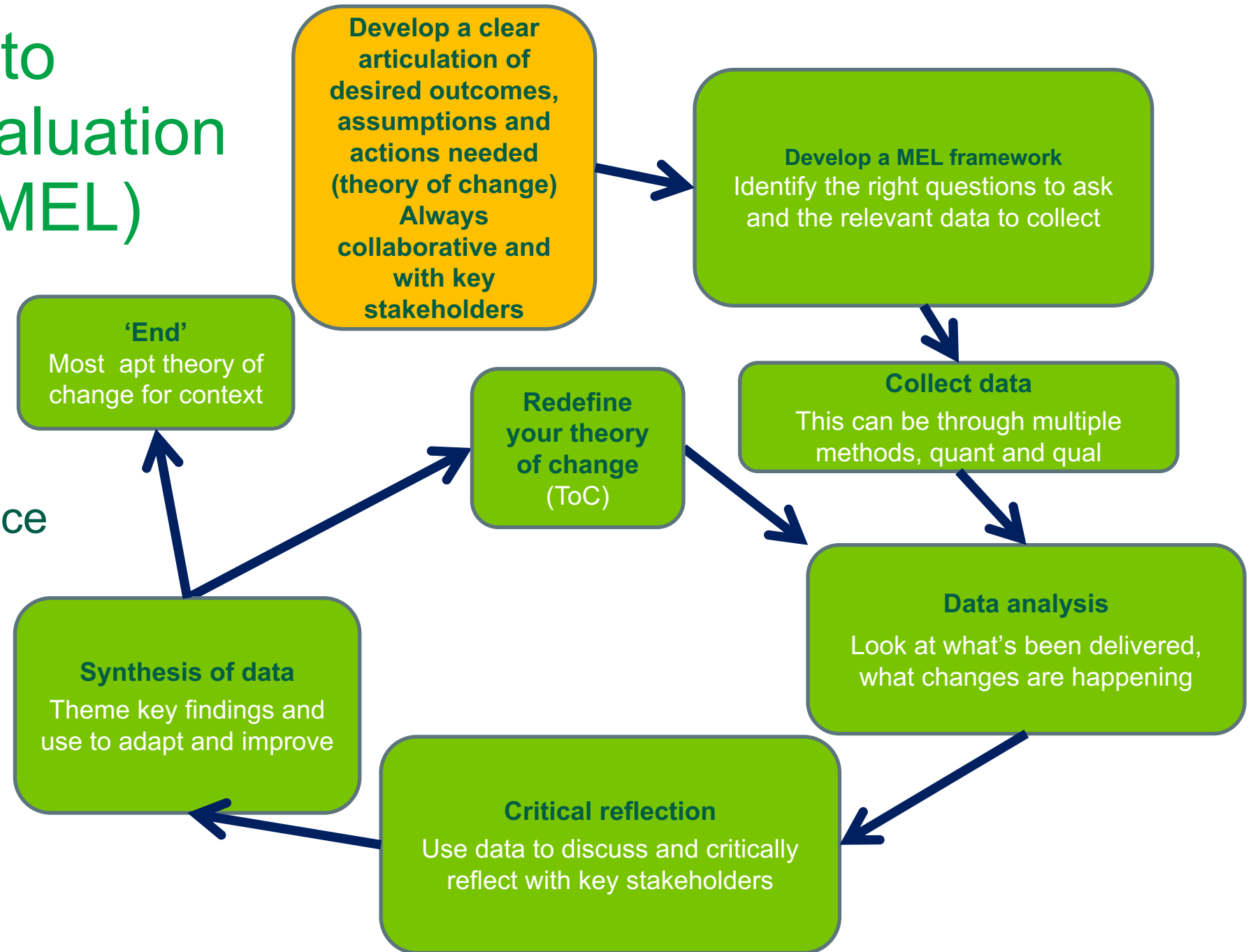
Develop a clear articulation of desired outcomes, assumptions and actions needed (theory of change) Always collaborative and with key stakeholders

Develop a MEL framework Identify the right questions to ask and the relevant data to collect

Collect data This can be through multiple methods, quant and qual

Data analysis Look at what's been delivered, what changes are happening

Critical reflection Use data to discuss and critically reflect with key stakeholders

Synthesis of data Theme key findings and use to adapt and improve

Redefine your theory of change (ToC)

'End' Most apt theory of change for context

Funding new evidence

Funding new evidence

Read more about the new projects on the Research Funding pages of the Macmillan website.

Go to www.macmillan.org.uk and search 'research funding'

Working together to drive research impact

MACMILLAN RESEARCH IMPACT FRAMEWORK

Maximise the impact of research Macmillan funds

Co-produced with people affected by cancer

Support researchers to plan, deliver and monitor impact

Launching alongside the 2018 call

Challenges in building the evidence base

# We need more than data; we need the right data

"So things are good, stuff is OK, and I reiterate my request for more specific data."

Improving PROs data collection in clinical trials

EPiC: A Systematic Evaluation of Patient-Reported Outcome (PRO) Protocol Content and Reporting in UK Cancer Clinical Trials

In 'EPiC: A Systematic Evaluation of Patient-Reported '

> EPiC
> International Team
> Publications
> Contact
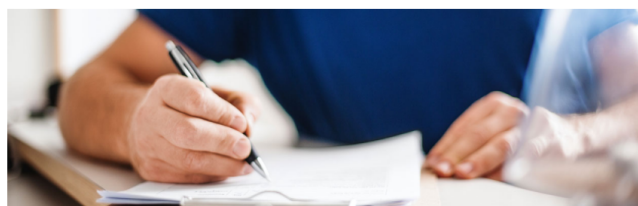
A mixed-methods study investigating PRO protocol content and reporting in UK cancer clinical trials.

CPROR
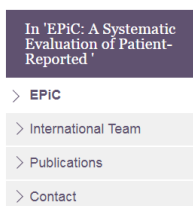
Centre for Patient Reported Outcomes Research

Funded by
WE ARE MACMILLAN.
CANCER SUPPORT

PER AD ARDUA ALTA

UNIVERSITY OF BIRMINGHAM

Clinical Review & Education

JAMA | Special Communication

Guidelines for Inclusion of Patient-Reported Outcomes in Clinical Trial Protocols
The SPIRIT-PRO Extension

Melanie Calvert, PhD; Derek Kyte, PhD; Rebecca Mercieca-Bebber, PhD; Anita Slade, PhD; An-Wen Chan, MD, DPhil; Madeleine T. King, PhD; and the SPIRIT-PRO Group

The Quality of Life Metric for cancer survivors

- Macmillan working with NHS England on a pilot

- Results will form part of a National Cancer Dashboard

- Results of pilot to be reported in March 2019

We need to support research that matters to patients

A strong patient voice in research
funding decision-making…

…and in setting research priorities

Living With and Beyond Cancer James Lind Alliance Priority Setting Partnership
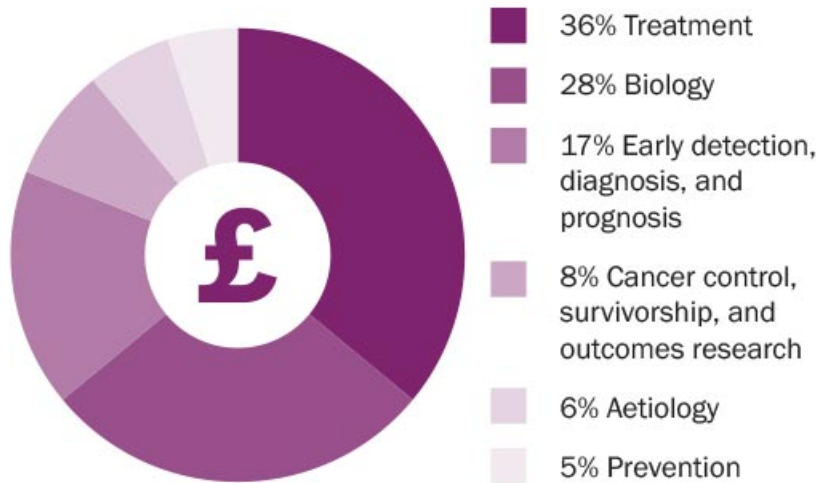
As part of the NCRI Living With and Beyond Cancer initiative, the Priority Setting Partnership aims to identify research priorities that matter most to people affected by cancer and relevant health care professionals.

We need sustained investment to build research capacity

Spend by research type

As in previous years, research into **cancer treatment** and **biology** make up around **two thirds** of the value reported. **Treatment** research now accounts for **36%** of research spend recorded.*

- 36% Treatment
- 28% Biology
- 17% Early detection, diagnosis, and prognosis
- 8% Cancer control, survivorship, and outcomes research
- 6% Aetiology
- 5% Prevention

Granstmanship – to upskill the research community

NCRI
National Cancer Research Institute

Securing large scale research infrastructure investments

HORIZONS
Understanding the impact of cancer diagnosis and treatment on everyday life

CREW
Understanding the recovery and wellbeing of those affected by colorectal cancer

Challenges in building the evidence base