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# NHS Confederation and ABPI: An examination of health inequalities in cancer care in Kent and Medway

## Preface

The COVID-19 pandemic has thrown into sharp focus the issue of health inequalities in the UK and demonstrated the need for a renewed focus on this deep-rooted and multi-faceted problem. The Association of the British Pharmaceutical Industry (ABPI) and the NHS Confederation are partnering on a series of activities focused on this crucial issue. Our aim is to share learning and look at the opportunities for greater cross-sector collaboration between industry and the NHS to address health inequalities. This report is part of this joint programme of work.

## Background

Health inequalities are defined within the context of the English health system as "unfair and avoidable differences in health across the population, and between different groups within society"[1].

Health inequalities arise because of the conditions in which we are born, grow, live, work and age, influencing opportunities for good health and shaping physical and mental health and wellbeing.

NHS England has documented health inequalities as existing across four overlapping dimensions: socio-economic status and deprivation; protected characteristics such as age, sex, race, sexual orientation and disability; vulnerable groups such as migrants, Gypsy Roma and Traveller communities, rough sleepers, homeless people and sex workers; and geography, though this list is not exhaustive.

The COVID-19 pandemic has shone a spotlight on health inequalities and the role of the public sector in tackling them. For the NHS, this has been underscored in the third and fourth phase planning for NHS service recovery[2] highlighting the need to be more aware of, and take steps to address, inequalities in health.

## Kent and Medway Integrated Care System (ICS)[3]

All NHS organisations and the Kent and Medway councils have been working together as a sustainability and transformation partnership since 2016 to serve the health and care needs of a population of 1.8m. During 2021/22 , this joint working will be developed into an integrated care system. This will include forty two primary care networks of general practices working together, and in partnership with community, mental health, social care, pharmacy, hospital and voluntary services; four integrated care partnerships drawing together all provider NHS organisations and working more closely with social care; and a single commissioning group, led by local doctors, taking a bird's eye view on tackling shared challenges such as cancer and mental health. Priorities identified by the ICS specifically include faster and better diagnosis, treatment and care for the most common killers, including cancer and improving survival rate, they also set out a pledge to reduce death among people with mental health problems, learning disabilities or autism, which are widely recognised as inequalities in health and social care.

## Health inequalities in Kent and Medway ICS

Kent and Medway both face the challenge of reducing health inequalities in their areas. Despite being based in the South-East, a region often associated with higher levels of affluence and health, both areas contain patches of deprivation and the health inequalities associated with this. Each local authority produces regular Joint Strategic Needs Assessments (JSNA) which sets out the size of the challenge.[4]

Most cancer diagnoses are in people over the age of 65 and in Kent and Medway 18% are over 65 (compared to 17% nationally) but this varies across the area. Only 15% of people are over 65 in Medway whereas over 22% are over 65 on the South Kent coast.[5] Deprivation is recognised to increase the risk of some cancers and

the level of deprivation in nine out of twelve Kent local authority districts has increased since IMD2015 relative to other areas in England according to The Index of Multiple Deprivation published in January 2020.

Kent and Medway STP is in the relatively ethnically diverse region of the South East with: 85% white British 5.4% white non-British 5.2% Asian 1.6% Black 2.5% Mixed and other Ethnic Minorities

Inclusion health specifically aims to prevent and redress health and social inequities among the most vulnerable and excluded population. 14,542 people in the South East region identify themselves as Gypsies or Travellers, out of 58,000 across England as a whole.

## Cancer statistics for Kent and Medway

A Public Health England report into cancer in Kent and Medway 2017[6] found that, across the Kent and Medway Cancer Alliance area in 2014, 54,500 people were estimated to be either living with cancer or to beyond their diagnosis and treatment. In the same year over 10,300 new cases were diagnosed, and by 2030 there could be 90,900 people living with cancer in the area. Although these figures show a lower incidence of cancer overall than the average for England, for some cancers incidence in the South East followed national patterns and varied by deprivation. For males, incidence rates of lung and liver cancers were higher in the most deprived groups compared to the least deprived. For females, incidence rates of lung, cervix, pancreatic and liver cancers were all higher in the most deprived groups. In contrast, the incidence rates of prostate and breast cancers were higher in the least deprived groups.

## Cancer care in Kent and Medway

In 2015, following publication of the Independent Cancer Taskforce's Strategy for improving services, care and outcomes for everyone with cancer, cancer alliances were set up across England to drive the taskforce's vision forward.

The Kent and Medway Cancer Alliance brings together healthcare providers from across Kent and Medway, commissioners, hospices, patient representatives, voluntary and charitable organisations and the National Institute for Health Research, to transform the diagnosis, treatment and care for cancer patients. These partnerships enable care to be more effectively planned across local cancer pathways.

The Cancer Alliance works closely with the emerging Kent and Medway ICS, and the single CCG in the area, driving forward the area's collective strategy for improving cancer care and outcomes.

The Alliance also works closely with the Kent and Medway Cancer Collaborative, which shares best practice and develops local care pathways, and the Kent and Medway Cancer Action Partnership, which involves local patients in the development of services. The Alliance's priorities cover five main areas: prevention and screening, earlier diagnosis, treatment and care, living with and beyond cancer and personalising aftercare.

Early diagnosis, which is viewed as key to improving survival rates is being tackled through introducing new streamlined diagnostic pathways, piloting a 'vague symptom' clinic, implementing the new 28-day faster diagnosis standard and reviewing the current diagnostic service provision across Kent and Medway.

In February 2020, Kent and Medway achieved the 62-day cancer wait performance standard for the first time in five years, making the Cancer Alliance the second highest performing in the country, an improvement attributed to the hard work and collaboration of everyone working across all cancer services in the area.[7]

## Viewpoints on cancer and health inequalities in Kent and Medway

The next section of this report summarises viewpoints from leaders working in or with cancer services in Kent and Medway. Participants' roles encompassed commissioning, public health, primary care, and the regional cancer alliance. One participant was a patient leader. Findings explore how cancer services work at

present in Kent and Medway, how health inequalities are being understood and addressed in relation to cancer care, what work is under way to address health inequalities in cancer, and what role participants envisage that the pharmaceutical sector could play in supporting this work.

## Cancer services in Kent and Medway

Participants highlighted that the cancer alliance is active, with strong links to local providers and commissioners, effective system-wide collaboration, and there is a growing ability of local organisations to work in a unified way, as particular strengths.

System strengths in primary care identified by participants included primary care involvement in tumour group work, primary care clinicians' roles as clinical commissioning group cancer leads, and the role of primary care networks in improvement work. "Safety netting" work under way in primary care to ensure vulnerable service users return for follow-up appointments, and mentorship and sharing of good practice in primary care involving primary care networks, were also highlighted as impactful primary care-based activities, but it was acknowledged that deprived areas often face higher demand for primary care, with fewer GPs to meet that demand.

Strengths identified in the public health sector included having a unitary authority with a provider arm, meaning that close links were possible between prevention activities that took place in the public health team such as stop smoking and weight management services, and other relevant services provided in-house, such as "prehab" services specifically to support people to improve their health before cancer treatment.

The local authority joint strategic needs assessment was also considered important, but there was a proposal that there would be potential benefit in reframing these assessments in part as a "joint strategic assets assessment", therefore giving the assets that already exist in local communities as much prominence as the needs those communities have, in order to facilitate greater discussion of opportunities to improve services.

## Drivers of improvement in cancer care

Having access to "good data" was viewed as the key starting point for work to improve cancer services, followed by bringing different people together to address issues identified in the data. Examples cited included using data to detect areas or pathways that could be contributing to delays, for example diagnostics, deploying data-driven approaches to understanding patient experience, and exploring national-level best practice.

Although participants felt the data available was improving, there was a sense that this could be improved further. Examples included concerns that data was not yet sufficiently reliable, and that it was sometimes out of date. It was suggested that making data more readily available at primary care network or practice level would be helpful in targeting effort.

Clinical leadership was considered important in supplementing a data-driven approach. One participant said: "A lot of what we do is clinically driven – in the absence of data, we rely on clinicians to say 'this is an issue'."

## Understanding health inequalities in relation to cancer

Participants understood health inequalities to be "inequalities in how people access and receive care […] due to deprivation", barriers to accessing care, variation in health provision, the "causes of the causes" of poor health and "disadvantage".

Drivers of health inequalities in cancer care were perceived to be inequalities in accessing care or even knowing care is available, barriers to access generated by patients' insecure working conditions and poverty, late diagnosis stemming in part from poor access, and cultural reasons such as mistrust of healthcare professionals, the perception that illness must be endured, or that service users should not bother health professionals. Those living in deprived areas, people with a Black ethnicity, people aged 55 and above, those with disabilities or existing long-term conditions,

or with either a caring need or a carer role, were viewed as particularly affected by health inequalities in Kent and Medway.

Participants all considered that the organisations they worked with or for were committed to tackling health inequalities relating to cancer care, and they were able to highlight structures and processes designed to achieve this. Examples included COVID-19 resulting in increased motivation to address inequalities locally, a detected "sea change" in national level policy work in this area over the past four to five years, and an expectation that health inequalities will feature heavily in NHS operational plans, such as the 2021/22 priorities and operational planning guidance[8]. Work to deploy population health management approaches launched in Kent following a recent restructure was also viewed as an important tool for addressing health inequalities.

Equal access to services was seen as a particularly important facet of reducing inequalities, as was the adoption of a "health in all policies" approach encompassing transport and schools, focusing efforts at the level of the system, and closing knowledge gaps by communicating more effectively with different communities about how to deal with concerning symptoms. Working with faith groups was considered to have particular potential as a means of communicating complex messages effectively.

## Role of the pharmaceutical industry in tackling health inequalities in cancer care

Only one participant had a strong view about the potential for the pharmaceutical sector to support health systems' work in addressing health inequalities in cancer care. This participant spoke of working more closely with pharmaceutical companies' service improvement arms to access analytic support capacity and capability in process mapping, pathway mapping and resource allocation. They mentioned the potential for artificial intelligence approaches to be used to contribute to understanding of where most impact could be made in addressing inequalities and where the NHS is "behind the curve". The participant suggested health services often asked "what do they want out of this", when

considering partnership work with pharmaceutical companies, but that this could potentially be overcome if industry presented its offer to the NHS in a more attractive way.

Others were unclear about the potential role of the pharmaceutical sector, but suggested interventions such as supporting the development of better designed communication tools, funding additional staff and resources such as Macmillan nurses, funding posts and research, and addressing wider determinants of health through their supply chains, for instance by reducing carbon consumption, and considering supply chains and their role as employers.

## Conclusion

Focused efforts to improve cancer care have been under way in Kent and Medway and continue to be a system priority. Data-driven approaches to quality improvement are under development, but the journey is not complete. On the whole, leaders in the local health and care system participating in the research had a clear understanding of drivers of health inequalities and were aware of or involved in policy interventions to address these. Participants were much less well-aware of the potential role of the pharmaceutical sector in supporting work to reduce health inequalities, but one leader articulated an important contribution that the sector could make through offering analytic support to provide a clearer underpinning in data for existing work on reducing inequalities.

## Industry view

This year the ABPI published "Cancer in 2020 and beyond"[9]. The report acknowledges the coronavirus (COVID-19) pandemic has disrupted many areas of healthcare, and this is particularly true of cancer services. It made a number of recommendations for recovery, and also recognised the importance of data-driven approaches to quality improvement.

The ABPI agrees that the pharmaceutical industry can play a crucial role in helping to tackle inequalities in cancer care and encourages NHS system leaders to draw on companies' expertise. Industry acknowledges the need to increase visibility as to what is possible through collaborative working. To that end the ABPI has launched a NHS-Industry Partnership Case Studies Repository and includes two exemplars of industry supporting building awareness and moving care into the community in this report.

There is a real opportunity for companies and the NHS to build stronger collaborations so that all patients get equal access to cancer services and ultimately achieve the best possible health outcomes. Companies and the NHS are committed to delivering for patients on this.

**Case studies: Industry and the NHS working together**

### MSD: Tackling the drop-in cancer detection rate due to pandemic presentation hesitancy – The Do It For Yourself campaign

**Issue**: The first UK wave of COVID-19 was associated with a dramatic drop in presentation and detection of all cancers which has still not recovered. Lung cancer referral was among the hardest hit and remains disproportionately low. Detecting these undiscovered cancers in the community at the earliest possible stage will limit the negative impact of the pandemic on outcomes.

**Intervention**: MSD worked with charities, professional organisations and NHS partners to produce and deliver a rapid cancer awareness programme targeted at a key lung cancer demographic of older men in areas of high deprivation. The campaign saw MSD take on a coordinating role with respective partner organisations to develop a creative messaging programme to target this hard-to-reach group. Driven by patient insights, the campaign focused on outdoor and radio advertising to deliver a simple message that a cough for three weeks or more should not be ignored or conflated with COVID-19, and encouraged a visit to their doctor. The campaign phase 1 ran in Greater Manchester and Northern Cancer Alliances in December 2020 – with a second larger phase for 8 cancer alliances due in summer 2021.

**Results**: Initial findings on the first phase of the campaign saw a correlating spike in "2-week wait" cancer referrals in the trial areas. Feedback from Cancer Alliances suggests strong take up of the campaign with partner organisations. Phase 1 feedback also enabled the campaign be refined to offer organisations a wider range of assets to communicate with their local communities – notably a public film and leaflet for voluntary organisations currently in production.

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**BMS: Redesigning health services to ensure the best possible treatment outcomes**

**Issue**: BMS worked closely with NHS England and in the devolved nations, as well as individual NHS trusts, to help redesign health services and identify how their therapies could be delivered in alternative ways, away from hospital settings to ensure the best possible treatment outcomes. With hospitals overwhelmed by COVID-19 patients, the NHS experienced interruptions to cancer services and treatment capacity issues due to the need for social distancing.

**Intervention**: To aid the continuation of services, BMS donated over £2million to NHS cancer services, charities and patient groups. This included £747,000 for Hope for Tomorrow, the largest provider of mobile cancer care units in the UK, who are using the funds to build two new mobile units.

**Results**: Once the new mobile units are built and launched, the BMS funding has the potential to expand their capacity by 30%, enabling delivery of over 6500 treatments to patients each year. These patients may otherwise have endured longer journeys, higher travel costs and growing waiting times.

# References

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9 Collaboration across UK cancer community vital to restoring and improving NHS cancer services | ABPI

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## About NHS Reset

COVID-19 has changed the NHS and social care, precipitating rapid transformation at a time of immense pressure and personal and professional challenge. One message from leaders and clinicians across the UK has been clear: we must build on the progress made to chart a new course.

NHS Reset is an NHS Confederation campaign to help shape what the health and care system should look like in the aftermath of the pandemic. Recognising the sacrifices and achievements of the COVID-19 period, it brings together NHS Confederation members and partners to look at how we rebuild local systems and reset the way we plan, commission and deliver health and care.

NHS Reset is part funded through sponsorship by Novartis Pharmaceuticals UK Limited.

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