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NHS Confederation and ABPI: An examination of health inequalities in chronic obstructive pulmonary disease (COPD) care in the North West

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 a 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.

Lancashire and South Cumbria Integrated Care System (ICS)

Lancashire and South Cumbria ICS serves the health and care needs of a population of 1.7m. It includes 41 primary care networks of general practices working together, and in partnership with community, mental health, social care, pharmacy, hospital and voluntary services; five Integrated Care Partnerships drawing together all provider NHS organisations and working more closely with social care; and five clinical commissioning groups (CCGs). Priorities identified by the ICS include:

- making faster progress on reform of the four priority areas: of urgent and emergency care, primary care, mental health and cancer services
- managing improvements within a shared financial control total across CCG and provider partners
- integrating services and funding within a single health system
- acting as a strong leadership cohort[3]

Cheshire and Merseyside ICS

Cheshire and Merseyside Health and Care Partnership has been working together as a sustainability transformation partnership (STP) since 2016, serving the health and care needs of a population of 2.6m[4] and will develop into an ICS during 2021/22. It is a collection of NHS, local authority, voluntary, community, faith and social enterprise organisations from the across the nine local authorities within Cheshire and Merseyside.[5] The Executive Team's objectives are to:

- support the development of nine Integrated Care Partnerships (ICPs)
- establish a Provider Collaborative
- support the system's workforce through transition arrangements
- develop a wider leadership team

- implement agreed transformation programmes
- implement clear system and partnership governance arrangements
- develop and implement an ICS financial framework
- be clear on what they do, how and why they do it and have effectively explained this[6]

Health inequalities in the North West

As a region, the North West has some of the most deprived areas in England. Blackpool, Liverpool and Knowsley were ranked the first, second, and third most deprived local authority districts respectively, according to the English Indices of Deprivation 2019.[7] The region has other areas that, while being less badly affected by deprivation, face challenges because of their rurality. Statistics on the region's population are outlined below:

- 4.5% are from BME groups in Cheshire and Merseyside,[8] 8.8% are from BME groups in Lancashire and South Cumbria[9]
- 4,147 people in the North West region identify themselves as Gypsies or Travellers, out of 58,000 across England as a whole
- 18.7% of people in the North West region are over 65 (compared to 17% nationally)[10]

The North West has pockets of high smoking levels. Office for National Statistics data from 2018 showed that 21.2% of people in Blackpool, 19.3% of people in Barrow in Furness and 18.1% of people in Knowsley were smokers, compared with an England average of 14.4%.[11]

Parts of the North West have some of the highest levels of COPD in England. In 2016/17, Blackpool South was the third worst affected parliamentary constituency area, with a COPD prevalence level of 3.7%, and Knowsley, Liverpool Walton and Blackpool North, and Cleveleys were joint fifth, with prevalence levels of 3.6%, compared with an England average of 1.9%.[12]

COPD care in the North West

Following the commitment in the NHS Long Term Plan to prioritise respiratory health, health systems have been focusing on improving respiratory care across the region. Respiratory networks have been established across the North West.

In Cheshire and Merseyside, the Cheshire and Merseyside Health and Care Partnership was awarded transformation funding to run a respiratory improvement programme in 2019-2020. The aim of the programme was to deliver the first Cheshire and Merseyside wide collaborative respiratory workforce to improve respiratory care for patients and bring physician associates into the workforce. The physician associates are hosted at the Liverpool Heart and Chest Hospital, a specialist provider that also provides community-based COPD services for the Knowsley area.

Elsewhere in the region, in Morecambe Bay, primary care providers are working closely with University Hospitals of Morecambe Bay NHS Foundation Trust to offer improved COPD services across an area that is more rural with some small towns. These two approaches highlight different aspects of effective programmes to improve COPD care in different local contexts.

Viewpoints on health inequalities and COPD in the North West

The next section of this report summarises views from health leaders working in respiratory services in the North West. Participants' roles encompassed tertiary, primary care and community provision, general and specialist primary care, community services and strategic planning. Findings explore the nature of COPD services in the North West, how health inequalities are understood in relation to COPD, programmes under way to improve COPD care in the region and potential roles for the pharmaceutical sector in relation to this work.

COPD services in the North West

Knowsley is the site of a national flagship programme to deliver respiratory services using a new community-focused care model. Participants described how the scheme began as a COPD service after commissioners concluded that a new approach was needed to respond to very poor outcomes among a population with a high level of deprivation.

The service now encompasses all aspects of respiratory care, with primary, secondary and tertiary care provided by one integrated team. Prior to the COVID-19 pandemic, the service was provided in local primary care settings, where patients could access quality diagnostic spirometry and see a respiratory consultant to get a COPD diagnosis. There was also 24/7 access to a respiratory nurse, with a two-hour response time.

In the more rural north of the region, the Morecambe Bay Respiratory Network has been set up by Bay Health and Care Partners, the Integrated Care Partnership in the Morecambe Bay area. The respiratory network currently covers two out of three localities in the area. Participants described its objectives as being to improve integration between acute, primary and community services, using a multidisciplinary team approach comprising primary care staff, specialist respiratory staff, mental health input, and with a future aspiration to involve a more diverse group of clinicians and therapists.

Drivers of improvement in COPD care

The Knowsley respiratory service is commissioned based on the outcomes it achieves, with targets based around reductions in hospital admissions, as well as patient and GP experience measures. Participants viewed this outcomes-focused approach as one of the mechanisms that helps the service to improve as clinicians are constantly improving and innovating in their practice to better meet the targets. A smoking cessation service is also provided via the unit, which has medicalised the pathway to avoid making patients feel judged for their condition and thus discouraging them.

In Morecambe Bay, the respiratory network has reduced referrals to secondary care by around 40%, with patients managed safely in primary care. Outcomes are measured in terms of admissions and referral data. Measures of quality of life and symptom control are not yet in place, but participants said they hoped these might be introduced in future. The funding and training for primary care enables direct access to specialist tests such as lung function and CT images. Pulmonary rehabilitation capacity has been doubled and local guidance and support brought together to improve medicines optimisation.

Primary care participants felt one of the key achievements of the Morecombe Bay respiratory network was supporting an increase in diagnostic quality, including via improved access to lung function testing and CT imaging. Participants said that by using these approaches, clinicians had been able to identify incorrect diagnoses – for example, a diagnosis of asthma when a patient has inducible laryngeal obstruction (ILO) or patients with bronchiectasis incorrectly diagnosed as COPD.

Understanding health inequalities in relation to COPD

In Cheshire and Merseyside, which covers the Knowsley area, the health system is using a data-driven approach to improve COPD care. Participants described how the system is working with partners in areas such as housing, social value, carbon reduction and green initiatives. At a neighbourhood level, primary care networks have used social prescribing approaches including volunteer programmes to support people with COPD to lead lives that are as active as possible, and the voluntary sector is embedded in discussions about services.

One participant spoke of an aspiration to use the 'might' of the NHS to tackle entrenched inequities, working with local authorities, public health leads, planners and regeneration teams to improve housing quality and employment opportunities for those living in the worst conditions in the area. The system has recruited a PhD student to explore how it can best use data to further its work in reducing inequalities. Participants said the

Knowsley COPD programme has been targeting work at some of the most vulnerable people in its catchment area, for instance by providing smoking cessation programmes tailored to drug users.

In the more rural Morecambe Bay Integrated Care Partnership area, participants were concerned that smoking levels, particularly in communities like Barrow and Morecambe, remained stubbornly high. They said in areas where there is more deprivation, patients often have a less detailed understanding of the significance and implications of poorly controlled COPD. Addressing this is a priority for the network and the team has been developing an education pathway to help patients understand their condition. However, with a service that is delivered in large part via primary care, the pressure that core general practice activities places on the time of GPs means that more resource will ultimately be required to expand the work further.

Participants described a data-driven approach in Morecambe Bay, with population health methods in use, including the triangulation of data between primary and secondary care, and upper and lower tier local authorities, to identify population groups requiring greater support.

Role of the pharmaceutical industry in tackling health inequalities in COPD care

Participants perceived a wide range of potential roles for the pharmaceutical industry in supporting COPD care and COPD patients.

One participant saw a role for the pharmaceutical sector in providing service user education, for instance by supporting patients with poorly controlled COPD to understand their health status better, both via educational events and resources and through increased availability of technological approaches such as smart inhalers. A further role was described in terms of using the data that pharmaceutical companies hold to identify inequalities in access to services across systems.

One participant felt that pharmaceutical companies should consider their status as large-scale employers in communities, and should become anchor institutions, embedding policies of local employment, local resourcing and supporting local regeneration activities in their business models. This aligns with opportunities highlighted in the NHS Confederation's Health on the high street report.

Conclusion

In the North West, pockets of extremely high deprivation exist, with high levels of smoking prevalence often found in the same areas. This has significance for COPD services, and for respiratory services more broadly.

Health leaders in rural and urban communities in the North West have been developing networks and multi-disciplinary teams as ways of improving COPD and respiratory care. So far, these have been able to broaden access to advanced diagnostic procedures and to improve the level of support that patients are able to receive. However, in areas where services are provided primarily via primary care, the existing burden of work that GPs face means that it can be harder to free up additional resource to devote to these activities.

Industry view

Tackling Health Inequalities is everybody's responsibility – this includes industry. This deep dive has highlighted that advances are being made through the use of data to support population health management, education and commissioning based on outcomes. Industry has significant expertise in all these areas which, if combined with the NHS, would accelerate recovery. For this to happen ICSs should include industry partners at the earliest opportunity when designing programmes and initiatives to address the needs of their populations.

Recent publications drawing on the lessons learned from the COVID-19 pandemic, highlighting the inequity experienced in some communities, provide insights into what needs to be

included within ICS frameworks.[13,14,15] These highlight several key action areas to be in place to support health inequalities work which include:

- Leadership and accountability – nominated individuals at all elements within the system
- Mitigation and protection – understanding how best to protect populations
- Population health management – strategies in place to ensure needs of populations are met
- Co-production and culturally competent engagement – understanding and working with different communities in the most appropriate ways
- Health inequalities impact assessment – ensuring new pathways and services consider detriments of health
- Data recording and monitoring – collecting data to help drive further service provisions and improvements

Industry is poised to be a positive partner in this. The development of more meaningful relationships and collaborations with industry would add value as has been evidenced in several case studies. Examples of industry collaborations can be viewed through the ABPI NHS-Industry Partnership Case Studies Repository.

Two case studies of industry and NHS partnerships to help optimise the care of respiratory patients are outlined overleaf.

Case studies: Industry and the NHS working together.

Developing an enhanced integrated multidisciplinary team to identify and optimise the care of respiratory patients in Oxfordshire: a joint-working partnership between the NHS and Boehringer Ingelheim

Overview

Through joint working, Oxfordshire Clinical Commissioning Group (OCCG) and Boehringer Ingelheim (BI) piloted an enhanced NHS multidisciplinary integrated respiratory team (IRT) aimed at:

1. improving accurate, timely respiratory disease diagnosis
2. optimising clinical management
3. enhancing holistic and end-of-life care
4 identifying patients at risk of respiratory admissions and
5. integrating patient care across primary, secondary care and community settings

The integrated team in North and City localities enhanced existing community, hospital-based and primary care by providing a community consultant working alongside additional respiratory nurses and physiotherapists, a dedicated psychologist, pharmacist, public health smoke-free advisers and specialists in palliative care. Awareness and links to third sector organisations, including Better Housing Better Health, were also improved.

This led to timely, coordinated care closer to home for respiratory patients, development of a proactive and preventative approach that showed potential to reduce system costs and resulted in positive individual patient outcomes.

For more detail and for further examples of Boehringer-Ingelheim working with the NHS, visit www.boehringer-ingelheim.co.uk/search/node/Joint%20working

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Care Optimisation in COPD Service – GlaxoSmithKline (UK Ltd) and NHS Borders Health Board

Overview

Author: Kerry Straughan (GSK Respiratory Partnership Manager) and Andy Currie (Regional Account Manager). This summary has been written by GSK with consultation and approval from the Joint Working Project Team.

NHS Borders Health Board and GSK are undertaking a Joint Working project with the aim of care optimisation in COPD. This involves a balance of contributions with the pooling of skills, experience and resources. The project aims to complement existing NHS service provision to provide equity of care and service for patients with COPD. Overall, the programme aims to:

- Provide patients with equity of care by ensuring patients are managed according to clinical need and current local guidelines
- Reduce practice burden of long-term condition management through provision of clinical pharmacist resource
- Which leads to sustained improvement in quality of primary care COPD management:
  - Education and upskilling of healthcare professionals
  - Quality Improvement (QI) platform to support the prioritisation of ongoing workstreams
- Improve COPD outcomes and expected reduction in non-elective hospital admissions through optimisation of COPD management

The project will run from April 2021–April 2022.

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Key Objectives:

- Increase in number of appropriate patients who have a recorded COPD annual review
- Increased formulary compliance in COPD across health board
- Increased use of CAT/MRC across Borders health board
- Through the successful delivery of the project demonstrate the value of collaboration between the NHS and GSK
- Reduce healthcare utilisation as demonstrated by reduced emergency GP attendances and Emergency Department attendances
- Education delivery for health care professionals within Borders Health Board

Patients	• Fewer COPD-related hospital admissions • Better informed about COPD management and treatment options • COPD managed in accordance with current best practice clinical guidance • Better experience of the healthcare system – access to a clinical pharmacist and/or upskilled primary care clinician at their own GP practice
NHS	• Services are configured around patient and local healthcare economy needs – programme modules have been selected to compliment existing services and/or meet any gaps in existing care provision • Insight into COPD population at practice level and local healthcare economy level to allow benchmarking and evaluation of care provision to support clinical governance and support equity of care • Provision of clinical pharmacist resource allows practice clinical staff to be deployed to focus on other workstreams • Opportunity to upskill primary care clinicians • Better health outcomes for the COPD patient population • Reduction in COPD-related hospital admissions
GSK	• Faster implementation of NHS Borders policy relating to COPD care provision • Expansion of the COPD patient population who are managed according to current clinical and best practice guidelines as a result of the programme • Increase in the appropriate use of medicines licensed for COPD aligned to local or national guidance, with likely increase in prescribing of GSK products as well as those of other pharmaceutical companies • Better understanding of the challenges faced by the NHS in delivering high-quality patient services and care • Helps GSK to live its values in being a patient focussed company

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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.

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Join the conversation #NHS RESET

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