NPCA
National Prostate Cancer Audit

How do we reduce variation in access to treatment for all men? The experience of black and ethnic minority groups

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KING'S HEALTH PARTNERS

Research and analysis

Final report on progress to address COVID-19 health inequalities

Published 3 December 2021

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Introduction

Following publication of the Public Health England (PHE) report COVID-19: review of disparities in risks and outcomes in June 2020, the Prime Minister and the Secretary of State for Health and Social Care asked the Minister for Equalities, Kemi Badenoch MP, with support from the Cabinet Office Race Disparity Unit (RDU), to lead cross-government work to address the report's findings.

Under the terms of reference for this work, which are set out in Appendix A, the Minister for Equalities was tasked with submitting quarterly progress reports to the Prime Minister. This is the fourth and final progress report, following those published on 22 October, 26 February and 25 May.

This final report provides a further update on cross-government work to address the disparities highlighted by the PHE report. It looks back to previous quarters and sets out how our understanding of and response to the pandemic changed over the lifecycle of this work. The report also includes a summary of progress against recommendations from previous reports (Appendix B), lessons learnt from this work and an action plan for addressing some of the longer-term issues identified during the course of this project.

This report should be read alongside the government's forthcoming response to the report of the Commission on Race and Ethnic Disparities, which will include actions to

Higher ethnic minority maternity risk examined

By Adina Campbell
BBC Community Affairs Correspondent

22 June

NHS backlog disproportionately affecting England's most deprived

Waiting lists for routine treatments up 50% in poorest areas compared with 35% in most affluent areas

- Coronavirus – latest updates
- See all our coronavirus coverage

Jonathan Ashworth, the shadow health secretary, says the waiting list crisis is in danger of leading to privatisation of the NHS. Photograph: Tayfun Salcı/Zuma Press Wire/Rex/Shutterstock

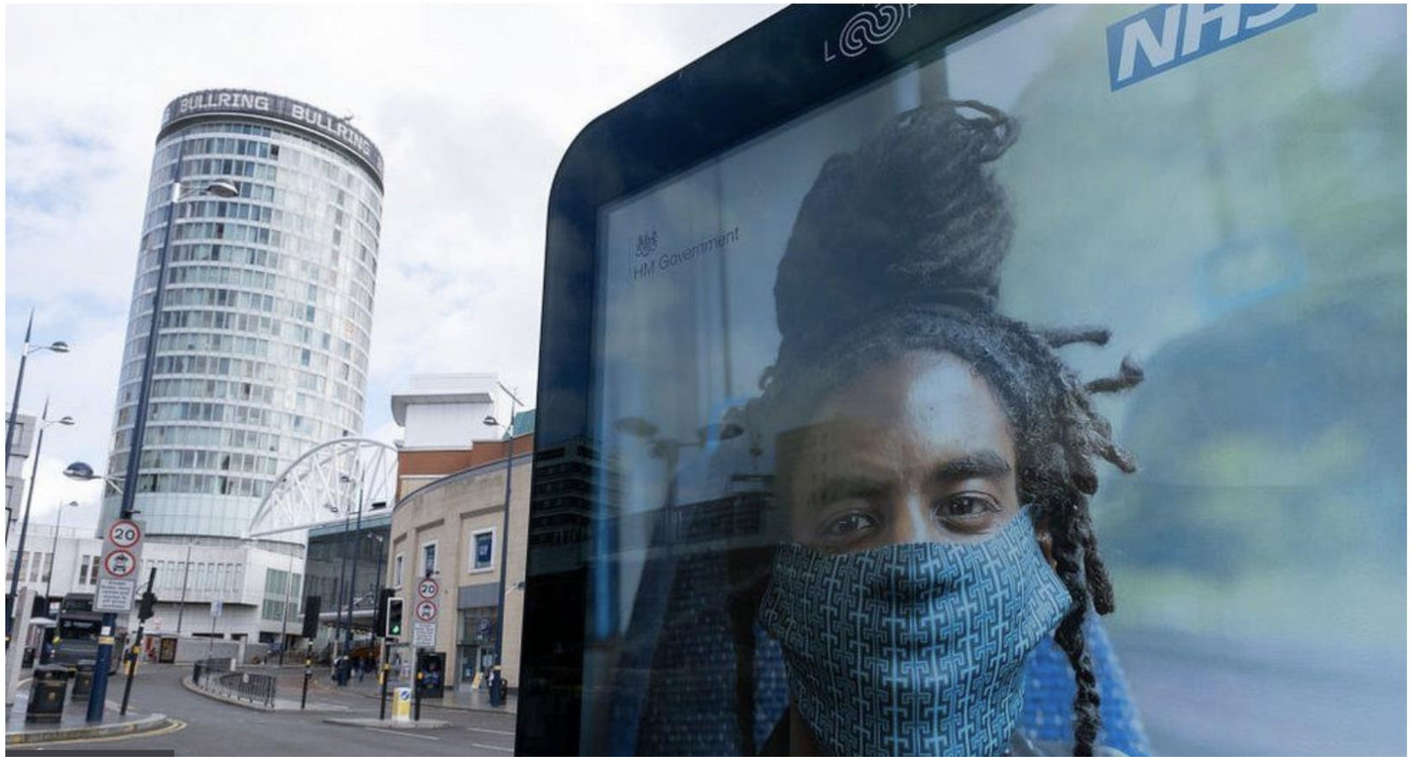
The NHS backlog is being disproportionately shouldered by people in poor areas, according to new research, amid a stark warning that waiting lists ar

Covid: Black leaders fear racist past feeds mistrust in vaccine

By Rachel Schraer
Health reporter

6 May

Coronavirus pandemic



ETHNIC HEALTH INEQUALITIES IN THE UK

BLACK WOMEN ARE

4x MORE LIKELY THAN WHITE

women to **DIE** in **PREGNANCY** or childbirth in the UK.

Ref: https://bit.ly/3ihDwcN

SOUTH ASIAN & BLACK PEOPLE ARE

2-4x MORE LIKELY TO DEVELOP

Type 2 diabetes than white people.

Ref: https://bit.ly/3ulDy88

IN BRITAIN, SOUTH ASIANS HAVE A

40% HIGHER DEATH RATE

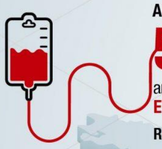
from **CHD** than the general population.

Ref: https://bit.ly/3iifo9V

IN THE UK, AFRICAN-CARIBBEAN MEN ARE UP TO 3x

more likely to **DEVELOP PROSTATE CANCER** than white men of the same age.

Ref: https://bit.ly/39KWqEs



ACROSS THE COUNTRY, FEWER THAN

5% OF BLOOD DONORS

are from **BLACK AND MINORITY ETHNIC** communities.

Ref: https://bit.ly/3ulg17r

BLACK AND MINORITY ETHNIC PEOPLE HAVE UP TO 2x

the mortality risk from **COVID-19** than people from a **WHITE BRITISH BACKGROUND.**

Ref: https://bit.ly/3EZS2Qd

BLACK AFRICAN AND BLACK CARIBBEAN PEOPLE ARE OVER 8x

more likely to be subjected to **COMMUNITY TREATMENT ORDERS** than White people.

Ref: https://bit.ly/3zK5IjL

ESTIMATES OF DISABILITY-FREE LIFE EXPECTANCY ARE

10 YEARS

LOWER FOR BANGLADESHI MEN living in England compared to their White British counterparts.

Ref: https://bit.ly/3urjmlt

24% OF ALL DEATHS IN ENGLAND & WALES, IN 2019,

were caused by **CARDIO VASCULAR DISEASE** in Black and minority ethnic groups.

Ref: https://bit.ly/3CYz22P

CONSENT RATES FOR ORGAN DONATION ARE AT 42%

for Black and minority ethnic communities and **71% FOR WHITE ELIGIBLE DONORS.**

Ref: https://bit.ly/3ogH3fm

For more information and sources for above statistics please visit:

www.nhsrho.org

October 2021

NHS RACE & HEALTH OBSERVATORY

Health disparities in prostate cancer - an American problem?

Racial and Ethnic Disparities Identified in Those With a High PSA Undergoing MRI Imaging for Prostate Cancer

November 11, 2021
Hayley Virgil

Investigators noted evident racial and ethnic disparities among patients with high prostate-specific antigen levels who received subsequent prostate MRI imaging.

Investigators noted that racial and ethnic factors influenced which patients with elevated prostate-specific antigen (PSA) levels received subsequent MRI, highlighting a need to improve decision making biases and identify other reasons for disparities in prostate cancer, according to a study published *in JAMA Open Network*.[1]

Black patients who had a PSA of more than 4 ng/mL were 24.1% less likely to receive a prostate MRI scan compared with White patients (odds ratio [OR], 0.78; 95% CI, 0.65-0.89). Similarly Black patients with a PSA of more than 10 ng/mL were 35.0% less likely to undergo further MRI scans vs White patients (OR, 0.65; 95% CI, 0.50-0.85). Moreover, Asian patients who had a PSA higher than 4 ng/mL (OR, 0.76; 95% CI, 0.58-0.99) and Hispanic patients who had a PSA higher than 10 ng/mL (OR, 0.77; 95% CI, 0.59-0.99) were also less likely to undergo further MRI than White patients.

“We can’t say definitively if the reason Black, Hispanic, and Asian men did not receive this particular test is that physicians did not refer them for it, or if the patients opted themselves out of further testing,” Danny Hughes, PhD, a professor of the school of economics at Ivan Allen College of Liberal Arts, Georgia Tech, said in a press release.[2] “Regardless, these disparities do highlight the need to understand what is happening and how to ensure patients of all races and ethnicities receive the best possible care.”

The cohort study utilized deidentified data pulled from an administrative database. Investigators identified a total of 1,563,534

Prostate Cancer and Prostatic Diseases www.nature.com/pcan

ARTICLE

Check for updates

Determinants of variation in radical local treatment for men with high-risk localised or locally advanced prostate cancer in England

Matthew G. Parry[1,2]✉, Jemma M. Boyle[1,2], Julie Nossiter[2], Melanie Morris[1,2], Arunan Sujenthiran[2], Brendan Berry[1,2], Paul Cathcart[3], Ajay Aggarwal[4,5], Jan van der Meulen[1,8], Heather Payne[6,8] and Noel W. Clarke[7,8]

- We have shown that men who are older , have more co-morbidities , are socially economically deprived or are of black ethnicity are less likely to receive radical local treatment

- Variation in the treatment of prostate cancer with respect to ethnicity and socioeconomic deprivation has been shown previously within the US health system but not within the publicly-funded English NHS

Suggested reasons?

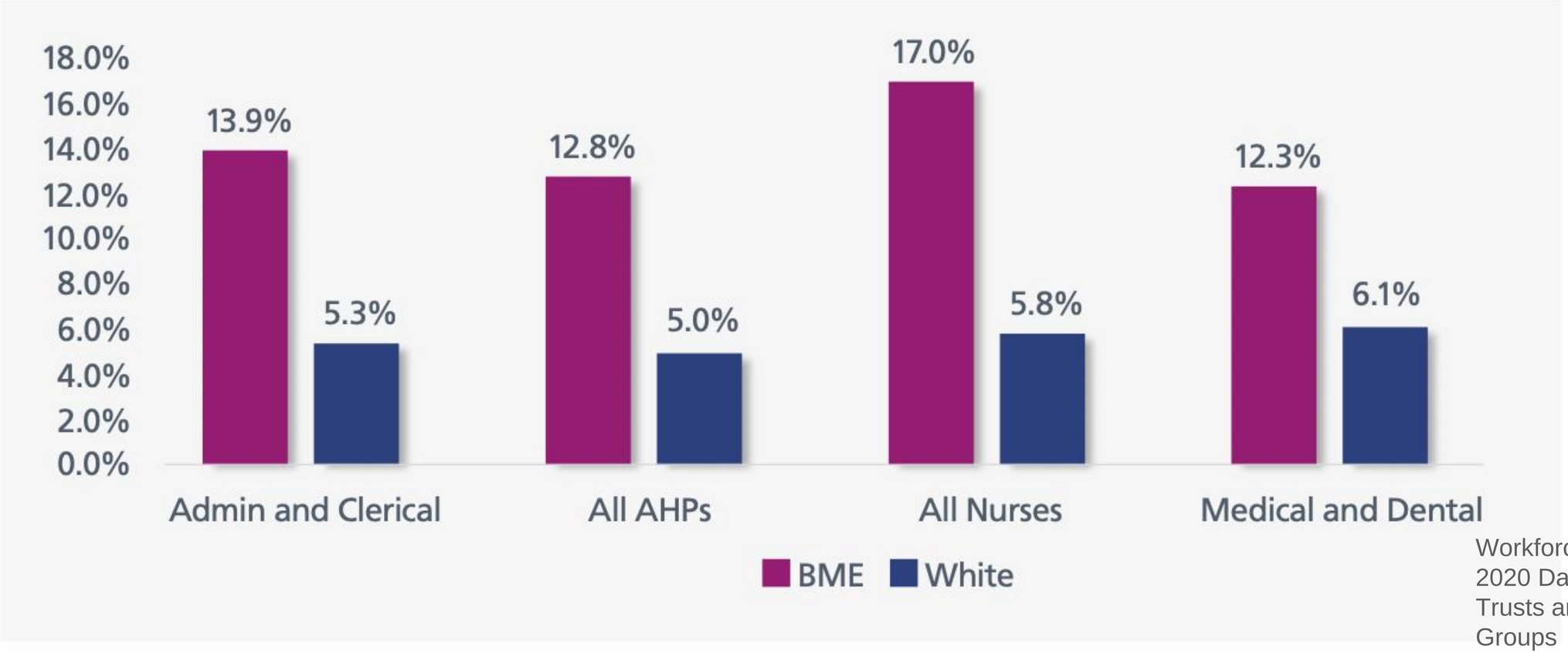
It is unclear how or why this treatment variation occurs. Factors such as the quality of the local healthcare environment, the resources available, the knowledge and skills of the professionals involved, patient understanding, and patient choice have all been indicated as factors that may explain the variation in treatment rates according to these criteria

STAFF factors?

An NHS staffing issue?

Percentage of staff who experienced discriminations at work from – a manager team leader or other colleagues by staff group (2019)

BME nurses had the highest proportion of staff that experienced discrimination at work from a manager, team leader or other colleagues.



Workforce Race Equality Standard 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups
February 2021

Happy staff , good NHS Care?

Summary

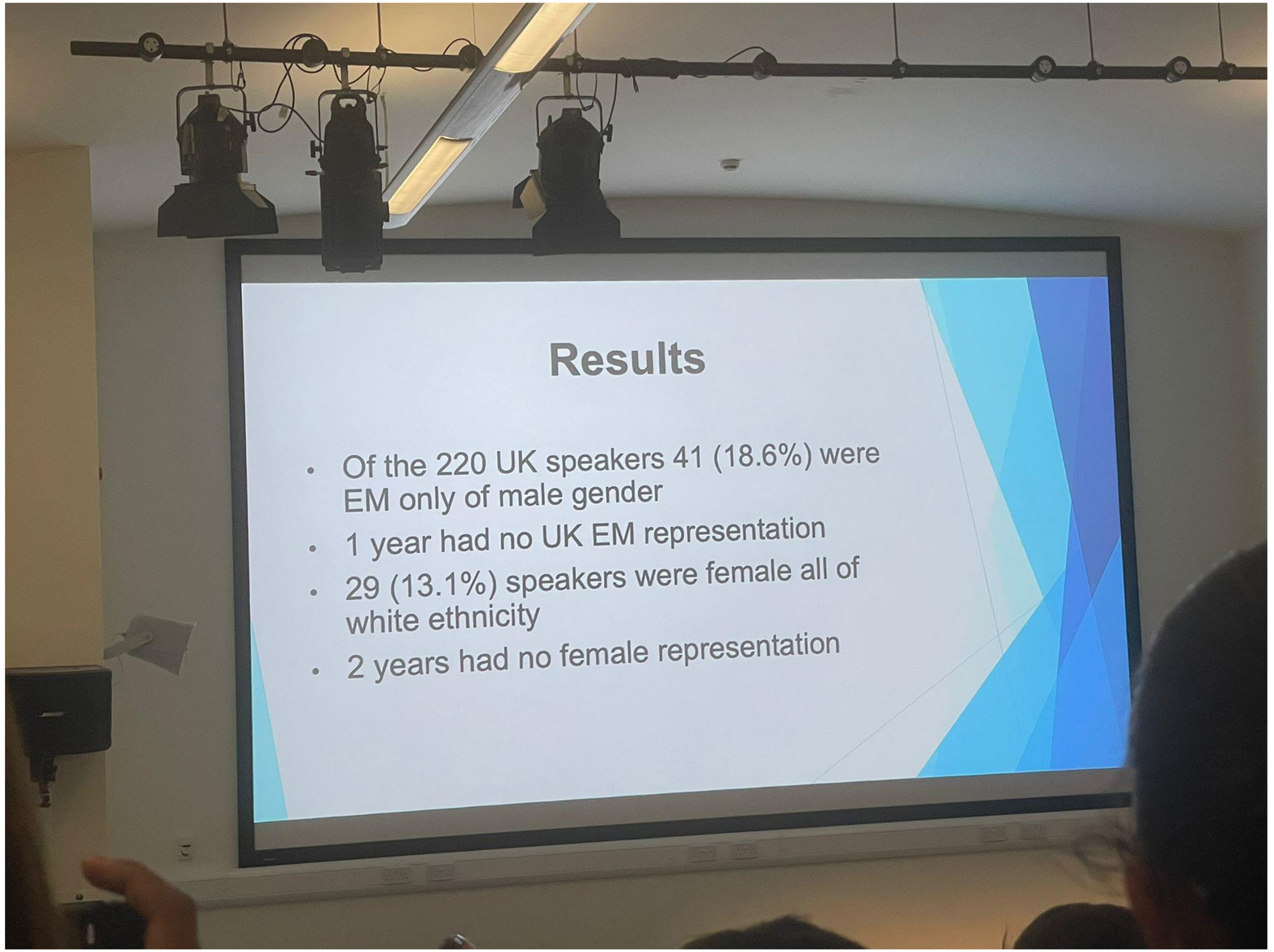
NHS England

	Indicator 5: Percentage of staff who report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months		Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months		Indicator 7: Percentage of staff who believe that trust provides equal opportunities for career progression or promotion		Indicator 8: 'In the last 12 months have you personally experienced discrimination at work from any of the following? - Manager / team leader or other colleagues'	
	White	BME	White	BME	White	BME	White	BME
Oxford University Hospitals NHS Trust	28.0%	32.0%	22.0%	24.0%	86.0%	52.0%	6.0%	17.0%
University College London Hospitals NHS FT	28.3%	29.2%	28.1%	32.2%	85.5%	69.6%	8.9%	16.6%
Cambridge University Hospitals NHS FT	24.0%	23.0%	25.0%	28.0%	88.0%	70.0%	10.0%	27.0%
Guy's and St Thomas' NHS FT	32.7%	30.2%	17.9%	27.7%	91.1%	74.2%	5.4%	22.1%
Newcastle Upon Tyne Hospitals NHS FT	25.0%	17.0%	21.0%	22.0%	93.0%	78.0%	8.0%	17.0%
Sheffield Teaching Hospitals NHS FT	23.0%	17.0%	19.0%	24.0%	93.0%	68.0%	6.9%	15.4%
Central Manchester University Hospitals NHS FT	25.0%	24.0%	21.0%	18.0%	90.0%	75.0%	9.0%	21.0%
Imperial College Healthcare NHS Trust	31.0%	27.0%	29.0%	23.0%	87.0%	76.0%	6.0%	17.0%
King's College Hospital NHS FT	39.0%	29.0%	25.0%	28.0%	88.0%	69.0%	9.8%	9.7%
University Hospitals Birmingham NHS FT	25.0%	12.0%	21.0%	23.0%	91.0%	77.0%	11.0%	10.0%
Higher or Lower score = better	**LOWER**		**LOWER**		**HIGHER**		**LOWER**	

Table is ordered by prevalence of red and alphabetical order.
Red = BME Staff report worse experience than White
Amber = Little or no difference between White & BME

Workforce Race Equality Standard 2020 Data Analysis Report for NHS Trusts and Clinical Commissioning Groups
February 2021

A Urology problem ?



Solutions : How do we reduce variation in access to treatment for black and minority men?

- **Prioritise** more research in at risk groups - ProTECT/PIVOT/SPCG-4 trial - <1% POC recruited
- More **diverse research PIs** in Clincal trials
  - Need for **targeted recruitment** for clinical trials
  - **?Quotas** for ethnic minority patients in CaP research.
- Targeted specific health inventions
  - Victor et al. A Cluster-Randomized Trial of Blood-Pressure Reduction in Black Barbershops.N Engl J Med 2018378:1291-1301

Enrolled a cohort of 319 black male patrons with systolic blood pressure of 140 mm Hg or more from 52 black-owned barbershops (nontraditional health care setting) in a cluster-randomized trial in which barbershops were assigned to a **pharmacist-led intervention** (in which barbers encouraged meetings in barbershops with specialty-trained pharmacists who prescribed drug therapy under a collaborative practice agreement with the participants' doctors) or to an active control approach (in which barbers encouraged lifestyle modification and doctor appointments). The primary outcome was reduction in systolic blood pressure at 6 months.

Among black male barbershop patrons with uncontrolled hypertension, health promotion by barbers resulted in larger blood-pressure reduction when coupled with medication management in barbershops by specialty-trained pharmacists.

- **Monitoring** of MDMs- like minded individuals (majority white males) making treatment decisions on people they have not met. ? role of conscious /subconscious bias.

- **Improve** understanding of cultural difference/ understanding to health /wellness ? Active surveillance promoted more in higher risk groups ?

- **Targeted** interventions for black men to help understand their disease

- South London Ca Prostate support group called “Brother to Brother - Man 2 Man” set up to address lack of black male support groups - traditionally white male dominated

  - Survey in 2019 of black men with prostate cancer in South London looking at reasons for lack of engagement with Ca Prostate support groups

  - Reasons for lack of engagement included “**calling it a cancer group put me off”** , **“held in the hospital, and not a different location”** , **“more people that look like me running it”**, **“I need to fell free to discuss alternatives (e.g. herbal treatments) without being shut down by doctors/nurses”.**

- **LACK OF REPRESENTATION - Medical staff, Prostate cancer nurse specialists , system design.**

- **“We don’t feel anyone has our best interests at heart”**

Can technology help ?

PROState AI Cancer – Decision Support (PROSAIC-DS) Study -NIHR

Project Aim - Evaluation of the DEONTICS AI platform for personalised, evidence-based treatment planning in multidisciplinary cancer care: Increasing compliance with national standards of care and streamlining MDTs in prostate cancer

NIHR /NHSX £845,000 2 year project – Artificial intelligence (AI) systems in the management of prostate cancer MDM, Additional funding via Deontics (£1.2M total fund)

Can the use of Artificial intelligence reduce the variation in clinical performance and patient outcomes of prostate cancer MDMs in the NHS ?

Pathway

REF — DX — ST — **TX** — SX — SY — SV

Clinical information Summary

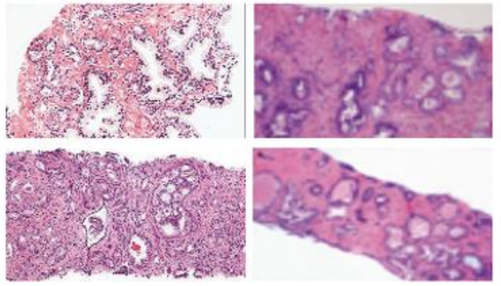
PSA (most recent)	8 ng/ml	Clinical T stage (most recent)	T2a
Prostate biopsy type	Systemic	N stage (most recent)	N0
Gleason primary grade	3	M stage (most recent)	M0
Gleason secondary grade	3	ECOG performance	0

Evidence based suggestions

- ○ Active surveillance (Preferred) [GL = 4] ›
- ○ Radical prostatectomy [GL = 3] ›
- ○ Radical radiotherapy [GL=3] ›

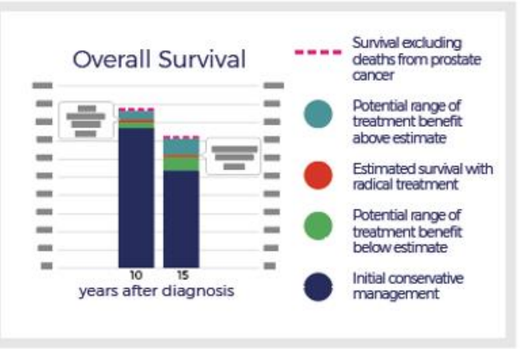
Pathology

Morphology	Adenocarcinoma
Gleason	7 (4+3)
ISUP	3
Biopsy type	Target
No of cores	5
Positive cotes	3



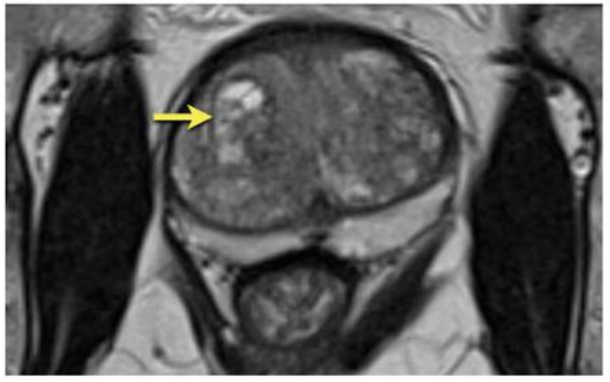
Prognostication

Tumour factors:	Gleason score = 6 (3 + 3) & ISUP grade group = 1
Risk factors:	NICE/EAU = Low risk, American = Low risk
Patient factors:	



Imaging

PI-RADS	4
Likert	4
Prostate vol	43 cc
M stage	M0
N stage	N0
T stage	T2b



Suitable clinical trials in your area

- ✓ PATCH [Prostate Adenocarcinoma TransCutaneous Hormones]
- ✓ PACE [Prostate Advances in Comparative Evidence]
- ✓ STAMPEDE [Systemic Therapy in Advancing or Metastatic or Metastatic Prostate Cancer]

Representation matters

Questions?

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