Nottinghamshire County Council

Equality Impact Assessment

Purpose of assessment

The Public Sector Equality Duty which is set out in the Equality Act 2010 requires public authorities to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation.
- Advance equality of opportunity between people who share a protected characteristic and those who do not.
- Foster good relations between people who share a protected characteristic and those who do not.

Protected characteristics are: age, disability, gender reassignment, pregnancy and maternity, race (this includes ethnic or national origins, colour or nationality), religion or belief (this includes lack of belief), gender and sexual orientation.

The purpose of carrying out an Equality Impact Assessment is to assess the impact of a change to services or policy on people with protected characteristics and to demonstrate that the Council has considered the aims of the Equality Duty. The Equality Duty must be complied with before and at the time that a change to services or particular policy is under consideration or decision is taken. A public body cannot satisfy the Equality Duty by justifying a decision after it has been taken.

Note: Please write in Plain English as this document, once approved, will be published on the Council's website.

Title	
Community Infection Prevention and Control Project	
Date	April 2014
Lead Officer for this assessment	Tracy Burton, Senior Public Health Manager, Public Health, Nottinghamshire County Council
List of other officers/organisations involved in the assessment	This Equality Impact Assessment has been completed by the Community Infection and Control Project Steering Group. This group consists of • The Project Owner (also acting as the "Senior User") – Jonathan Gribbin, Consultant in Public Health • The Programme/ Project Manager – Tracy Burton Senior Public Health Manager • Community Infection Control Matron • Public Health Finance representative – Zoe Maxey, Senior Finance Business Partner • Procurement representative – Sheila Gaskin / Adrian Griffiths, Category Manager The group is chaired by Jonathan Gribbin , Consultant in Public Health and is accountable to the Public Health Committee which through the Policy Committee is accountable to the Health and Wellbeing Board

1a	**What is being considered and why? Explain rationale behind proposed changes and other options considered, if applicable.**

The purpose of this project is to ensure that by April 2015 outcome focussed, high quality and patient centred Community infection and control service across all ages are in place across Nottinghamshire that are cost effective. This will be done through an open, fair and transparent procurement process.

Within the context of this document, Health care associated infections (HCAIs) are those associated with health and social care delivery in any setting. The term community infection and control refers to "community infection control" refers to the prevention of infections in those receiving care in either health or social care settings, especially in community settings such as GP practices or care homes. It specifically excludes the infection control work which takes place in settings which are managed by healthcare providers.

Healthcare-associated infections arise across a wide range of clinical conditions and can affect people of all ages. They can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life. Healthcare-associated infections can occur in otherwise healthy people, especially if invasive procedures or devices are used. Healthcare workers, family members and carers are also at risk of acquiring infections when caring for people. A number of factors can increase the risk of acquiring an infection, but high standards of infection prevention and control practice, including providing clean environments, can minimise the risk. It is estimated that 300,000 patients a year in England acquire a healthcare-associated infection as a result of care.

Within Nottinghamshire population of approximately 662172 (excluding Bassetlaw) people, healthcare associated infections (HCAIs) cause significant morbidity and mortality. It is important that patients with a HCAI receive seamless care when being transferred from one organisation to another. It is also vital that organisation's work together across the health economy to develop strategies to reduce healthcare associated infections.

Reducing Health care associated infections remains high on the national agenda, since 2006 there has been a legal requirement on all health and social care organisations to implement the Health and Social Care Act 2008, Code of practice (DH 2008) for the prevention and control of HCAIs. The Health and Social Care Act 2012 is fundamentally changing the way health and social care is delivered. The focus on quality, improving quality of care for service users, where services are safe and effective.

All providers of health and social care services are required to be registered with the Care Quality Commission and therefore declare themselves compliant with the Health and Social Care Act. Commissioners of services will need to assure themselves that providers are providing safe and effective care where health care associated infections are minimised by safe and effective care and practice.

The Health and Social Care Act 2012 also sets out a clear expectation that the care system should Consider NICE quality standards for infection prevention and control specifies that services should be commissioned from and coordinated across all relevant agencies. A person-centred, integrated approach that promotes multi-agency working is fundamental to delivering high-quality care and preventing and controlling infection. The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality.

Despite recent success in reducing incidence rates, HCAIs remain a cause of significant illness and early mortality. A significant proportion, at least 20% HCAIs are preventable. Infections prolong hospital stays, create long term disability, represent a massive additional financial burden to health and social care systems, reduce quality of life for residents and cause unnecessary deaths.

Infection Prevention and Control service currently provides specialist advice and support relating to infection prevention and control to Community-based services providing NHS services including, but not exclusively GPs, Dentists and care homes with nursing and intermediate care beds. The service is provides this adhoc due to the level of resource.

The proposed level of ambition involves adopting a proactive approach across a wider audience to incorporate residential care homes to provide a comprehensive specialist advice in a timely and efficient manner promoting better CIPC techniques to both staff and service users, to reduce the burden of HCAI across the health and social care community.

A new approach to the prevention and management of HCAI is required as:

- The current service provision does not meet the identified needs of the local population
- There are parts of the CIPC agenda which there are gaps (for example there is no service to residential homes currently)
- Resources are currently not aligned to those areas of highest need or to those groups most at risk of HCAIs.
- Currently there is not an appropriate balance of investment and effort between prevention and treatment.
- There is inequity in current service provision across the county with Bassetlaw having a well resource dedicated service.
- Current interventions may not be compliant with NICE national guidance in relation to the reduction of HCAIs or appropriate prescribing.

The shortcomings of the current service provision affect both the equity of access and quality of service

provision. An additional £200K from the Public Health monies has been agreed to meet the current gaps in service provision. The commissioning of a well-functioning CIPC service should overcome these issues, as well as being more cost effective and providing value for money.

In addition to the required system redesign, there is a requirement under national procurement guidelines to ensure that all goods and services are competitively tendered. Where the value of services are above EU thresholds (in the region of £120,000) there is a legal obligation for the Local Authority to engage in a competitive process for contracts and award them in accordance with procedures set out in EU public procurement Directives. This is also a requirement in the Local Authorities Standing Financial Instructions/Standing Orders. There are legal and significant financial penalty consequences for failure to comply with these legislative provisions.
In addition to addressing the above issues, investment in the service will ensure

- Reduction in HCAIs and the burden of disease
- Improved quality of life for service users
- Reduced risk of infection to service users

1b What is the demographic profile of the community you are serving? What is the profile of your services users by protected characteristics, where information is available?

Nationally

It is estimated that 300,000 patients a year in England acquire a healthcare-associated infection as a result of care within the NHS. The prevalence of healthcare-associated infections in hospitals in England in 2011 was 6.4%. The most common types of healthcare-associated infection are respiratory infections (including pneumonia and infections of the lower respiratory tract) (22.8%), urinary tract infections (17.2%) and surgical site infections (15.7%). Each one of these infections means additional use of NHS resources, greater patient discomfort and a decrease in patient safety. In 2007, methicillin-resistant *Staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections were recorded as the underlying cause of or a contributory factor in, approximately 9000 deaths in hospital and primary care in England]. Since 2006 there has been an 18-fold reduction in MRSA bloodstream infections (from 1.3% to less than 0.1%) and a 5-fold reduction in *Clostridium difficile* infections (from 2% to 0.4%).

Nottinghamshire
Nottinghamshire is a diverse County, with seven districts**.** The impact of HCAIs is felt within all districts with some significant variation. The burden of HCAIs is uneven across our communities , with certain groups more at risk- lower socio economic and socially disadvantaged groups, particularly older people and those very young. HCAIs are also more evident within Mansfield and Ashfield districts.

Within Nottinghamshire County population, healthcare associated infections (HCAIs) cause significant morbidity and mortality. It is important that patients with an infection receive seamless care when being transferred from one organisation to another. It is also vital that organisations work together across the health economy to develop strategies to reduce healthcare associated infections.

Rates of MRSA bacteraemia nationally have decreased by nearly 70% between 2008/9 and 2012/13; similar reductions are seen in Nottinghamshire. The highest recorded rates are seen in those aged 65 and over. There is no significant variation in rates of MRSA positive cases between Nottinghamshire County CCGs.

- MRSA reduced –currently breaching targets across all CCGs- zero tolerance
- E coli- rates per 100,000 population aged over 65years East Midlands 343, National 356 –

C Diff - rates per 100,000 population aged over 65 years, East Midlands 343, National 356- Nottingham County significantly higher than National and East Midlands

Table 1 Rate of Infections for individual organisms and crude rate of HCAIs, per 100,000 registered population, 2012/13

Area	MRSA	MSSA	C. difficile	E.coli	Crude rate of HCAIs per 100,000 registered population
Nottinghamshire (including City)	**1.7**	**18.4**	**29.6**	**77.7**	**127.4**
East Midlands	1.1	17.4	29.4	72.2	120.0
National	1.7	16.4	27.3	**60.0**	105.4

Bassetlaw	3.6	10.9	16.3	76.2	107.1
Mansfield and Ashfield	0.0	19.3	43.5	96.3	159.0
Newark & Sherwood	1.6	20.7	30.2	64.4	116.8
Nottingham City	2.7	19.7	24.0	76.7	123.1
Nottingham North and East	1.4	20.3	36.4	63.0	121.1
Nottingham West	2.2	21.1	32.2	99.8	155.3
Rushcliffe	0.0	14.0	25.5	68.3	107.8

Source: Public Health England Mandatory Surveillance data, financial year counts and Rates by Clinical Commissioning Group

1c What will be the effect on service users?

- To develop a comprehensive specialist advice service to provide the full range of evidence based advice and recommendations in line with NICE guidance and eliminate any duplication or gaps in service provision
- To develop a service specification that ensures equity of access and outcomes across the whole county and meets the requirements of the Equality Act (2010) so that protected characteristics are not disadvantaged.
- To have an comprehensive CIPC service in place for the residents of Nottinghamshire that offers person-centred advice, help and support to providers to empower them in the reduction of HCAI
- To ensure access to the service is accessible and acceptable to those groups who are at increased risk of infections.
- To ensure that new arrangements are in place and fully operational by 31st March 2015

1d Even if the proposals apply to everyone equally, could they have a disproportionate/adverse or negative impact on people with the following protected characteristics, if so how?

Age:
There is an increased risk of HCAI within the elderly population within a care home environment. The service will proactively target this setting for care. The very young are also at increased risk within an acute setting- the service is not designed to address this area of work.

MRSA
Nationally, in both males and females alike, the highest rates of MRSA bacteraemia have been seen in the over 64 year's age group. MRSA rates are higher in those aged under 1 year and over 64 years, and are significantly higher in males than in females in the 45-64 years and the over 64 years age groups. Death rates associated with MRSA are also significantly higher in males than in females. The local picture mirrors the national picture.

MSSA
The highest rates of MSSA bacteraemia are seen in those aged under 1 year and over 64 years. MSSA rates are highest in females for those aged under 1 year and in males for those aged over 64 years. Rates are higher in males for every age group. The local picture mirrors the national picture.

Cdiff
The significant majority (84 per cent) of cases of C difficile-associated disease occur in patients aged 65 years and over. Among the elderly, there are more cases of C difficile infection (CDI) in women than in men. The local picture mirrors the national picture.

PVL
Over the last two decades, PVL-MRSA has been observed internationally with increasing frequency. Whilst cases are mainly sporadic and community-associated, outbreaks in healthcare settings have been observed in England and abroad. Whilst PVL-SA may be less clearly associated with healthcare interventions, it is none the less an important consideration for community infection prevention and control teams, as a source of spread in the community of MSSA and MRSA infection. It also can potentially cause very serious infection including necrotizing pneumonia, necrotizing fasciitis, severe osteomyelitis and sepsis syndrome with increased mortality having been described in both children and adults. Such cases have been recorded locally in Nottinghamshire.
This procurement project focuses on the provision of a comprehensive specialist service that is able to target areas of greatest need.

Disability (physical, sensory or learning disabilities including effects on carers):
The literature suggests clients in residential/institutional care settings who are supported to live independently

maybe at increased risk. Those clients who have a physical disability due to reduce mobility and are at increased risk of co-morbidities e.g. those catheterised long term may also be at increased risk. Those receiving nursing care will come under the remit of provider services.

Commissioned services will be accessible and acceptable to those with physical and learning disabilities.

Gender (Sex):
Evidence suggests that at present men are at an increased risk of MRSA , with women at increased risk of Cdiff infection.

Commissioned services will be accessible and acceptable to both genders with an emphasis on targeting where trends are identified.

Gender Reassignment:
There is no available evidence regarding gender reassignment and HCAI. There should be no negative impact for those who have reassigned their gender.

Pregnancy and Maternity:
There is no available evidence regarding pregnancy and maternity and HCAI in the community.

Race:
There is no straightforward relationship between HCAI and ethnicity, with a complex interplay of factors affecting health in minority ethnic communities in the UK; although it is clear that different ethnic groups may have different risks for development of a specific infection – PVL.

Religion or belief:
There is no available evidence regarding religion or belief and HCAI.

Sexual orientation:
There is no available evidence regarding sexual orientation and HCAI and it is not anticipated that there will be any negative impact

1e	**Will your proposal have any positive impacts on people with the above protected characteristics to advance equality of opportunity or foster good relations?**

Given that some of the protected groups are disproportionately at risk of HCAI, the elderly population and children and some settings where health and social care is delivered providing a comprehensive CIPC service should ensure a positive impact for groups with protected characteristics. It is expected that this procurement project will benefit:

- Those residents living in care homes
- People living in the most deprived areas of Nottinghamshire
- Those accessing health and social care within a community setting
- Residential/care home staff

There is no evidence that the issue of HCAI is a cause of tension within or between the protected characteristics. It is not expected that this procurement project will lead to a deterioration of relations between groups.

2a	**In terms of any disproportionate/negative/adverse impact that the proposal may have on a protected group, what steps (if any) could be taken to reduce that impact for each group identified. Attach a separate action plan if necessary.**

Due to lack of data, no evidence has been found relating to gender reassignment, religion and sexual orientation. By ensuring that the services are inclusive and accessible to the whole population, there should be no adverse impact on any of the groups listed above.

2b	**If ways of reducing the impact have been identified but are not possible, please explain why they are not possible.**

Not applicable

3	**Evidence Sources** **(i) Give details of any data or research that has led to your reasoning above, in particular, the sources used for establishing the demographics of service users.** **(ii) Give details of how you have engaged with service users on the proposals and steps to avoid any disproportionate impact on a protected group and how**

	you have used any feedback to influence your decision.
i.	Details or data and guidance used is detailed below: • The Health and Social Care Act 2008 – Code of practice on the prevention and control of infections and related guidance (DH 2010) • Regulations, outcomes and judgment framework (CQC 2010) • Essential standards of quality and safety: guidance about compliance (CQC 2010) • Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (NHS England 2014) • Everyone Counts: planning for patients 2013/14 (NHS Commissioning Board 2013) • Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from April 2014 (NHS England 2014) • Clostridium *difficile* infection objective for NHS organisations in 2014/15 and guidance on sanction implementation (NHS England 2014) • Infection prevention and control of healthcare associated infections in primary and community care NICE clinical guideline 139 (NICE 2012) • Infection prevention and control NICE quality standard 61 (NICE 2014) • Patients first and foremost – Francis report (DH 2013) • Hard truths: the journey to putting patients first vol1 – Francis report (DH 2013) ii. Consultation with commissioning stakeholders is on- going iii. Consultation with staff will be undertaken as part of the process

(Complete this section where staff are directly affected:)

4a	**What is the profile of your current staff by age group, disability, gender, race and ethnicity, religion or belief, sexual orientation?**
Two members of staff, 1.3 WTE, Age group 37-50 years. Female, Married, no disabilities, White British, Heterosexual.	
4b	**Give details of how the proposed service changes (if applicable) will affect staff? Will staff of any particular protected equality characteristic be affected more than any other?**
Potentially staff may be transferred to new providers through TUPE arrangements. Therefore it is not anticipated that staff of any particular protected equality characteristic will be affected more than any other.	
4c	**In terms of any disproportionate/negative/adverse impact that the proposal may have on a protected staff group, what steps (if any) could be taken to reduce that impact for each group identified.**
By implementing TUPE arrangements it is not anticipated that there will be any disproportionate / negative /adverse impact on a protected staff group.	
4d	**If ways of reducing the impact have been identified but are not possible, please explain why they are not possible.**
Not applicable	

5	**Decision Log – (detail how Elected Members and Senior Managers have been involved in the decision process (give dates of key meetings and decisions made)**
• The CIPC Procurement Project Steering Group approved this EIA on the XXXXXXX. This group is made up of senior representatives from Nottinghamshire County Council. The group is chaired by Jonathan Gribbin, Consultant in Public Health and is accountable to the Public Health Committee which through the Policy Committee is accountable to the Health and Wellbeing Board. Elected Members are members of the Health and Well Being Board.	

6a	**Date of Next Review:** N/A
6b	**If review is not required, explain why.**

	This is a time limited project and new arrangements are anticipated to be in place end March 2015.

7a	**Approved by:** Jonathan Gribbin , Consultant in Public Health, CIPC Procurement Project Steering Group
7b	**Approval date:** 19th May 2014