NHS
Birmingham and Solihull
Clinical Commissioning Group

Equality Analysis

(Health Inequalities, Human Rights, Social Value)

Frequent Urinary Tract Infections (UTI)

Before completing this equality analysis it is recommended that you:

- ✓ Contact your equality and diversity lead for advice and support
- ✓ Take time to read the accompanying policy and guidance document on how to complete an equality analysis

1. Background

EA Title	Frequent UTI Project		
EA Author	Bernie Faulkner	**Team**	Integration - LTC
Date Started	28/05/2019	**Date Completed**	27/06/19
EA Version	V0.1	**Reviewed by E&D**	27/06/19

What are the intended outcomes of this work? Include outline of objectives and function aims

Following a successful project conducted within Solihull in reducing emergency admissions of patients with frequent urinary tract infections it is the intention to develop a similar service within Birmingham.

In Solihull, a cohort of patients aged 70+, having had 4 or more emergency admissions with a primary or secondary diagnosis of UTI (or catheter infection) over a 3-year period were identified and offered case management to reduce further admissions. This project was delivered over a 12-month period and achieved QIPP of 131k in reduced admissions. A final report of outcomes includes feedback from the patient cohort. From the completed questionnaires patients were significantly more aware of why have infections, more able to recognise symptoms and were less dependent on urgent care.

The proposed project within Birmingham identifies an opportunity to reduce emergency admissions for those suffering with recurrent urinary tract infections. (UTIs). This intervention may result in initially reducing at least emergency admissions per annum for a cohort of c50 patients. The cohort of patients is those: age 70+, having had 3 or more emergency admissions with a primary or secondary diagnosis of UTI (or catheter infection) in the past 12 months. The approach will be to facilitate person-centred care and an empowered patient population.

Who will be affected by this work? e.g. staff, patients, service users, partner organisations etc.

The proposed case management will apply to all patients over the age of 70 years only, in Birmingham. The provider organisation is BCHC who will employ a band 7 nurse to carry out the project.

2. Research

What evidence have you identified and considered? This can include national research, surveys, reports, NICE guidelines, focus groups, pilot activity evaluations, clinical experts or working groups, JSNA or other equality analyses.

Research/Publications	Working Groups	Clinical Experts
Solihull frequent UTI project	Solihull UTI steering group	HEFT community services
Case management service for patients suffering with recurrent UTI – final report Aug 2018		

3. Impact and Evidence:

In the following boxes detail the findings and impact identified (positive or negative) within the research detailed above; this should also include any identified health inequalities which exist in relation to this work.

Age:

The proposed case management will apply to all patients over the age of 70 years only. Consent will be obtained from the patient. The rationale for using this age to determine the cohort is that older people are particularly vulnerable to UTIs, this was highlighted by the original RightCare data for the CCG. Research states that urinary tract infection is an important cause of morbidity and antibiotic use in older adults. Estimates suggest community dwelling older adults experience around 11 episodes per 100 years at risk. Incidence is higher in older adults with diabetes, and in the very frail (Ahmed, H. et al (2018). Incidence and antibiotic prescribing for clinically diagnosed urinary tract infection in older adults in UK primary care). Taking preventative measures in settings with high volumes of older people – such as residential care homes – could help to reduce the incidence of UTIs.

Disability:

No one will be excluded from the project on the basis of a disability, however as the project does involve educating the patient in symptom awareness and preventative measures, the patient and/or carer will need to have the cognitive ability to undertake instruction and act upon it.

The majority of patients are elderly, often frail, with complex co-morbidities.

The King's Fund 2011

Causes of recurrent UTIs:

- An underlying health condition may also be responsible. A poor immune system increases the risk of having any infection, including urine infections. Such as, having chemotherapy to treat cancer. Diabetes can also increase the risk of having urine infections.
- Being constipated can be responsible. If the lower gut (bowel) is full and swollen, it may press on the bladder. This may stop it emptying properly, making a patient more prone to urine infection.
- Recurrent UTIs can also be as a complication of incontinence.

Older people are particularly vulnerable to UTIs. A recent NCEPOD report found that clinicians who cared for patients with sepsis identified the respiratory tract and urinary tract as the top two presumed sources of infection, along with respiratory infections.

Those older patients are also more likely to have asymptomatic bacteriuria which does not require treatment with antibiotics. Taking preventative measures in settings with high volumes of older people – such as residential care homes – could help to reduce the incidence of UTIs. Such measures include adequate hydration through offering regular drinks, and effective management of incontinence, with invasive catheterisation being employed only when absolutely necessary and using sterile technique to reduce the chances of bacteria entering the bladder and causing

3. Impact and Evidence:

infection. The early detection and treatment of UTIs is likely to reduce the development of sepsis and of chronic kidney infections.

Proposed project:

The project aims to benefit the patients in a number of ways:

- The patient receive care from a community matron through visits to them, assessment of their needs thorough history, continence assessment, delivery of patient education re fluids, voiding, prophylactic antibiotics (if appropriate) or standby antibiotics for early intervention.
- The matrons ascertain that necessary urology reviews have been done; bladder scans etc., referral to diabetic team, memory services, social care etc.
- The community matrons provide regular contact for each patient to check their wellbeing and to ensure they know when, who and how to contact for help if bladder symptoms begin.
- The patients have access to a single point of access for assessment having had a jointly agreed care plan between patient and service.
- The patient receives continuity of care to reduce the risk of an unplanned admission to hospital and self-care to empower them to manage their own condition.

Gender reassignment (including transgender):

No one will be excluded from the project in terms of gender reassignment; all data is obtained to provide hands on care. Staff are bound by confidentiality and uphold GDPR principles

Marriage and civil partnership: no known impact

Pregnancy and maternity: no known impact given the age profile of the patient cohort.

Race: No one will be excluded from this project apart from those under the age of 70 years. No evidence identified that suggests any particular race are more susceptible to UTI's.

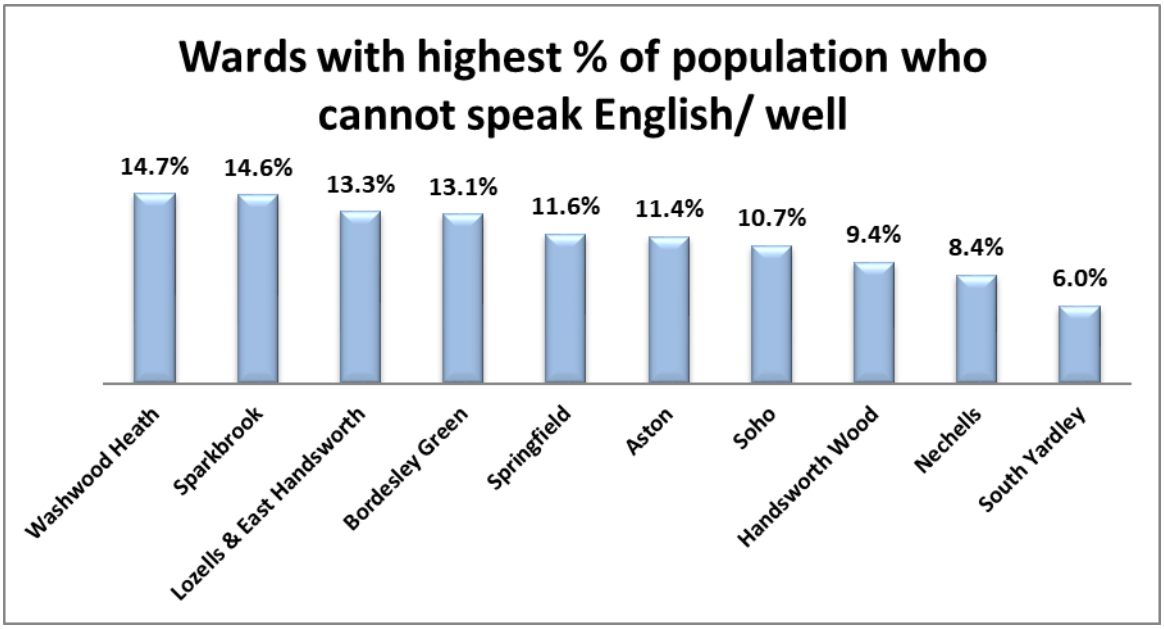
Ethnic diversity is a significant feature for Birmingham's demography with a Black and Minority Ethnic (BAME) profile of around 42% and a range of languages spoken. Around 22% of Birmingham's residents are born overseas and 15% of the population is classified as having a main language other than English. There is a recognised link between poor health outcomes and English language needs. Wards with the highest number of recent migrants (arriving between 2001 and 2011) were Ladywood 73%, followed by Nechells (59.5%) and Harborne (50.7%).

A range of languages are spoken within Birmingham. 15% of the population are classified as having a main language other than English. There is a recognised link between poor health outcomes and English language needs. Around 22% of

3. Impact and Evidence:

Birmingham's residents are born overseas. The top five languages spoken in Birmingham are Urdu, Punjabi, Bengali. Pahari, and Polish.

 The following table illustrates the wards within Birmingham with the highest % population who cannot speak English well.



Birmingham is a significantly diverse area where population needs around language and culturally sensitive services are likely to be more enhanced than that of Solihull. Provider of the service will need to ensure that they can meet the potential language needs of the patient cohort.

Religion or belief: No impact identified.

Sex:

Women can be more susceptible to UTIs and live longer than men and so could potentially benefit more from this project. Both men and women are within scope of the patient cohort.

Sexual orientation: No known impact

Carers:

Carers of older people are likely to benefit from this case management approach improving experience of the care/health system, supporting better care outcomes, reducing utilisation of hospital based services and improved education, knowledge and support.

Other disadvantaged groups: No known impact

4. Health Inequalities	Yes/No	Evidence
Could health inequalities be created or persist by the proposals?	No	This is based on QIPP project carried out in Solihull
Is there any impact for groups or communities living in particular geographical areas?	Yes	This is for Birmingham Patients only, Solihull patients have received this service and was so successful, numbers dropped that continuation was not viable
Is there any impact for groups or communities affected by unemployment, lower educational attainment, low income, or poor access to green spaces?	No	

How will you ensure the proposals reduce health inequalities?

UTI's are more common in older adults, by supporting this specific cohort, these patients have the support needed to reduce their risk of admissions. Clinical teams across the health and care system are learning to take more of a coaching approach in consultations, encouraging people and their carers to learn more about their own conditions, so they can care for themselves and each other more effectively.

5. FREDA Principles/ Human Rights	Question	Response
Fairness – Fair and equal access to services	How will this respect a person's entitlement to access this service?	This is a targeted project – the service will be available to anyone in Birmingham, over the age of 70 that has had a 3+UTI admissions in the previous year
Respect – right to have private and family life respected	How will the person's right to respect for private and family life, confidentiality and consent be upheld?	Training - Staff are trained to understand their duty of confidentiality and their responsibilities regarding the security of patient information both on our premises and when out in the community. Staff are also obliged to undertake online training in data security and confidentiality on an annual basis to demonstrate that they understand and are

		complying with Trust policies on confidentiality
Equality – right not to be discriminated against based on your protected characteristics	How will this process ensure that people are not discriminated against and have their needs met and identified?	The provider organisation has a set of policies and processes that aim to ensure that patients are not discriminated against – patients accessing their services have the appropriate language support -there is access to an interpreter and support for deaf patients if required.
	How will this affect a person's right to freedom of thought, conscience and religion?	The patient will be assessed utilising a person centred approach based on the 'what matters to me' principles.
Dignity – the right not to be treated in a degrading way	How will you ensure that individuals are not being treated in an inhuman or degrading way?	As above
Autonomy – right to respect for private & family life; being able to make informed decisions and choices	How will individuals have the opportunity to be involved in discussions and decisions about their own healthcare?	As above, the assessment and care plan is co-produced between clinician and patient/carer based on the 'what matters to me principles'
Right to **Life**	Will or could it affect someone's right to life? How?	Not applicable
Right to **Liberty**	Will or could someone be deprived of their liberty? How?	Not applicable

6. Social Value

Consider how you might use the opportunity to improve health and reduce health inequalities and so achieve wider public benefits, through action on the social determinants of health.

Marmot Policy Objective	**What actions are you able to build into the procurement activity and/or contract to achieve wider public benefits?**
Enable all people to have control over their lives and maximise their capabilities	Patient satisfaction is collated to ensure individual outcomes have been met and the patient recognised symptoms to support prevention
Create fair employment and good work for all	Not applicable – this is a short term project and so a secondment opportunity is being utilised
Create and develop health and sustainable places and communities	The project may also involve the practitioner providing education to patients and staff in a care home (if the identified cohort are from a care home)
Strengthen the role and impact of ill-health prevention	The role focuses on UTI prevention, the patient, carer and relevant staff are provided with

	strategies to ensure preventative illnesses/infections are prevented.

7. Engagement, Involvement and Consultation

If relevant, please state what engagement activity has been undertaken and the date and with which protected groups:

Engagement Activity	Protected Characteristic/ Group/ Community	Date

For each engagement activity, please state the key feedback and how this will shape policy / service decisions (E.g. patient told us …. So we will …..):

No pre-engagement work to be undertaken prior to the project being implemented in Birmingham.

This project is evidence based following a successful project in Solihull. Patients are identified from SUS activity data and supported in the community to avoid preventable admissions. Patient/Care experience and feedback was gained following the project within Solihull this showed that the patient cohort were significantly more aware of why they had infections, more able to recognise the signs of symptoms and were less dependent on urgent care.

8. Summary of Analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work:

Older people are particularly vulnerable to UTI's, this project will have a positive impact on those aged 70+, having had 3 or more emergency admissions with a primary or secondary diagnosis of UTI (or catheter infection) in the past 12 months. The approach will be to facilitate person-centred care and an empowered patient population.

Positive impacts are also likely to be achieved for their carers by improving their experience of the care/health system, supporting better care outcomes, reducing utilisation of hospital based services and improved education, knowledge and support.

The feedback from the pilot in Solihull does not include protected characteristic data, and so unable to determine any particular needs or impacts.

9. Mitigations and Changes :

Please give an outline of what you are going to do, based on the gaps, challenges and opportunities you have identified in the summary of analysis section. This might include action(s) to mitigate against any actual or potential adverse impacts, reduce health inequalities, or promote social value. Identify the **recommendations** and any **changes** to the proposal arising from the equality analysis.

Where Patient and carer experience feedback is obtained, the information should also be supported by protected characteristic data – specifically sex and race to further understand the impact and experience of these groups.

Ensure that the provider has mechanisms in place to be able to access interpreter services as required.

10. Contract Monitoring and Key Performance Indicators

Detail how and when the service will be monitored and what key equality performance indicators or reporting requirements will be included within the contract (refer to NHS Standard Contract SC12 and 13):

Patient identified -
The service will identify patients in Birmingham who attend ED with a recurrent UTI
Patient Local Identifier to be used to enable tracking of reduction in ED attendances/admissions
Patient assessment –
The service will aim to keep all referral to assessment treatment times within XXX working days
Assurance that necessary urology reviews have been done; bladder scans etc., referral to diabetic team, memory services, social care etc. link to social prescribers

Care delivery -
Response to advice and guidance requests maximum of 2 working days of receipt of the request
Patient access to advice and /or an appointment within a maximum of 2 working days of contacting the Community Matrons

Patient receives care from an advanced practitioner employed such as, a community matron, to visit them, assess their needs, do a thorough history, continence assessment, carry out patient education re fluids, voiding, prophylactic antibiotics (if appropriate) or standby antibiotics for early intervention.

Patient education -
Maintaining health outcomes

The service will endeavour to develop and implement patient support and education initiatives that will contribute towards the goal of encouraging and maintaining self-care and self-management of urinary symptoms
Nutritional and hydration advice and support given as part of initial assessment and follow up visits
Risk register in GP practices
Patients in the identified cohort can easily be tracked

Flags on patient record, including for 111 and 999

A single point of access for assessment and a joint care plan
Patients will know who is managing their care and who to contact

Regular contact for each patient to check how they are, ensure they know when, who and how to contact for help if bladder symptoms begin

Appropriate caseloads to ensure that patients are receiving optimum care

Continuity of care to reduce the risk of an unplanned admission to hospital self-care, to empower patients to manage their own condition.

Patient experience -

To determine satisfaction of case management service
Active and continual patient involvement in the review and redesign of service provision will be sought.

The service will develop a patient experience survey to be conducted on a 6 monthly basis.

An evaluation report summarising the survey results as well as detailing an action plan to address issues or concerns raised by patients and service users will be produced. The report will be available to commissioners and user groups.

Service delivery -

The service lead will collect defined data

Report monthly to the CCG Lead Commissioner

Data to be collected:

Assessment date, Diagnostics appointment, Results received, Medication prescribed, Number of planned visits, Dates of follow up visits, GP/Consultant appointments, Referral to other services (Social Care, Dieticians, and Continence Specialists etc.)
Form of contact – F2F, telephone, GP referral, ED referral

Date referral received, Date patient first visited, By whom? (Band of nurse)

Formal service review

To ascertain how successful, the project has been in terms of achieving against its overall aim.

At 6 months

Monitoring levels of ED attendances /emergency admissions to hospital.

ED attendances will decline, as will emergency admissions and inappropriate/ unnecessary calls to WMAS -Reduction of 1 admission/attendance per patient in first year

If identified cohort of patients is 50, then ED admission/attendance to reduce by 50 in 12-month calendar months, for recurrent UTI.

11. Procurement

Detail the key equality, health inequalities, human rights, and social value criteria that will be included as part of the procurement activity (to evaluate the providers ability to deliver the service in line with these areas):

N/A this is a short term project

12. Publication

How will you share the findings of the Equality Analysis?

This can include: reports into committee or Governing Body, feedback to stakeholders including patients and the public, publication on the web pages. All Equality Analysis should be recommended for publication unless they are deemed to contain sensitive information.
Publication of the EA will be on the CCG webpages following approval by QIPP Integration board.
Following approval all finalised Equality Analysis should be sent to the Communications and Engagement team for publication: bsol.comms@nhs.net

13. Sign Off

The Equality Analysis will need to go through a process of **quality assurance** by the Senior Manager for Equality Diversity and Inclusion or the Manager for Equality Diversity and Inclusion prior to approval from the delegated committee

	Name	Date
Quality Assured By:	M K Dunne	27/06/19
Which Committee will be considering the findings and signing off the EA?	Clinical Policy Sub Group	July 2019
Minute number (to be inserted following presentation to committee)		

Please send to Balvinder Everitt or Michelle Dunne, Equality, Diversity and Inclusion for Quality Assurance.

Once you have committee sign off, please send to Caroline Higgs, Communications & Engagement Team for publication: bsol.comms@nhs.net