The Health Equalities Framework – embedding good practice

Report from two workshops to support implementation

learning disability

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Introduction

The Health Equalities Framework (HEF) has now been implemented by a number of health and social care organisations across England, as well as some family carer groups. However apart from an initial workshop and some limited e-mail contact, there has been nothing to support ongoing implementation, and no systematic way of gathering feedback about people's experience of using the HEF, what they are finding, and what else might be helpful.

In order to support the implementation and development of the HEF, Skills for Care commissioned the National Development Team for Inclusion to run two free workshops, one in the North and one in the South of the country for organisations and family carers who are using the HEF. The aims of the workshops were to:

- Find out what information people are gathering, and how they are using it;
- Find out the best approaches for people to learn to use the HEF;
- Establish if there are additional learning needs for specific groups such as social care organisations or families and carers in order to make full use of the HEF;
- Explore any changes to practice/service delivery that have taken place as a result of implementing the HEF;
- Provide a forum for sharing experiences of using the HEF and learning about the process;
- Develop a network of users who can support each other;
- Ensure people are aware of current HEF initiatives such as the e-learning package being developed;
- Identify any further developments to the HEF that would be helpful.

The workshops were held on the 19th June 2014 in Warrington, and the 9th July 2014 in Gloucester. Organisations represented at the workshops are detailed in appendix 1. The workshops were publicised via the Janet Cobb network, the National Valuing Families Forum and the Consultant Nurse Network. The information was also sent to contacts in all areas where HEF workshops had run. This report sets out the findings from the two workshops.

How is the HEF being implemented – and any changes to practice identified?

Warrington 19th June 2014

Cheshire and Wirral Partnership Trust started with paper copies and are about to implement the e-HEF. They have a HEF CQUIN and the plan is for all team members to complete 4 HEFs by the end of June. Everyone is involved, including the consultants. The HEF will be completed early in episode of care but not at initial referral. There are seven teams who will be providing information to seven Clinical Commissioning Groups. A structure is being put in place to pull off data and report it.

In Manchester the Occupational Therapists and Physiotherapists are piloting with a group of four people, and have identified good initial outcomes.

Wigan piloted using the HEF on paper. Ten professionals have done approx. two people each totalling twenty people. The HEF was completed retrospectively to identify the impact made and good individual outcomes were identified. They are considering doing the first HEF at the initial assessment, and are suggesting that the care co-ordinator inputs the information. They may get a CQUIN in 2014/15.

In South Staffordshire all staff are expected to start using the HEF. It is on a shared drive, and the lead there is working to made a link with RIO so that the HEF will be populated with basic data. It is proposed that intake teams do the HEF at referral.

Gloucestershire 9th July

The 2gether Trust were the first to implement the HEF two years ago, and have implemented it with over 200 people across the four community teams, but not yet in assessment and treatment services, although this is planned. They are also implementing it in the new LDISS team. They have aggregated data demonstrating that they have managed to reduce the impact of the determinants of health inequalities over a period of 12 months, and are just completing an audit report. All multi-disciplinary team members use the HEF, and the care co-ordinator completes the HEF where more than one team member is involved. Within Gloucestershire the Intensive Health Outreach Team (IHOT) have implemented the HEF with approximately 25 people. They do the HEF at referral and on discharge, and if the individual requires a review. IHOT focus on complex health issues only, and use the HEF accordingly. They have linked the HEF to care pathways, care

plans and appropriate assessments and tools. Hereford, have recently joined 2gether, and have just started to implement the HEF.

Aneurin Bevan Health Board started to implement the HEF two months ago and have piloted it with 15 people across in patient services and the hospital liaison team. It is too early to determine outcomes but the results are looking promising. They are also piloting it with two CLDTs, and have so far completed the HEF for 20 people.

Camden have been piloting the HEF with thirteen people who have profound and multiple learning disabilities. They are using it to develop care planning.

Avon and Wiltshire Partnership have been piloting the HEF in the Bristol area for people with learning disabilities being supported in the community and in in-patient services. They have completed the HEF for 22 people referred to the service, and again at 6 months or on discharge.

With regard to changes to practice, this was most evident in Gloucestershire, the area that has been using the HEF the longest, and has aggregated data showing changes over 12 months. Aggregated data from teams has changed the way that teams work, and the IHOT team reported that linking care pathways to the HEF has improved the way the team works.

Lessons from implementing the HEF

The following general points were made regarding implementation:

- It is important to ensure that there is a good understanding of what the HEF is measuring – the exposure to the determinants of health inequalities – not what individual clinicians are doing
- The HEF does not replace other tools the team might be using for specific issues regarding things like mental health problems and pain assessments
- Teams need to agree who to pilot the HEF with and when to implement it – for example, new referrals, a sample of existing service users, for episodes of care…
- It is important for clinicians to understand why the data needs to be collected, and to get regular feedback on how things are going
- There are risks to comparing scores from different services working in different ways with different people
- HEF scores prompt further questions about what is going on – for example issues regarding where a person lives
- The HEF is not a performance management tool and to use it in this way would destroy its meaning
- Aggregated HEF data should prompt further questions to understand what is happening rather than leaping to conclusions about service or support deficits
- It would be helpful to share HEF data with local Health and Wellbeing Boards
- It is helpful to add a pdf copy of the HEF profile to the care record or discharge plan
- Helpful to flag the HEF during the new CQC inspection visits
- The underpinning evidence document is helpful for supervision and to use with students, but is not something that should be used routinely for all

There were also some specific comments about how the HEF could be used by different staff groups and in different settings:

Commissioning

- Commissioners want to reduce inequalities, which the HEF can demonstrate, and ensure consistent use of the HEF across the services they commission
- Teams can present evidence from the HEF to CCGs to argue for resources
- The CQUIN can be a helpful tool to implement the HEF

Supported living

- The HEF can be used as a tool to support staff to ensure they are giving best care and support to people in their services
- CCG/CQC/regulators want to know if care is safe, effective and responsive. The HEF can help demonstrate this

Acute hospitals admission and discharge

- The HEF may trigger a referral to CLDT if longer or frequent admissions
- Review HEF that is in place with CLDT/provider on discharge – likely to be a change to care plan/HAP
- The HEF could work well in some clinics. For example the diabetes clinic

Prisons

- The HEF could be very relevant to people with learning disabilities in prison

Using the HEF – data management

It had not been possible to include guidance about how files and folders should be organised in the original HEF guidance, in part due to the huge variety of organisational arrangements across the country. Implementation of the HEF also uncovered issues that it would have been difficult to foresee. The following table sets out the issues identified during the workshops along with some of the solutions people had identified locally.

Issue	**Solution**
Thinking through access to the e-HEF spreadsheets and how to organise things like shared folders was important. Only one person can use the spread sheet at any one time so this needs to be taken into account.	Involve IT from the start
Clinicians may enter information on the wrong spreadsheet or accidentally delete information	Ensure there are password controls or shared drives with limited access. Ensure regular back up of data
What happens if a spreadsheet becomes corrupted	Ensure regular back up of data
Putting someone's name in the free text box means that their data becomes identifiable in the aggregated report.	Guidance for staff
Don't change the e-HEF file name as the aggregation tool won't be able to find it.	Guidance for staff

It was noted that the search function can be used to identify individuals.

Current HEF initiatives

An e-learning package to support the implementation of the HEF is being developed and should be available within health services in the Autumn. The package covers some of the general health issues for people with learning disabilities, the determinants of health inequalities, and the use of the e-HEF.

There are plans to develop a children's HEF as this could improve early intervention and prevention as well as increase the likelihood of a smooth transition.

There are plans to roll out the HEF across three health boards in Scotland. An initiative that could in the future provide valuable information.

What further developments would be useful?

It would be helpful to have a day for IT and other staff who are tasked with co-ordinating the HEF across services, and data collection. It would also be helpful to have more input on the aggregation of data and what this can show. The aggregation tool does not allow staff to easily produce reports and charts of aggregated data. This is something that is being looked at, and an updated aggregation tool may become available in the future.

Generally people with learning disabilities were not being involved in HEF scoring. Although it is unlikely to be practical or helpful to use the easy read HEF to go through every aspect of the scoring, it could be used for selected items, and may help to raise awareness of the impact of issues such as diet and exercise. It would be helpful to know of any examples of where this has been tried.

It would be helpful to share developments in linking care pathways/care planning to the HEF, and any guidance about how it might work with Health Action Plans.

Conclusions

Although many areas have started to use the HEF, and feel positive about using it, only Gloucestershire had aggregated data, and was able to demonstrate the impact their work was having on exposure to the determinants of health inequalities. In this area, use of the HEF has led to changes in practice, but it is too early to determine what the impact will be in other areas.

The evaluations from the days indicated that participants found the days a helpful way to share their experiences of the HEF, and gain further knowledge. Participants requested that e-mail contacts were shared following the days and this was done. Participants were also made aware of the discussion site regarding the HEF on the IHaL website, and were urged to use it.

Appendix 1

Organisations represented at the workshops

Warrington

Cheshire and Wirral Partnership NHS Foundation Trust

Manchester Learning Disability Partnership

South Staffordshire and Shropshire NHS Foundation Trust

NHS Chorley, South Ribble and Greater Preston CCG

Enable care and home support

Bridgewater Community Healthcare LD Service

Gloucester

Southern Health NHS Trust

Cornwall Partnership NHS Trust

2gether NHS Trust

Aneurin Bevan Health Board

Devon Partnership Trust

Camden Community Learning Disability Service

Hackney Integrated Learning Disability Service

South Staffordshire and Shropshire NHS Foundation Trust

Avon and Wiltshire Partnership Trust

Carers Gloucestershire

Community Therapeutic Services