Health equalities framework: the effect of moving from a care home to other settings on determinants of health inequalities

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Introduction

This paper will detail the changes in determinants of health inequalities of a group of people with learning disabilities who moved from a long stay care home to other settings. A decision was taken by the owners of a care home that they wished to close the home and consequently there was a need for the people who lived there to find alternative accommodation. The care home was in a geographically isolated location in Scotland and at the time of closure in September 2016 had 19 people residing there. A project team was set up by the health board, as lead agency for adult social care, to lead on the assessment and planning of the moves. The project team worked alongside the people themselves, their families, the owners and staff from the care home. New accommodation was required for all of the people along with new care providers and staff teams to deliver the necessary support. Recruitment and retention of care staff proved to be an ongoing challenge for the providers supporting the people after the move had taken place.

In this evaluation the Health Equalities Framework (HEF) is used as a pre and post measure. The HEF is an outcomes framework based on determinants of health inequalities that enable specialist learning disability services to measure change (Atkinson et al 2013). The main variable that is considered in the course of this paper is the change in living setting for the cohort. In addition to care setting there are a range of factors that have been shown to contribute to improved quality of life for people with learning disabilities including:

- Front line staff and managerial working practices reflecting the values and principles of organisation and place of quality of life.
- Culture of service
- Organisational characteristics, policies and processes
- Coherence of mission, governance and operating procedures
- Training for staff
- Staff characteristics

(Bigby et al 2016)

All or some of these factors will have played a role in changes observed in this evaluation and some are captured in the indicators that are included in the HEF. Due to the nature of the analysis capable of being carried out within the HEF they cannot be reported on. Everyone in the cohort continued to

receive input from specialist learning disabilities services based on assessed need throughout the duration of the evaluation.

The disparity in health between people with learning disabilities and the rest of the population is well established and documented (Heslop and Marriott 2015, Jaydeokar et al 2015, Norah Fry Truesdale and Brown 2017, Centre for Disability Studies 2018). People with learning disabilities experience high levels of multi-morbidity and a different pattern of multi-morbidity than the rest of the population (Kinnear et al 2018). Life expectancy is shorter and many of the health inequalities experienced by people with learning disabilities are amenable to change through the provision of appropriate and timely assessment, diagnosis and treatment (Truesdale and Brown 2017). Addressing these health inequalities has become a primary focus for services in Scotland and the HEF is being used as a tool to capture the impact of services in addressing these challenges (Atkinson et al 2015, Duff 2016).

The HEF addresses the five areas of determinants of health inequality identified by Emerson and Baines (2010). The five areas are

- Social determinants including poverty, poor housing, unemployment, discrimination and isolation
- Genetic, biological and environmental causes of learning disabilities
- Communication difficulties and reduced health literacy
- Lifestyle behaviours such as poor diet and sedentary lifestyle
- Lack of access to high quality health services.

The HEF measures these five areas through 29 health inequality indicators, each of which is rated by the practitioner using an indicator statement and descriptor. A five-point Likert scale ranging from little exposure to a great deal of exposure is used across all indicators. These are then aggregated to produce an overall percentage HEF score from each of the five areas (Atkinson et al 2014). If service input, or change, brings about a reduction in levels of exposure to determinants of health inequalities then this provides some degree of mitigation of potential hazardous consequences (Atkinson et al 2013). During the development and evaluation phase of the HEF it was found to promote reflective practice, have strong face and construct validity and be quick to use (Atkinson et al 2014). Staff, carers and service users have been found to have generally positive views of the HEF (Rooney et al 2018). The HEF can assist professionals to focus on support systems and can provide a longer term perspective on addressing health inequalities than an approach purely focused on health status (Hebron et al 2014). In addition the HEF can aggregate data across populations and

inform the commissioning of services, as well as influence the development of public health initiatives (Jaydeokar et al 2015).

The move from institutional settings to more community based settings has been found to bring a range of benefits for those people undergoing the transition (Walsh et al 2010). Following a move from institutional care people with learning disabilities have tended to exercise greater choice and self-determination, have greater participation in social networks/relationships and display higher levels of personal satisfaction (Walsh et al 2010, Perry et al 2011, McConkey et al 2016). Supported living has however been found to have some negative factors, for example increased risk of exploitation and feelings of loneliness (Bigby et al 2016). The evidence shows that there tends to be a greater increase in quality of life in the period immediately after the move from institutional care to other settings with a plateau effect observed after that point in time (Chowdhury and Benson 2011). Additionally some studies have found that there may be challenges in ensuring that healthcare needs are adequately met in community settings when compared to institutional settings (Chowdhury and Benson 2011).

This project was deemed by senior management within the health board to relate to service evaluation and as such was exempt from the need for full research ethics approval. Approval was granted by senior management within the health board for the evaluation to go ahead and for subsequent publication of the findings.

Demographics

The cohort in this evaluation comprised of 19 people who were required to move from the care home to other settings. The gender distribution of the cohort was 9 men and 10 women. The youngest person in the cohort was 40 and the oldest 81. The mean age of the cohort was 60.7 years. All of the people in the cohort had lived in the care home for a number of years, the shortest period of residence was 9 years and the longest 30 years. The mean length of residence was 20.6 years.

The people living in the care home had varied ability levels and as part of the process of moving ability level was categorised either by formal psychological assessment or professional judgement of healthcare staff. There were 8 people (42%) categorised as functioning within the mild range of learning disabilities, 9 people (47%) categorised as functioning within the moderate range of learning disabilities and 1 person (5%) categorised as functioning in the profound range of learning disabilities. Information around 1 person's (5%) level of functioning was not recorded.

A number of the people moving from the care home had multiple assessed needs and presented with varying degrees of comorbidity. Assessed needs with higher levels of prevalence included behaviours perceived as challenging (n=14, 74%), diagnosed mental health condition (n=11, 58%), physical impairment (n=11, 58%) and epilepsy (n=5, 26%).

All but one of the people who moved from the care home were assessed as lacking capacity to make decisions as to future care needs and to require Welfare Guardianship under Adults with Incapacity (Scotland) Act 2000 legislation. The remaining person moved to England to be closer to their family and so the decision around the move was made using 'best interests' principles. An independent advocate was assigned for each person in the cohort and learning disability nurses used Talking Mats to work with individual's out with the formal meetings to gather views around future living preferences. The people living at the care home and their families/legal proxies participated in a series of individual planning meetings to reach decisions around what would be the most appropriate accommodation and care setting for them to move to. The majority of the people involved in the move found new places to live in the same county (albeit in a town setting), although 3 people moved to another urban centre in the region and 1 person moved to a new care setting in England. A full breakdown of type of accommodation that people moved to is shown in Table 1.

Accommodation Type Descriptor	Number of People
Care Home with Nursing	3
Care Home without Nursing	1
Individual Supported Accommodation (Cluster)	9
Supported Accommodation (more than 3 people)	1
Own House (with 1 – 1 Support)	5

Table 1: Accommodation Type Following Move

Method

As part of the evaluation a HEF assessment was completed for all the cohort prior to the closure of the home and a follow up HEF assessment was completed between 12 and 16 months after the move. All HEF assessments were completed by one of the learning disabilities nurses from the locality team.

Anonymised data for overall and domain scores was extracted from the Health Equalities Framework by the authors and entered into SPSS Statistics 24 for statistical analysis. The data did not meet the conditions required to assume normal distribution and non-parametric methods were selected as the appropriate route for statistical analysis. Wilcoxon Signed Rank Tests were conducted to determine the significance of changes observed before and after the move from the care home.

Analysis was conducted on overall HEF score and domain scores before and after the move. Descriptive analysis of indicator scores is provided to illustrate the changes that were observed.

Outcomes

This section will provide a comparison of the changes observed following the move of care setting on the determinants of health inequalities as measured by the HEF. A reduction in scores represents a reduced exposure to determinants of health inequalities and is indicative of a positive outcome.

Overall Impact and by Domain

Prior to the move from the care home the overall median HEF score for the cohort was 45 and following the move the median HEF score reduced to 34. A Wilcoxon Signed Rank test showed that there was a statistically significant reduction (Z = -2.014, p = 0.044) in scores in the new care settings.

Figure 1 illustrates the changes in scores for the full cohort across each of the HEF domains.

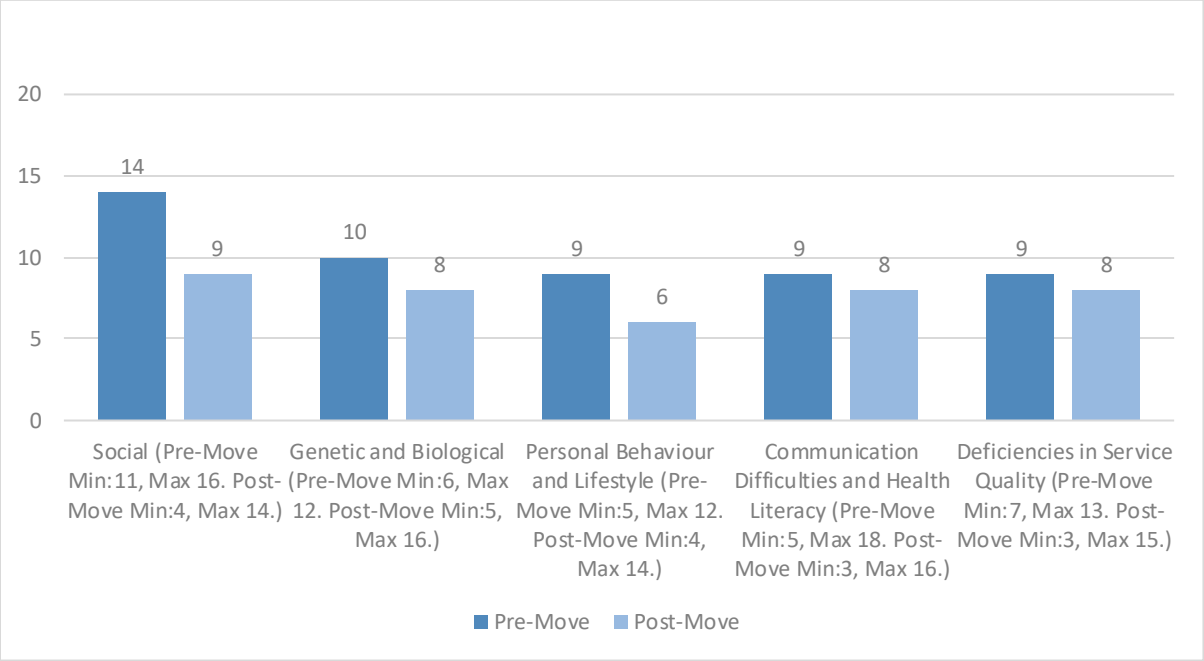

Figure 1: Overall Median HEF Scores Pre and Post Move by Domain

There were statistically significant reductions in domain scores observed in the Social domain (Z = -3.672, p = <0.01) and the Personal Behaviour and Lifestyle domain (Z = -2.283, p = 0.022). The changes observed in the Genetic and Biological domain (Z = -0.024, p = 0.981), Communication Difficulties and Health Literacy domain (Z = -0.086, p = 0.932) and Service Quality domain (Z = -1.862, p = 0.063) were statistically non-significant.

Impact by HEF indicator

Tables 2 to 6 provide a detailed overview of the pre and post move scores for each indicator within the HEF domains.

	Pre-Move		Post Move	
	Median	Standard Deviation	Median	Standard Deviation
Accommodation	3.0	0.32	1.0	0.62
Activities	2.0	0.48	1.0	0.84
Finances	2.0	0.86	1.0	0.58
Social Contact	3.0	0.61	2.0	0.83
Marginalisation	2.0	0.48	2.0	0.57
Safeguarding	2.0	0.61	1.0	0.54

Table 2: Pre and Post Indicator Scores for Social Domain

	Pre-Move		Post Move	
	Median	Standard Deviation	Median	Standard Deviation
Assessment of Needs	1.0	0.54	1.0	0.97
Review of Needs	2.0	0.51	1.0	0.77
Care Planning	2.0	0.51	1.0	0.76
Crisis/Hospital Planning	2.0	0.60	2.0	0.74
Medication	1.0	0.51	1.0	0.45
Specialist Services	2.0	0.58	2.0	0.56

Table 3: Pre and Post Indicator Scores for Genetic & Biological Domain

	Pre-Move		Post Move	
	Median	Standard Deviation	Median	Standard Deviation
Diet and Hydration	1.0	0.84	1.0	0.90
Exercise	2.0	0.90	2.0	0.82
Weight	1.0	0.92	1.0	0.84
Substance Use	0.0	0.46	0.0	0.23
Sexual Health	1.0	1.13	0.0	0.76
Risky Behaviours / Routines	2.0	0.67	2.0	0.61

Table 4: Pre and Post Move Indicator Scores for Personal Behaviour & Lifestyle Domain

	Pre-Move		Post Move	
	Median	Standard Deviation	Median	Standard Deviation
Body / Pain Awareness	2.0	0.97	2.0	0.86
Communication Needs	2.0	0.99	2.0	0.66
Carers Awareness	1.0	0.68	2.0	0.69
Carers Response	1.0	0.58	1.0	0.77
Understanding and Choice	2.0	0.82	2.0	0.78

Table 5: Pre and Post Move Indicator Scores for Communication Difficulties & Health Literacy Domain

	Pre-Move		Post Move	
	Median	Standard Deviation	Median	Standard Deviation
Organisational Barriers	1.0	0.48	1.0	0.52

Consent	1.0	0.50	2.0	0.77
Transition between services	1.0	0.42	1.0	0.54
Health Screening/Promotion	2.0	0.77	1.0	0.61
Primary / Secondary Care	2.0	0.37	2.0	0.84
Non-Health Services	3.0	0.51	1.0	0.61

Table 6: Pre and Post Move Indicator Scores for Deficiencies in Service Quality

Discussion

This evaluation found that following the move from a geographically isolated care home to other care settings there was statistically significant reduction in overall exposure to the determinants of health inequalities for the cohort. This would seem to reflect the findings from previous studies that people with learning disabilities who live in supported living settings tend to experience better outcomes than people with learning disabilities who live in more institutionalised settings (Jaydeokar et al 2015). People moving from congregate settings tend to experience the greatest benefits soon after the move, with subsequent longer term follow ups showing a maintenance of those gains, but little further overall improvement (Chowdhury and Benson 2011, Sines et al 2012).

In the social determinants' domain all 6 indicators showed a reduction. The quality of accommodation was the indicator with the largest reduction in median scores, reflecting the move from a care home setting that was due to close to predominantly more modern individualised accommodation. For those moving to supported living settings their financial status improved due to increased eligibility to access the full range of benefits available (National Development Team for Inclusion 2010). Levels of activity have been found to be greater in supported living settings than larger congregate settings (McConkey et al 2016). Moving to a town setting enabled people to access a broader range of activities more readily than had been the case when the people lived in a remote setting that required transport to access any off-site activities. Social isolation and lack of social connectedness increase the risk of early mortality (Holt-Lunstad et al 2015). Following the move from a geographically isolated setting there appears to have been an increase in social contact for the cohort as whole. People living in smaller community settings tend to have more frequent informal social contacts than people living in larger congregate settings (Kamstra et al 2015), although in this evaluation evidence at the individual level is not available to support this finding.

In the personal behaviour and lifestyle domain a statistically significant reduction in median scores before and after the move were observed. Whilst the median scores for 5 of the 6 indicators were unchanged, there was a reduction in the indicator relating to sexual health. This was primarily related to two male individuals who received enhanced levels of supervision to prevent higher risk sexual behaviours taking place and minimise the risk to other people living in the home. People living in larger congregate setting have been shown to be at higher risk of sexual victimisation (Fisher

et al 2016) and so the move of the two males to individual tenancies will have impacted on the risk of such behaviours occurring. Previous studies have found that living in more independent community settings increases the risk of a person with learning disabilities developing obesity (Ranjan et al 2018), however there was no change in median score for the weight indicator observed in this evaluation.

Reductions in median scores were observed in the indicators relating to Transition between Services and Non-Health Services. The indicator Transition between Services relates to issues of the individual moving between different services which at times may be difficult for some people with learning disabilities (Atkinson et al 2013). The reduction in scores suggest that transitions between services were improved and barriers reduced. The planning activities undertaken prior to the move may have had some positive impact in helping to making transitions across services easier for the people in the cohort by putting in place the connections needed. Additionally the ongoing involvement of learning disability nurses from the locality team may have assisted in the development of key relationships across health and social care that are needed to support people with learning disabilities to access services effectively (Jaques et al 2018).

A range of other services including social care, education, employment and housing have an impact on the health and well-being of people with learning disabilities (Atkinson et al 2013). The move from a geographically isolated care home to other, more urban based, settings may have offered the cohort greater opportunities of access to a broader range of services that could contribute to health and well-being.

The pattern of change found in this evaluation was different from the findings in studies that have used the HEF to measure the impact of interventions on the exposure to determinants of health inequalities by people with learning disabilities (Duff, 2018, Rooney et al 2018). In part this may be due to the focus in this evaluation being around change of accommodation and the move of people away from a geographical isolated care setting. In the evaluation of the HEF in four health board areas in South East Scotland (Duff 2018) found that following input from community learning disabilities nurses there were reductions in all 29 HEF indicators. This was not replicated in the current evaluation, where reductions in median scores were observed in 10 of the 29 indicators. The Genetic and Biological domain showed the greatest reduction in exposure to health inequalities in both the Duff (2018) and Rooney et al (2018) studies. In this present evaluation this was not the case, with the change in Genetic and Biological domain scores observed in the evaluation being the second smallest.

In addition, independent providers had to recruit a large number of staff for the new services required to complete the resettlement process. This led to the people moving being supported by staff who did not have existing knowledge and relationships with the people who moved. Having an underpinning knowledge of health inequalities experienced by people with learning disabilities and what is required to mitigate these are key skills necessary for all staff working with people with learning disabilities (NHS Education for Scotland 2016). Relationships between staff and the people they support are central in the development of staff knowledge around how best to support particular individuals (Bradshaw and Goldbart 2013). Additionally, staff had to become familiar with each providers' documentation systems and methods of care planning. Having tools which are readily available to services that support the sharing of information about the individual has been found to be a key way in which the effectiveness of support can be enhanced (Kersten et al 2018).

In a review of the literature around the impact of deinstitutionalisation on quality of life Chowdhury and Benson (2011) reported that quality of healthcare provision tended to be slightly higher in institutional settings than in community ones. Independent care providers need to have clearer health improvement policies that articulate how they will work to improve the health of the people that they support (Truesdale and Brown 2017). In part the limited reductions in HEF scores at indicator level may relate to changes in the skill mix in the staff supporting the people who have moved. In the care home staff included registered nurses, after the move the staff were social care staff without specific health qualifications.

Limitations

There are a number of limitations to the current evaluation. Firstly, the sample size was small and representative only of those who moved from the care home which was very geographically isolated from any other population centre. The small sample size increases the likelihood of a Type II errors occurring and this should be born in mind when considering the results of the evaluation. Although the people moved from the care home, the majority of people moved to small population centres which were themselves geographically remote from larger urban centres. The evaluation also looked at a relatively short timescale following the move. If a more prolonged period of time had been used, then further data would have been available to indicate whether the changes found had been sustained over time.

Conclusion

After moving from a geographically isolated care home setting to other community-based care settings a statistically significant reduction in the exposure to determinants of health inequalities in

the Social and Personal Lifestyle and Behaviour Domains was observed. Various factors will have impacted on the changes observed, including some challenges for providers with recruitment and retention of care staff. Longer term monitoring of exposure to determinants of health inequalities would be beneficial to ensure that the improvements are maintained and to ensure that attention is given to putting in place interventions to address the areas where change is less well established. This may include additional training and support to ensure that the new service providers have the appropriate knowledge and skills to continue to meet the needs of people with learning disabilities they are supporting within community settings.

Implications for practice

- This evaluation shows that the HEF can be used to determine changes occurring following change of accommodation by people with learning disabilities

Declaration of conflicting interests: The Authors declare that there is no conflict of interest

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