Improving Health and Lives: Learning Disabilities Observatory

UK Learning Disability Consultant Nurse Network

NDTi National Development Team for Inclusion

The Health Equalities Framework (HEF)

An outcomes framework based on the determinants of health inequalities

A Guide for Commissioners

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About this guide

This guide is part of a suite of materials about the Health Equalities Framework. The Framework was initially developed by the UK Learning Disability Consultant Nurse Network and has been further developed and tested in collaboration with multi-disciplinary service teams, commissioners and the Learning Disability Professional Senate. It has been welcomed by the National Valuing Families Forum and people with learning disabilities. The guide consists of general commissioning guidance, a framework for identifying evidence based commissioning intentions and priorities, and a draft CQUIN which can be adapted for use locally.

Alongside this guide for commissioners is a full guide for services, setting out the theory and detailed guidance on use of the tool in practice. See: http://www.ndti.org.uk/publications/other-publications/health-equality-framework-HEFguide/

On the same webpage you can also download:

- a guide for family carers
- an easier read guide
- a separate document containing the detailed indicators
- a guide to the e-HEF

The Commissioning Guide

Improving the Health and Wellbeing of People with Learning Disabilities: Commissioning for health equality outcomes

A guide for commissioners of health and social care services for people with learning disabilities

Introduction

This guide explores the application of the Health Equalities Framework within commissioning. Commissioning for health equality outcomes is the responsibility of public health, social care and the NHS; data from the HEF can help commissioners to determine the impact and effectiveness of the services they are commissioning. This may be particularly useful in relation to specialist health services, where there has been a lack of evidence about outcomes. This guide places the HEF within the national commissioning context, and sets out other evidence and information sources that can be used to measure the impact of local services. Information on health inequalities is included, illustrating how the HEF can be applied in practice. The guide supports *Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs)*[1.]

National commissioning context

The NHS and other public services should be focused on improving outcomes for those who use them. To support this ambition the Department of Health has published an inter-related series of outcomes frameworks:

- NHS: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131700
- public health: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132358
- social care: www.dh.gov.uk/health/2012/11/ascof1314/

NICE has drafted a Clinical Commissioning Group Outcomes Indicator Set, linked to the NHS outcomes framework: www.nice.org.uk/aboutnice/cof/cof.jsp

The frameworks contain little that is specific to people with learning disabilities, but the Department of Health has undertaken to see how data on people with learning disabilities could be extracted in order to check how the NHS is meeting its equality duties. Therefore in future it may be possible to compare data for people with learning disabilities against other population groups under each of the outcomes.

An NHS Commissioning Board objective is to: *ensure that CCGs work with Local Authorities to ensure that vulnerable people, particularly those with learning disabilities and autism, receive safe, appropriate, high quality care. The presumption should always be that services are local and that people remain in*

[1] http:/www.improvinghealthandlives.org.uk/publications/1134/Improving_the_Health_and_Wellbeing_of_People_with_Learning_Disabilities:_An_Evidence-based_Commissioning_Guide_for_Clinical_Commissioning_Groups

their communities; we expect to see a substantial reduction in reliance on inpatient care for these groups of people [2]. Measuring outcomes for people with learning disabilities will be particularly important to demonstrate improvements as commissioners implement the requirements of *Transforming Care*[3], whilst sustaining a focus on improving the general health of people with learning disabilities.

To support the implementation of the outcomes frameworks, national policy emphasises the importance of joint working between NHS commissioners (Clinical Commissioning Groups and the NHS Commissioning Board), Public Health and social care under the aegis of the local Health & Wellbeing Board:

- gathering and analysing information on population need through the Joint Strategic Needs Assessment (JSNA)
- developing and agreeing the Joint Health & Wellbeing Strategy (JHWS)
- taking a collaborative approach to investment in local services to deliver agreed priorities.

Information about people with learning disabilities should be included in the JSNA, to enable good joint service planning to take place. People with learning disabilities should be enabled to access mainstream services, and may need support to do this from specialist learning disability services. Historically there has been a lack of evidence about the contribution of specialist learning disability health services and the outcomes they achieve, particularly through their facilitating and supporting roles.

The purpose of specialist learning disability health services may be summarised briefly as [4]:

- To improve health, wellbeing and access to health care for people with learning disabilities, reducing health inequalities
- To help to remove or reduce the health barriers to independence, autonomy and citizenship for people with learning disabilities.

The roles required to deliver this purpose include:

- direct clinical and therapeutic interventions
- health promotion and health facilitation (supporting mainstream health services)
- teaching and support (families, social care and other services)
- service development (contributing their knowledge to planning processes).

For further information about commissioning specialist services, please refer to *Improving the Health and Wellbeing of People with Learning Disabilities: An Evidence-Based Commissioning Guide for Clinical Commissioning Groups (CCGs).*

[2] Department of Health (2012). *The NHS Mandate.*
[3] Department of Health (2013). *Transforming Care: A National Response to Winterbourne View Hospital. Department of Health Review. Final Report.*
[4] Department of Health (2007) *Commissioning Specialist Adult Learning Disability Health Services: Good Practice Guidance, 2007*

Evidence about determinants of health inequalities

Commissioners will need good intelligence about the pattern of determinants of health inequalities in their local populations to inform JSNAs, decisions about investment in health care and their contributions to social care and public health outcomes.

NHS commissioners need to map determinants of health against NHS and other Outcomes Frameworks to ensure that the work of specialist learning disability health services is targeted to reducing health inequalities and thereby delivering NHS outcomes. (See the framework tool; pp 75-81).

Information gathered can be fed into the Equality Delivery System (EDS), which is designed to help NHS organisations improve equality performance, embed equality into mainstream NHS business and meet their duties under the Equalities Act. Intelligence from this framework will also be useful to inform completion of the annual Joint Health and Social Care Learning Disability Self Assessment (replacing the Health Self Assessment from April 2013).

Illustrative example

Information on the Improving Health and Lives website showed that people with learning disabilities locally were ***accessing health checks*** *at well below the national average. There is clear evidence that annual health checks identify unmet health need, and lead to actions to address these needs. Therefore they are an important* ***reasonable adjustment*** *for reducing health inequalities. The commissioner included this information in the JSNA, and commissioned the community learning disability team (CLDT) to work with GP practices to improve uptake. The plan formed part of the Joint Health and Wellbeing Strategy. The CLDT used the HEF to demonstrate how their interventions were improving* ***access to primary care services*** *and health checks for people with learning disabilities. The information was used by the commissioner to demonstrate the impact the team were having, along with improved health check numbers the following year.*

Health inequalities and people with learning disabilities

People with learning disabilities have poorer health than their non-disabled peers. These differences in health status are to an extent avoidable, and as such represent health inequalities.

There are five key determinants of health inequalities[5]:

[5] The full evidence is given in the HEF guide, pp.18-25

1. Exposure to social determinants of poorer health, such as poverty, poor housing, unemployment and social disconnectedness.
2. Physical and mental health problems associated with specific genetic and biological conditions in learning disabilities.
3. Communication difficulties and reduced health literacy.
4. Personal health behaviour and lifestyle risks such as diet, sexual health and exercise.
5. Deficiencies in access to and the quality of healthcare and other service provision.

The following sections include case studies that illustrate some of the ways that learning disability services work with people with learning disabilities to reduce health inequalities. Work on one determinant of health inequalities often has a positive impact on other health inequalities.

The social determinants of poorer health

The impacts of poverty, poor housing, unemployment and social isolation on health are well known. People with learning disabilities are more likely than their non-disabled peers to experience some or all of these factors. Bullying and discrimination are also related to poorer health, and are a common experience for people with learning disabilities.

Tackling these issues requires joint strategic planning between local authorities, health and public health. The JSNA should include good information about the local population of people with learning disabilities.

This determinant also has the potential to be a good indicator of effective joint health and social care team working. For example, the Report of the NHS Review of commissioning of care and treatment at Winterbourne View (NHS South of England, 2012) found no examples of comprehensive health and social care policies on how best to respond to patient needs and prevent continued escalation. Good joint working has the potential to reduce the likelihood of people ending up in accommodation such as Winterbourne View; the HEF can be used to inform a dialogue between health and social care about priorities and ways of working.

Case study

John was referred to the intensive response team because of high levels of aggression and self-injury. He had a history of failed placements, and admissions to assessment and treatment services. His current placement was breaking down.

The multi-disciplinary assessment noted that there had been a recent change of staff team. John was autistic and needed clear and consistent communication. This was not happening. The health team worked with social services on developing a ***stable environment and home*** *for John using a personal budget. They worked with John's support staff to* ***adjust their communication*** *to meet his needs. John is now much calmer, and is now being supported to use community facilities, including the local gym, which has reduced his* ***social isolation****.*

A number of syndromes associated with learning disabilities are also associated with specific health risks. For example, congenital heart disease is more common in people with Down's syndrome, as is early onset dementia.

Specialist learning disability staff provide direct support to people with learning disabilities and their families when their needs cannot be met by mainstream services alone. This includes detailed assessment and formulation of needs, which can help develop an understanding of the possible

interactions between specific causes of learning disability and the environment, and can enable environmental modifications to be made, increasing an individual's quality of life.

In addition, specialist health staff can ensure that the specific health needs of individuals with learning disabilities are understood and responded to in mainstream healthcare.

Health staff also have a role in enabling support providers to understand specific risks and any potential interactions between genetic, biological, psychological, social and environmental factors, so that appropriate reasonable adjustments can be put in place to improve quality of life.

Case study

Jean has Prader-Willi syndrome and lives in a small residential home. She was referred to the team by the GP as she was becoming dangerously obese. When the team assessed Jean they realised that, although the staff had been given guidance on how to manage her diet, some staff did not understand the full implications of Jean's condition, and thought that she should be able to choose what she ate. The inconsistent approach was also leading to behaviour problems as Jean could not understand why her access to food varied. The team worked with the residential staff group to enable them ***all to understand the implications of Jean's syndrome****, and put in place an* ***effective plan*** *to* ***modify the environment****, manage Jean's diet and* ***improve her quality of life****.*

Communication difficulties and reduced health literacy

People with learning disabilities may have a poor awareness of their bodies and health issues generally. They may not express pain or discomfort in a way that others recognise. Limited communication skills may reduce their ability to let others know that something is wrong.

Specialist health staff support people with learning disabilities to understand their own health needs, and let people know when they are not well. They also enable those who support people with learning disabilities (family carers, providers and mainstream health staff) to recognise health needs and take appropriate action.

Case study

A GP requested support from the community team with Marcella, a patient with a five year history of vaginal bleeding, who had refused investigation. The team worked with Marcella and her partner ***to develop an understanding of their needs, and used a range of accessible information to help them understand the health issues involved, and the treatment proposed.*** *They also worked with the acute liaison nurse to implement* ***reasonable adjustments*** *prior to the proposed procedure. This included developing the understanding of hospital staff regarding working with people with a learning disability,* ***enabling better access to services****.*

Following a successful surgical intervention, there were a number of other physical, social and emotional benefits. Marcella has subsequently lost three stone in weight since referral, ***reducing her risk of developing other health problems****. Marcella has been on holiday four times since the operation (something that she had not done for 5 years due to fear of poor bladder control), which has reduced her* ***social isolation****.*

Personal health behaviour and lifestyle risks such as diet, sexual health and exercise

People with learning disabilities take less exercise than the general population, and their diet is often unbalanced. They can also find it hard to understand the consequences of lifestyle on health, and are much more likely to be overweight (or underweight) than the general population.

This determinant also covers the risks to health that may be posed by behaviour, such as challenging behaviour or offending behaviour.

Specialist staff support people with learning disabilities to understand the relationship between health, lifestyle and behaviour, and develop healthier lifestyles. They also enable those who support people with learning disabilities to gain a better understanding of lifestyle/health issues so that they can help people with learning disabilities become healthier and stay healthier.

Case study

Raju, a 35 year old man, was referred to the team after a diagnosis of mouth cancer. Owing to Raju's history of alcohol abuse and self-neglect, the family have struggled to obtain appropriate treatment and support for him.

The team carried out desensitisation work and ***enabled Raju's understanding*** *of the proposed procedure through use of a DVD that explains radiotherapy in an appropriate manner.*

Following successful treatment for cancer, Raju has been ***enabled to take more control over his own health*** *and consequently his life****, maintaining a healthier lifestyle*** *by not drinking alcohol for 2 years. Subsequently Raju contributed to the development of a DVD about how it was for him and his mother to receive 'bad news' and he felt* ***empowered to tell his story*** *through the support he received.*

Deficiencies in access to and the quality of healthcare and other service provision

People with learning disabilities can find it hard to access mainstream health services for a number of reasons, including the failure of health services to make reasonable adjustments to enable access, disablist attitudes among health care staff and 'diagnostic overshadowing'.

Specialist health staff work with mainstream health services (primary, secondary and health promotion/screening) to put reasonable adjustments in place, including health checks, and thus improve access.

Case study

A practice nurse was unable to contact Sharifa regarding her cervical screening appointment. The health facilitator managed to make the necessary ***contact with Sharifa through use of easy read information.***

The practice arranged a ***double appointment time for Sharifa to visit.*** *Sharifa attended with the health facilitator and a friend. During the appointment Sharifa decided that she would like to have the procedure there and then.*

Sharifa and the practice staff both indicated that ***in the future they would feel more confident*** *at undertaking such appointments.*

Introducing the Health Equalities Framework

The Health Equalities Framework (HEF) is an Outcomes Framework based on the determinants of health inequalities for people with learning disabilities, as described above. It is designed to measure the impact of interventions on reducing exposure to the known determinants of health inequalities. It is not an eligibility tool or a needs assessment. It was developed by the consultant nurse group, but can be used by all specialist services for people with learning disabilities.

The HEF uses five-point (Likert) impact scales, alongside Indicators for each determinant in order to profile the impact of each determinant on any given person with learning disabilities. High scores indicate a significant detrimental impact of exposure to the determinants, whilst low scores indicate minimal impact. The central role of learning disability services is seen as tackling the impact of exposure to the determinants of health inequalities, which can be demonstrated through individual and population HEF profiles.

The HEF rates the *consequence* of exposure to determinants of health inequalities for individuals, rather than merely profiling the complexity of a person's needs, specific conditions or presentations. People with learning disabilities are much more likely to have medical conditions, require more hospital care and are more likely to suffer premature death than the general population. Rather than focusing on individual diagnoses, the intention is to ensure that long-term conditions and needs are identified and that individuals are receiving appropriate support. For example, someone with complex epilepsy or severe challenging behaviour receiving a good level of care and support in appropriate accommodation may score lower than someone else with a less complex presentation whose needs are being less well met. It is also feasible for an individual's health to deteriorate but for outcome scores to improve (as a result of being in receipt of good quality palliative care, for example). The approach aims to quantify the success of interventions in reducing the impact of these known determinants and therefore demonstrate reduced probability of exposure to health inequalities.

Each determinant consists of a number of health inequality indicator statements; these indicators have been drawn from a body of evidence [6] and have been further validated through a process of consultation with the learning disability leads from each of the relevant Professional Bodies, the National Valuing Families Forum and local groups of people with learning disabilities. These indicators are considered in turn to determine the indicative level of impact of each indicator within each determinant. For example, within social determinants, accommodation status is a key indicator:

- Being homeless or in hospital with no agreed discharge destination is viewed as having a major impact on health and therefore scores the maximum of 4.
- However, being in appropriate, settled accommodation that reflects personal choice, or is the result of a 'best interests' decision making process, is viewed as having no negative impact on health and so scores the minimum of 0.

Each indicator statement within each of the determinants is identifiable which enables a personal HEF profile to be developed for each individual. People with learning disabilities and their families can initiate the process themselves; where a practitioner or multi-disciplinary team does so, they will involve the individual and their family wherever possible and appropriate, in order to rate each determinant area both prior to and after any intervention, giving an indication of the impact the intervention has had on reducing health inequalities. An electronic template (eHEF) has been designed to enable a team to

[6] Emerson, Baines, Allerton and Welsh (2011). *Health Inequalities and People with Learning Disabilities in the UK 2011.*Improving Health and Lives Public Health Observatory.

record this information easily, and enable data to be aggregated to monitor health equality impact and for commissioning purposes.

A template Commissioning for Quality and Innovation (CQUIN) payment framework can be found at the end of the commissioning guide, and is designed to support commissioners with implementation. CQUINs enable commissioners to link a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

Illustrative example - using the HEF

Eileen has mild learning disabilities and was admitted to an assessment and treatment unit one year ago with paranoid delusions and depression. She was malnourished and had been neglecting herself and her accommodation. Since being admitted, her illness has been treated and she is now ready for discharge on a section 117, but, as she lost her tenancy, she is homeless. The community team has therefore scored her 4 on the HEF for accommodation under determinant 1. Health and social care commissioners need to ***work together to agree a support package and accommodation****. They need to find housing and a support provider who can meet Eileen's needs. A flat is found for Eileen, and she is visited regularly by the community team who* ***monitor her mental health and check she is taking her medication****. Although she is now in settled accommodation, she has little in the way of meaningful activity. In addition, the community team has become aware that Eileen is vulnerable to sexual and physical abuse as she is regularly engaging in sexual activity with strangers. Therefore, although she now scores a 2 for accommodation, she scores a 3 for sexual health. Her HEF profile shows the changing balance of risks against each indicator under every determinant and helps to inform discussions with Eileen. The team continue to work with Eileen to help her* ***understand the impact of her lifestyle****.*

Conclusion

The HEF offers people with learning disabilities and family carers a way of measuring health equality outcomes and tracking the impact of actions aimed at reducing health inequalities. The development of a personal profile helps everyone to have a shared understanding of which determinants of health inequalities are having an impact on an individual at any point in time. The HEF gives practitioners and service managers a valuable tool to demonstrate the impact of their work across the range of roles that specialist learning disability services should fulfil. Using the determinants of health inequalities approach also offers commissioners a way of linking population need to the service activity to be commissioned and the outcomes to be measured. The framework in the next section shows how information from the HEF can be used with other data and information to inform commissioning intentions and priorities.

A framework for identifying evidence based commissioning intentions and service priorities

How to use this tool

This tool can be used by commissioners to summarise evidence of health inequalities locally, priorities for action, plans to reduce health inequalities, and evidence of change. It is not designed to capture detailed information, but to provide an overview.

Column 1 – lists the determinants of health inequalities

Column 2 – describes the National Outcome Framework domains relating to each determinant (NHS, Public Health and the Adult Social Care Outcomes Framework)

Column 3 – having considered the determinants of health inequalities, and how these relate to the National Outcome Frameworks – this column is for local services to add sources of evidence of health inequalities in the local population. It may be helpful to categorise this information into evidence that provides:

- **Numbers** (for example: IHaL health profiles, which include numbers of people known to GPs and numbers of people who have had health checks);
- **Objective outcome indicators** (for example: HEF data analysis)
- **Subjective outcome indicators** (for example: results of Patient Reported Outcome Measures – PROMS)
- **Individual stories**

Some examples are given in the template provided.

Column 4 – having considered the evidence, including the HEF profile, this column is for summarising priority outcomes relating to the health inequalities identified.

Column 5 – a summary of local plans to tackle the determinants of health inequalities should be added to this column.

Column 6 – this column should be used initially for noting sources of evidence that might help determine whether changes have taken place, and can be used in the longer term to track impacts on the determinants of health inequalities. The information can be categorised as for column 3.

Outcomes framework for commissioning improved health equalities for people with learning disabilities

Determinants of health inequalities	Related National Outcome Framework domains	Where to find evidence of health inequalities in population	Priority outcome (examples)	Plans to reduce health inequalities (examples of what services can do)	Evidence of change (examples of measures)
Social determinants: • Accommodation • Employment & activities • Financial support • Social contact • Additional marginalising factors (e.g. ethnicity) • Safeguarding	**Public Health** 1. Improving the wider determinants of health **NHS** 2. Enhancing quality of life for people with long term conditions (2.2) Improving functional ability (including employment) **ASCOF** 1. (1.E) Proportion of adults with LD in employment (1.G) Proportion of adults who live in their own home or with their family 4. Safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm	**Numbers** IHaL health profiles **Objective outcome indicators** JSNA SAF SAAF LDPB reports HEF	e.g. Supporting more people into work. e.g. Reducing hate crime.	e.g. Occupational therapist works with an individual enabling them to use the bus so that they can get to work. e.g. Team members work with the police, self-advocacy group and family carers' group on staying safe and reporting abuse or hate crime.	**Numbers** Number of people with learning disabilities in work. Number of people who live in their own home. Number of reports of hate crime. Number of safeguarding alerts. **Objective outcome indicators** SAF C1, C3, C4, C5, C7, C8, C11 HEF data **Subjective outcome indicators** Questionnaires **Individual stories.**

Determinants of health inequalities	Related National Outcome Framework domains	Where to find evidence of health inequalities in population	Priority outcome (examples)	Plans to reduce health inequalities (examples of what services can do)	Evidence of change (examples of measures)
Genetic and biological determinants: • Assessment of health needs • LTC pathways, review of health needs • Care plans, HAPs • Crisis plans, hospital passports • Medication • Availability of specialist services	**NHS** 2. Enhancing quality of life for people with long term conditions **Public health** 4. Preventing premature mortality	**Numbers** QOF data SAF **Objective outcome indicators** JSNA LDPB report HEF	e.g. Supporting providers to recognise and respond to the health needs of people with autism, thus enabling them to live successfully in the community. e.g. Supporting people with Down syndrome to have regular thyroid function tests	e.g. The intensive response team develops a multidisciplinary training and support package. e.g. Nurses support GPs to provide regular tests and source easy read materials about thyroid problems.	**Numbers** Number of people with Down Syndrome on QOF register. Number of people with Down Syndrome who have had thyroid function tests. Number of people with autism known to local services. Data on number of people out of area (new placements and plans for resettlement) Number of health checks/health action plans/hospital passports **Objective outcome indicators.** HEF data Audits **Subjective outcome indicators** PROMs **Individual stories**
Communication and health literacy:	**Public health** 2. Health improvement (people are helped to live healthy lifestyles, make healthy choices and reduce health	**Numbers** QOF data	e.g. Hospital staff need to know when people with learning	e.g. Acute liaison nurse provides training and support to hospital staff	**Numbers** **Objective outcome indicators**

Determinants of health inequalities	Related National Outcome Framework domains	Where to find evidence of health inequalities in population	Priority outcome (examples)	Plans to reduce health inequalities (examples of what services can do)	Evidence of change (examples of measures)
• Body and pain awareness • Communication of health needs • Recognition by others of pain • Recognition of health needs and response by others • Understanding health information, making choices	inequalities) **NHS** 2. Enhancing quality of life for people with long term conditions (2.1) Ensuring people feel supported to manage their condition	**Objective outcome indicators** HEF	disabilities are in pain and unable to communicate this. e.g. Women with learning disabilities need support to understand what happens when they attend breast screening, and why this is important.	regarding use of a pain recognition tool. e.g. The team develop a photo journey for breast screening in their local area, and a DVD to help women understand what happens.	HEF data Take-up of screening Audit of available easy read information and tools such as hospital passports/pain recognition documents **Subjective outcome indicators** Patient/carer satisfaction surveys **Individual stories**
Behaviour and lifestyle: • Diet	**Public health** 2. Health improvement (people are helped to live healthy lifestyles, make healthy choices and reduce health	**Numbers** QOF data	e.g. Improved skills of supported living staff regarding	e.g. The team work with support staff on balancing risk and choice, and the	**Numbers** Number of people with learning disabilities who have type 2 diabetes. Number of people who are

Determinants of health inequalities	Related National Outcome Framework domains	Where to find evidence of health inequalities in population	Priority outcome (examples)	Plans to reduce health inequalities (examples of what services can do)	Evidence of change (examples of measures)
• Exercise • Weight • Substance use • Sexual health • Risky behaviours	inequalities) **NHS** 1. Preventing people from dying prematurely (1.7) Reducing premature death in people with learning disabilities	**Objective outcome indicators** JSNA LDPB report HEF	diet/exercise and informed choice. e.g. Improved inclusion in substance misuse programmes.	physiotherapist and dietician work with the provider on an exercise and healthy diet plan. e.g. The nurse and psychologist work with the CARATS team in prison to identify prisoners with learning disabilities and offer reasonable adjustments so they can access treatment programmes	obese. Number of people accessing health promotion opportunities. **Objective outcome indicators** HEF data Audit of PCPs/HAPs **Subjective outcome indicators** Feedback from providers. Training evaluations **Individual stories**

Determinants of health inequalities	Related National Outcome Framework domains	Where to find evidence of health inequalities in population	Priority outcome (examples)	Plans to reduce health inequalities (examples of what services can do)	Evidence of change (examples of measures)
Deficiencies in access to and the quality of healthcare and other service provision • Organisational barriers • Consent • Transitions • Health screening/ promotion • Primary and secondary health services • Other services	**NHS** 1. Preventing people from dying prematurely (1.7) Reducing premature death in people with learning disabilities 4. Ensuring people have a positive experience of care 5. Treating and caring for people in a safe environment and protecting them from avoidable harm. **ASCOF** 2. Delaying and reducing the need for support. **Public health** 2. Health improvement (people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities)	**Numbers** QOF data HES data DES IHaL health profiles Data re screening uptake compared to general population. **Objective outcome indicators** SAF HEF Audits	e.g. Identifying people at risk of not having health checks/serious health problems being unnoticed – so that no-one presents with late stage life threatening conditions. e.g. Identifying people at risk through: • Epilepsy • Dysphagia • Body shape distortion so that no-one known to services dies of these conditions.	e.g. Ensure registers are up-to-date and links made with other QOF registers. Support the implementation of health checks e.g. Acute liaison to mitigate risks in hospital e.g. Specialist skills in epilepsy, dysphagia and postural care to: • Co-work with primary/ secondary care. • Support families/ providers • Provide direct interventions.	**Numbers** Number of people with learning disabilities registered with GPs, and cross referencing between registers. Number of people with health checks. Number of people who have accessed health screening **Objective outcome indicators** SAF A1-A8, A10 Audits **Subjective outcome indicators** PROMS **Individual stories** Case studies

Draft CQUIN for implementation of the Health Equality Framework for services to people with learning disabilities

CQUIN Table 1: Summary of goals

Goal Number	Goal Name	Description of Goal	Goal weighting (% of CQUIN scheme available)	Expected financial value of Goal (£)	Quality Domain (Safety, Effectiveness, Patient Experience or Innovation)
	Health Equality Framework: outcome measurement for services to people with learning disabilities	To implement use of the Health Equality Framework, capturing how interventions have resulted in improvements for the target group agreed for initial implementation [specify, e.g. 5 referrals from each clinician during Q2]			Safety; effectiveness; patient experience

CQUIN Table 2: Summary of indicators

Goal Number	Indicator Number	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected financial value of Indicator (£)
	1			
		Totals:	100.00%	

CQUIN Table 3: Detail of indicator (to be completed for each indicator)

Indicator number	1
Indicator name	Health Equality Framework: outcome measurement for services to people with learning disabilities
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	To implement use of the Health Equality Framework, using it to capture salient outcome measures for people with learning disabilities using the service. The tool will be implemented in phases to allow for training to be completed and any necessary systems put in place. ***Q1 Familiarisation and training*** Introduce the tool to the staff who will be using it. Discuss data capture with these staff and with information systems colleagues; agree on a system. Agree a sampling approach with commissioners to build up coverage over the year [e.g. one team to start in Q2, another in Q3, etc]. ***Q2 Implementation*** Implement the tool in the phased approach agreed. Carry out initial baseline scoring. ***Q3 Relate to practice*** Report on baseline scores and agree on a sampling frame for audit. Audit of 20% of care records of the initial group to show how outcomes are being built in. ***Q4 Assess progress*** Reassess the initial group, score and evidence outcomes. Report on reassessments compared to baseline figures to evidence changes in scores and relate these (where relevant) to the impact of the interventions offered to date. Report on roll-out agreed in Q1.
Numerator	
Denominator	

Rationale for inclusion	There have not previously been adequate outcome measures to demonstrate the impact of service interventions on the health and wellbeing of people with learning disabilities. The Health Equality Framework (HEF) has been developed to fill this gap. It is based on the five determinants of health inequalities set out by the Public Health Observatory for learning disabilities and can be linked firmly to the NHS, Public Health and Social Care Outcomes Frameworks. The HEF enables services to demonstrate the impact of interventions on individuals. Individual outcomes can also be collated to demonstrate impact on priorities for the population.
Data source	Reports on progress against the plan agreed in Q1 Change against individual baseline scores
Frequency of data collection	Quarterly
Organisation responsible for data collection	
Frequency of reporting to commissioner	Quarterly
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	March 20xx
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	At end of Q3 Report on baseline scores and agree on a sampling frame for audit. Audit of 20% of care records of the initial group to show how outcomes are being built in.
Final indicator reporting date	April 20xx
Are there rules for any agreed in-year milestones that result in payment? (see Table 4 below)**?**	Yes
Are there any rules for partial achievement of the indicator at the final indicator period/date? (see Table 5 below)	Yes

CQUIN Table 4: Milestones (only to be completed for indicators that contain in-year milestones)

Goal No.	Indicator No.	Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to Commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
	1	Q1	Introduce the tool to the staff. Agree on a data capture system. Agree a sampling approach with commissioners.	July 20xx	50%
	1	Q2	Implement the tool in the phased approach agreed. Report on initial baseline scores.	September 20xx	15%
	1	Q3	Audit of care records to show outcomes built in.	December 20xx	20%
	1	Q4	Report on reassessments compared to baseline figure to evidence improvements in scores. Report on roll-out.	March 20xx	15%
				Total:	100%

CQUIN Table 5: Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)

Goal No.	Indicator No.	Final indicator value for the part achievement threshold	% of CQUIN scheme available for meeting final indicator value

CQUIN Table 6: Maximum aggregate CQUIN Payment

Contract Year	Maximum aggregate CQUIN Payment
2013/14	2.5% of Actual Annual Value
Subsequent years	To be determined nationally and inserted locally

CQUIN Table 7: **CQUIN Payments on Account**

Commissioner	Payment	Frequency/Timing	Agreed provisions for adjustment of Payments on CQUIN Account based on performance

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