PAPER K2

	2014/15 Measures	Response	Final RAG	PreviousRAG
	A1: Learning Disabilities Quality and Outcomes Framework register in primary care. There is concern that many people with learning disabilities (LD) are unknown to services and do not subsequently get access to the healthcare they need. This indicator aims to encourage the building of accurate registers to ensure equity of access to healthcare for people with learning disabilities. All people with learning disabilities need to be identified using the QOF. Local data needs to be scrutinised and systems put in place in primary care to ensure that all people with learning disabilities are put on the QOF register.			
	LD registers reflect prevalence data AND data stratified in every required data set (e.g. age / complexity / Autism diagnosis / black and minority ethnicities etc.).	For 2013/14 the LD Registers identify people with Downs Syndrome and the level of learning disability where this is known. All registers are verified annually as part of the learning disability health check contract. From April 2014 practices have been asked to include patients aged between 14 and 17 with a learning disability. This is an improvement to ensure that primary care can capture patients during the transition from children's services to adult services. We have rated this as amber as the validity of data for those under 18 years old requires further assurance.		
	LD registers reflect prevalence data but are not stratified in every required data set (e.g. age / complexity).			
	The numbers of people on LD registers reflect the requirements outlined in QOF.			
	A2: Finding and Managing Long Term Health Conditions: obesity, diabetes, cardiovascular disease, epilepsy. Currently there is little specific comparative data between the health of people with learning disabilities and the non-learning disabled population, yet we know that people with learning disabilities have poorer access to healthcare and die younger than their non-learning disabled peers. There is a lack of robust data from which the JSNA and Health and Well-Being Strategy can be informed. This indicator looks at four major long term health conditions (obesity, diabetes, cardiovascular disease and epilepsy) to enable localities respond more effectively to clinical needs and be in a strong position for future planning of reasonably adjusted health services for people with learning disabilities			
	We compare treatment and outcomes for all four conditions between people with learning disabilities and others in: the area and at local GP level.	Rutland has comparitive data on obesity, diabetes, CVD and epilepsy which has been analysed by Public Health. This analysis will help target specific pieces of work to help improve services and access to services to patients with LD. There is also a local research study happening to help people with diabetes to get the right help . The screening clinics have been adapted to meet the needs of people with a LD, a variety of communication aids are used and clinics are run by qualified LD nurses. Reasonable adjustments are made to ensure the needs of those taking part are met e.g. Capacity Assessments, Easy Read information and Communication Aids. Changes have been made to the Stop Diabetes education programme based on feed back from participants, carers, educators / facilitators. The Stop diabetes programme is looking to develop resources and improving uptake for people with Learning Disabilities		
	We compare treatment and outcomes for some of the conditions between people with learning disabilities and the general population in the area.			
	No comparative data available.			
	A3: Annual health checks and annual health check registers (To be completed by IHAL)			
	80% or more of people with learning disability on the GP DES Register had an annual health check.			
	between 41% and 79% of people with learning disability GP DES Register had an annual health check.			
	Fewer than 40% of people with learning disability on the GP DES Register had an annual health check.			
	A4: Specific Health Improvement Targets (Health Action Plans) are generated at the time of Annual Health Checks (AHC) in primary care. The LD DES (2013/14) guidance puts the onus on GPs to generate meaningful health improvement targets (health action plans) at the time of the annual health check to address health priorities. Integrated annual health checks and health improvement targets (health action plans) will ensure person centred care and improved individualised health outcomes. This indicator provides an opportunity to improve primary, secondary and specialist community team engagement which supports the reduction of inappropriate secondary care referrals. It also provides the person with a learning disability (and their carer, if appropriate) with a clear understanding of 'what needs to happen' over the next 12 months.			
	70% or more than of Annual Health Checks generate specific health improvement targets (Health Action Plan).	GP surgeries have been provided with a post health check action plan and are advised to use the read code to indicate if it has been given or if the patient has declined the offer. UPDATE WITH NEW GP DATA In 1n Rutland 120 were eligible to have a Health Action Plan and 67 were completed = 55.83% As practices are not required as part of the DES contract to provide a patient with a health action plan practices are encouraged to do this as a reasonable adjustments for their patients with a learning disability.The plan is that there will be a field built into the annual health check document which is filled in at the annual health check, this will be manadatory from 2015. The field will need to be completed before the rest of the annual health check template is unlocked for editing		
	50% - 69% of Annual Health Checks generate specific health improvement targets (Health Action Plan).			
	Fewer than 50% of Annual Health Checks generate specific health improvement targets (Health Action Plan).			
	A5: National Cancer Screening Programmes (bowel, breast and cervical) IHAL will complete this rating.			
	Screening takes place for the same proportion (+ or – 5%) of eligible people with learning disabilities as the general population. (23%)			
	Screening takes place for half the proportion or more of eligible people with learning disabilities compared to the rate of screening for the general population.			
	Screening takes place for less than half the proportion of eligible people with learning disabilities compared to the rate of screening for the general population or data unavailable.			

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	A6: Primary care communication of LD status to other healthcare providers Healthcare providers continue to state that having no prior warning of somebody's learning disability and specific needs resulting from their disability prevents them from being able to fully meet their needs through reasonable adjustments. This indicator encourages the development of standardised local systems to address this problem. The patient journey of people with learning disabilities needs to be trackable as identified within primary and secondary care. By including the learning disability status in the referral will give notice to the secondary care provider enabling them to make reasonable adjustments if necessary. This will potentially lead to a reduction in DNA's, length of stay and inappropriate repeat attendances.			
	Secondary care and other healthcare providers can evidence that they have a system for identifying LD status on referrals based upon the LD identification in primary care and acting on any reasonable adjustments suggested. There is evidence that both an individual's capacity and consent are inherent to the system employed.	A new system, PRISM (Pathway and Referral Implimentation System) has beeen implemented in 98% of GP Practices and all have received training. The new system has a central storage hub which includes direct referral details for LD services and a Pathway and Referral Implementation System where relevant information can be added. Any reasonable adjustments can be added but it is not a LD specific field and not a mandatory field. Information is only included if added by the referring GP. If a patient is registered on the Learning Disability Register they will automatically be alerted to the service on admission by the red tick flagging system so patients can be easily identified by the Team and seen by the acute liaison nurse team. We know however that the system doesn't capture all of our admissions. UHL is moving towards using an electronic patient record, disability status and associated requirements will be part of the patient record template. The implementation is some way away.		
	There is evidence of a local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments if required, are included in referrals. There is evidence that both an individual's capacity and consent are inherent to the system employed.			
	There is no local area team/clinical commissioning group wide system for ensuring LD status and suggested reasonable adjustments are included in the referrals.			
	A7: Learning disability liaison function or equivalent process in acute setting In Healthcare for All (recommendation 10) the value of advocacy, including learning disability liaison is clearly described, as well as a clear call for Trust Boards to publicly report they have effective systems to deliver reasonably adjusted health services. Many Trusts have appointed learning disability liaison nurses though there is more than one way in which the learning disability liaison function can be delivered. This indicator seeks to explore the full extent of the learning disability liaison function in England. Of particular importance is whether providers and commissioners are gathering and using HES data to inform decisions on where the greatest need for a learning disability function may be given trends and evidenced need.			
	Designated learning disability function in place or equivalent process, aligned with known learning disability activity data in the provider sites and there is broader assurance through executive board leadership and formal reporting / monitoring routes.	The Acute Liaison Nurses continue to be employed by UHL and service capacity is aligned to the known population figures. The SLA is being monitored and a report on progress of the service is reported through the quality schedule, education and practice development. Hospital staff have training on Learning disability awareness Person Centred Care sessions as part of the induction with Human Resources trainers. A 3 day programme to 74 Health Care Assistants . The programme was delivered by the practice development lead for planned care and the Acute Liaison Nurses. Sessions were provided by the hospital's Safeguarding Lead Nurse and the Lead Nurse for Older People. The Acute Liaison Nurse service has been in place for 4 years and is accountable to the Executive Quality Board via the Safeguarding Assurance Committee. There is a designated Executive lead for the service. Service reports are included in the twice yearly Trust Board reports.		
	Designated learning disability liaison function or equivalent process in place and details of the provider sites covered has been submitted. Providers are not yet using known activity data to effectively employ LD liaison function against demand.			
	No designated learning disability liaison function or equivalent process in place in one or more acute provider trusts per site.			
	A8: NHS commissioned primary care: dentistry; optometry; community pharmacy; podiatry. Any health service accessed by a person with learning disability may need to reasonably adjust what it does in order to meet their additional needs. This indicator captures examples of where this is happening well in wider primary care services including dentistry, optometry, community pharmacy and podiatry. In order for reasonable adjustments to occur routinely, services need a way to both record the patients learning disability status and describe the reasonable adjustment required. This measure is specifically about the 4 listed, NOT those services specifically commissioned for people with a learning disability.			
	All people with learning disability accessing/using service are known and patient experience is captured. All of these services are able to provide evidence of reasonable adjustments and plans for service improvement.	There is currently no flagging system in place for people with learning disabilities when accessing community services. Some services are able to provide evidence that reasonable adjustments for LD service users are being made. However, due to the lack of an identification process this only happens at the point they realise the person has a learning disability. Some of the services are now able to identify and offer reasonable adjustments as follows: longer appointment, appointment at time to suit needs, use of easy words and language, provide easy read information.		
	Some of these services are able to provide evidence of reasonable adjustments and plans for service improvements.			
	People with learning disability accessing/using these services are not flagged or identified. There are no examples of reasonable adjusted care.			
	A9: Offender Health and the Criminal Justice System Evidence suggests 7% of the prison population, and a greater number in the criminal justice system have learning disabilities. It is important that these individuals have access to a range of health services. Information gathered from local criminal justice systems on prevalence will inform provision regarding: • What is available including prevention • Development required • Ensuring accessible health services. This indicator captures local information and data about people with learning disabilities in prison and the criminal justice system and how their health needs are being met.			
	Local Commissioners have and act on data about the numbers and prevalence of people with a learning disability in the criminal justice system.	The Prison Mental Health Team provided the following information. HMP Stocken has low numbers of people with LD on the case load. There is a pathway in place for assessment and care. Prisoners identified with LD are taken onto the In-Reach case load and can be seen, if required, by the Clinical Psychologist and Forensic LD Consultant. Prisoners who are identified as having a diagnosed LD are under the care of the Mental Health Team. If required, hospital transfers to specialist LD services would be coordinated by the team and the Psychiatrist. The Team works closely with the Prison Psychology team in identifying those prisoners with LD.		
	Local commissioners have a working relationship with regional, specialist prison health commissioners AND			
	There is good information about the health needs of people with LD in local prisons and wider criminal justice system and a clear plan about how such needs are to be met AND			

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	Prisoners and young offenders with LD have had an annual health check which generates a health action plan, or are scheduled to have one in the coming 6 monthsAND.			
	Evidence of 100% of all care packages including personal budgets reviewed at least annually.			
	In the absence of the above (or elements of the above) An assessment process has been agreed to identify people with LD in all offender health services e.g. learning disability screening questionnaire. Offender health teams receive LD awareness training to know how best to support individuals to meet their health needs AND There is easy read accessible information provided by the criminal justice system.			
	There is no systematic collection of data about the numbers of people with LD in the criminal justice system. There is no systematic learning disability awareness training for staff within the criminal justice system. The local offender health team does not yet have informed representation of the views and needs of people with learning disability.			
B1: Commissioners know that all funded individual health and social care packages for people with learning disability across all life stages are reviewed regularly. Regular Care Review – This measure is about ensuring that in all cases where a person with a learning disability is receiving care and support from commissioned services, the needs behind this support are reviewed in a co-productive and inclusive way.				
	Evidence of 100% of all care packages including personal budgets reviewed within the 12 months covered by this self assessment.	Health - 100% of LD patients who meet the Winterbourne Criteria have had a care review within the last 12 months. Local Authority - 90% of adult social care packages were reviewed in this period & 100% of disabled children cases were reviewed.		
	Evidence of at least 90% of all care packages including personal budgets reviewed within the 12 months covered by this self assessment.			
	Less than 90% of all care packages including personal budgets reviewed within the 12 months covered by this self assessment.			
B2: Contract compliance assurance – for services primarily commissioned for people with a learning disability and their family carers This measure asks localities to demonstrate how thorough their contracting processes are. This is important to ensure individual reviews are complimented by robust contract management.				
	Evidence of 100% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance and including un announced visits . Evidence that the number regularly reviewed is reported at executive board level in both health & social care.	Local Authority - contracts are in place for all services. All Social Care individual placements have annual person centred review. Spot checks monitor the quality of care and provide assurance about safeguarding. CCG commissioned LD health services have service specifications in place which outline the requirements and expected KPIs, these are monitored monthly via the Financial and Technical Group meeting. As part of the Contracting process with LPT the KPIs related specifically to quality are detailed in the Quality Schedule, these are monitored via the monthly Clinical Quality Review Group meeting (CQRG). An LLR wide Mental Health and Learning Disabilities Clinical Sub Group meets monthly and is attended by Clinicians from CCGs, LPT and Local Authorities. Discussions around pathway redesigns, service concerns, and legislative requirements will come to this group. Unannounced quality visits take place base on the intelligence gathered via CQRG and requests from the CCG boards.		
	Evidence of at least 90% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance. Evidence that the number regularly reviewed is reported at executive board level in both health & social care.			
	Less than 90% of health and social care commissioned services for people with learning disability: 1) have had full scheduled annual contract reviews; 2) demonstrate a diverse range of indicators and outcomes supporting quality assurance.			
B3: Assurance of Monitor Risk Assessment Framework for Foundation Trusts Following the publication of Healthcare for All in 2008 the Care Quality Commission (CQC) developed a number of essential standards for healthcare providers to meet in order to assure a minimum standard of care, to be offered to people with learning disability. Subsequently MONITOR (the independent regulator of Foundation Trusts (FT) adopted the same standards into their compliance framework. As these are minimal quality standards it would be expected that all FT's should be meeting these. This indicator not only seeks confirmation that this is the case but expects commissioners to demonstrate the evidence gathered from providers to confirm this and the evidence that where trusts strive to achieve foundation status, commissioners support the attainment of monitor standards.				
	Commissioners review Monitor returns and review actual evidence used by Foundation Trusts in agreeing ratings. Evidence that commissioners are aware of and working with non-Foundation Trusts in their progress towards Monitor compliance.	At the monthly Strategic Contract Performance meeting LPT report on their performance against Monitor, Access and Outcome Metrics. This is a shadow summary as LPT are currently working towards foundation status. During 2013/14 the Trust was not actively part of MONITOR assessment, prior to this the Trust was rated as amber against the Health Care for All Indicators based on the merging of LPT with Community Health Services. There are currently no providers with Foundation Trust status in the area		
	Commissioners review Monitor returns of Foundation Trust providers. Evidence that commissioners are aware of and working with non-Foundation Trusts in their progress towards Monitor compliance.			
	Commissioners do not assure themselves of the on-going compliance, via Monitor returns, for each Foundation Trust - OR - for non-Foundation Trusts, commissioners are not aware of the Trust's position in working towards Monitor standards and Foundation Trust status.			

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B4: Assurance of safeguarding for people with a learning disability. Governance, safety, quality and monitoring. Learning from Winterbourne View review and good commissioning practice identifies failures and risks within the quality and safety of people's placements, both individually and across organisations. This must cease. This measure asks localities to robustly evidence the safeguarding governance for people with learning disability in all provided services and support.				
Green	Evidence of robust, transparent and sustainable governance arrangements in place. in all statutory organisations including Local Safeguarding Adults Board(s), Health & Well-Being Boards and Clinical Commissioning Executive Boards. The provider can demonstrate that delivery of Safeguarding Adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service has assured their board and others that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services. Key lessons from national reviews are included. There is evidence of active provider forum work addressing the learning disability agenda.	Partners work to the LLR multi-agency policy and procedures produced by the Safeguarding Adults Board. There is a designated safeguarding lead for learning disability and adult mental health services within the Trust. Local Authority safeguarding lead ensures single point of access. Safeguarding requirements are explicit in contracts with providers, there are robust sharing information protocols in place across partners. We are assured by the SAAF that LD is a priority area and the practice in our experience reflects this. Safeguarding Adults Board keeps abreast of national reviews via the Serious Case Review Sub Group. There is a policy in place for the Trust which includes procedures for allegations against staff by patients.The Trust does have a Winterbourne View Action Plan related to the LD Assessment and Treatment Service.	Green	Amber
Amber	Regular Board reporting and key points and lessons learned are included in action plans. Evidence that Learning Disability Partnership Board(s) and/or health sub group(s) are involved in reviewing progress. The provider can demonstrate that delivery of Safeguarding Adults within the current Statutory Accountability and Assurance Framework includes people with learning disabilities. This assurance is gained using DH Safeguarding Adults Assurance (SAAF) framework or equivalent. Every learning disability provider service has assured their board that quality, safety and safeguarding for people with learning disabilities is a clinical and strategic priority within all services.			
Red	No Board assurance and learning points not identified. Action plan(s) either not in place, or not yet discussed with partners.			
B5: Training and recruitment: involvement This measure is about the nature and benefit of involving 'Experts by Experiences'. A number of best practice reports suggested that there are improved outcomes when families and people with learning disabilities are involved in services. Localities should provide evidence from providers of routinely involving people with learning disabilities and family carers in recruitment and training.				
Green	In Learning Disability specific services there is evidence of all of services involving people with learning disabilities and families in recruitment and training.	The 3 LLR CCG's and the Local Authority require all staff to complete online mandatory Equality and Diversity Training at induction which includes an LD awareness section.UHL deliver equality and diversity training across the Trust. Recent LD provider survey reported that nearly all providers include service users/and or family/carers in staff recruitment and training. Service specifications include involving service users in the running of the service. Health have involved people with a learning disability in the following interviews: Trust Chief Executive, Divisional Director, Clinical Directors and some direct care posts. Local Authority Learning Disability Service involve people with a learning disability in all interviews for staff.	Amber	Amber
Green	Commissioners of universal services can provide evidence of contracting for Learning Disability awareness training (for example as part of Disability Equality Training).			
Amber	In Learning Disability specific services there is evidence of some services involving people with learning disabilities and families in recruitment and training.			
Amber	Commissioners of universal services can provide evidence of contracting for Learning Disability awareness training (for example as part of Disability Equality Training).			
Red	No evidence of involvement in recruitment and training and appropriate levels of disability equality training.			
B6: Family carers and people with a learning disability agree that providers treat people with compassion, dignity and respect. Commissioners can show that providers are required to demonstrate that recruitment and management of staff is based on compassion, dignity and respect and comes from a value based culture. It is clear from the Winterbourne View report and wider evidence from Six Lives and the Confidential Inquiry that compassion is core to the best care for people. This measure asks commissioners to think about how this can be assured in all care for people with a learning disability. This is a challenging measure but it is felt to be vital that all areas consider this. In this year's self-assessment commissioners are requested to ensure that this question is answered by people who use services and their family members. The reason for this is that they are best placed to answer the question on the basis of their experience. This question will be best answered by the local Learning Disability Partnership Board (or equivalent) representatives of family carers and self-advocates.				
Green	Family carers and people with a learning disability agree that all providers do.		Amber	
Amber	Family carers and people with a learning disability agree that some providers do.			
Red	Family carers and people with a learning disability agree that few or no providers do.			
B7: Commissioning strategies for support, care and housing are the subject of Impact Assessments and are clear about how they will address the needs and support requirements of people with learning disabilities This measure is about how effectively your locality assesses and addresses the needs and support requirements of people with learning disabilities through local and health authority strategies with clear reference to current and future demand. In particular impact assessments will ensure that Equality Act 2010 duties are met.				
Green	Up to date commissioning strategies and Impact Assessments are in place.	There is an overarching strategy across Health and Social Care called Better Care Together which includes an LD workstream. The LA Housing Strategy is supported by a specific housing needs survey of people with LD and their carers. There is a Carers Strategy in place. EIA reports are published on the Council website. The Council Equality and Diversity sub group quality assure a random selection of completed EIA's	Amber	Amber
Green	Impact Assessments and strategies have been developed with and presented to people who use services and their families.			
Amber	Up to date commissioning strategies and Impact Assessments are in place.			
Red	Not all commissioning strategies and Impact Assessments are in place.			

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B8: Commissioners can demonstrate that all providers change practice as a result of feedback from complaints, whistleblowing experience This standard requires evidence of a learning organisation that integrates learning from complaints, incidents, patient, carer and staff feedback with wider learning from national reports and incidents to improve the quality safety, safeguarding and provision to people with learning disabilities. Failings by Services to respond to concerns raised about the quality of services are at the centre of the Winterbourne View Review. Evidence need to be provided of robust partnership working to assure the safety, quality and safeguarding of people's commissioned placements.				
Green	90 % or more of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (for example complaints, surveys, quality checking),. There is evidence of effective use of a whistleblowing policy where appropriate.	LPT provide monthly complaints monitoring data to the CCG Clinical Quality Review Group. Random sampling of complaints is undertaken on a quarterly basis. CCG Patient Safety teams collate GP practice concerns. LPT produce a quarterly report of feedback from Patients which demonstrates how issues are being addressed within the organisation and timescales for completion. In relation to whistleblowing, there is requirement in the Quality Schedule for LPT to evidence an up to date whistleblowing policy and related procedures. LPT are also required to produce a report outlining the numbers of instances where staff have raised concerns. Every patient seen by the Liaison nurse service is given a patient diary to complete and concerns are addressed as they arise. LA provider survey demonstrated positive provider actions as a result of feedback/complaints. LA have a Whistleblowing policy in place and whistleblowing is included in contracts and service specifications.	Green	Green
Amber	50-89% of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (for example complaints, surveys, quality checking),. There is evidence of effective use of a whistleblowing policy where appropriate.			
Red	Less than 50% of commissioned services can demonstrate improvements, based on the use of feedback from people who use services (for example complaints, surveys, quality checking),. There is evidence of effective use of a whistleblowing policy where appropriate			
B9: Appropriate use of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).				
Green	Commissioners can evidence that all relevant providers have well understood policies in relation to the MCA and DoLS in place and routinely monitor their implementation.		Amber	Amber
Amber	Commissioners have limited evidence about the adoption and implementation of policies in relation to MCA and DoLS by relevant providers.			
Red	Commissioners cannot produce any evidence about the adoption and implementation of policies in relation to MCA and DoLS by relevant providers.			
C1: Effective joint working across health and social care. This measure looks for the evidence that formal arrangements are in pace which foster the best joint working between commissioners. Informal arrangements and evidence of good practice are also welcomed, as are future plans, particularly where these have been signed up to formally if not yet implemented.				
Green	There are well functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of single point of health and social care leadership, joint commissioning strategies and or pooled budgets, integrated health and social care teams.	Evidence of Joint Working; • CHC and Social Care Funding Panel • Short Breaks Strategy across Health and Social Care • Health and Social Care providers are members of the Rutland LD Partnership Board • Better Health Sub Group of the Rutland LD Partnership Board • A multi disciplinary team consisting of health and social care professionals meet fortnightly to jointly discuss care and support for service users in Rutland • There is a joint Autism Strategy Planning group • There is a joint Regional Winterbourne View meeting • There is a joint LLR SAF group • Health and Social Care – Better Care Together strategy	Amber	Amber
Amber	There are some examples of functioning formal partnership agreements and arrangements between health and social care organisations. There is clear evidence of at least on of the following:			
	single point of health and social care leadership,			
	joint commissioning strategy and/ or pooled budgets and,			
	integrated health and social care teams.			
Red	Joint working has not met either of the above measures.			
C2: Local amenities and transport This measure asks for evidence of reasonable adjustments within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. It is important that the assurances are provided by commissioners of those services which show that they are ensuring that local amenities and transport are provided in a way that makes reasonable adjustments for people with learning disabilities.				
Green	Extensive and equitably distributed examples of people with learning disability having access to reasonably adjusted local transport services, changing places and safe places (or similar schemes) in public venues and evidence that such schemes are communicated effectively.	Training for people with LD to be able to use public transport and travel around safely. Training currently takes place at Rutland County college and Catmose College. Bus station has good accessibility. Bus stops have raised curbs for low floor buses. We have a well-promoted, effective "safe places" scheme in Rutland that has recently been re-launched. There are Changing Places in Oakham Town and at Rutland Water. The Rutland Access Group monitor the accessibility of services and amenities in Rutland. In conjunction with Bikeability, the Aiming High Team at Rutland County Council ran Level 1 and Level 2 courses in 2014 targeted at disabled people up to the age of 25.	Green	Green
Amber	Local but not widespread examples of all of these types of schemes.			
Red	Reasonably adjusted levels of support in these schemes do not reach any of the standards above.			
C3: Arts and Culture This measure asks for evidence of reasonable adjustments within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. It is important that the assurances are provided by commissioners of those services which show that they are ensuring that local amenities and transport are provided in a way that makes reasonable adjustments for people with learning disabilities				
Green	Extensive and equitably distributed examples of people with learning disabilities having access to reasonably adjusted facilities and services that enable them to use amenities such as cinema, music venues, theatre, festivals and that the accessibility of such events and venues are communicated effectively.	Libraries, museums, arts and culture venues in Rutland are used regularly by people with LD. Services include disability access as part of their planning processes. A regular Museum Cafe is run by people with learning disabilities. The Aiming High Team at Rutland County Council provides targeted activities up to the age of 25. Activities during 2014 have included music, sensory and art and drama sessions. The Aiming High Team also works in conjunction with The Rutland Rotaract Family Support Centre to run a fortnightly Filmclub once a month.	Green	Green

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	Local but not widespread examples of people with learning disabilities having access to reasonably adjusted facilities in these amenities. The accessibility of such events and venues are communicated effectively.			
	Reasonable adjustments of these amenities do not reach any of the standards above.			
	C4: Sport and leisure This measure asks for evidence of reasonable adjustments within providers and across the broader strategies for the community, reflecting the specialist needs of people with a learning disability. It is important that the assurances are provided by commissioners of those services which show that they are ensuring that local amenities and transport are provided in a way that makes reasonable adjustments for people with learning disabilities.			
	Extensive and equitably geographically distributed examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups. Designated participation facilitators with learning disability expertise are available. There is evidence that such facilities and services are communicated effectively.	A wide variety of activities are offered on a regular basis. For example, the Aiming High Team provide targeted activities for disabled people up to the age of 25. Activities during 2014 have included Boccia, archery, trampolining, ball sports, dance, sailing, climbing, football and fly fishing. The team work closely with a small group of volunteers who run a weekly inclusive basketball club, The Conquerors, for 11-25 year olds who recently affiliated to the Special Olympics. The Team also work in conjunction with The Rutland Rotaract Family Support Centre to run targeted swimming lessons and horseriding lessons on a weekly basis. The team are also working closely with a local football club to provide disability awareness training for a number of their volunteers who lead an inclusive session.		
	Local but not widespread examples of people with learning disability having access to reasonably adjusted sports and leisure activities and venues for example use of local parks, leisure centres, swimming pools and walking groups. Designated participation facilitators with learning disability expertise are available. There is evidence that such facilities and services are communicated effectively.			
	Reasonable adjustments of these amenities do not reach any of the standards above.			
	C5: Supporting people with learning disability into and in employment This measure is about the importance of employment and the support that needs to be provided to people with learning disabilities to ensure they have the best chance of getting a job. Evidence of initiatives that find the appropriate mix of support by mainstream and specialist agencies, and data of the local picture are important. There is an important link to the standard relating to support for preparing for adulthood (C6) where strategies and pathways should include access to support to get jobs.			
	Clear published local strategy for supporting people with learning disabilities into paid employment. Relevant data is available and collected and shows the strategy is achieving its aims.	The Employment Service has achieved its aims set out within the Employment Strategy for Disabled Adults in Rutland by: • Supporting people into paid and voluntary employment opportunities. • Actively making progressive steps towards employment opportunities in education, training, work experience and skill development. • Supported individuals, under the permitted work agreement. employed or self-employed. The employment service supports individual to create a pathway to realistic employment opportunities that will meet the aspirations of the individual. The data/information is collected for each service user and added to a data sheet which links the information together.		
	Clear published strategy for supporting people with learning disabilities into paid employment but limited evidence of aims being met or outcomes achieved.			
	Not meeting either of the above measures.			
	C6: Preparing for Adulthood in Education, Health and Social Care Delivering effective transitions for young people is recognised as a way of addressing the difficulties confronted by young people with learning disabilities and their families at transition. Previous research has demonstrated that information is a key need at this time, the delivery of a 'local offer' within the scope of the Children and Families Act will support this. A foundation for good support during the transition from childhood to adult life is co-production of local plans and having a sound knowledge base of future need to inform commissioning strategies. This descriptor ascertains if localities have good plans in place to ensure locally available provision of the future mainstream and specialist health and social care services needed to support young people approaching adulthood.			
	There is a monitored strategy, service pathways and multi-agency involvement across education, health and social care. There is evidence of clear preparing for adulthood services or functions that have joint health & social care scrutiny and ownership across children and adult services.	There remains a firm commitment by Rutland County Council for the Transitions process. The Children and Families Act has introduced Preparing for Adulthood which requires pathways to be looked at in reviews and planning holistically. Rutland EHC plans are integrating Preparing for Adulthood reviews, to ensure our young people work toward their aspirations. We are also aligning our pathways with not only the Children and Families Act but the Care Act. The Transitions Operations Group meet 6 weekly and track young people in Transition from 13 years old to 25 years old. This information informs commissioning needs.This group is a multi-agency group.		
	There is some evidence of clear preparing for adulthood services or functions that have joint education, health & social care scrutiny and ownership across children and adult services..			
	There is no evidence of clear preparing for adulthood services or functions that include joint education, health & social care scrutiny and ownership across children and adult services.			
	C7: People with learning disability and family carers are involved in service planning and decision making. For the purposes of this assessment Co Production means that people with learning disabilities and family carers are actively involved in discussion and decision making about service planning and strategy. This is about people with learning disabilities and family carers involvement in service planning and decision making, including personal budgets. This measure seeks to stimulate areas to continually review and improve the involvement of people who use and rely on services in strategic development and planning.			
	Clear evidence of co-production in universal services and learning disability services. The commissioners use this to inform commissioning practice.	Big Health Day' was held in November 2013 Engagement Carers event held in June 2014 - promote cancer screening In October 2014 two local service users were invited and attended an NHS and Public Health England workshop about improving the uptake of cancer screening. Parent/carer membership of the SEN Reform steering group. Consultation for Local Offer involved service users and carers. Individual service planning uses information from Person Centred Plans to produce outcome focussed support plans. This will indicate how people have chosen to spend their personal budget. Service users are members of the Speaking up for Health Group, Better Care Together reference group and have been involved in the future of the Short Breaks service. People with learning disabilities and family carers are fully involved with the Rutland Partnership Board.		
	Clear evidence of co-production in all learning disability services that the commissioner uses to inform commissioning practice. Inconsistent or no evidence of co-production in universal services.			
	There is no evidence that people with learning disability and families have been involved in co-production of service planning and decision making.			
	C8: Family carers Consultation on the SAF raised a strong call for family carers to be given a place to specifically contribute about their needs in the measures. This measure asks for evidence that family carers are involved not only in service design and			

2014/15 Measures		Response	Final RAG	PreviousRAG
This measure should be rated by family carers. Examples of the forums that could do this are Carers' Partnership Boards, Carers Centres or local carer networks etc. It is important to include as wide a range of family carers as possible. This measure uses a question informed by the National Valuing Families Forum:				
How satisfied are you that your needs as a family carer are met? Consider carers' health checks from GP's, carers' assessments from the Local Authority and relevant information advice and guidance/ training from mainstream and carers' services.				
We want to know how this question was answered and how many carers were involved in the process.				
	Most carers are satisfied that their needs were being met.	A recent survey of carers (56 questionnaires) reported most carers to be satisfied. Representative of Rutland Parent Carer Voice are members of the Rutland LD Partnership Board and the Children's Trust.		
	Most carers were neither satisfied nor dissatisfied that their needs were being met			
	Most carers thought that their needs were not being met.			