

Somerset Sensory Review

**Final Report
by
Peter Fletcher Associates Ltd**

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Peter Fletcher Associates Ltd
Research and Consultancy

Somerset Sensory Review

Final Report

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Glossary and Definitions

Glossary

Adult Social Care (ASC) - Formerly known as Social Services before adults' and children's services were divided.

Adult Social Care Worker (ASCW) - A term used in Somerset to identify unqualified workers within adult services.

Advocacy – the provision of independent support for service users in helping them speak up for themselves and ensuring that their views are heard, understood and taken into account.

Best Value Review – A former Government (Labour) initiative to ensure services provided were of the best possible value rather than simply the cheapest.

Brokerage – Assistance provided or commissioned by local authorities to help service users and carers plan and organise the support they want. It can include help with developing support plans or how a personal budget will be used. Some Councils have in-house brokers who work exclusively at piecing together the best care package. Other local authorities now fund independent organisations to broker with users. And users on personal budgets can also fund a broker themselves. (Service users should be able to choose who they want to assist them in this way, e.g. a relative, friend, neighbour, or social care professional.)

Care pathway – Care pathways describe the route that a service user will take from their first contact with adult social care to the time when they no longer need to use services. The term 'integrated care pathway' is used to describe care that goes across several disciplines, for example across social and health care or across different forms of health treatment.

Certificate of Visual Impairment (CVI) – The certificate signed by a Consultant Ophthalmologist that enables sensory specialists to register a person as 'severely sight impaired' or 'sight impaired'.

Direct payments – Budgets paid directly to social care users to meet their needs. They are a form of personal budgets, giving service users direct control of the money allocated to them for care.

Fair Access to Care Services (FACS) – The national framework on which decisions about eligibility criteria must be based.

In Control – Social enterprise set up to transform the current social care system into a system of self-directed support. For more information see www.in-control.org.uk.

Individual budget – Sum allocated to an individual user of services, originally drawn from a number of funding streams in the individual budget pilots. Now often used interchangeably with ‘personal budget’.

PCT Primary Care Trust – The commissioning arm of the NHS.

Personal budget – The amount of money allocated for an individual’s social care, either paid directly to the individual in direct payments or held by social services or a third party. Now often used interchangeably with ‘individual budget’.

Personalisation – The theory behind the current transformation of social services; also refers to the process of providing individualised, flexible care that is intended to promote the independence of those who need care; usually associated with self-directed assessment, individual budgets and self-directed support.

Re-ablement – Short-term intensive support following illness, accident or hospital stay. It is intended to help people live as independently as possible in their own homes.

Resource Allocation System (RAS) – System each council has for allocating social care budgets to individuals, based on need determined by assessment/self-directed assessment.

Self-directed assessment – The assessment process involved in self-directed support – a simplified assessment process that is led as far as possible by the service user in partnership with professional staff, focusing on outcomes service users want to achieve.

Self-directed support (SDS) – The means used by each council to enable service users to control how their personal/individual budget is used. The term comes from the organisation In Control, which champions the rights of people to control their care budget.

Self-funder – Someone who, because of their income, is not eligible for council-funded care. They are still entitled to advice and help from the council to make their social care arrangements, which they pay for themselves.

Sensory Specialist – Specialist workers within ASC, including social workers and rehabilitation workers both qualified and unqualified.

Single Assessment Process - A common format for collating information and recording assessments of individual people shared between Health and Social Care Services to avoid duplication.

Somerset Direct – A free information and advice service provided by Somerset County Council for older people, carers, relatives and other adults with care needs. Information can be given over the phone, in different formats or arrangements made for the most suitable person to help with:

- Social care services and occupational therapy
- Blue badges, mobility aids and health
- Your home, energy, efficiency and safety
- Pensions, benefits and money matters
- Help and support for carers
- Support groups and other agencies in Somerset

Support plan – Summary of the agreed care that an individual is to receive, based on outcomes and using their personal/individual budget. May refer to outcomes or aspirations not covered by their social care budget (e.g. aspirations to make use of universal services such as leisure or learning facilities).

SWIFT – Somerset's database to record client details.

Universal services – Unlike personal social care services, which are means-tested, universal services are available to everybody, including those who need social care and support. For example, people who are not eligible for free social services (self-funders) are entitled to advice from the council on where they can find services, such as home care or residential care, which they will pay for themselves.

Definitions of sensory loss or sensory impairment

Definitions of different types of sensory loss are provided in Section 2.5 of the report under the following terms:

- Deaf
- deaf
- Hearing Impairment
- Visual impairment
- Dual sensory loss
- Deaf blind

Executive Summary

Somerset County Council commissioned Peter Fletcher Associates (PFA) to undertake an appraisal of sensory services in Somerset against a backdrop of severe financial constraints and the need to make significant advances towards more personalised services in the context of “Putting People First”. The review was undertaken between January 2010 and December 2010 and covered people of all ages experiencing a sensory loss including those with multiple disabilities/needs.

The review refers specifically to:

- People who are blind/severely sight impaired or partially sighted/sight impaired (visual impairment)
- People who are Deaf (British Sign Language users)
- People who are hearing impaired
- People who have a dual sensory impairment including those who are deafblind

The population of Somerset in 2009 was about 534,000 and it is expected to increase to 567,000 by 2015.¹ Of the total population more than 20% are over 65 years of age with Somerset having a higher proportion of people in this age range than the average for the South West. The vast majority of people with a sensory loss are over 65, numbers increasing significantly with age. Based on prevalence rates² for the whole population, however, there are approximately 98,000 people in the county who already have or will experience some form of sensory loss which is not immediately remedied by treatment or correctable. The overall number of people experiencing sensory loss is set to increase proportionate to the ageing population.

Not only is the estimated number of people with a sensory loss very high, the number of people in receipt of health care relating to hearing and/or sight loss runs into many thousands per year. The number who receive support from Adult Social Care (ASC) is much lower than from health and lower than we would have expected. The review looks into this in order to better understand how people’s needs are currently being met, and how a model might be developed that prevents people needing more costly services at a later stage through the provision of information, advice and signposting as well as ensuring that services

¹ POPPI information system Dept of Health

² Good Practice in Sight. RNIB 2008 & Facts and Figures on Deafness and Tinnitus. RNIB information. 2006.

are equipped to assess and meet the eligible needs of people with more complex needs.

The Good Practice Guide³ developed from the UK Vision Strategy⁴ refers to 2 key outcomes of the strategy relating to people who have lost their sight and efforts that should be made to support them to live as independently as possible:

- Eliminating avoidable sight loss and delivering excellent support to people with sight loss
- Inclusion, participation and independence for people with sight loss

The guide identifies benchmarks for good practice including the provision of information and advice. It states that “Information is key to ensuring that service users can make informed decisions about the care they want to receive”. It continues: “Information should be made available to all people with a sight loss, even if they are not eligible for state – funded care”. Identifying, therefore, a suitable service model will not only help the Local Authority to meet its performance targets, it will prevent people making demands on services unnecessarily, improve opportunities for independence and potentially avoid costly services at a later stage.

Rurality and low population density presents challenges for people experiencing sensory loss due to difficulties with transport, accessibility to local services and employment difficulties, all of which need to be taken into account when developing the best model to meet the future needs of people with a sensory loss in Somerset.

The appraisal was undertaken by a team of consultants from PFA based on an agreed project plan supported and advised by a group of individual service users, representatives of voluntary organisations and relevant professionals constituting a stakeholder group. The appraisal was overseen, and quality monitored, by a project management group comprised of representatives of the stakeholder group and statutory agencies.

In order to understand what constitutes sensory services and how they operate, the project team was asked to appraise:

- Shortfalls of need and consistency of service provision
- ASC services in terms of value for money
- Roles of sensory specialists
- Current assessment and provision arrangements
- Commissioning arrangements

³ Good Practice in Sight. RNIB 2008.

⁴ UK Vision Strategy 20/20.RNIB 2008

- Engagement of service users

The review team undertook to clarify the current context of service provision by:

- Considering the impact of previous reviews and consultation exercises
- Identifying through an accompanying research project (Appendix 1), relevant legislation, guidelines and models of good practice elsewhere
- Mapping service provision across health, ASC and the voluntary sector

In order to ensure people with a sensory loss, their families and carers were at the centre of the process, the following approach was taken:

- Fifteen stakeholder workshops were held during the course of the review to consult on current services, possible developments and recommendations
- A questionnaire was distributed as widely as possible including to people from harder to reach communities
- A series of structured interviews were held with key stakeholders

In all, approximately 300 people have been consulted in addition to nearly 100 responses to the questionnaire.

During the consultation, there were repeated references to certain services felt to be particularly supportive. In the main, these are commissioned by Somerset County Council (SCC) from voluntary sector providers such as support groups run for the benefit of people who have lost their sight and/or hearing. Specialist healthcare services also earn considerable praise although that is not wholly consistent and the project team has witnessed considerable dissatisfaction expressed about levels of awareness of sensory loss within the health services generally.

As regards services provided directly by the county council, they also earn praise in small pockets although users of their services have been little in evidence during consultation. Deaf people were quite vocal and critical of sensory specialists but the project team takes the view that further engagement is needed with this client group to better understand their views, wishes and aspirations.

Overall, whilst services on an individual basis fare reasonably well, there is a consistent view that they are patchy with variations in the level and quality of services depending on where a person lives. Poor inter agency co-operation has been highlighted both by service users and professionals and there was little evidence to demonstrate care pathways between agencies. Information on a range of specialist subjects is of a reasonable standard but there is no strategy to ensure it is distributed evenly, consequently the evidence points to a very low level awareness of what is available and how to access it.

The overall spend on ASC sensory services is near average for the South West if not a little above, given the scale of commissioning of certain services such as equipment provision and support groups. However, the model of service provision is unusual with a healthy number of sensory specialists within community teams but only one qualified rehabilitation worker for visually impaired people for the whole county. A comparable authority, Devon, has in excess of 12 rehabilitation workers with additional specialists attached to children's services. The role of sensory specialists is generally not very clear as their span of operation is very broad covering the needs of children and families, people with mental health issues and learning disabilities as well as more generic work. There is no direct specialist strategic management of sensory services or resources. There are, therefore, significant service model and workforce issues to be addressed in addition to some of the specific service issues.

Somerset is to be commended for the development of some of its services such as rehabilitation support for people with a dual sensory impairment and commissioning including consultation with service users. It needs, however, in the light of "Putting People First" and the Coalition Government's *Vision for Adult Social Care* (November 2010), to make some significant changes by disinvesting and reinvesting. This represents a challenge as some of the services under consideration are valued and although they may serve some people well, the majority may not be served at all.

As a result of this appraisal, the project team proposes a new vision with 15 recommendations which include:

- The establishment/commissioning of a consortium of voluntary agencies to develop a sensory "Hub"
- The Hub will be a first point of contact for many people where information, advice and signposting can be easefully obtained and is part of a care pathway
- Services to be run within the Hub, proportionate to need whereby people come into contact with ASC only when it is really necessary
- Reconfiguration of sensory resources to accommodate the above but ensuring expertise is maintained within community teams
- A universal offer which embraces the need for improved access to information including, for example, in BSL (British Sign Language) format
- A universal offer which embraces the need for access to information and advice and other forms of support that enable people to identify their own care needs towards self help wherever possible

A financial modelling exercise has taken place as part of this review to ensure that the above recommendations are affordable and sustainable within existing

budgets and population projections. The review identified a number of areas where there are potential savings. The PFA project team is confident that if the recommendations are implemented, not only will they represent a significant step towards personalisation, they will bring improved outcomes for people with a sensory loss. This report proposes a vision for sensory services based around these recommendations.

1. Introduction

Peter Fletcher Associates (PFA) was commissioned by Somerset County Council to undertake an appraisal of sensory services in Somerset. This report outlines the review of existing sensory services in the county against a backdrop of severe financial constraints and the need to make a significant advance towards more personalised services. The evaluation was undertaken against a number of benchmarks including:

- National legislation
- Best practice guidelines
- Somerset County Council Sensory Best Value Review 2002
- Best practice elsewhere

The report provides analysis of the feedback gathered during widespread consultation with service users and other stakeholders. It also provides analysis of research carried out into best practice across the UK with recommendations for a business model to deliver sensory services in Somerset. The report covers the work undertaken between January 2010 and December 2010.

The objectives of the sensory loss appraisal are:

- To examine current sensory loss provision in preparation for the development of a new model of service which will deliver better outcomes and a better quality of life for people with sensory impairments, in the most effective and efficient way.
- To undertake research and consultation which will help to develop a strategic vision for Sensory Support Services in the future
- To make recommendations about what the universal offer will be to service users with sensory loss and their carers
- To ensure that sensory support services align with the new government social care agenda and to make recommendations about the specialist Sensory Support Service that Adult Social Care will provide
- To examine ways of improving the consistency of service for people with sensory impairments and their carers
- To strengthen the service user and carer voice to improve advocacy and equality of opportunity for people with sensory loss.
- To establish sustainable engagement mechanisms with people with sensory impairments to help future service objectives

- To contribute to Adult Social Care workforce development by clarifying specialist sensory support roles
- To work with partner agencies to ensure a strong network of support for people with sensory loss in the community
- To consider ways of embedding sensory impairment knowledge in other Services delivered by Adult Social Care and partner agencies

A major consideration within this review is the Government's Transformation agenda and the implementation of Personalisation. The review, therefore, is conducted within this context and serves as a constant feature in the thinking and behaviour of those structuring the work and undertaking consultation. At this stage, however, it is the principles and likely components of Personalisation that construct the approach rather than any pre-conceived ideas or prescription as to outcomes.

1.1 Current Financial Context

The context of this review is the Government's Transformation agenda and the need to dovetail sensory services and Personalisation. The original rationale and the objectives of the review do not refer specifically to the need for economies or reduced investment in services. The Product Initiation Document stated "Evaluation work undertaken will ensure that efficiencies will have been examined and proposals for streamlining and focusing resources will assist the You First, Transformation Programme".

During the course of the appraisal, however, it has become apparent from meetings of the Project Management Group that the financial climate is changing significantly and the likelihood of significant dis-investment in services is increasing. The team, whilst not changing its main focus of the review, is becoming increasingly mindful that recommendations cannot ignore the possibility of:

- Service reductions
- Doing the same with less
- Only providing that which is required by law
- Workforce changes
- Changing levels of commissioning

2. Methodology

2.1 Project Team

This Section of the report provides a brief outline of the methodology which has been used by Peter Fletcher Associates to carry out an independent appraisal of current sensory service provision against legislation, best practice guidelines and the views of service users and stakeholders. PFA established a specific team for this project:

- Peter Fletcher (Quality Control)
- Peter Wareham (Project Lead)
- Trevor Eardley (Project Manager)
- David Hess (Research)
- Liz Wareham (Admin Support)
- Avis Duncan (Admin Support/Data Analyst)
- Ann Shearer (Admin Support/Data Analyst)

2.2 Approach

The project team has carried out the work in the following manner by:

- Understanding the local context and how sensory services fit into wider strategic planning and the change agenda in the county: achieved by face to face discussion with commissioners and other key stakeholders
- Making use of information already available, including reports, documents and contracts
- Talking directly to people affected by sensory loss and other stakeholders involved with the provision of sensory services
- Undertaking further quantitative and qualitative research to reach a broader range of people affected by sensory loss via a questionnaire
- Actively using examples from other authorities/organisations and an ongoing body of research to provide case studies and benchmarking data

2.3 Accountability Arrangements throughout the Project

The project was set within the following accountability framework:

- A tender specification and business case to the consultant from the project commissioners
- A Somerset County Council Project Initiation Document
- A Project Plan submitted by the consultant and accepted by Somerset County Council
- The establishment of a Project Management Group with specific and agreed terms of reference to ensure the project remains on track.

This group meets regularly, its membership comprising:

- Barrie Fitzpatrick, Somerset County Council, Adult Social Care (joint chair of Project Management Group).
- Julia Ingram, Somerset County Council, Adult Social Care (joint chair of Project Management Group)
- Representatives of the Stakeholder Group

- Julie Shorrocks, Somerset County Council, Project Manager
- Alison Rowswell, NHS Somerset
- Peter Fletcher Associates: Peter Wareham, David Hess, Trevor Eardley.
- Tom Blake and Ella Rix, Somerset County Council, Project Support

2.4 Project Timescales

The project has been split into two phases with key project milestones:

- Phase One: Consultation/research and delivery of interim report by October 2010
- Phase Two: Consolidation of findings, financial modelling and further consultation at Stakeholder events to agree recommendations for delivery of final report by January 2011

2.5 Definitions

The terms “sensory loss” or “sensory impairment” are very general descriptions for a range of conditions covering hearing and sight loss, including people who experience a combination of both, i.e. “dual sensory loss”. The authors of this report are mindful of the many terms in daily use within the subject and sensitivities therein. There are those, for example, with congenital conditions who assert that they have lost nothing. Some members of the Deaf community, who identify themselves as such, are averse to the term “impairment”. For the purposes of this report the terms “sensory” and “sensory loss” will be used unless it is appropriate to be more specific. The following terms apply:

- Deaf – people who consider themselves to be culturally Deaf, often from birth, users of British Sign Language (BSL)
- deaf – people who have a severe hearing loss, usually acquired in adulthood
- Hearing impairment – a general term, covering deaf and those with lesser hearing losses, including hard of hearing
- Visual impairment – a general term covering blind/severe loss of sight and people who are partially sighted/sight impaired.
- Dual sensory loss – loss or impairment of both hearing and sight to the degree that it impacts on information gathering, communication and mobility
- Deaf blind – as above but tends to refer to people with more severe impairments inc. those with congenital condition and those who may use manual forms of communication

Case Examples

In order to further assist with understanding of how sensory loss affects peoples’ lives and the need for timely, high quality support which links to other services, the following case examples have been chosen:

Ms B

Ms B is in her thirties and is almost totally blind. She is a single parent, with advanced diabetes, and has had a kidney transplant. Her son is aged 2, and has some developmental delay. Ms B receives support from her mother, but would prefer to be more independent. However, because of the severity of her sight loss, there have been many practical issues to resolve, around mobility, daily living skills and management of her health problems. Parenting with such a severe sight loss presents great challenges, and although Ms B is managing extremely well, there has also been a need for intensive specialist support in this area. Ms B is receiving independence training from the visual impairment rehabilitation worker, and a specialist social worker.

Mrs M

Mrs M is in her early nineties. She has a profound hearing loss, and recently developed a serious visual impairment, creating a severe dual sensory loss. Mrs. M was totally dependent on her husband “to be her eyes and ears”. He ran the household, cooked, shopped and generally supported her in every aspect of her life. When her husband died, Mrs. M was initially unable to cope with her severe communication and practical problems. Mrs M receives a care package, but also has a guide communicator, to help her deal with paper work, access to appointments and services and facilities in the community. She is now coming to terms with her bereavement and is coping successfully with her life.

Mr A

Mr A is in his fifties and is profoundly Deaf. His main form of communication is British Sign Language, although he tries to use speech and to lip read. His deafness has had a profound effect on his ability to participate in family life and in education, as signing was not used in his home and school environments. Communication difficulties have led to emotional difficulties, depression and social isolation. Up till recently, Mr. A lived with his mother. His mother’s health has deteriorated, and because of communication problems, Mr. A found himself at a disadvantage when negotiating the care system and dealing with health professionals. Mr. A has been supported by specialist social workers, and outreach workers from the RNID, who have assisted with developing communication skills, helping with finances, budgeting, health issues and daily living skills. There have also been safeguarding issues, because of break-ins to his home, and possible financial abuse. Mr. A’s mother has now had to go into residential care, and Mr. A will need to be re-housed. He will need support in understanding the process of re-housing, and the options open to him. Mr. A has experienced much psychological distress over the years, and is very vulnerable. Appropriate counselling support is being sought.

3. National Context

3.1 National Policy

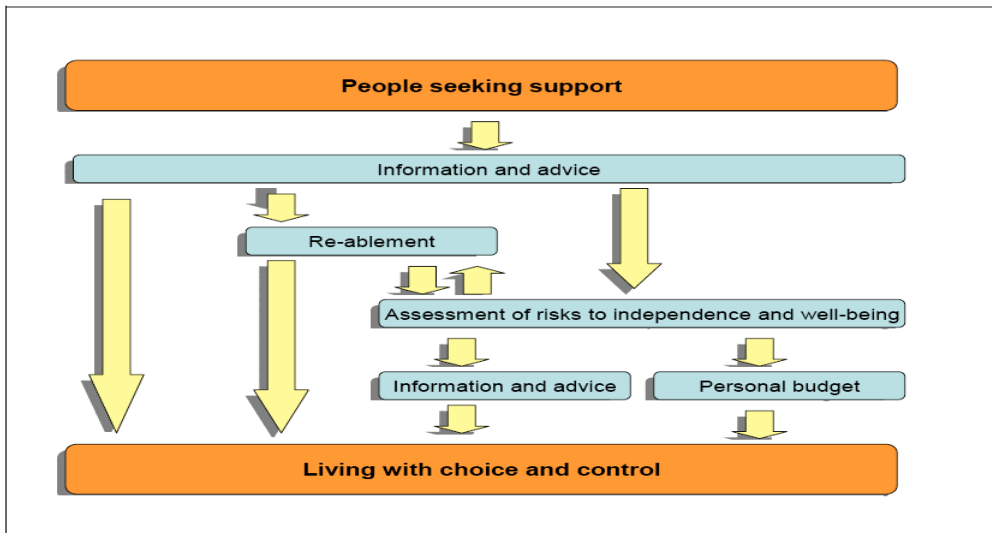
Outlined below are the most relevant and recent legislation, policy and best practice guidance as applicable to sensory loss services. The list is not exhaustive but does provide a picture of how policy and legislation has evolved and how complex this area is.

National Policy - General

- Department of Health *A Vision for Adult Social Care: Capable Communities and Active Citizens* (November 2010) sets out the new Coalition Government's vision for adult social care. There is continuity with the previous government's personalisation and "Putting People First" agenda. However, there is a stronger emphasis on shifting *power from the state to people and communities*. The Vision sets out 7 principles based on: prevention, personalisation, (including information, advice and advocacy), partnership, plurality, protection, productivity, and people
- Alongside the Vision the government also published a new Partnership Agreement *Think local, Act Personal: Next Steps for Transforming Adult Social Care* (November 2010), which was developed together with a wide range of partners in the adult social care sector, which reinforces personalisation as the core direction of travel, and which sets out what the government terms *concrete steps to transform social care*
- Department of Health, *Guidance on Eligibility Criteria for Adult Social Care, England (2010) - Best Practice guidance*. The aim of the revised guidance is to support fairness, transparency and consistency of application and to reflect the increased focus on personalisation and prevention as set out in *Putting People First*. This guidance supersedes *Fair Access to Care Services: guidance on eligibility criteria for adult social care, 2003*
- Department of Health, (2010) LAC (93)10: *Approvals and directions for arrangements from 1 April 1993 made under schedule 8 to the National Health Service Act 1977 and Sections 21 and 29 of the National Assistance Act 1948* - Social services authorities are required to provide "facilities for social rehabilitation and adjustment to disability." They are also required to provide "such advice and support as may be needed for people in their own homes or elsewhere". This has been deemed to include counselling
- Department of Health, *Local Authority Circular (DH) (2009) 1: Transforming Social Care* - This Local Authority Circular sets out information to support

councils and their partners in the ongoing transformation of adult social care as set out in Putting People First (2007), and preceding policy documents

- Department of Health (2008) Good Practice in Support, Planning and Brokerage. It is part of the Putting People First Personalisation Toolkit and gives a number of models developed by Local Authorities
- Department of Health (2007), *Putting People First: a shared vision and commitment to the transformation of Adult Social Care*, HMG, - Sets out a shared ambition for radical reform of public services, promoting personalised support through the ability to exercise choice and control against a backdrop of strong and supportive local communities. To broaden their focus beyond those with the highest needs, councils should ensure that the application of eligibility criteria is firmly situated within this wider context of personalisation, including a strong emphasis on prevention, early intervention and support for carers. The Putting People First' (PPF) concordat was published by the Department of Health (DH) in December 2007. It set out information to support the transformation of social care, as outlined in the Health White Paper, 'Our Health, Our Care, Our Say: a New Direction for Community Services' in 2006. It describes the vision for development of a personalised approach to the delivery of adult social care. Putting People First is underpinned by four key themes:
 1. Access to universal services such as transport, leisure and education as well as information, advice and advocacy – planning for these to consider the implications for disabled and older people
 2. Prevention and early intervention – helping people early enough or in the right way, so that they stay healthy and recover quickly from illness
 3. Choice and control – people who need support can design it themselves, understanding quickly how much money is available for this, and having a choice about how they receive support and who manages it
 4. Social capital – making sure that everyone has the opportunity to be part of a community and experience the friendships and care that can come from families and friends

Fig. 3-1: Putting People First approach

Guidance on Eligibility Criteria for Adult Social Care, England, DH, Feb. 2010

- *Prime Minister's Strategy Unit, (2005) Improving the Life Chances for Disabled People* - This report states that by 2025: "disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society"
- *Department of Health (2005) The National Service Framework for Long Term Conditions*, Department of Health - It promotes autonomy and independence for individuals by advocating a person-centred approach, improving access to services, providing specialist support and ensuring that families and carers needs are also considered
- *Disability Rights Commission (2005) Duty to Promote Disability Equality: Statutory Code of Practice* - This document provides a code of practice based on the Disability Discrimination Act 1995. "Public authorities can make an enormous contribution towards removing the barriers (both environmental and attitudinal) to equal opportunities for disabled people. They can do this by addressing the way in which they run their own services and employ people, and also by exerting their considerable influence in the community at large"
- *Department of Health (2003) Direct Payments Guidance: Community Care, Services for Carers and Children's Services (Direct Payments) Guidance* - The aim of this statutory (compulsory) guidance is to help local councils in making direct payments. It also provides guidance on how local councils might manage and administer direct payments
- *Disability Discrimination Act (1995)* -The key requirements of the Disability Discrimination Act (1995) are that service providers are required to take reasonable steps to change practices, policies or procedures which make it impossible or unreasonably difficult for disabled people to use a service; to provide auxiliary aids or services which would enable disabled people to

use a service; and to overcome physical barriers by providing a service by a reasonable alternative method

- Department of Health (1948) *Section 29(1) of the National Assistance Act 1948 and Section 2 of the Chronically Sick and Disabled Persons Act 1970 ("the 1970 Act")*. - Local Authorities functions relating to social services provision for disabled adults are set out in these provisions - Local Authorities may, and in certain circumstances must, make arrangements for promoting the welfare "of persons aged 18 or over who are blind, deaf or dumb

National Policy - Visual Impairment Specific

- Department of Health (2009) *Improving community based eye health services* - This is a guide to support Primary care Trusts in commissioning primary eye health services
- *ADASS & RNIB, (2008) Good practice in sight*. How excellent services for blind and partially sighted adults can boost the overall performance of local authorities. ADASS and RNIB joint publication which shows local authorities how a holistic, person-centred approach to the delivery of services that focuses on a defined number of key outcomes for blind and partially sighted people can help them reach their performance targets. Significantly, the guide is also an integral part of the UK Vision Strategy
- *RNIB, (2008) UK Vision Strategy 2020*: The UK Vision Strategy was formed from a desire to reduce all avoidable blindness by the year 2020 and to produce a unified framework for action on all issues relating to vision
- *Department of Health (2007) Step-by-Step Guide to Commissioning Community Eye Care Services NHS Primary Care Contracting* - The purpose of this guide is to provide information and practical tools for Primary Care Trusts and Practice Based Commissioners as they commission enhanced primary eye care services. This guide offers a practical, analytical, 'how to' approach to some of the key issues in commissioning high quality community eye care services locally
- Department of Health (2004) *First Report of the National Eye Care Services Steering Group, Best Practice Guidance – Pathways* - The group was set up by Ministers in December 2002 to develop proposals for the modernisation of NHS eye-care services, maintaining and developing an integrated, patient-centred service, and improving access, choice, waiting times and quality for all sectors of the community. As its first priority the Steering Group established subgroups to develop model care pathways for cataract, glaucoma, low vision and Age Related Macular Degeneration. The group aimed to deliver proposals consistent with and to support the Vision 2020 programme
- Association of Directors of Social Services (ADSS), 2002: *Progress in sight: National standards of social care for visually impaired adults* Although many

local authorities and social services departments implemented Progress in Sight, it no longer reflects the current performance framework

National Policy - Hearing Impairment Specific

- *RNID (2008) NHS hearing aid services commissioning* - You will find these guidelines useful if you are a PCT commissioner. They provide you with up-to-date information about hearing aid services in order to support effective commissioning
- Department of Health (2007) *Good Practice in Transforming Adult Hearing Services for Patients with Hearing Difficulty (Please note that this document has now been removed from 18 week pathway site pending review by new government)*. The Audiology Framework sets out the aspiration to transform patient experience of audiology services, with a series of actions that the NHS will take to help make this happen. It sets out how health reform levers can be brought to bear to improve quality
- Department of Health (2007) *Improving Access to Audiology Services in England*. The Audiology Framework sets out the aspiration to transform patient experience of audiology services, with a series of actions that the NHS will take to help make this happen. It sets out how health reform levers can be brought to bear to improve quality, efficiency and access to audiology services
- Department of Health (2005): *Mental Health and Deafness - Towards Equity and Access: Best Practice Guidance* - Provides advice on ways to promote mental health and improve services for people who are deaf
- Association of Directors of Social Services in conjunction with the British Deaf Association, Local Government Association and RNID Best Practice Standards – *Social Services for Deaf and Hard of Hearing People* (1999)
- *Department of Health 1999, Stepping away from the Edge: Improving Services for Deaf and Hard of Hearing people* -This booklet is a practical tool for social services departments aiming to provide the best possible services for people who are deaf, deafened or hard of hearing. It offers practical guidance and examples of positive practice in services for adults who are hearing impaired

National Policy - Dual Sensory Loss

- Department of Health, Section 7 Guidance; “Social Care for Deafblind Children and Adults” LAC 2001(8). - The Statutory Guidance on Social Care for Deafblind Children and Adults is issued under Section 7 of the Local Authority Social Services Act 1970. This guidance is now being republished under cover of LAC(DH)(2009)
- Department of Health LAC(DH)(2009)6, *Social care for Deafblind Children*

and Adults- This guidance should be read, and given effect to, in the context of Local Authority Circular (DH) (2009) which sets out information to support councils and their partners in the ongoing transformation of adult social care as set out in *Putting People First*

- Department of Health (1997) *Think Dual Sensory – Good Practice Guidelines for Older People with Dual Sensory Loss* This document sets out good practice guidelines for social and health care services when dealing with deaf blindness in the elderly. It looks at the need for better provision in care and strategies for setting up new services. This report also examines the development of existing sensory services
- Sense (undated) *Deafblind Guidance: a practical guide*, Sense website - It covers issues relating to identification of deafblind people; information provision including all types of communication; assessment; service development and in particular one to one support; and finally deafblind training

3.2 National Prevalence

Visual Impairment Specific

- Demographic forecasts show that by 2021, 40 per cent of the population will be over 50; a significant proportion of sight loss is related to age and one in eight over-75s and one in three over-90s have serious sight loss.⁵ Diabetes, and hence diabetic retinopathy among children and young adults is also increasing and this too will prove a challenge to service providers
- There is a significant proportion of the older population in the UK that have undetected partial sight and blindness. For example, Evans and Rowlands (2004) estimated that between 20 per cent and 50 per cent of older people have undetected reduced vision, with the majority of this group having correctable visual problems, such as refractive error and cataracts.⁶ Also, due to the greater risks of developing certain eye conditions, and the additional barriers to eye care services faced by minority ethnic groups, it is expected that prevalence of undetected eye conditions is greater in this population⁷
- Some black and ethnic minority communities have a higher incidence of eye disease than a comparable population of white Europeans - for example African Caribbean people are four times more likely to have glaucoma while conditions like diabetic retinopathy are more prevalent in the Asian community

⁵ Evans J R et al. Prevalence of visual impairment in people aged 75 years and older in Britain. *British Journal of Ophthalmology* 2002

⁶ Minnasian, D. et al. p. 146

⁷ Minnasian, p.160

The following estimates were obtained from a report prepared for the RNIB that informed the UK Vision Strategy 2010⁸

- In the UK it is estimated that by 2010, 132,970 people will be partially sighted and 90,254 people will be blind. This is assuming that the new treatment for NV Age Related Macular Degeneration (AMD) covers 75 per cent of those eligible from 2010. By 2020, the numbers of people expected to be partially sighted are 171,530, and 120,452 people are expected to be blind. This is under the same assumption that 75 per cent of people with NV AMD will be treated, but it also allows for an increase in the older population
 - For 2010, the estimated prevalence of partial sight due to cataract for the UK will be 206,224 and blindness to be 27,907. In 2020, should this condition remain visually impairing at this level in the population, it is estimated that 248,504 people will be partially sighted, and 32,750 will be blind
 - In the UK 57,646 people in 2010 will be partially sighted from glaucoma and 17,511 will be blind, assuming that the level of detection of this disease in the population is at 50 per cent
 - In the UK 40,982 people in 2010 will be partially sighted from diabetic retinopathy and 24,976 will be blind. In 2020, 46,473 people are expected to be partially sighted and an additional 29,957 to be blind
 - 71,806 people are expected to be partially sighted by 2020, and 22,261 to be blind under the same assumption about detection
- High levels of sensory impairment are common in people with learning disabilities. An institutional survey of vision (McCulloch et al, 1996)⁹ showed that 12% of mildly disabled people, more than 40% of severely disabled and 100% of profoundly disabled people had poor visual acuity. The prevalence of ocular health problems ranged from 25% in the mildly disabled group to 60% in the profoundly disabled group. A study of severely disabled children and adolescents in another residential institution reflected this high prevalence (Kwok et al, 1996). Here 25% had severe visual impairment and 24% refractive errors
 - Amongst adults, the prevalence of visual impairment increases with the severity of the learning disability and with age. A literature review by the Valuing People Support Team found people with learning disabilities to be between 8.5 and 200 times more likely to have a visual impairment compared

⁸ Minassian, D. et al. *Future sight loss in the decade 2010 to 2020: an epidemiological and economic model*, *EpiVision 2009*

⁹ Kerr, M, Improving the general health of people with learning disabilities, *Advances in Psychiatric Treatment* (2004) 10: 200-206

to the general population. In March 2006, the Down Syndrome Medical Interest Group reported a high incidence of ocular disorder among people with Down's syndrome:

- Refractive errors and/or squint often present from an early age
- Cataract and/or glaucoma occurring in infancy
- Nystagmus present in at least 10% of the DS population
- Keratoconus more common in adolescents and young adults

Hearing Impairment Specific

- It is estimated that there are 8.9 million people in the United Kingdom who have some degree of hearing loss. Of these around 5.9 million are thought to be sufficiently deaf or hard of hearing to be considered disabled in terms of the Act. The great majority are older people, who have age related hearing loss. As more people live longer, there will be more deaf people in the population. About 673,000 of these people are thought to be severely or profoundly deaf. 42,000 people are too deaf to use the telephone
- It is difficult to obtain reliable information about deaf people. It has been shown that registers of deaf people are inevitably inaccurate and that there is usually a tendency to underestimate the numbers
- According to LINK 150,000 UK residents live with the effects of acquired total deafness. Around 70,000 people grow up with deafness. These are the percentages of those over the age of 50 and over the age of 70 who have various degrees of hearing loss in the UK¹⁰
 - 71.1% of over 70-year-olds will have some kind of hearing loss
 - 26.7% of over 70-year-olds will have mild hearing loss
 - 36.8% of over 70-year-olds will have moderate hearing loss
 - 6.3% of over 70-year-olds will have severe hearing loss
 - 1.3% of over 70-year-olds will have profound hearing loss
 - 41.7% of over 50-year-olds will have some kind of hearing loss
 - 21.6% of over 50-year-olds will have mild hearing loss
 - 16.8% of over 50-year-olds will have moderate hearing loss
 - 2.7% of over 50-year-olds will have severe hearing loss
 - 0.6% of over 50-year-olds will have profound hearing loss.
- High levels of sensory impairment are common in people with learning

¹⁰ http://www.nid.org.uk/information_resources/aboutdeafness/statistics/

disabilities. Evenhuis et al (1997) identified hearing loss in 25 - 42% of community samples of people with learning disabilities¹¹

Dual Sensory Loss

- Many Deafblind people are not known to their local social services authority. Of those who are in contact with social services, not all are identified as having dual sensory impairment nor are they in receipt of appropriate services. This applies to both adults and children¹²
- The Department of Health estimated the number of deafblind people at 40 per 100,000 of the population¹³ SENSE estimates that this is likely to be an underestimate, suggesting that there may be 10 times that number. They suggest that 4.6% of over 75s, or almost 1 in 20, are sufficiently sensory impaired to be considered deafblind. This is approximately 186,000 people in England, Wales and Northern Ireland
- SENSE state that many local authorities who have made serious efforts to identify deafblind people in their area have certainly identified over three times the 40 per 100,000 figure. The Office of National Statistics published the following charts based on registration figures¹⁴

Fig. 3-2a Percentage of people registered as blind who are deaf or hard of hearing & Fig. 3-2b Percentage of people registered as partially sighted who are deaf or hard of hearing

Fig.3-2a

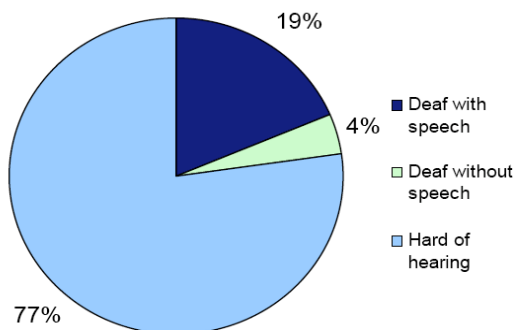
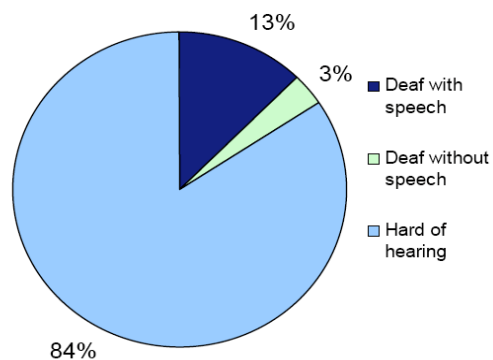


Fig. 3-2b



Source : IC triennial return SSDA902

¹¹ Kerr, M, *Improving the general health of people with learning disabilities*, Advances in Psychiatric Treatment (2004) 10: 200-206

¹² Local Authority Circular LAC(DH)(2009)6, *Social Care For Deafblind Children and Adults*

¹³ Local Authority Circular LAC(2001) 8, *Social Care for Deafblind Children and Adults*

¹⁴ Information Centre, *People Registered Deaf or Hard of Hearing Year ending 31 march 2007, in England*

- In their most recent report 'A Sense of Urgency'¹⁵, SENSE states there is a significant underestimate of the numbers of deafblind people referring to an 'explosion' in the numbers over the next 30 years and the need for improvement in the way people are identified by health and social care agencies. Based on its research it now estimates there are 572 people per 100,000 of the population who are deafblind with the number rising to 806 by 2030. 78% of those are over 60 years of age
- Many people do not define themselves either as Deafblind or having dual sensory loss. They may use such phrases as 'I don't see too well or hear too well'. However, they do describe their vision and hearing loss in terms, which indicate that they have significant difficulties in their day-to-day functioning and may need support to live independently

¹⁵ SENSE. A Sense of Urgency. 2010

4. Local Context

4.1 Local Policy

There are a number of local policies and strategies, which could have an impact on Sensory Services, most notably:

- The *National Service Framework* is the driver for ensuring service improvement and implementing strategy with developments via Local Implementation Teams. Most have a link with voluntary and community sector organizations but there is no sensory loss representation
- NHS South West requires self assessment and performance frameworks to be undertaken by all Primary Care Trusts on:
 - Mental Health
 - Long Term Conditions
 - Learning Disability
- The *Strategic Ambitions Framework for NHS South West* - no specific performance framework for sensory services
- The *Somerset Sustainable Community Strategy* looks further ahead to 2025. It focuses on long term sustainability of Somerset and plans for future generations and how Somerset will fulfil its potential to become one of the south west's most vibrant counties for people who live, work and visit
- The *Local Area Agreement* is a three year, countywide agreement by central Government, the local authorities, Government Office South West (GOSW) and Local Strategic Partnerships. The agreement identifies priorities for action to improve the most important issues in Somerset
- *Position Statement for joint commissioning for NHS Somerset and Somerset County Council* - There is joint planning and commissioning in progress by NHS Somerset and Somerset County Council that includes the needs of people with sensory loss. The recommendations of the Joint Strategic Needs Assessment included:
 - Improving access to public transport particularly for isolated and vulnerable groups (NI 175)
 - Improve mental health through provision of a community based service for less severe mental illness and roll out mental health promotion strategy

- Improve health assessments for those with learning disabilities through hearing, vision and targeted screening tests
- Develop the Active Learning Network (NI 137)

4.2 Local Prevalence

Visual Impairment

Based on Good Practice in Sight¹⁶, there are 19,266 people in Somerset with sight loss. The following information has also been extracted from Somerset's own client database (SWIFT) showing the number of people with a sensory loss from BME groups who have received an assessment:

- People with a visual impairment 22
- People with a hearing impairment 5

In order to gain more robust information and a clearer understanding of the needs of people with a sensory loss amongst BME communities attempts have been made to contact people from those communities. Unfortunately, despite considerable effort the amount of information forthcoming has not helped to provide a full picture.

Hearing Impairment

Based on RNID¹⁷ prevalence rates, there are approximately 77,142 people in Somerset with a hearing loss. The estimated number of people in Somerset from BME groups is 23,320 of which 3,331 also have a hearing impairment. Somerset County Council's own client database (SWIFT) shows the number of people with a sensory loss from BME groups who have received an assessment as five people with a hearing impairment.

Dual Sensory Loss

Based on original Department of Health estimates, there should be approximately 216 people in Somerset with a dual sensory loss. NB: There are already 483 registered people with a dual sensory loss. (figure taken from the S.C.C. register of people with disabilities, dual sensory loss specific) This figure supports later research undertaken by SENSE, as referred to above, that where Local Authorities had made a serious attempt to identify people with a dual sensory loss, those numbers could be multiplied 3 times.

¹⁶ Good Practice in Sight. RNIB 2008

¹⁷ Facts & figures on deafness & tinnitus. RNID information. 2006.

Deaf

According to RNID prevalence rates in Somerset there should be over 500 Deaf people who consider themselves to be culturally Deaf, most of whom use BSL. The number registered in Somerset is over 1,000 but that includes people who are not culturally Deaf i.e. those who have acquired severe hearing loss during adulthood. There are, therefore, no accurate statistics relating to either category.

The following information has been provided by the Mental Health Social Worker for people who are Deaf or have sensory loss for the Somerset Partnership Trust. The Trust currently supports the mental health needs of a significant number of people over the age of 65 with a sensory loss and in many instances those who would be deafblind or have a dual sensory loss. Numbers are not currently accessible due to the configuration of recording systems and inconsistent recording of such information in core assessments.

The Mental Health Foundation and Signhealth in their Executive briefing¹⁸ argue that mental illness amongst the Deaf population could be as much as 40%. Based on these statistics that could amount to 226 people experiencing a mental health condition in the Deaf community in Somerset at some point. If people over the age of 17 were included that figure would increase to 242.

Between October 2007 and June 2009 there were 91 referrals to the specialist social worker with their sources as follows:

- GP/Primary Care: 1
- Internal referral, inpatient units: 9
- Internal referral, community services: 72
- Local Authority: 9

The number of open referrals to the service between September 2009 and September 2010 was 32.

4.3 Previous Reports

There are a number of existing local reports that help to form the background of this Review and whose findings contribute to it. The following paragraphs are a resume of the main issues from those reports.

Best Value Review (2002/3) - It is recognised that this review is now quite dated but reference to it has been included as the outstanding issues are felt by Somerset County Council and NHS Somerset to be pertinent.

¹⁸ <http://www.signhealth.org.uk/index.php> page ID 66

As a result of this review, there have been several service developments, including:

- Improvement of response times to referral
- Development of improved sensory loss information for service users
- Development of courses supporting people newly diagnosed with sight and hearing loss
- Development of electronic sensory loss registers and sensory loss IT processes on SWIFT
- Development of County Lead role
- Development of dual sensory loss social worker role and expansion of service for people with dual sensory loss
- Sensory loss issues raised across County Council and with providers
- Annual consultations with service users

However, there are some outstanding areas of work from the Best Value review:

- Failure to fully address issues of consistency of sensory loss service throughout the county;
- Roles and career structure for sensory loss workers still need to be clarified;
- Strategic links with Health need to be made more robust;
- Sensory loss awareness in County Council and in partner agencies needs to be improved, despite input that has already been given
- Mechanisms for more comprehensive consultation need to be put into place

Mobility in Transition (2009) - A review of services for young people with visual impairment in transition to adulthood. The project team included representatives from specialist sensory services, children's services, Connexions and Education. The report suggests the significant gap in provision appears to be related to an absence of children's social care services for sensory needs. The impact of these issues is considerable in terms of independence, community participation and demand on services in later lives for most visually impaired young people.

Summary of issues:

- The provision of mobility and orientation provision for young adults with sight loss
- A lack of agreed policy for 16 to 18 year olds requiring mobility and orientation provision

- Lack of life skills training in conjunction with mobility and orientation training
- Lack of appropriate level of knowledge and awareness in post 16 college providers
- Lack of home linked training for young people attending out of county schools
- Absence of trained sighted guides within existing post 16 provision and community settings
- Lack of accredited and accessible training for all levels of specialist and support workers, including volunteers
- Lack of an identified route from special education to adult services for mobility and orientation training

Although co operative working means that the needs of some children are met, the above issues are largely still outstanding.

Somerset Access and Inclusion Network (SAIN) 2007/8 – A series of consultation reports, which identified a number of issues. These included:

- Difficulty of contacting specialist social workers
- Access to buildings
- Access to information and equipment including trialling and renting
- Travel passes
- Understanding registration and the SCC client database
- Social workers communication skills (BSL) are not good enough
- Access to digital hearing aids
- Delays in social work visits
- Removal of client details from database after 3 years
- Difficulty of access to Somerset Direct
- Unclear equipment policy
- Need for improved sensory loss awareness in the community

The above issues remain outstanding although there are some improvements e.g. delays in social work visits and access to digital hearing aids.

4.4 Cross Cutting Themes

In the past Somerset, like many other local authorities, has had commissioning strategies around individual client groups, e.g. older people. The intention now is to integrate client groups into an overarching strategy working with health commissioners. A strong emphasis is being placed on re-ablement to help people remain as independent as possible but this is still very much at strategic level.

Under the banner of Personalisation, the Personalisation and Portfolio Board is looking at “You First”. Within that programme there is the intention to develop social capital and partners. To deliver choice and control, social capital and effective partnership working, solutions have to be found to a decreasing resource situation. Service re-design, therefore, has led to four work streams:

- Delivering independence
- Transforming community services
- Active lives
- Learning disability futures

Because sensory loss cuts across all other client groups, it fits within each of those work streams. The crosscutting themes within this scenario are as follows:

- Extra care housing
- Assistive technology
- Home improvement agency
- Double-handling
- New initiatives with the NHS
- Equipment
- Care home planning
- You First – a programme of transformational change in health and social care

5. Description of Current Services

5.1 Introduction

The purpose of this Section is to describe current service provision in Somerset across statutory and voluntary agencies including those which are formally commissioned. It begins with a brief overview of current expenditure on specialist services provided directly by Adult Social Care Services (ASC) and those commissioned from the voluntary sector. Some comparisons are made with other Local Authorities in the South West. It then briefly describes the ASC specialist workforce and management and training arrangements.

The way in which the main components of a complete service are provided are explained under the following headings. Many of these components overlap with one another and under “screening and assessment” there are details about links with other services which also provide for people with a sensory loss:

- Prevention and early intervention
- Equality of access, information, advice and advocacy
- Screening and assessment, care management/resource allocation
- Service provision – equipment, rehabilitation, registration and commissioned services

Many of the service components are common to the various types of sensory loss, but where there are specific differences these are highlighted under the client groups of visual impairment, Deaf and hearing impairment and dual sensory loss throughout the report.

5.2 Current spend by Adult Social Care and benchmarking

The table below, Fig. 5-1 sets out the current spend in Somerset for sensory impairment services.

Fig. 5-1: Current spend on specialist services for sensory impairment

Somerset Adult Social Care (ASC) direct provision	Spend £
Sensory specialists, not including salary costs for Lead Sensory Policy role. (See Section 5.4 for detail)	556,000
Services Commissioned by Somerset ASC (see 5.8 for description of services)	Total contract value
Somerset Sight – range of services	113,000
Somerset Sight equipment	10,700
deafPLUS – mobile advisory service and communication support groups	66,000
Action for Blind People - Guide communicator service	5,000
Medequip - Equipment	62,000
RNID - Interpreter services	26,000
Compass Disability - Annual service user consultation	7,500
TOTAL SPEND ON SENSORY SERVICES	846,200

Somerset stands slightly above average within the South West for its spend on salaries for sensory specialists (£556,000), with neighbouring authorities varying between about £400,000 and £700,000. This information has not been verified but has been provided by people in management or similar posts to the Somerset County lead position.

Somerset is not unusual in investing the highest proportion of its spend on Sensory Services on salaries for sensory specialists and in terms of the ratio of specialists to the over 65 population it rates as about `average` when compared with other authorities in the South West. The following table¹⁹ should be used for indicative purposes only:

- Wiltshire 1:11,250
- Cornwall 1: 8,500
- Somerset 1: 7,400
- Devon 1: 6,600
- Plymouth 1: 6,000

¹⁹ Cornwall "sensory loss services review. Mim Bingham. January 2010. Also information provided directly from other local authorities

5.3 ASC Workforce: Sensory Specialists

5.3.1 Sensory Specialists

Although sensory specialists have a range of titles and areas of expertise, the processes they follow are the same as their non specialist colleagues in locally based ASC teams. Additionally though, they complete a sensory loss assessment as part of the Single Assessment Process (SAP). They also complete registrations and the exact role they fulfil can vary according to circumstances and the degree to which an assessment and/or care plan requires specialist involvement. The role of individual specialists also varies according to job role/title. Rehabilitation workers for visually impaired people concentrate largely on the provision of specific skills training e.g. independent living, communication and mobility. Social workers are responsible for the more complex cases whilst adult social care workers (ASCW) pick up a range of assessment and provision with the exception of complex work.

The roles can be differentiated as follows:

Social Workers

- Assessment
- Equipment provision
- Arrangement of specialist services
- Care management of people with complex needs
- Provision of advice and information on specialist needs and services

Adult Social Care Workers

- Assessment
- Equipment provision
- Arrangement of specialist services
- Provision of advice and information on specialist needs and services

One of a number of issues raised by the Best Value Review, which has not been fully resolved, is the issue of consistency or uniformity of services across Somerset. By locating sensory specialists in local/community ASC teams they are spread across the county in a reasonably uniform pattern but their profile inevitably varies within ASC, children's services, NHS and in the community generally due to their diverse roles. The likelihood is, therefore, that most people will be unaware of a sensory specialist in their locality particularly as referrals are directed through Somerset Direct and referral/care pathways are not prominent.

The tables below provide further information about the sensory specialist posts.

Fig. 5-2: ASC Sensory Specialists Posts in Somerset

AREA	TOWN	S.W. (VI) POSTS & HOURS	ASCW (VI) POSTS & HOURS	S.W. (HI) POSTS & HOURS	ASCW (HI) POSTS & HOURS	DUAL ROLE POSTS & HOURS
Taunton	Taunton	1 x 30	1 x 25 2 x 7.5	1 x 20	1 x 35	
South Somerset	Yeovil	1 x 35 1 x 15	2 x 30	1 x 25	1 x 30 1 x 7	
Sedgemoor/ South Somerset	Minehead & Bridgwater	1 x 37			1 x 18.5	1 x 21 2 x 37 1 x 30
Mendip	Glastonbury					1 x 22 1 x 37
	Frome					1 x 37 1 x 32

Fig. 5-3: Qualified Social Workers

POSTS & HOURS	AREA OF SPECIALISM
1 x 17	VI
1 x 37	DUAL
1 x 30	VI
1 x 22	HI
1 x 18.5	DUAL
1 x 35	VI
1 X 37	DUAL

Fig. 5-4: Rehabilitation Specialists Countywide

POSTS & HOURS	AREA OF SPECIALISM
1 x 37	VI
1 x 18.5	DSI

TOTAL NUMBER OF SENSORY (PRACTITIONER) HOURS = 568

TOTAL NUMBER OF QUALIFIED HOURS = 196.5 (34%)

N.B. The countywide specialist posts (2) referred to above are not assigned to area establishments. Their salaries are part of the sensory budget. The budget for the Sensory County Lead post is excluded because it is now part of commissioning.

5.3.2 Management and Supervision Arrangements

Sensory specialists are based in local Adult Social Care (ASC) teams in the 5 areas of Somerset and undertake predominately work with adults. They are managed by local team managers and form part of their establishment. Their supervision is sourced mainly from non-specialist supervisors with little or no experience of sensory loss. Although they are recognised as specialists, some workers are required to respond to other priority non-sensory social care work at times. This issue is discussed later in the report. Following the BVR, it was anticipated that qualified sensory specialists would receive additional professional development support from specialist senior posts. This move has not been achieved.

5.3.3 County Sensory Lead

Although sensory specialists are locally managed within ASC teams, they are also supported and developed by the county sensory lead post which is a full time position. The post is also responsible for service direction/development including policies but it has no management or executive function.

The Best Value Review made a number of recommendations in relation to the role of the county sensory lead, the management of sensory specialists and the roles they perform. It was specifically recommended that the countywide focus on sensory loss be strengthened in order to raise the profile of sensory work, to provide greater coherence and direction and to better ensure the development of services. It was anticipated that this would lead to improved morale and motivation amongst sensory specialists.

To strengthen the focus of sensory work, the BVR proposed that the main functions of the role would be:

- To coordinate service plans with the PCT lead once identified
- To coordinate service provision throughout the County
- To ensure consistency of practice
- To represent the sensory loss service at senior management level
- To spearhead new developments in policy and practice
- To act as a link with national agencies and policy making bodies

Changes to the local management structure for sensory loss services were also proposed, as follows:

- The creation of a senior social work (sensory loss) role in each area

- The senior social worker will supervise a mini team of sensory loss workers and be directly line managed by a team manager in each area but receive professional supervision from the county sensory lead

The BVR also proposed that the post would meet regularly with the 4 senior social workers and with all sensory specialists. The “dual role” of some workers would be phased out and role of sensory specialists clarified.

The changes to the role of the county lead post have taken place, but changes to the line management and supervision of sensory specialists have not. The county lead does convene regular specialists meetings, has been responsible for the development of policy and some training opportunities for sensory specialists. More strategic developments, particularly in relation to joint working arrangements with health, have been less successful.

5.3.4 Training

The need for ongoing specialist training is referred to in the BVR and sensory specialists have raised it as an issue. The appointment of a county sensory lead has contributed to resolving this issue as follows:

Resource material

- Induction Manual for new workers
- A-Z of specialist services and resources on Intranet
- Library of text books relating to sensory loss in each area office
- Provision of specialist magazines
 - “New Beacon”
 - Macular Disease Society magazine
 - “One in Seven”
 - “BDN News”

Training held on regular basis

- British Sign Language training – mandatory for all staff working with Deaf service users. Staff attend accredited courses in local colleges. Training is funded by SCC
- VI Awareness training for all ASC staff including sensory staff, (twice yearly)
- Deaf Awareness training for all ASC Staff, including sensory staff, (twice yearly)

- Presentation by Consultant Ophthalmic Surgeon on eye conditions and treatments (once every 12-18 months)
- Presentation by Audiologist on ear problems and treatments (once every 12-18 months)
- Equipment demonstrations (once or twice a year)
- Aspects of rehabilitation work with visually-impaired people (once a year)
- British Sign Language Refresher Training (once a year)

Training via County Meetings

Sensory Loss County Meetings are held regularly. The aims of the meetings are:

- To provide updates on policies, procedures and practice
- To provide information on services and resources (usually via external speaker)
- To provide a forum for discussion and exploration of practice issues
- To facilitate “cross-fertilisation” of ideas and sharing of good practice
- To provide peer support

One-off training events

One-off training events are held throughout the year. In the last three years, training has included:

- SW Peninsula Sensory Conferences (variety of national experts on aspects of sensory loss research)
- Dual Sensory Loss training – causes, problems, services, communication methods, provided by RNIB Bristol on several occasions
- Low Vision – utilising residual vision, magnifiers and high-tech equipment etc, provided by Optima Low Vision Services
- Electrical Safety Training
- Equality and Diversity

5.4 Prevention and early intervention

The term `Prevention` means very different things to different people including professionals. Prevention is not a specified part of the role of sensory specialists but, from the information provided by them, it is evident they see themselves as having a significant part to play and the functions they fulfil are within a wider definition of the term.

In summary, sensory specialists prevent situations, or the effect of sensory conditions, worsening. This is achieved by the timely provision of information, advice and advocacy, assessment, equipment, emotional support and rehabilitation. Assessments also take into consideration the health, recreational and financial needs of individual people. Such interventions reduce the risks to people, the likelihood of people losing their independence and/or getting into crisis including mental health difficulties.

5.5 Equality of Access, Information, Advice, Advocacy

Specialists respond to requests for simple service provision, including advice, information and equipment provision although Somerset Direct is able to reduce the volume of demand through their own screening processes. Unfortunately no figures are available but most referrals are received via Somerset Direct, screened and logged on to SWIFT, being the client database. A small number are taken locally and all visual impairment referrals from ophthalmic consultants i.e. certifications, are sent direct to a central point for reasons of expedience. These certifications are also logged as referrals.

5.6 Screening and Assessment, Care Management and Resource Allocation

Referrals originate from a wide range of sources including social care colleagues, service users and their families. The majority of referrals emanate from health sources including GPs, hospital consultants, audiology, ophthalmology, etc. The total number of referrals received by sensory specialists between August 2009 and August 2010 was 1101.

5.6.1 Sensory Referrals – August 2009 – August 2010

Contacts and referrals to ASC are initially screened through Somerset Direct which is the single point of contact for ASC (more details are given in the

glossary). Contacts and referrals for sensory loss clients from 01 August 2009 - 01 August 2010 are set out in the chart below.

Fig. 5-5: Contacts and Referrals for Sensory Loss Clients (Aug 09-Aug 10)

Contact reason	Contact outcome	All Client Contacts	Clients Progressing to Referral
Deaf/Hard of Hearing	Advice and Information	23	
Deaf/Hard of Hearing	Not Recorded	7	
Deaf/Hard of Hearing	Progress to Referral	532	532
Deaf/Hard of Hearing	Requires Assessment	148	148
Dual Sensory Loss	Advice and Information	2	
Dual Sensory Loss	Progress to Referral	31	31
Dual Sensory Loss	Requires Assessment	33	33
Visual Impairment Non Registration	Advice and Information	16	
Visual Impairment Non Registration	Not Recorded	8	
Visual Impairment Non Registration	Progress to Referral	225	225
Visual Impairment Non Registration	Requires Assessment	115	115
Visual Impairment Registration	Progress to Referral	15	15
Visual Impairment Registration	Requires Assessment	2	2
	Total	1157	1101

Sensory services provide for people of all ages and include those with other conditions, e.g. mental health, learning disability and physical disability. Some service users have multiple long-term conditions but most are older people. Sensory specialists work closely with their ASC colleagues who can arrange generic services e.g. home care so service users not only receive an holistic assessment but service provision reflects this.

In addition to ASC generic processes and procedures, sensory specialists operate to specialist policies although these are now deemed to be out of date.

Sensory specialists also undertake more complex work requiring allocation for further assessment of need and care planning. Guidance states that comprehensive assessment should be reserved for “the minority of users with the most complex needs”. It is anticipated that most people with difficulties associated with sensory loss would meet this criteria, as follows:

- Registrations for people with severe sight impairment and sight impairment
- Visual impairment assessments indicating complex need

- Deaf assessments to include Deaf, deafened and hard of hearing people where complex need is indicated
- Dual sensory loss assessments

Sensory specialists are required to assess for eligibility using criteria drawn up under the headings of “dependency” and “risk”. Where an individual fulfils the eligibility criteria, including carers, an assessment is required to be offered. Whether assessment forms are completed by a sensory specialist will depend on circumstances but where a person has a significant sensory loss it is expected that assessment covers a range of issues including emotional reaction, mobility, communication, education, employment, rehabilitation, housing and carers needs. In some instances the skills and knowledge of other specialist workers might be needed, e.g. mental health. Sensory specialists are expected to make such referrals as necessary and are not expected to “hold” cases where sensory loss is not the primary issue. Under such circumstances, specialists contribute to assessment and care planning. However, practice can vary from locality to locality.

Although the primary role of sensory specialists is to assess and provide services, their role is also to provide up to date advice and information. They also refer people on to a range of commissioned and non-commissioned services, e.g., low vision clinics, communication skills groups and lip reading classes. Sensory specialists also spend time improving the awareness of the needs of people with a sensory loss and raising the profile of sensory loss services. This involves input to training courses on occasions and advice to social care colleagues and other professionals.

Once eligibility is established under resource allocation i.e. Fair Access to Care Services (FACS), and assessment completed, specialists may provide a range of services including equipment and guide communicator services for people with a dual sensory loss. Some of the services provided may be commissioned, particularly those which can be “called off” from a contract, whilst others might be provided by workers themselves through direct work/teaching, e.g. daily living skills/mobility. Equipment is provided from commissioned services covering all areas of specialism. There are occasions when sensory specialists are required to demonstrate and assist people in appropriate and safe usage of such equipment. This particularly applies if a person has a dual sensory loss and/or is undertaking a potentially hazardous activity, e.g. cutting food or pouring hot liquids.

All referrals from ophthalmic consultants for registration result in a home visit for assessment.

5.6.2 Links with Children' services

Sensory specialists do undertake a small amount of children's work but from consultation, this appears to constitute no more than 2% of their work on average and there is some potential for conflicting priorities particularly as work is undertaken without any formal commission. This suggests a rather ad hoc approach to children's work with no real measure of how priorities are determined. Evidence from special education suggests there may be considerable need amongst children with a sensory loss and their families and a significant role for sensory specialists. This is not evidenced from the volume of children's work undertaken by sensory specialists. All referrals to sensory specialists are responded to but many result in the need for the provision of information and equipment only. Funding for equipment has to be applied for via children's teams on an individual basis and is not always successful. Consequently, children's equipment is often purchased from adult budgets.

The undertaking of children's work is not formalised as part of a service level agreement so it is not possible to accurately gauge the volume of work done. As an acknowledgement of the shortfalls in service provision for children with a sensory loss, an informal working party recently produced a paper identifying need, shortfalls including processes and a range of issues that constitute a uniform view that children are not well served. The working party consisted of staff from Education, ASC and Children's Services.

Protocol arrangements between sensory services and Education can be see at Appendix 2.

Whilst a protocol for transition from children's to adult services exists, with the exception of individual sensory specialists who occasionally attend reviews, the process relies upon a Transition Personal Adviser post whose responsibility is to signpost to relevant services. However, attendance at reviews is dependent upon timely information about dates and venues, which is sporadic. Children with a sensory loss are not, therefore, represented at all reviews.

5.6.3 Links with Mental Health Services

Similarly, the mental health specialist social worker does not attend transition reviews for D/deaf children receiving a service from Children and Mental Health Services (CAMHS) due to difficulties in establishing links with Deaf Children's Mental Health Services based in Taunton. This could lead to a range of possible problems long term as once service users are discharged or transitioned from CAMHS there will not be the same level of on going support from ASC locally. The mental health specialist social worker can support sensory specialists with link working and will carry out joint assessments to help ascertain if a referral to mental health services is needed. Liaison also takes place in relation to the equipment needs of individual people as responsibility lies within ASC.

5.6.4 Links with Learning disability services

In some cases, Sensory specialists co-work with a key worker from an ASC team or other area of specialism, e.g. Learning Disability. The project team had hoped to provide statistical information relating to the number of people in Somerset known to have both a learning disability and sensory loss. Unfortunately, due to the timing of this review and pressures on county council departments, it has not been possible to obtain this information. Nevertheless, it is significant as the prevalence rates in Section 3.2 show, and although it is not possible to be conclusive, the evidence from research suggests a need for sensory expertise within learning disability services.

The above paragraphs (3) referring to ways in which sensory specialists link to other services, although not comprehensive, do explain why their role can become very diverse. This is not unusual in the UK but is one reason why the role of specialists is not always clear. This issue is addressed later in the report.

5.7 Service Provision - Equipment, Rehabilitation, Registration

5.7.1 Services Commissioned by ASC

The costs of specialist services commissioned from the voluntary sector are detailed in Section 5.1. These details show that most categories of people with a sensory loss are provided for to some degree by commissioned services.

RNID Contract

A “call off” contract providing a range of communication support services for people with a hearing loss but its use is predominantly by Deaf people whose first language is British Sign Language. Interpreters are employed for a range of everyday situations enabling users to maintain independence. The contract can also be used for speech to text provision, note takers or lip speakers for people whose first language is English but the demand is very small.

Somerset Sight

A local independent Charity providing a wide range of support services to people with a sight loss, some of which are commissioned from ASC as described above. Services include: advice and information, advocacy, recruitment of volunteers for the voluntary visiting service and eye clinic liaison officers, resource centre, equipment provision, support groups, rehabilitation inc `Living with sight loss` courses joint funded by Somerset Sight and ASC, Talking Books, Wireless for the Blind, training and transcription. A new mobile resource centre has recently been acquired which will visit more rural areas on a regular basis. A successful application to the Big Lottery will now fund running costs.

deafPLUS

Locally based, national organisation providing rehabilitation services, including communication skills groups, advice, information and support. The organisation also provides for people in rural areas through its mobile resource unit.

The majority of people who use the mobile resource unit require help with their hearing aids (cleaning and re tubing) indicating that the unit is easier to access than local audiology clinics. An informal arrangement exists between the mobile unit and audiology services whereby simple materials e.g. tubing for hearing aids, is supplied. Although the majority of users of this service require attention to hearing aids, the service itself is commissioned by Somerset County Council.

Communication Skills Classes run by deafPLUS are spread across Somerset and provide for a range of needs over and above communication but transport is not included. The groups themselves are led by an experienced teacher who is able to support individuals and partners through group activities. The activities are aimed at helping people to better manage their lives after the onset of hearing loss. This includes advice and information, emotional support, the learning of communication skills and tactics to help people cope better.

Action for Blind People

Action for Blind People is a “call off” contract for the provision of guide communicator support for individual people, experiencing dual sensory loss. The contract provides support for 12 people but the provider is withdrawing at the end of the current arrangement. The current spend on guide communicator services exceeds the contract value.

Medequip

Medequip is an independent provider, supplying equipment to people with a sensory loss in their own homes upon receipt of a requisition from sensory specialists. The provider does not have specific expertise in this specialist field but they do install equipment e.g. loop systems for T.V. listening, which requires technical knowledge. They also provide specific pieces of lighting equipment for visually impaired people.

Compass Disability (SAIN)

An independent, user led and disabled peoples` organisation that runs a network of individual disabled people and organisations in Somerset through its project Somerset Access and Inclusion Network. The project has been commissioned to undertake user consultation on an annual basis with people experiencing sensory loss.

5.8 Services Commissioned and Provided by Health

Health Services provision for people with eye and hearing care needs is extensive and quite complicated so it is not the intention to go into great detail but to provide an overview only of how and what services are provided. The complexities of provision are due, in part, to commissioning arrangements, some of which cross county boundaries. For example, some eye care services provided through ophthalmology in Yeovil District Hospital are commissioned by the Dorset PCT. Similarly, some audiology clinics in Dorset are run from Yeovil Hospital. Also, people living in parts of North Somerset receive services from Bath and Bristol. Where a person is treated depends on a number of factors including patient choice, their condition, facilities available and where their GP is situated.

Services cater for people of all ages and particularly with regard to eye care there are not only clinics in various parts of the county but some of these are specific to certain conditions, e.g., age related macular degeneration, glaucoma, diabetic retinopathy, etc.

It is regrettable that more specific information about services, e.g., numbers of patients and costs, is not readily available. Some figures relating to the numbers of patients have been forthcoming and they run into many thousands but it should be noted that the majority of people who are referred for eye and hearing care have minor difficulties only.

5.8.1 Services for People with Visual Impairment

Musgrove Park Hospital in Taunton sees 30 – 40,000 people per year at Eye Clinics. (This figure was supplied directly by the Ophthalmology Department). For information and comparison purposes, in Hull²⁰ for example, approximately 60,000 appointments are made for people coping with sight loss. Because population sizes are different between Hull and Somerset and areas covered by acute hospitals tend to be very large, true comparisons are hard to make. The above mentioned statistics therefore, are referred to, only because they give an indication of the scale of visual problems in all parts of the UK.

Most patients with any form of sight difficulty are referred via GPs or opticians/optometrists to general eye clinics run by ophthalmology units in general hospitals or to low vision clinics (LVCs). In Somerset, the main clinics are based within Musgrove Park Hospital and Yeovil District Hospital but they each run local clinics in a number of different locations including:

- Chard
- Burnham on Sea

²⁰ “Low vision and patient support”, June Crosby, Hull Infirmary. New Beacon 2010.

- Minehead
- Bridgwater

A full list of clinics has been requested but has not been forthcoming. Most of clinics operate weekly and are attended by ophthalmic consultants as well as nursing and other relevant personnel. Clinics cater for the treatment of a wide range of eye conditions as well as assessment and diagnosis. For certain specific conditions and assessment e.g. photographs of the eye, patients have to travel to the main hospitals, as the smaller clinics do not have the full range of (expensive) equipment needed. A large percentage of referrals received related to diabetes but clinics also screen people with a learning disability for eye conditions given the higher incidence within that sector of the community.

Eye care services also cover schools screening and orthoptics, which assess and treat squints, double vision and other specific eye conditions.

When asked how they know the extent of patient satisfaction with eye care services, the ophthalmology department of Musgrove Park Hospital were unable to offer any evidence of how patients feel about their services. However, they did say that they are able to satisfy the 18-week target from referral to treatment. The sister in charge is aware that patients are given little or no information after diagnosis or treatment and said that services are not “joined up”. She said “we don’t know much about what goes on in the community”. However, a volunteer from Somerset Sight does attend some clinics to offer information, support and guidance to patients.

Low vision is described ²¹ as “impairment of visual function where full remediation is not possible by conventional spectacles, contact lenses or medical intervention and which causes restriction in that person’s everyday life”. There are 8 low vision clinics in Somerset which are commissioned by the PCT and provided by an independent company, namely OPTIMA. The clinics provide assessment of a patients residual vision together with background information, the provision of low vision aids (magnifiers) and therapy including assistive technology solutions where needed. Very few clinics are attended by sensory specialists.

Low vision clinics are held at:

- Musgrove Park Hospital
- Somerset Sight
- Bridgwater Community Hospital
- Chard and District Hospital
- David Millican Opticians, Wells
- David Hart Partners, Yeovil

²¹ M. Cole. Consultant Ophthalmologist, Torbay. Draft Nuffield proposals 2010 (unpublished).

- Crammers Opticians, Minehead
- Burnham Hospital

The cost of commissioning low vision services from OPTIMA currently are based on a fixed price per patient which includes professional fees, administrative costs and the provision of low vision equipment e.g. magnifiers.

Annual cost of Low Vision Services: £52,000

5.8.2 Services for People who are Deaf or Hearing Impaired

Musgrove Park Hospital operates about 32,000 appointments per year in its audiology clinics (figures supplied by head of audiology). Most referrals to the Ear, Nose and Throat (ENT) department and/or audiology clinics are via GPs. The latter are able to refer patients directly to audiology where there is no medical condition to be investigated. Audiology itself involves the measurement of what a person hears and seeks technical solutions rather than medical.

Like ophthalmology, audiology clinics are based around the big general hospitals, namely Musgrove Park in Taunton and Yeovil District Hospital. There are regular, local clinics across Somerset including:

- Bridgwater
- Burnham
- Minehead
- Chard
- Wincanton
- Crewkerne

The frequency of these clinics varies according to need, availability of facilities and other reasons, e.g. audiology staff. These clinics are for the benefit of people who require assessment, for those who already have hearing aids and need further attention including repairs, for those who require fitting of new aids and for patients who need re-assessment.

Musgrove Park audiology department has one full time hearing therapist and Yeovil has provision for one day a week. The role of the hearing therapist is to assist people to adjust to more severe forms of hearing loss including those who are traumatically deafened. A great deal of time is also spent in helping people's emotional adjustment to hearing loss through counselling including the effects on family members. Support and training to people suffering from tinnitus and Menieres Disease also feature prominently in the role of the therapist.

Musgrove Park audiology services also includes a paediatric audiologist who works closely with members of the Hearing Support Team (education).

Sensory specialists do not feature greatly within the work of audiology and where social care assessment is considered necessary, patients are directed to Somerset Direct. This arrangement is not seen as seamless by audiology, who feel a closer working relationship with sensory specialists would benefit patients although they do acknowledge that onward referrals do sometimes work well.

Where patients require further information, support or equipment, audiology staff do not feel they have anywhere suitable to signpost people.

The audiology departments have no real measurement for patient satisfaction other than individual comments from patients but the 18 week target from referral to treatment is currently being satisfied across Somerset whereby all patients are treated within 18 weeks whether referred direct from their GP or via ENT.

Services for People with a Dual Sensory Loss

There are no specific healthcare services for people with a dual sensory loss. Consultation suggests there is some awareness by individual practitioners of the additional difficulties experienced by people with a dual loss and, in some cases, extra time is allowed for appointments. However there is no shared or agreed protocol with ASC to identify people and to ensure they receive appropriate assessment and support for their condition.

Given the potential threat to a person's independence it is very important that dual sensory loss is recognised amongst older people especially and they have regular access to hearing and sight tests in addition to specialist assessment as per Department of Health Guidelines²²

People with dual sensory loss are 4 times more likely to have a stroke which has a greater disability impact than any other chronic disease. Supporting people with a dual loss to have a healthy lifestyle with relatively low cost services e.g. guide communication, could make substantial savings.²³

5.9 Voluntary Services that are self- funding or part self-funding

Somerset has a range of independent/voluntary organisations, some of which are service providers commissioned by Somerset County Council to provide specific services. Like most other parts of the UK, the bias of organisations is in favour of

²² DoH Section 7 Guidance. Social Care for Deafblind Children and Adults LAC 2001(8)

²³ SENSE. A Sense of Urgency. 2010

people with a visual impairment and some of the independent organisations provide for people on an individual basis only e.g. St. Dunstons, based in Brighton supports ex services personnel who have been blinded. It has not been possible therefore to quantify or place a value on services provided by non commissioned organisations.

The following offers a snapshot of the organisations in Somerset with references to some of the services commissioned.

5.9.1 Visual Impairment

Somerset Sight - Living with sight loss` courses joint funded by Somerset Sight and ASC.

Ability Net – Regional service providing training for visually impaired people in the use of computers.

Action for Blind People/RNIB – Regional services including support with employment, benefits, housing, rehabilitation, holidays, recreation and help line.

Guide Dogs Association – Regional services, based in Bristol.

National Blind Children’s Society – Supports visually impaired children and their families with a range of services.

SeeAbility – Residential home in Wellington for young adults with a visual impairment.

Retinitis Pigmentosa Society – Local group offering mutual support and fund raising activities.

Macular Disease Support Group – Local support groups in Taunton and Wells.

5.9.2 Hearing Impairment

Taunton and Bridgwater Deaf Club – Social/cultural centre for Deaf people.

Yeovil Deaf Club – Social/cultural centre for Deaf people.

RNID – Communication support to D/deaf people including BSL, lip speaking and note taking.

Taunton Hard of Hearing Club – Social support group for people who are hard of hearing/deafened.

deafPLUS - Locally based, national organisation providing rehabilitation services, including communication skills groups, advice, information and support

5.9.3 Dual Sensory Loss

SENSE - National body with network of local branches providing advice, information and support to individuals and families.

Deaf blind UK – National organisation aimed at helping individuals to overcome isolation, living independently and live active lives.

Action for Blind People/RNIB – Guide communicator service.

5.10 Other Support Organisations

Library Services – Talking books, provision of a range of titles on tape and CD which can be requested and borrowed free of charge. Libraries also provide enlarging options on public computer terminals. “Supernova” software can also be activated on these terminals, providing magnification and text to voice facilities to assist people to use online services.

Employment – Connexions, careers services for younger people. Disability Employment Advisers, help for disabled people seeking employment.

It should also be noted that given the high numbers of older people in particular who have a sensory loss, there are many non specialist community organisations providing information, support and advocacy to those people e.g. Age UK, CAB, SOCA, A4e etc. A4E, for example is able to provide informed advocacy for people with a visual impairment in particular and claims to have supported many individuals in successfully appealing against decisions made in response to applications for certain benefits.

SCC Adult Learning – Lip reading classes across Somerset allowing students to gain accreditation. Information also provided.

5.11 Commissioning and engagement mechanisms for people with people with sensory impairments

Representation & Governance

In order to ensure that services to people with a sensory loss are implemented according to the needs and wishes of people with a sensory loss, it is anticipated

that governance arrangements are established to ensure wider representation and a stronger voice for service users.

Current arrangements in Somerset

People with a sensory loss in Somerset do have the opportunity for representation on occasions, but that representation rarely extends to governance, with this review being an exception to the rule.

Services commissioned from voluntary organisations by SCC can be influenced by service users but there are no consistent or structured arrangements for their involvement in governance and commissioning arrangements. Service users are represented on the low vision committee for example which advises the PCT on commissioning for low vision services but their role is restricted to representation.

Compass Disability, an independent user led and disabled people's organisation, runs a network of individual disabled people and organisations in Somerset through one of its projects, Somerset Access and Inclusion Network. That project has been commissioned to undertake user consultation on a bi annual basis with people experiencing sensory loss. Reports have been considered as part of this review but the contents are not intended for governance purposes. It should also be noted that people with sensory loss who may be in receipt of services, e.g. learning disability, mental health, long term conditions, are not represented in governance arrangements for those services.

Governance: Guiding Principles

The following are offered as guiding principles in relation to governance:

- There should be a structured approach to decision making so that people with a sensory loss are involved in decisions about their individual circumstances and the wider development of sensory services
- The involvement of people with a sensory loss requires assurances that communication support with documents in appropriate formats will ensure full participation
- People with a sensory loss should be in the majority in any body which holds statutory agencies to account for the delivery of sensory services
- Links to governance arrangements are needed for services providing for other client groups where there is a high incidence of sensory loss
- Partnership boards should ensure that people with a sensory loss are represented on all relevant decision making forums

Low Vision Services Committee (LVSC)

Low Vision Services Committees have been established in many parts of the UK and are in response to the recommendations of the UK Vision Strategy.²⁴

The aim of the LVSC is to improve low vision services in Somerset for adults and children by working in partnership with health and social care agencies, the voluntary sector and service users.

Its objectives are:

- To consult with service users about their needs
- To identify gaps in provision
- To use the national standards as set out in Low Vision Services Consensus Report 1999 as a benchmark
- To raise awareness of need and represent that need to the appropriate authorities
- To coordinate expertise and knowledge and act as a consultative forum to relevant professional individuals and bodies
- To advocate for improved service provision
- To monitor, evaluate existing services and plan future services
- To ensure that services respond to and reflect national guidance and priorities

Its guiding principles are:

- Services should be available to all, regardless of impairment or condition, age, gender, sexuality, ethnic origin, financial circumstances and geographical location
- Services should support independence
- Service planners should be committed to the social model of disability
- Service users should be involved in all aspects of planning and provision
- Service users rights to choice and control should be respected
- Services should promote social inclusion, not exclusion and be easily accessible and well publicised
- Services should be accountable

Details of work carried out to date on care pathways can be seen at Appendix 3.

²⁴ UK Vision Strategy 20/20. RNIB 2008.

Compass Disability

Through its user network “arm”, namely Somerset, Access and Inclusion Network, Compass Disability provide an annual service user consultation. See S5.7.1 above.

6. Consultation

This Section sets out the initial (Phase 1) appraisal of Sensory Services based on consultation meetings with a range of service users, staff and managers from NHS Somerset and Somerset County Council Adult and Children's Services and representatives from the voluntary sector.

6.1 Methodology

In order to carry out this appraisal, the project team have used legislation, guidelines and best practice elsewhere identified through the parallel research project to identify relevant themes and subject areas to structure consultation. The material has been used in different ways, according to people consulted, in order to achieve compatible results. Additionally, the context of "Putting People First" has influenced the way in which questions have been asked.

The themes used to construct questions included:

- Prevalence
- Promoting social inclusion
- Prevention and early intervention
- Universal information, advice and advocacy
- Assessment and diagnosis
- Resource allocation and service provision
- Commissioning and market development
- Workforce

These themes were intended to provide a structure and not to restrict members of the project team in their approach to consulting service users and stakeholders. The intention was also to avoid any restriction placed upon people consulted. Initially, people attending stakeholder meetings were asked for their views on what services work well and which work less well. They were then asked to consider ways in which services could be better delivered within the current context.

Contact has been established with people directly affected by sensory loss in a number of ways. The project team has tried to reach as many people as possible to advise them of the Review and to seek their views. Additionally, a questionnaire has been used to elicit additional information. (See Section 6.6 below).

Working with the Communications and Marketing manager of the Community Directorate of Somerset County Council, a press release was issued, over 3,000 flyers were distributed as part of Phase 1 consultation and many hundred more were sent out electronically. The same details were also included in relevant local publications. The information explained what the Review is hoping to achieve. It also provided details of how to express views, dates and venues of public meetings to openly discuss the remit of the Review.

The following groups of service users have been consulted as part of this Review at consultation events, one to one interviews, by telephone, letter, email and small group meetings:

- People who are Deaf
- People who are Hearing Impaired
- People who are Visually Impaired
- People with a Dual Sensory Loss
- People with a Sensory Loss whose needs are met by non specialist staff
- Carers, including parents, of people with a Sensory Loss
- Carers who themselves have a Sensory Loss

In total, the project team has consulted directly with over 115 service users in Phase 1 of this review (excluding the questionnaire).

The following professionals and organisations were also represented at consultation events or interviewed individually:

- Managers of Voluntary Organisations
- Sensory Specialists
- Somerset County Council Managers
- Somerset Partnership Trust
- Voluntary Organisations, Volunteers and Staff
- Community Matrons
- Senior Citizens Groups
- Deaf Church
- Somerset Community Health
- Learning Disability Services
- Parents Organisations

In total, the project team has consulted directly with over 70 stakeholders in Phase 1.

For a full breakdown of venues, dates and the number of people who attended consultation meetings, see Appendix 4.

For details of all individuals/small groups interviewed, see Appendix 5.

The following is a summary of the key points arising from each of the service user groups consulted. The figures in brackets represent the number of people who either expressed a particular view or supported it.

6.2 Consultation with People who are Visually Impaired

6.2.1 Equality of Access, Information, Advice and Advocacy - Key Points

- Transport services, especially buses, do not always meet needs
- Sight loss isolates people
- Services are not consistent across the County

Whilst some professionals, including those in specialist eye care services, receive praise, there are widespread concerns about the lack of awareness of sensory loss. This finding is consistent with the strategy set out within the document UK Vision Strategy²⁵ which sets the challenge to local professionals and organisations to improve inclusion, participation and independence for people with a sight loss.

Transport is also cited as a barrier to easeful mobility and independent living in terms of the number of bus routes but more particularly the fundamental access to information required. For example, whether the bus stopping is the one required or knowing which is the right stop to get off. One visually impaired man referred to much better bus services elsewhere, e.g. Bournemouth, where auditory descriptions are available at bus stops.

A woman, with age related macular degeneration, who lives in a residential home due to her sight loss, wrote to the Project team. She praises her Somerset Sight volunteer who regularly visits her but she feels very cut off from her home area and her social life even though it is only a few miles away. She wrote:

²⁵ UK Vision Strategy 20/20. RNIB 2008

“Living in a rural area is lovely, but is very isolating, and despite various investigations to seek reliable transport solutions, I am left having to decline social interaction for lack of means to get to venues. For anyone living outside the County Town this is a problem “

6.2.2 Service Provision – Equipment, Rehabilitation Registration and Commissioned Services - Key Points

- Clinical provision from Eye Clinics, Optometrists and Low Vision Clinics receive few criticisms
- Breaking bad news is not always sensitively dealt with
- The number of registered sight impaired people in Somerset is consistent with similar authorities
- Registration process is meaningful as there are benefits
- Public and professional awareness is poor and causes distress including to carers
- Greater potential to develop support services exists within Somerset Sight
- Rehabilitation services whether in service users home or as a group, are well received

Based on the scale and value of social care services commissioned, people with a visual impairment are better served than people with a hearing loss. This may account for relatively little negative feedback about actual service provision both from health care, ASC and the voluntary sector.

Clinical provision including ophthalmology and low vision receive quite a lot of praise. Responses to questionnaires sent to people attending low vision clinics show high levels of satisfaction with 90% of people (118) stating that their needs were met. Typical comments were: *“Very satisfied and very pleased with the service I was given”* and *“I was very satisfied and impressed with her knowledge and care”*. No such attempts have been made towards customer feedback from other eye care services in Yeovil or Taunton but some service users are unhappy at the way bad news was broken to them from ophthalmology services (2). They said they were left in limbo. It was also suggested (2) that consultants are reluctant to talk about the condition or give information/diagnosis due to the fear of dealing with emotions. Somerset Sight has contact with many visually impaired people and their Director and Deputy stated that they are aware of cases where newly diagnosed people have had no support/intervention after the

breaking of bad news. *“The way people get a service/information is often ad-hoc”*. One visually impaired person explained her feelings of isolation upon diagnosis. She felt unsupported and was given no help. She emphasised that *“it is a loss”*.

Registration is undertaken by sensory specialists most of whom are unqualified in rehabilitation work but have undertaken some relevant training. Only one post for the county is designated exclusively for rehabilitation work as compared to Devon which has 15 and Cornwall which has 4. The RNIB recommends one post per 45,000 people in the population generally. Based on that ratio, therefore, rehabilitation provision in Somerset appears inadequate but it has to be emphasised that other sensory specialists are undertaking rehabilitation work. Somerset Sight and ASC jointly commission rehabilitation courses but these cover a relatively small number of people only (approximately 25 per year). They appear to be well received but the only way to gauge their effectiveness is by user feedback. One lady with a severe loss of sight stated that *“it’s the best way to get support/rehabilitation”*. A young person with a dual sensory loss said *“most visually impaired people need a rehabilitation worker, not a social worker”*. Another younger visually impaired person said *“the crucial point is the interface between diagnosis and support thereafter”*. These views were clearly echoed amongst other people consulted and are consistent with the professional views of sensory specialists within Adult Social Care and Health Care Services.

Successive reports, e.g. Progress in Sight²⁶, refer specifically to the need for rehabilitation services for people at appropriate times after the diagnosis or significant change in sight loss. In Somerset, adjustment to loss of sight is achieved in a number of ways amongst the, approximately 1,150, new registrations per year. The provision of rehabilitation services, however, is not restricted to persons registered.

6.3 Consultation with Deaf People

6.3.1 Equality of access/information, advice and advocacy - Key Points

- Access to information/services can be very difficult because of a range of barriers inc. telephones, signage and language used
- Poor public awareness of deafness means that Deaf people often feel marginalised. For example, assumptions are made that Deaf people can lip read and are fully literate
- Lack of awareness amongst professionals including specialists. Deaf

²⁶ Progress in Sight. Service standards. ADSS. 2002

people maintain that their needs are not understood

- Access to social workers for support, information and advocacy. Some Deaf people feel they need easy access to support inc. advocacy with everyday matters and naturally turn to people who are able to communicate in their language
- Poor levels of BSL amongst social workers. Specialist workers can use BSL but their skills are not at a high enough level
- Communication support to facilitate access to public services are inconsistently funded. Deaf people find themselves in positions where they need communication support but agencies refuse to fund interpreting
- Lack of clarity of who provides communication support
- Access to equipment requires social work involvement. They see equipment as a normal part of their cultural existence
- The general view of the Deaf Community is that they are not a `disabled group` trying to adjust. Their wish is that they be enabled to live independent lives within the culture of their choice
- Children's services are difficult to access as service providers are not set up to accommodate parents who are Deaf
- Specialist mental health services are not available locally

The key points identified from consultation are similar to those previously recorded as part of the BVR and subsequent consultation exercises run by SAIN in 2007 and 2008.

Of overriding significance and importance to virtually all Deaf people consulted is access to appropriate forms of communication support in order that they might have easy and equal access to everyday services and information including health care and education. It is not within the remit of this Review to identify the various forms of communication support preferred by different people, but the strong emphasis from Deaf people themselves is for the provision of suitably qualified BSL interpreters.

There are many misconceptions about Deaf people and Deafness itself. One of these is that Deaf people generally have a command of the English language within the normal range. There tends also to be an assumption that all deaf people can lip read and that with a little adjustment communication can be quite satisfactory. *"GPs are not aware of the need to provide interpreters and there is a lot of confusion about who pays"*. This was a view supported by virtually all Deaf people consulted (31), not only in relation to health care but in many other

situations as well. In the case of most people who are deafened, small adjustments are adequate but for Deaf people who consider themselves to be culturally deaf their first and preferred language is BSL, since they find the written and spoken word to be foreign. Their choice is to use BSL particularly in situations where crucial decisions have to be made. *“There is a need for more awareness of interpreters, how to book them and who pays for them in different situations”*. Whilst it appears from consultation that some deaf people do receive satisfactory communication support on occasions, this statement is generally supported.

Traditionally, many Deaf people have relied upon specialist social workers for communication support. With moves towards communication support becoming more readily available as a separate and distinct service, that reliance has reduced considerably. Based on consultation, there appears to be limited evidence of the need for specialist social work support within the Deaf community but that is not to suggest some Deaf people do not need support. Opinions do vary, with some criticism being levelled at the skill level of most specialist social workers, but the extent to which social work support was said to be needed is quite limited. One man stated that *“deaf people need a social worker, only because they have the budget”*. He continued by saying that *“we need the money for interpreters and equipment, I would love to get it myself but I have to go to social services”*. There is insufficient evidence to corroborate that view, but where examples were given of where social work support is needed, it appears to be appropriate, e.g. parenting or children’s issues. Examples were also given of Deaf parents having to access support via an ASC sensory specialist with limited BSL skills and knowledge of children’s issues/services. There is some general agreement amongst users and ASC sensory specialists that children and families where deafness is a significant issue are not well served.

6.4 Consultation with People who are Hearing Impaired

6.4.1 Equality of Access/Information, Advice & Advocacy - Key Points

- Many hearing impaired people dislike making phone calls
- The biggest barrier to everyday living is the lack of public awareness
- People access information about services and equipment in varying ways

Of people consulted, the majority (50+) stated that information is their single most important need. That information is acquired in a number of ways including audiology, sensory specialists and Somerset Direct. The biggest single source of information declared, post audiology involvement, is via deafPLUS (20+).

Most hearing impaired people are assessed by and receive services from non-specialist staff both from health and ASC. Their main concern is the poor level of awareness of hearing loss amongst staff generally and barriers to easeful access. Most staff are non specialist and, therefore, these comments are aimed at the majority of them. Criticisms range from a complete lack of awareness of what deafness means, to an individual, for example, not gaining attention before speaking, to assumptions about lip reading and the significance of hearing aids.

This issue was well demonstrated by a case example of a woman who contacted the Project team to advise of her mother's experience in hospital when her hearing aids were lost. The daughter stated that her mother's final weeks before she died were very difficult and painful for the family. She hoped that by conveying her mother's experience of the lack of concern shown by medical staff that other people could be saved from the same distress. The case example is summarised at Appendix 6.

Consultation showed the same concern about the lack of sensory awareness across, particularly health, services from all sensory groups including carers.

Another significant barrier to social inclusion for people with a hearing loss is the lack of loop systems in public places. A general view is that loop systems in the community often don't work because staff do not know how to use them (25+).

6.4.2 Screening and Assessment, Care Management/Resource Allocation - Key Points

- Links between Audiology and sensory specialists are ad-hoc and lack structure
- Audiology signpost people via Somerset Direct, but with limited conviction as there is little feedback on outcomes

Referral statistics to sensory specialists do not tell us how many originated from audiology but the number of people who refer themselves from audiology is small. In a 10 month period, April 2009 to January 2010, hearing impaired referrals to sensory specialists were 612. During that same period approximately 27,000 appointments were completed by audiologists from Musgrove Park Hospital within the hospital itself and at clinics across a large part of the county.

Accurate statistics are not available so the number who require further assessment would need to be researched more thoroughly.

6.4.3 Service Provision – Equipment, Rehabilitation, Registration and Commissioned Services - *Key points*

- Hearing therapy does not cover the whole county and there is only 1 post in Taunton and 1 day per week in Yeovil. The service itself appears to be valued but numbers consulted were very low
- Although people with a hearing impairment believe they have rehabilitation needs, there is inconsistency as to who receives rehabilitation support and how that comes about
- Skills learning and social support via communication groups (deafPLUS) is well appreciated
- Registration has little meaning
- No commissioned services for Deaf service users with mental health problems e.g. time and recovery workers, community support workers and day care.
- Such services are available to hearing people but without the necessary additional skills or resources to accommodate Deaf people.

Audiology Services based in Taunton, Yeovil and Bath and their respective outreach clinics are generally the subject of few criticisms about their clinical effectiveness as the general view appears to be that *“they try hard to make life easier for people suffering hearing loss”*. However, they are not immune from other comments such as *“ENT – I cannot hear my name called out. Why don’t they use some technology for this?”* Again, the level of awareness of what deafness means attracts the greatest number of comments.

Whilst Audiology services earn praise, many people expressed concern at the lack of ongoing support and information. *“The availability of information, especially for people newly diagnosed is essential”*. (15+). At a meeting with audiology staff in Taunton (4), it was stated that clients are given Somerset Direct telephone number for self-referral where additional needs are identified but it was felt that the support is not seamless. *“No pathways have been established”*. The hearing therapist in Taunton gave an example of a man with dual sensory loss and additional severe orientation problems who needed a lot of training support/rehabilitation. The hearing therapist maintains that lack of a clear pathway to community based services and not having a relationship with sensory

specialists, not only delayed the help needed but the sense of understanding between complimentary services was missing.

People consulted referred to communication groups making a real difference both in terms of improving communication skills and confidence through social contact with others. Such provision constitutes rehabilitation as it covers many practical aspects, communication tactics and emotional response. The service also supports other family members and carers.

Registration as hearing impaired with ASC appears to be little known about and there are a number of misconceptions. The number of people registered currently is clearly not representative.

6.5 Consultation with People who have Dual Sensory Loss

The project team acknowledges that the scale of consultation to date involving people with a dual sensory loss, is too small to draw any firm conclusions. In relation to the overall number of people consulted, people with a dual sensory loss have been relatively well represented. At one consultation meeting, for example, 3 people attended who experience loss of hearing and sight. However, the sample of people overall with a dual sensory loss is small and further consultation was carried out as part of the Phase 2 work. Meanwhile:

6.5.1 Prevention - Key Points

- No cross Agency understanding/agreement exists to identify people with a dual sensory loss
- Audiology and Ophthalmology do not record data relating to unmet need

6.5.2 Equality of Access/Information, Advice and Advocacy - Key Points

- No cross agency understanding/agreement exists to identify people with a dual sensory loss
- Audiology and Ophthalmology services are mindful of the needs of people with a dual sensory loss but there are no policies to allow more time for such patients

6.5.3 Screening and Assessment, Care Management/Resource Allocation - Key points

- Referral for an ASC assessment is relatively hit and miss

People interviewed (3) with a dual sensory loss commented that referral to Adult Social Care for specialist assessment is hit and miss. Other people (3) who attended a consultation meeting had not received a specialist assessment and were aware of its existence. One lady who is a carer for her husband who has a dual sensory loss referred very positively to the support she receives from someone who calls regularly to check on how they are getting on. Unfortunately, it was not possible to establish who that person is but at the meeting of carers, all (9) agreed that someone who calls to check how things are going is really valuable.

6.5.4 Service Provision – Equipment, Rehabilitation, Registration and Commissioned Services - Key Points

- A higher than average number of people have been registered in Somerset. Indications from consultation are that many more people exist who are unknown and have not received an assessment

Somerset has a higher than anticipated number of registrations, which appears to contradict the apparent lack of awareness of services available. What it almost certainly demonstrates is that the number of people with a dual sensory loss is substantially higher than predicted as stated by SENSE in response to the Department of Health prevalence rates in the guidelines.

Somerset has a contract with Action for Blind People for the provision of guide communication services, which stems from the Department of Health guidelines. Currently, 13 people are in receipt of this service, of which 3 receive direct payments or individual budgets. At the time of writing, Action for Blind People was unable to offer any quantitative or qualitative information about the guide communication services due to staff sickness.

6.6 Questionnaire Feedback

Although the project team is very conscious of the difficulties faced by many people with a sensory loss in accessing written communications, it was felt that a questionnaire might still usefully inform this review as to peoples' experiences of services and sensory loss itself. However, Deaf people were excluded as the Project Management Group took the view that direct contact through the Deaf Club, using much the same material as the questionnaire, would be more effective and avoid the difficulties associated with questions presented in written form.

Approximately 300 questionnaires were distributed including to people from BME communities who appear on the SCC client database. A total of 98 responses were received.

The questionnaire itself can be seen at Appendix 7.

Responses have been analysed and presented in quantitative (questions 1 and 3) and qualitative (questions 2, 4 and 5) formats as follows:

Fig. 6-1: Q1 Satisfaction with services

	Total	Very satisfied	Fairly satisfied	Neither	Fairly dissatisfied	Very dissatisfied
Information provided by Health services	85	18 21.2%	39 45.9%	12 14.1%	11 12.9%	5 5.9%
Services provided by Health e.g. audiology or eye clinics	92	49 53.3%	35 38.0%	1 1.1%	5 5.4%	2 2.2%
Information provided by Social Services	80	34 42.5%	20 25.0%	13 16.3%	7 8.8%	6 7.5%
Services provided by Social Services	79	34 43.0%	19 24.1%	14 17.7%	7 8.9%	5 6.3%
Support from Voluntary agencies	74	26 35.1%	22 29.7%	17 23.0%	5 6.8%	4 5.4%
Understanding of your religious/cultural needs	62	8 12.9%	15 24.2%	36 58.1%	1 1.6%	2 3.2%

Fig. 6-2: Q1 Satisfaction with services

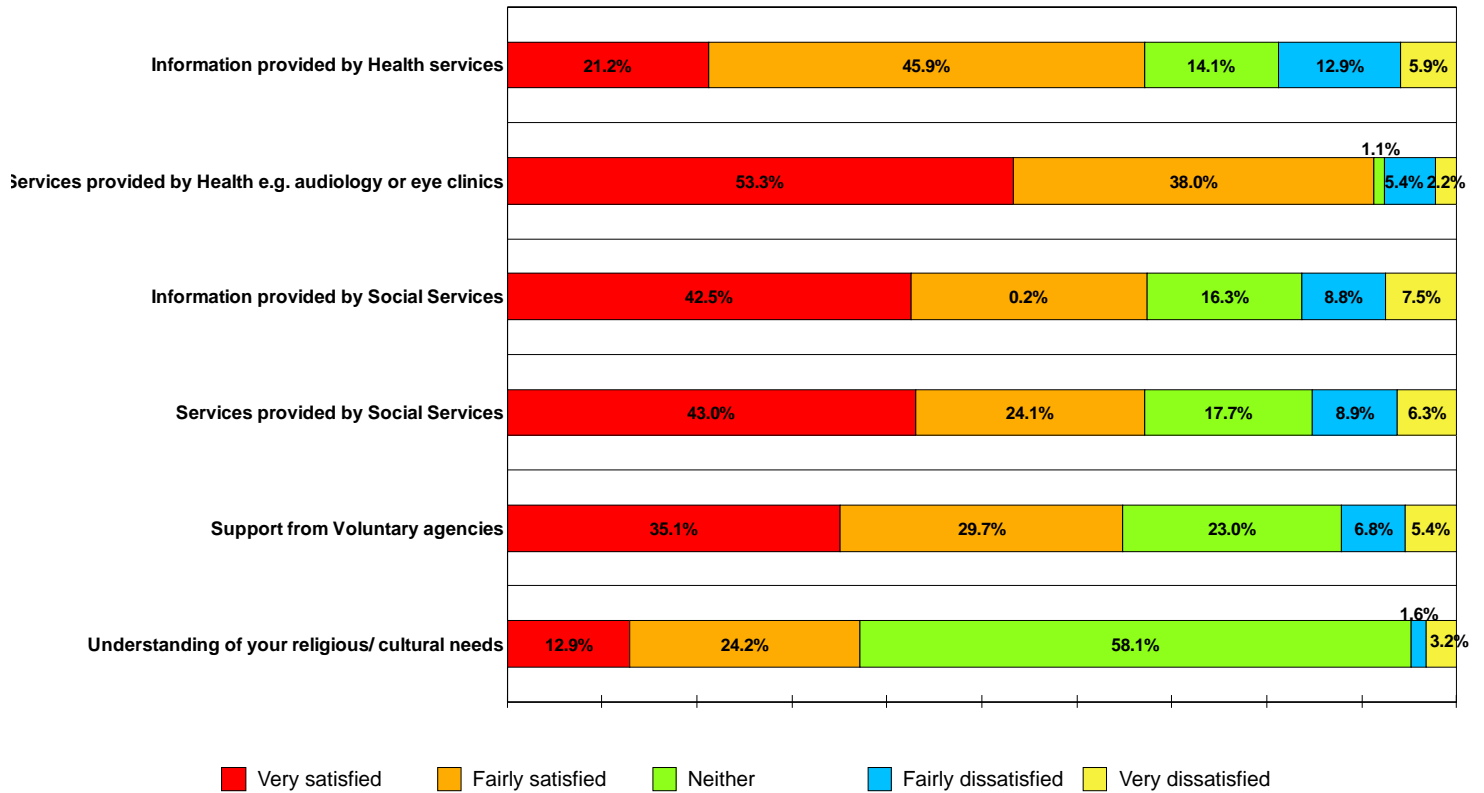
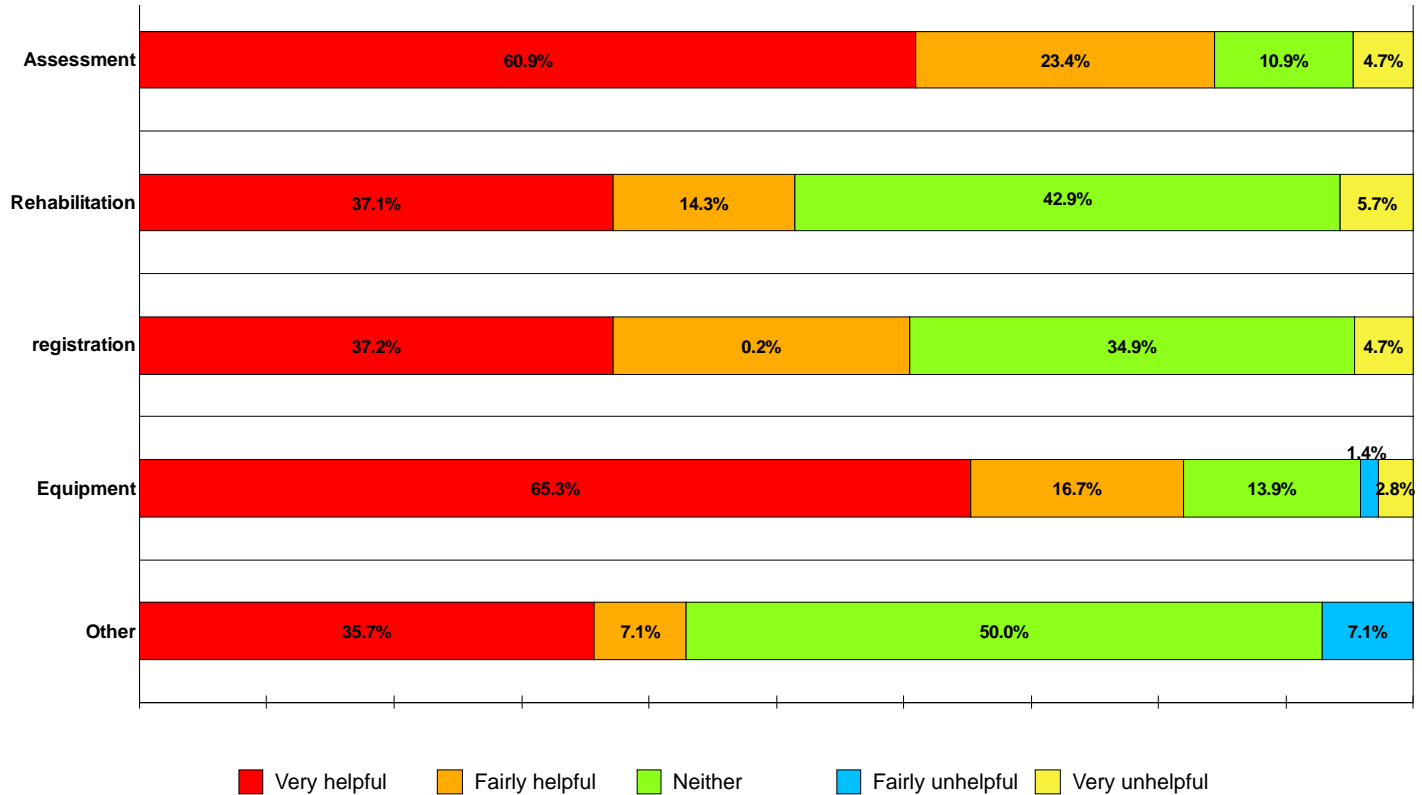


Fig. 6-3: Q3 Help from Social Services

	Total					
		Very helpful	Fairly helpful	Neither	Fairly unhelpful	Very unhelpful
Assessment	64	39 60.9%	15 23.4%	7 10.9%	-	3 4.7%
Rehabilitation	35	13 37.1%	5 14.3%	15 42.9%	-	2 5.7%
registration	43	16 37.2%	10 23.3%	15 34.9%	-	2 4.7%
Equipment	72	47 65.3%	12 16.7%	10 13.9%	1 1.4%	2 2.8%
Other	14	5 35.7%	1 7.1%	7 50.0%	1 7.1%	-

Fig. 6-4: Q3 Help from Social Services

Highlights

Levels of satisfaction with Services

- 67.3% of people were either very satisfied or fairly satisfied with information provided by health or social services
- 79.2% of people were very satisfied or fairly satisfied with services provided by health or social services
- 64.8% of people were very satisfied or fairly satisfied with support from voluntary agencies

Help from social services

- 84.3% of people found assessment very helpful or fairly helpful
- 82% of people found equipment very helpful or fairly helpful
- 51.4% of people found rehabilitation support very helpful or fairly helpful
- 45% of people were neither satisfied or dissatisfied with understanding of religious or cultural needs

- 4.8% of people were fairly or very dissatisfied with understanding of religious or cultural needs

Qualitative responses

Figures in () represent the number of people expressing the same or similar view

Question 2: Please tell us what you have found helpful or unhelpful about any services you have received.

Lip reading/deafPLUS Communication Support Groups

A range of responses from strong appreciation to feeling incensed at the prospect of lip reading being treated as a foreign language (38).

“deafPLUS group has been invaluable in helping me to understand my condition and how to work through daily problems”.

Audiology Services

Very little criticism, a range of positive remarks about staffing, hearing aids and spread of clinics (16).

“Audiology Department are very helpful in their on going support of my condition”.

Ophthalmology/Eye Clinics

Very little feedback but some positive comments (2).

Information Availability

Comments varied, positive and negative from poor availability to the availability of helpful information, demonstrating the significance of good information (8).

“Lack of information”.

Public Awareness

Feedback relates to everyday situations where, mostly, hearing impaired people are frustrated by poor awareness and lack of announcement facilities in public places (5).

“Callers on telephone speak too fast and GP talks with his back turned”. “ All services need to be more tuned in and deaf aware”.

deafPLUS Mobile Resource Unit

Positive remarks about this service, including references to its role in maintaining hearing aids (4).

ASC – Sensory Specialists

Many positive responses, including compliments about individual workers for their support from equipment provision to rehabilitation training (18).

“A warm and caring individual who has proved most understanding to her needs”.

Fire & Rescue Service

People found their advice helpful and the provision of smoke alarms for Deaf/hearing impaired people (5).

Other

Positive remarks about:

Low vision services (1)
Somerset Sight (2)
RNIB chat room (1)

Negative remarks about:

Inter agency information sharing (2)
Consultant/GP awareness including breaking bad news (5) *“My consultation at X with Mr. Y was devastating. He has no sensibility and handled me so brutally that I needed counselling”*
Transport (2)
Isolation (5)
Support needed (2)

Question 3: If you have received help with any of the following from Social Services, please tick the box that best describes your experience.

The question also gave the opportunity to specify other services received.

Comments were largely individual, summarised as follows:

- Suggestion of renting equipment including text phones and arrangements to recycle unused equipment (1)
- Information can be obtained satisfactorily in different ways but not always easy to come by (4)
- Lack of clarity about registration (1)

- After registration as blind, no follow up (1)
- Fire alarm provision (1)
- Delay in receiving a home visit from ASC (1)

Question 4: What particular problems relating to your hearing/sight loss do you still experience in every day life?

Access to computer training

No other information given (2)

Access – general

Responses reflect extent to which visual impairment impacts on daily life including lack of information available in Braille, print being too small to read on everyday items such as sell by dates, shopping and money management (11).

“Everything is difficult when you are blind and deaf”

Isolation/Communication

Many comments/concerns expressed about communication in everyday life by people with a hearing loss causing feelings of disempowerment and isolation. Some of the difficulties relate to public places and announcements. Overlaps with issues relating to hearing aid management (40).

“Because I don’t hear what people generally say/ask me I don’t know how to reply and avoid social occasions because of it.”

Transport

Cost of taxis, availability, inconvenience and announcements (3).

“It is very expensive going to Musgrove Park Hospital”.

Hearing Aid Management

Most comments indicate that hearing aids are a partial answer only for most wearers as they still experience difficulties with their usage and communication in a variety of situations especially where there is extraneous noise (7).

“Still hard of hearing , even with hearing aid - the usual difficulties this causes”.

Information

Difficulties in locating information (2).

“Agencies consistently send me information in print format which makes me reliant on my support worker”.

Awareness

Overlaps with Sections above relating largely to the difficulties hearing impaired people experience in communication where people, including professionals, fail to understand how to communicate (10)

“If you have a stay in hospital it is really difficult for any decent communication – no deaf awareness”.

“Some staff in public places like banks, hospitals, post offices, do not know what the loop system is and whether it’s on or off”.

Mobility

Difficulties associated with visual impairment, especially shopping and getting about (2).

Tinnitus

Responses suggest that this condition is not well understood within the medical profession and there is little help available (11).

“GPs not aware of tinnitus advice and treatment for the condition”.

Loop Systems

Frustration expressed at lack of working equipment in a variety of, mostly, public places (5)

“Loop systems that are not fitted or don’t work properly”.

Question 5: Tell us how services could better help people with a hearing/sight loss.

Suggested service improvements:

Befriending service (1)

Help with daily tasks (2)

Public awareness (2)

Improvement to talking books for people with a hearing loss (1)

Isolation (3)

Training groups for deaf people (1)

Better information (2)

Retain service users on record (1)

Summary

- Isolation features prominently, primarily due to difficulties with communication and public awareness. Transport also has an impact
- Sources of support, especially individualised, whether statutory services, befriending or voluntary groups are highly valued
- Information availability in suitable formats to aid daily living appears key to independence and psychological well being
- Although information is not always explicit, it appears that a minimum of 5 respondents experience a dual sensory loss

6.7 Consultation with Sensory Specialists

The project team met with sensory specialists on 2 occasions and on the second occasion local team managers with responsibility for sensory specialists were present. For a summary of that meeting see Appendix 8.

Key Points

- Conflict between special and non specialist work for some workers
- Lack of specialist management and supervision
- Inadequate training opportunities
- Poor strategic planning
- Inconsistency of service provision across the county
- The universal needs of people with sensory loss are not being met, e.g. employment and transport
- Sensory loss awareness in the community is poor
- Children with a sensory loss and their families do not receive an adequate service
- Sensory specialists are expected to work across all ages
- Insufficient career opportunities
- Need to review the role of sensory specialists
- Too much reliance upon sensory specialists across all client groups e.g. learning disability, mental health, physical disability, children and older people
- A clearer working model is needed

The above are issues raised by sensory specialists but they also gave some positive feedback:

- Sensory specialists are committed to the work they do in the belief that they can make a real difference to the lives of people with a sensory loss
- There is a reasonable spread of alternative providers in Somerset
- The county project/policy post is a positive asset

When asked for a vision for the future the following feedback was received:

- The universal needs of people with a sensory loss need serious consideration
- A centralised, specialist sensory loss team with specialist management, leading to improved consistency and direction based on better user involvement and relevant research
- Service developments needed including a “one stop shop” and greater partnership working
- Wider provision of sensory loss awareness training

6.8 Consultation with Carers of People with Sensory Loss

A recent comprehensive evaluation of carer’s service in Somerset contacted over 1500 carers via either a questionnaire, 1:1 interviews or via consultation events. It was not possible to analyse what proportion of these carers were supporting people with a sensory impairment. Consequently, we have looked at some general themes which emerged from the wider consultation and then more specific issues which were directly attributable to carers of people with a sensory loss.

General feedback from carers and other stakeholders suggest that improvements need to be made if the current model of service delivery system is to improve the outcomes for carers outlined in the Somerset Multi-agency Carers Strategy and support a greater number of carers in the medium to long term. Carers indicated that any future model should include the following characteristics:

1. Practical, flexible and reliable support with an emphasis on continuity and the need for support to be provided by trained staff
2. Contingency plans which included planned short breaks which are easily accessible and flexible so the carer can have more choice and control over when, where and how this support is provided

3. A helpline with access to practical, emotional support and short breaks to both prevent crises occurring and in times of emergencies in conjunction with professionally run Carer Support groups
4. Information and advice available at a local community level including from GPs, supermarkets, etc. A single access point for information and advice with the right information for all different types of carers
5. Streamlined, simplified assessment process including on-line and self assessment with an outcome of a support plan for the carer
6. Access to independent advocacy for carers. Greater say in the decision-making process and carers to be recognised as an “expert” by staff both at a strategic and family level
7. Clear eligibility criteria and charging policies

Although a number of carers attended sensory review consultation events around the county a meeting (attended by 9 people) was arranged at Somerset Sight to discuss issues relating to caring for people with a sensory loss. They described the key difficulty as the lack of awareness by the general public and professionals about the needs of people with sensory loss. The impact of the rural geography of Somerset was described as difficult for the carer group due to lack of transport and local services for sensory loss.

Somerset Sight and Deaf Plus were valued resources and the support groups for carers (both specialist and generic) are welcomed as a great source of emotional and practical support. Experience of Somerset Direct was mixed with a suggestion that staff should be trained to be better aware about the impact of sensory loss and relevant services.

Some carers have a sensory loss themselves and described the added difficulty this presents: *“I’m a carer 24 hours a day for my wife who is blind and my learning disabled son but no account is taken of my deafness”*.

The key message is that there is not enough support for carers of people with a sensory loss, with a lack of awareness, training and specialist support required. There is an added difficulty of many carers not being viewed as carers by themselves or others. Other feedback included:

- Carers would appreciate an annual telephone call to check on how they are getting on
- Carers sometimes resort to buying equipment due to time delays
- There is a lack of realisation that sensory loss conditions change over time.
- Professionals do not offer information at clinics

- One carer said *“I’m a carer 24 hours a day for my wife who is blind and my learning disabled son but no account is taken of my deafness”*
- Insufficient carer’s assessments. One carer referred to their last assessment being 7 years ago
- Somerset Sight services are not fully utilised

6.9 Overall summary of key conclusions from the consultation

Based on the consultation exercise, the level of satisfaction with direct service provision is reasonably high but the scale of comments referring to service issues, unmet needs, and the ways in which services could be improved suggests a slightly different picture.

The main issues arising were as follows:

- People living in rural areas cannot access support services due to their location and limited transport facilities
- Feelings of isolation and disconnection with the community are prevalent across the sensory spectrum
- Insufficient cross agency strategy to identify people with a sensory loss and plan accordingly resulting in poor co ordination and lack of uniformity of services
- Low level understanding of registration
- Poor public awareness
- Inadequate information availability including equipment
- Communication support does not cover needs sufficiently
- Existing resources are not utilised to best effect

7. Researching Best Practice

This Section highlights some of the most relevant national guidance and best practice models of services delivery and draws some comparisons with other Local Authorities. The full research report can be found in appendix 1. It identifies core legislation, guidelines and standards for service provision across the various categories that constitute sensory loss. Although there are a number of interesting best practice models for various service components and helpful national guidance there is no single overall service model, which can be used to benchmark Somerset against. Therefore we have drawn from a number of sources under the various service component headings.

7.1 Prevention and early intervention

To effectively deliver the transformation envisaged in *Putting People First* and beyond, councils should have both a strong focus on the overall well-being of their communities and a recognition that people should be helped in a way that may prevent, reduce or delay their need for social care support. This shift in focus to community well-being and preventative approaches is also fundamental to the effective application of eligibility criteria. There is a growing evidence base that interventions can prevent or delay people entering the social care system and therefore produce better outcomes for people at a lower overall cost.²⁷

7.1.1 Visual Impairment

Failure to invest in early detection and treatment of eye conditions means increased spending on health, social care, education and training to support people in the later stages of eye disease.

Indirect costs such as those relating to falls or increased care costs are also significant; for example, the medical cost of falls related to visual impairment was estimated at £128 million over a 12-month period.²⁸

²⁷ DoH, *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care - Guidance on Eligibility Criteria for Adult Social Care, England 2010*

²⁸ Scuffham PA et al. *The incidence and cost of injurious falls associated with visual impairment in the UK*. Visual Impairment Research 2002 April Vol 4, 1-14

Best practice examples

Leeds has set up a network of community eye champions. Existing primary and social care staff will be given extra training so they can be a focal point for eye care and sight loss support in the community. Their role will be to identify those at greatest risk of eye disease and direct them towards appropriate services.

In Devon, adult social care, RNIB, Action for Blind People and secondary health care have combined to seek funding from the Lottery to set up an Eye Care and Liaison information officer post (ECLO). Based in the hospital eye department, the service enables visually impaired people attending eye clinics to have access to community-based services.

An alternative model is the “One Stop Shop” which has evolved from the National Eye Care services steering group. Its operation is based on integrated local services aimed at maximising residual sight involving patients in the setting up and ongoing evaluation. Such a model has been successfully piloted in various parts of the UK including Brighton and Hove, Hartlepool, Morecombe Bay and Devon.

In Hampshire, sight loss advisers are employed by adult social care as part of an “early intervention service”. The role is to provide visually impaired people with information and both practical and emotional support. The roles are similar but in principle the model utilises social care staff in health settings in the interests of early intervention.

7.2 Equality of Access, Information, Advice and Advocacy

Models and recommendations for the development of information, advice and advocacy services²⁹:

- Articulate and re-iterate the principle that transformation and personalisation are dependent upon good information, advice, advocacy, support planning and brokerage being available.
- Frame the development of information, advice and advocacy in the context of the spectrum of interpersonal support including support planning, support brokerage, the ongoing management of services and underpin all of these with the dimension of safeguarding

²⁹ Scrutinising the Transformation of Adult Social care: Practice Guide, Centre for Public Scrutiny, I&DEA, ADASS, LGA, 2010

- Market the sources of information, advice and advocacy services that are available currently
- Build the statutory information base on the DirectGov and local authority website core that currently exists.

7.2.1 Equality of access, information, advice and advocacy - Visual impairment

Reliable, accessible and relevant information on eye conditions, eye care, sight loss services, support networks and legal entitlements should be easily available in a range of formats, to enable people to understand their options, select services and make informed decisions. Without good access to information one cannot have real choice and control.

“Good Practice in Sight” jointly published by RNIB and ADSS builds on the UK Vision strategy with a particular focus on Local Authorities. It suggests the following good practice points:

- Access to clear information that informs service users reliably about their options will become increasingly important with the introduction of individual budgets
- The provision of relevant information needs to be combined with advocacy and advice for those who find it hard to decide which services will best meet their needs
- Specific arrangements should therefore be made to link service users to a competent local source of welfare rights advice and advocacy

Best practice examples

In Lincolnshire, a consortium involving Visual Impairment Services, Lincolnshire County Council, SENSE and DeafLincs has produced a document setting out minimum requirements for service providers under the disability discrimination Act. The intention is to ensure that service providers in Lincolnshire will provide for the needs of people with sensory loss and will result in a more inclusive environment. The aim of the pack is to give as much information about communication and access as possible.

In West Sussex, information is available in a range of formats and is routinely monitored and where necessary, amended. It can be translated on request. The “Reach Out” website offers easy read information for people with disabilities including “Browse Aloud” software, which reads text out loud.

7.2.2 Equality of access, information, advice and advocacy - Deaf

The RNID carried out research into deaf people's experiences of accessing services (RNID, 2004) and found that nearly a fifth of those consulted received the wrong form of communication support when accessing public services; a further quarter reported no support provided to enable them to access services, highlighting the importance of considering accessibility in IAA provision. Nearly half of those researched (46 per cent) reported that they were unable to interact with public services 'all of the time' or 'often' due to a lack of communication support.

Best practice examples

In the London Borough of Lewisham, as with a number of other Boroughs and Councils, communication support for Deaf people is funded on a corporate basis giving D/deaf people access to all of the council's services. The range of communication support also accommodates people whose first language may not be English or who have a limited understanding of English.

In Manchester, Deaf people can access services via their Link-worker scheme, which can help them access the full range of council services including with communication support if needed.

In Bristol the use of video clips in sign language, for BSL users, can be found on the Bristol City website. This gives access to a wide range of information such as advice and benefits, starting a business, crime prevention, health and social care, education and learning, environment and planning, housing, transport etc.

In Devon, Living Options Devon an independent user organisation, has set up a "Deaf Advocacy Project" aimed at empowering Deaf people with the support from other Deaf people and appropriate communication support where necessary. In addition to a specific advocacy service, support is also available with everyday matters including benefits and employment.

In Oxfordshire, Hereford and Worcestershire, Deaf Direct, an independent voluntary organisation, provides a range of services to D/deaf people with the specific aim of empowering people and enabling them to lead full, active and independent lives afforded by understanding information and options leading to more informed choices being made. The organisation is largely run by D/deaf people who play a big part in its governance.

7.2.3 Equality of access, information, advice and advocacy - Hearing impairment

People with poor hearing are more likely to be isolated socially and to suffer

reduced quality of life. The charity Sense stated that, 'deaf, deafened and hard of hearing people are vulnerable to isolation and depression'. The 'Hidden Lives' report suggests that rates of depression amongst deafened individuals is five times higher than the national average and that anxiety levels are two and one half times higher. Newly deafened people have to learn a new set of communication skills, which can have a massive impact on relationships, everyday tasks and employment. The study found that society has little concept of what deafness means and underestimate the serious effects and consequences.³⁰

Deaf and hard of hearing people rarely have access to the social support available to hearing people. Few Citizens Advice Bureaux or marriage counselling services have arrangements for booking and paying for interpreters. It is to be remembered that the exclusion of Deaf and hard of hearing people from these services may also increase their eligibility for social services' help.³¹

Good Practice example: Bristol City Council

The use of brief video clips in sign language, for BSL users, can be found on the Bristol City Council website. This gives access to a wide range of information such as advice and benefits, starting a business, crime prevention, health and social care, deaf access, education and learning, environment and planning, housing, leisure and culture, transport etc.

7.2.4 Equality of access, information, advice and advocacy - Dual sensory impairment

Deafblindness poses particular challenges in ensuring that information and services are accessible in ways that comply with the requirements of the Disability Discrimination Act 1995 and the regulations made under that Act. In the same way that Local Authorities ensure that information they produce and issue about services, procedures etc. is accessible to those with one sensory impairment, so they should ensure that such information is also available in formats and methods that are accessible to deafblind people. Local Authorities will need to consider not only various sizes of Large Print, as well as Braille, Moon, audio or video (subtitled or signed) versions but also computer disk or use of email (to be accessed by specialist technology), text-phones and Type-Talk. For some deafblind people no method of communication other than tactile communication delivered by another person is available (e.g. hands-on sign, deafblind manual). In these rare circumstances, the provision of a suitably skilled

³⁰ Hallam et al., *Hidden Lives: The psychological and social impact of becoming deafened in adult life.*, The LINK Centre and The University of Greenwich, 2005

³¹ DOH, *Stepping Away from the Edge*, 1999

communicator e.g. an interpreter and/or LSP to deliver information would be appropriate.³²

Sense state that deafblind people are isolated and social services are often not aware of their existence. Once Social Services are alerted to the fact that there is a deafblind person in need of services, assessments often fail to understand the needs of a person with both hearing and sight loss or the services and support that can make a difference. Where people need an assessment, social workers with expertise in one sensory loss often fail to understand the different problems faced by deafblind people. Sensory specialism is usually based in the working age adults department so that children's services, older people's services and learning disability services often failed to properly address the needs of deafblind people.

Local Authorities will want to ensure that they are able to access the services of specifically trained one-to-one support workers (e.g. communicator-guides, interveners, Language Service Professionals (LSPs) for both adults and children whether from within their own staff, by the use of consortia arrangements or by contracting with independent providers, for those people they assess as requiring one.³³

Recent research into deafblind people's experience of the NHS suggests that changes in attitudes, practices and procedures are needed to ensure more equitable treatment and better access to healthcare for this group. Particular areas of improvement recommended in "Cause and Cure" – Deafblind people's experience of the NHS" includes³⁴:

- Need for raised awareness of NHS staff of the particular difficulties faced by people with dual sensory impairment
- Promoting the work of the NHS Patient Advice and Liaison Service and Independent Complaints Advocacy Service to deafblind people, to empower them to use these services
- Individualising patient records to enable healthcare staff identify a deafblind patients' support needs and communication requirements
- Large print to be used for all letters, appointment cards and information leaflets
- Ensure that NHS contracts for interpreting and communication support meet the needs of all deafblind people
- Empowering deafblind people to request extended NHS appointments to assist with their communication needs

³² Department of Health, LAC(DH)(2009)6, Social care for Deafblind Children and Adults

³³ LAC(DH)(2009)6

³⁴ Deafblind UK (2007) "Cause and Cure" – Deafblind people's experience of the NHS

Sense highlights that ‘People with dual sensory impairment are no less likely to suffer from a whole range of serious psychiatric conditions than anyone else. Psychotic, manic and depressive illnesses exist in the deafblind community as they exist in the hearing/sighted community. There are, however, specific problems associated with the loss of sight and hearing. The difficult process associated with the loss of a major sense is multiplied, as is the need for support in learning new coping strategies’.³⁵

Best practice example

Many local authorities, including Somerset, Lancashire and Bristol commission “guide communicators” who act as “communicators” for individuals enabling them to take part in every day life. This may mean helping them to go out shopping, to sort out bills, clothing, or interpret at the doctors.

7.3 Screening, Assessment, Care Management and Resource Allocation

Under Section 47 of the NHS and Community Care Act, a local authority is obliged to carry out an assessment and make a service provision decision where it appears that a person may be in need of services. The duty to assess is proactive; it is triggered by an appearance of need and is not dependent on a request. The assessment must be provided within a reasonable period of time. Therefore, as soon as a local authority becomes aware of someone who may be in need of their (low vision or rehabilitation) services they should take steps to organize the assessment. The Department of Health guidance on eligibility criteria in the light of *Putting People First*³⁶ sets out the assessment process for social care, which will need to be kept in mind when reviewing services for people with sensory loss. The key elements are repeated below.

Evidence suggests that the quality of response to a person’s first contact with the council is crucial to the outcomes they later experience. However, submissions to the CSCI review and evidence from CSCI inspectors have raised concerns about the quality of this first response across councils. In particular, the review highlighted the inexperience of staff making judgements, that people’s needs (and the willingness and ability of their carers) are often insufficiently explored and that people are screened out too early or not given adequate signposting to other sources of support.

³⁵ Standards for Services for adults who are deafblind or have a dual sensory impairment, Sense, B Lewin supported by DoH

³⁶ Guidance on Eligibility Criteria for Adult Social Care, England, DH, Feb. 2010

Councils should help individuals who may wish to approach them for support by publishing and disseminating information about access, eligibility and social care support, including personal budgets, in a range of languages and formats.

Councils may wish to consider encouraging those who can and wish to do so to undertake an assessment of their own needs prior to the council doing so.

Assessment should be co-ordinated and integrated across local agencies relevant to the individual concerned. Agencies should work together to ensure that information from assessment and related activities is shared among professionals, with due regard to data protection, in such a way that duplication of assessment is minimised for service users, carers and professionals alike.

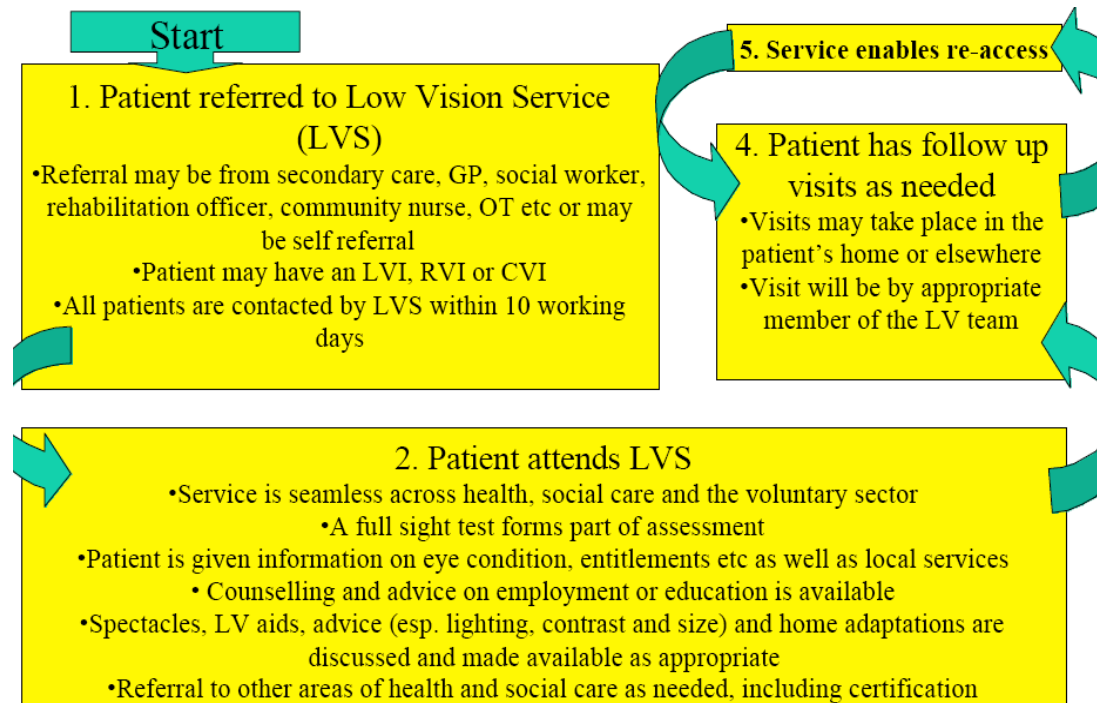
7.3.1 Screening, assessment, care management and resource allocation - Visual Impairment

“Good Practice in Sight” jointly published by RNIB and ADSS builds on the *UK Vision Strategy in 2008* with a particular focus on Local Authorities. It suggests the following good practice points regarding assessment:

- Low vision and rehabilitation services should be based on the needs of the service user and should be flexible enough to meet any additional needs such as dual sensory impairments and mobility needs
- Service users should be involved in every aspect of their assessment through the proper provision of accessible information on the assessment process and on the support options available to them as well as details of waiting times
- Importantly, under the National Service Framework for Older People, older people should be given a single assessment of their health and social care needs to avoid duplication and ensure that the person being assessed does not have to tell his or her story more than once. While in some instances the entire assessment will be done by one professional the need for specialist assessment must remain an option. This holistic approach insures that all of the needs of each individual can be addressed
- There should be a single point of access for individuals to contact for any additional information. The best professional to provide different aspects of the service will vary. What is essential is for specialist knowledge in visual impairment to inform the assessment even if the overall needs of an individual with multiple disabilities or long-term conditions are assessed by a generic rehabilitation worker
- A clear and smooth transition pathway from children’s and young people’s services to adult services should be established or maintained, to ensure that rights to benefits and support are not lost during this process and young people are enabled to fulfil their potential. This

applies equally to health services and social care services. Broader integration of these services with other services such as education and employment is also needed

Fig. 7-1: Low vision services pathway³⁷



The low vision pathway offers a multi-disciplinary approach – involving collaboration between health, social and voluntary sectors – towards the delivery of clinical and non-clinical low vision services. Its main aims are:

- To develop an integrated low vision and rehabilitation assessment pathway (by an optometrist or dispensing optician (trained in low vision) and a rehabilitation officer respectively)
- To provide services locally within community settings
- To involve patients in the setting up and on-going evaluation of the service
- The projects demonstrate significant innovation such as: in the integration of low vision and rehabilitation services with voluntary sector services, the conversion of a community building into a purpose based clinic, the training of nursing and residential home staff in order to raise awareness about low vision, and in the development of volunteer programmes

³⁷ First Report of the National Eye Care Services Steering Group. DoH 2004

- Multi-sector staff involved in the pilot projects emphasise the value of low vision services and highlight the wider issues with respect to low vision. Their feedback confirms the devastating consequences of low vision such as the loneliness and depression that is experienced, the need for early intervention and holistic approaches that include information and emotional support, particular issues with respect to the elderly and the need to raise awareness among user and professional groups
- Patient experience of the pilot projects has been positive. There is thus strong indication of improved opportunities and outcomes for patients, and evidence of improved waiting times, early intervention, integration of services, and provision of patient centred care. Equality of access is however, still a key concern, particularly with respect to minority ethnic groups and people with learning disabilities. Children's services are also under-developed

7.3.2 Screening, assessment, care management and resource allocation - Hearing impaired

Research carried out by the LINK Centre and University of Greenwich in 2005 suggests the following provision should be available:

- Timely and appropriate rehabilitation support for newly deafened people and their close family
- Specialised counselling support for deafened people and their families
- Employers need better awareness of their obligations under the Disability Discrimination Act
- More communication technology installed and in working order

7.3.3 Screening, assessment, care management and resource allocation - Dual Sensory Loss

Local Authorities should ensure that as soon as an initial assessment identifies that a person may have a dual sensory impairment, a specialist assessment is arranged, to be carried out by a specifically trained experienced person/team equipped to assess the needs of a deafblind person - including communication, one-to-one human contact, social interaction and emotional wellbeing, support with mobility, assistive technology and rehabilitation:³⁸

- The care pathways are probably the same as for visually impairment and hearing impairment but with greater awareness and recognition required of individual communication requirements and issues of living

³⁸ Department of Health, Social Care for Deafblind children and adults, LAC(DH)(2009)6

Support to manage direct payments: An example of good practice by a local direct payments support service

A deafblind person who is a Braille user employs several staff through direct payments. He receives payroll support from the local direct payments support service. At the end of the month, he emails the support service with details of the hours that his staff have worked.

The support service work out any deductions from pay (such as National Insurance and tax) and email him to tell him how much he should pay the staff via cheque. They then send him pay slips to be given to staff. The envelope that the payslips are sent in has two staples in the corner so that he knows who the letter is from. The payslips themselves are labelled in Braille so that he knows which staff to give them to. The support service also tells him how much he needs to pay each quarter in National Insurance and tax. The service also fills in quarterly Inland Revenue paperwork.

At the end of the year, the support service sends relevant information to the local authority, so that they are aware of how the direct payments are being spent. The support service also uses Typetalk to communicate with him. This individual has taken on only some of the responsibilities of employing people and the support service has taken on what he wants support with. Control still remains with the individual and confidentiality is maintained by using accessible labelling. These accessible systems were suggested by the direct payments user, and the support service has adjusted its service to meet this individual's preferred means of communication.³⁹

7.4 Rehabilitation

7.4.1 Rehabilitation – Visually impaired

“Good Practice in Sight” jointly published by RNIB and ADSS builds on the UK Vision strategy with a particular focus on Local Authorities. It suggests the following good practice points regarding rehabilitation:

- Training in the proper use of aids and equipment is essential to ensure that users gain maximum benefit from the equipment provided
- The provision of training in orientation and mobility, independent living and communication skills, and low vision enhancement should be part of a multidisciplinary rehabilitation programme

³⁹ Deafblind Direct Consultation Report Deafblind people and families' experiences of direct payments February 2008, www.sense.org.uk/directpayments

- According to Local Authority Circular 93(10) Appendix 2 para 2(1)(a), social services authorities are required to provide, whether at centres or elsewhere, facilities for social rehabilitation and adjustment to disability

7.4.2 Rehabilitation - Hearing impairment

Newly deafened people have to learn a new set of communication skills, which can have a massive impact on relationships, everyday tasks and employment. The study found that society has little concept of what deafness means and underestimate the serious effects and consequences.⁴⁰

7.5 Equipment – Sensory loss

National guidance⁴¹ makes the following recommendations:

- Technological knowledge about equipment should be continually updated
- A one stop shop should be created within the Audiology department so that people may receive an initial assessment for equipment when they are tested for a hearing aid
- Eligibility criteria should be made clear and based on the 'Fair Access to Care' guidance
- People are not always clear about what help they may receive with equipment and therefore attempts should be made to ensure that information about this service is available
- Training on how to use equipment should be available
- Direct Payments schemes should enable people to purchase equipment
- Deaf people should be consulted about the kind of equipment they would wish to have available

⁴⁰ Hallam et al., *Hidden Lives: The psychological and social impact of becoming deafened in adult life.*, The LINK Centre and The University of Greenwich, 2005

⁴¹ ADSS, 'Best Practice Standards': 'Social Services for Deaf and Hard of Hearing People' was produced by the Association of Directors of Social Services (ADSS), the British Association for the Deaf (BDA), The Local Government Association (LGA) and the Royal National Institute for the Deaf (RNID) 1999.

7.6 Registration – Sensory loss

Under Section 29 of the National Assistance Act 1948 Councils are required to compile and maintain classified registers of "persons who are blind, deaf or dumb and other persons who are substantially and permanently handicapped by illness, injury, or congenital deformity". Local Authority Circular (93)10 provided further guidance to Councils on registration practice and the collection of statistics.

A recent Network 1000 survey ("Access to information, services and support for people with visual impairment", Network 1000 Survey 2, October 2008) found that 45% of people registered in the previous eight years received no explanation of the registration process at the time of certification in the eye clinic.

Saying nothing about registration or focusing solely on the limited statutory benefits does not give people the full picture. As one survey participant said: *"You don't really know what there is and what you need to know – it's things you find out later that make you wonder why you weren't told things."*

The reasons why some eye clinic staff fail to explain registration are not clear. Time may be a factor, but many in social services and the voluntary sector believe a lack of awareness of the wider benefits of registration is also partly to blame. As a result, many patients and professionals do not realise that registration often paves the way to emotional and practical support, mobility training and other services. In reality, it is these softer benefits of being registered that usually have the biggest impact on individual lives.

7.6.1 Registration - Hearing impairment

There is no statutory registration system for D/deaf people. However, many will be registered on a voluntary basis with their local authority social services department.

7.6.2 Registration - Dual Sensory Loss

Many deafblind people are not known to their local social services authority. Of those who are in contact with social services, not all are identified as having dual sensory impairment nor are they in receipt of appropriate services. For this reason, the Department of Health issued, under Section 7 of the Local Authority Social Services Act 1970 guidance for local authorities about how to identify and keep records on deafblind people in their area.⁴²

⁴² Department of Health, Social care for deafblind children and adults, LAC(DH)(2009)6

8. GAP Analysis - Appraisal of Services

This Section uses a GAP analysis to summarise comments/feedback from service users and other stakeholders following consultation in Phase 1 of the review. It also draws on legislation, best practice elsewhere and guidelines to help the analysis show how well the needs of people with a sensory loss in Somerset are being met. A red, amber and green rating is used for each of the service components, e.g. advice and information, considered essential to a good service.

- **Green** suggests the service fully meets the needs of service users
- **Amber** indicates a risk of not meeting the needs of service users
- **Red** suggests this element of the service is not meeting the needs of service users

Existing services are described in the aforementioned Sections followed by the key points from consultation. A more detailed account of feedback from consultation can be seen in Appendix 9.

The gap analysis is structured under the following themes:

- Prevention and Early Intervention (Section 8.1)
- Equality of Access, Information, Advice and Advocacy (Section 8.2)
- Screening, Assessment, Care Management and Resource Allocation (Section 8.3)
- Equipment (Section 8.4)
- Rehabilitation (Section 8.5)
- Registration (Section 8.6)
- Conclusions (Section 8.7)

8.1 Prevention and Early Intervention

8.1.1 GAP Analysis - visual impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Prevention and early intervention Rating: AMBER	<p>Health strategies towards early detection/treatment of eye conditions</p> <p>Good spread of eye clinics</p> <p>Low vision services and low vision services committee</p> <p>Services provided by Somerset Sight including information, equipment and rehabilitation</p> <p>Some good information availability in different formats</p> <p>Assessment and rehabilitation services</p>	<p>Lack of clear pathways between health and ASC Somerset</p> <p>Sight services are not equally spread</p> <p>Lack of consistent emotional support</p> <p>Information not adequately circulated, updated or accessible</p> <p>Professional links especially between health and ASC</p> <p>Lack of emphasis, planning and priority given to rehabilitation</p> <p>Lack of clarity regarding provision for children</p> <p>Poor public and professional awareness of visual impairment</p> <p>Access to sensory specialists is not easy</p> <p>Prevention strategies that include those from BME communities</p>	<p>Reconfiguration of existing services towards greater emphasis on rehabilitation and easy Access to better information and support</p> <p>Strategic planning, especially with health</p> <p>Completion and adoption of care pathways</p> <p>Clarification of roles of workforce including work with children and people with a learning disability</p> <p>Raise awareness of visual impairment Information that includes BME communities</p>

8.1.2 GAP Analysis – Deaf People

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Prevention and early intervention	<p>Provision of communication support via commissioned services</p>	<p>Despite there being a contract for communication support, its operational parameters are not clearly understood</p>	<p>Taking a more strategic approach to the provision of communication support and</p>

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rating: AMBER	Existence of specialist services including those with mental health difficulties	Communication support is funded by SCC when responsibility lies with other service providers in many instances Lack of public and professional awareness disadvantages Deaf people as they are often denied essential information	information provision to improve inclusion

8.1.3 GAP Analysis - Hearing impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Prevention and early intervention Rating: AMBER	Health targets requiring audiology departments to assess referrals within 18 weeks being achieved Support/rehabilitation services commissioned from deafPLUS Range of audiology clinics across Somerset	Unclear pathways from audiology services to other sources of support Many hearing impaired people not prepared/able to use the phone to contact Somerset Direct Poor public awareness leads to marginalisation/exclusion	Better joint strategic planning to agree and own pathways Rationalise role of hearing therapy and sensory specialists in rehabilitation

8.1.4 GAP Analysis - Dual Sensory Loss

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Prevention and early intervention Rating: AMBER	Joint funded specialist post (p/t) Training for sensory specialists Commissioned guide communicator service	Specialist post is part time only and covers whole county Current service provider is withdrawing Lack of public awareness of the potential to prevent onset through relevant health checks Lack of non specialist awareness leads to greater potential for falls for example	Review basis on which guide communicator services are provided Seek alternative service provider Increase awareness training

8.2 Equality of Access, Information, Advice and Advocacy

8.2.1 GAP Analysis –Visually impaired

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Equality of access Information, advice and advocacy</p> <p>Rating: AMBER</p>	<p>Information available in different formats and languages by SCC, Somerset Sight and Action for Blind People</p> <p>Sensory awareness training provided to staff within SCC and ASC</p> <p>Somerset Sight's new MRU</p> <p>Some good information available in different formats</p> <p>Information, advice and advocacy provided by the voluntary sector, e.g. information packs supplied by Somerset Sight</p> <p>Information available at low vision and eye clinics</p> <p>Eye clinic liaison provided by volunteers through Somerset Sight</p>	<p>Communications from health and ASC are often not presented in suitable formats</p> <p>Insufficiently aware or trained personnel dealing with the public, especially in health</p> <p>Services focused around acute hospitals and the major towns and cities</p> <p>Lack of informed advocacy provision</p> <p>ASC information not up to date</p> <p>Somerset Direct is not widely known about, requests are small in number and no specialist sensory expertise</p> <p>Service users have to make specific requests to obtain information</p> <p>Insufficient general information available in different formats including via GPs</p>	<p>Strategic/inter agency approach to the availability of information in different formats</p> <p>Campaigns to improve public awareness</p> <p>Strategic/inter agency approach to the availability of information</p> <p>Increasing amount of information available via general outlets including health</p> <p>Provide training to other organisations to improve their information and advocacy</p> <p>Identify a more centralised way to provide advice, information and advocacy</p> <p>Scope potential for extension to eye clinic liaison service (volunteers currently)</p>

8.2.2 GAP Analysis - Deaf

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Equality of Access Information, Advice & Advocacy</p>	<p>Contract with Compass Disability to consult on an annual basis</p>	<p>See previous Sections Information about SCC services is not available in BSL</p> <p>There is an absence of</p>	<p>See previous Sections Identification of the actual needs of deaf people and who is responsible</p>

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rating: RED		<p>information generally in Somerset in a format appropriate to deaf people who use BSL</p> <p>Deaf people do not know how to access advocacy</p>	<p>Public/professional awareness training wherever possible</p> <p>Information in BSL format</p> <p>Improved access to communication support</p>

8.2.3 GAP Analysis - Hearing impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Equality of Access Information, Advice & Advocacy Rating: AMBER	<p>Availability of communication support via RNID (interpreting) contract</p> <p>Loop systems fitted in various public places including ASC offices</p> <p>Sensory awareness training provided for ASC staff</p> <p>Some information is available via audiology and hearing therapy</p>	<p>The RNID contract is used almost exclusively by Deaf people requiring BSL interpreters. People who are hearing impaired do not know the service could be used more flexibly</p> <p>People who use loop systems state that many of them do not work as staff do not know how to use them</p> <p>Verbal announcements in public places including clinics and surgeries are inaccessible</p> <p>Profile of information availability relating to hearing loss within the community generally is low</p> <p>Access to Somerset Direct is difficult and few people know about it</p> <p>No independent advocacy agencies with expertise in the needs of people with a hearing loss</p>	<p>Greater awareness of hearing loss especially within the health services</p> <p>Sensory awareness training for staff in ASC should include use of loop systems</p> <p>More community based information, advice, advocacy and equipment “centres” that could be developed by the voluntary sector</p>

8.2.4 Gap Analysis - Dual sensory impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Equality of Access, Information, Advice and Advocacy</p> <p>RATING: AMBER</p>	<p>Previous Sections on Visually impaired and hearing impaired comments apply</p> <p>Somerset has an identified lead manager for services to people with a dual sensory impairment</p>	<p>Very limited public and professional awareness of dual sensory impairment within generic services</p> <p>Health correspondence in particular which is not accessible to people</p> <p>Communication support contract (RNID) not utilised by people with a dual sensory impairment, largely due to lack of awareness</p> <p>No specific information available for or about the condition</p> <p>Lack of information in suitable formats to help individuals decide on what help they think they need and desired outcomes</p> <p>Lack of information available through primary care settings and professional groups, e.g. optometrists and dispensing opticians</p>	<p>Previous Sections apply</p>

8.3 Screening, Assessment, Care Management and Resource Allocation

8.3.1 GAP Analysis - Visual Impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Screening & Assessment, Care Management & Resource Allocation</p>	<p>Consistency via Somerset Direct that provides a central point of contact and, in theory, preserves practitioner time</p> <p>Good quality assessments by sensory specialists that include generic needs</p>	<p>Too few people are aware of Somerset Direct and access to sensory specialists</p> <p>Lack of sharing of information about service users between health and ASC</p>	<p>Improved inter agency working towards sharing of information especially about service users</p> <p>Development of fast track referrals from health to low level</p>

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Rating: AMBER</p>	<p>The % of people with a visual impairment who contact a sensory specialist is small indicating that needs are met in other ways</p> <p>Some usage of personal budgets</p> <p>Integrated specialist services</p> <p>Complex casework undertaken requiring high level of specialist skill and knowledge</p>	<p>Inconsistent pathway between health and Somerset Direct/sensory specialists</p> <p>Role of sensory specialists doesn't cover needs of all client groups, e.g. learning disability</p> <p>Some assessment / provision undertaken that could be achieved by fast track approach, particularly referrals from health</p> <p>Sensory work sometimes given a lower priority by local managers</p> <p>Line management of sensory specialists is non specialist</p> <p>Specialist work does not adequately span all client groups, e.g. learning disability</p> <p>Transition arrangements are not robust</p>	<p>support including emotional, information and equipment</p> <p>A well defined universal offer would reduce the number of people needing an assessment</p> <p>Universal offer could reduce demands on care management.</p> <p>Ensuring retention of skilled specialist workforce with specialist professional lead and specialist professional development opportunities</p> <p>Reconfigure sensory resources to better align with need and other services e.g. learning disability</p> <p>Re-visit transition arrangements and reconfigure sensory services to re invest in childrens` services</p>

8.3.2 GAP Analysis - Deaf

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Screening & Assessment, Care Management & Resource Allocation</p> <p>Rating: AMBER</p>	<p>Sensory specialists able to care manage complex cases</p> <p>On occasions they co work with other specialists, e.g. learning disability and childcare</p>	<p>No culturally Deaf people employed to undertake assessments or care management</p> <p>Line management of sensory specialists with limited understanding of Deaf people and their culture</p>	<p>Serious consideration given to recruiting Deaf people as specialists</p> <p>Re visit professional support arrangements</p>

8.3.3 Gap Analysis - Hearing impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Screening & Assessment, Care Management & Resource Allocation RATING: AMBER	<p>High level of awareness of hearing loss amongst sensory specialists</p> <p>Feedback about audiology services is largely positive</p> <p>Sensory specialists able to care manage or co work depending on circumstances</p>	<p>Most people with a hearing loss do not receive any sort of social care assessment because they are unaware of services including sensory specialists and Somerset Direct</p> <p>No specialist sensory expertise within Somerset Direct</p> <p>Lack of co-ordination between hearing therapy and the role of sensory specialists</p> <p>Lack of sensory expertise in care management with other client groups, e.g. elderly and learning disability</p>	<p>Establishment of clear pathways to sources of information and advice as part of universal offer</p> <p>See previous Sections</p> <p>Distinguish between social work and rehabilitation role and clarify role of rehabilitation in the Hub</p> <p>Role clarification and that of the Hub will support this</p>

8.3.4 Gap Analysis - Dual Sensory Loss

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Screening & Assessment, Care Management & Resource Allocation RATING: AMBER	<p>Some awareness of dual sensory impairment within Somerset Direct</p> <p>Specialist assessments cover daily living needs, mobility and communication</p> <p>Use of personal budgets and evidence of good practice contributing towards people living independently</p> <p>Specialist services cover the essential requirements including emotional wellbeing and assisted technology</p>	<p>Lack of awareness within specialist health services of the requirement to identify and register</p> <p>Unclear pathways from health to ASC specialist assessment</p> <p>Lack of any self assessment to ensure service users remain central to consideration of need</p> <p>No overarching/central point to decide whether referrals require a dual sensory impairment specialist</p> <p>Lack of awareness of and</p>	<p>The universal offer should include comprehensive information and opportunities for self-assessment. Further assessments should be outcomes based and user lead</p> <p>Extend specialist training to more sensory specialists</p> <p>Greater integration of services especially with health</p> <p>Improved information availability</p>

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
		little publicity relating to the service Many people do not receive a specialist service	

8.4 Equipment

8.4.1 Gap Analysis - Visual impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Equipment Rating: AMBER	<p>Outsourced provision to voluntary agency, i.e., Somerset Direct with relevant expertise</p> <p>Somerset Sight resource centre is well presented and highly valued</p> <p>Adequate equipment budgets, higher than average in the South West</p>	<p>Issue of equipment does not always happen with sensory specialist present to demonstrate and advise</p> <p>Inconsistency of provision of low cost equipment. Some service users pay for this</p> <p>Opportunities to view and try equipment favours people living in Taunton</p> <p>Equipment for children is sometimes funded from ASC budget</p>	<p>Explore opportunities to expand resource centre provision</p> <p>Clarify provision of low cost equipment</p> <p>Cease funding equipment for children from ASC budgets</p> <p>Universal offer could add consistency to equipment provision and ensure more people have access to it as early as possible with suitable advice and information</p>

8.4.2 GAP Analysis - Deaf and Hearing impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Equipment	<p>Adequate budget to meet most needs within FACS.</p> <p>Externally commissioned equipment service</p> <p>Smoke alarm provision by Fire Service</p>	<p>Very limited expertise by equipment provider within the field of specialist equipment</p> <p>No voluntary agencies demonstrating or advising on equipment</p>	<p>An independent agency to demonstrate and advise on equipment</p> <p>Universal offer and/or retail model will embrace this</p>

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rating: AMBER			

8.4.3 GAP Analysis - Dual Sensory Loss

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Equipment RATING: AMBER	Previous Sections apply	Equipment providers are not specialist with this client group Previous Sections apply	Previous Sections apply

8.5 Rehabilitation

8.5.1 GAP Analysis - Visual impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rehabilitation Rating: AMBER	Provision is varied, i.e. via health, voluntary agencies and sensory specialists Quality of provision is high and person centred Provision via sensory specialists includes equipment provision, its usage and other aspects of daily living / independence	Provision varies according to where people live Provision is not well co-ordinated and no clear understanding about who gets what Pathways are not well defined A single rehabilitation officer post for whole county is well below recommended level	Universal offer to include low level rehab services Potential to develop current voluntary organisation services Reconfiguration of current resources to accommodate the universal offer leading to greater uniformity / consistency across Somerset, reaching more people

8.5.2 Gap Analysis - Deaf

This Section is not appropriate to this sector of the community who have a cultural identity and do not seek change.

8.5.3 GAP Analysis - Hearing impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rehabilitation Rating: AMBER	Services commissioned from deafPLUS Hearing therapy services, particularly for people with more severe and complex conditions Direct referrals from GP's to audiology Lip reading and hard of hearing support groups	Rehabilitation is not adequately defined within ASC and health Services provided by deaf PLUS are small scale Audiology find it difficult to signpost people to specific sources of support Rehabilitation for hearing impaired people not considered on a par with rehabilitation for visually impaired people	See previous Sections, especially Prevention Dis investment and re investment in universal offer as part of Hub Creation of Hub will resolve. Negotiation then needed as to how that links with Hearing Therapy

8.5.4 GAP Analysis - Dual Sensory Loss

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rehabilitation RATING: AMBER	Collaboration between sensory specialists as necessary to ensure focused provision High quality assessment and provision covering generic and essential specialist areas e.g. communication and daily living skills	Delays in rehab. provision due to lack of inter agency working	Universal offer that ensures the necessary information and support is available early

8.6. Registration

8.6.1 GAP Analysis – Visual impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Registration	Certificates of Visual Impairment are sent to central point for allocation	Delays in CVIs being dispatched from hospital consultants leading to delayed	Joint strategic planning leading to fewer delays in CVIs being dispatched and more

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Rating: AMBER	<p>Registration leads to assessment by sensory specialist</p> <p>The number of people registered in Somerset is consistent with other authorities of similar size</p>	<p>assessments</p> <p>Register not kept fully up to date</p> <p>Low levels of awareness of existence and purpose of register</p> <p>The process of certification, leading to registration, does not always prompt adequate support, especially emotional</p>	<p>coordinated support</p> <p>Externalise management of register</p> <p>Consider ways of improving levels of awareness of registration including through strategic planning referred to above</p>

8.6.2 GAP Analysis - Deaf

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Registration</p> <p>Rating: AMBER</p>	<p>Registration is undertaken by appropriately trained sensory specialists</p> <p>The number of Deaf people registered in Somerset is similar to equivalent authorities.</p>	<p>Registration is not fully understood</p> <p>The register itself has limited value to Deaf people or for planning purposes</p>	<p>Update the register, better inform people of its purpose, require staff to encourage people to register and devise ways to turn it into a useful tool</p>

8.6.3 GAP Analysis - Hearing impairment

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
<p>Registration</p> <p>Rating – AMBER</p>	<p>None</p>	<p>Register does not reflect the number of people with a hearing loss in Somerset</p> <p>There is no clear strategy to keep it up to date</p>	<p>See previous Sections</p> <p>Explore ways of updating register via health information</p>

8.6.4 GAP Analysis - Dual Sensory Loss

Strategic Priority and rating	Positive practice	GAPS	Possible solutions
Registration RATING: AMBER	Register of people with dual sensory impairment Above average number of people registered	Information on the register cannot be cross referenced with client database and is not utilised for planning purposes	Ensure register is compatible with SWIFT

8.7 Conclusions

The picture of services in Somerset as portrayed by the GAP analysis is a varied one with positive practice being apparent in most instances as well as gaps. Some service provision is of a good standard and highly valued by individual service users but there is a lack of co-ordination, direction and consistency across the county. There is only one rehabilitation worker for visually impaired people, although it is evident that significantly more rehabilitation support is provided by sensory specialists but it is not clearly identified as such. There is no identifiable rehabilitation service for hearing impaired people other than those services commissioned from deafPLUS. Hearing therapy is provided by health but patients with a hearing loss who receive this service mostly have more complex conditions including psychological adjustment, tinnitus and balance problems. There is no real alignment of hearing therapy to the role of sensory specialists either in practice or strategically, including the provision of equipment.

The only GAP analysis to register RED relates to Deaf people and equality of access. The reason is that whilst Deaf people may, on occasions, access support from sensory specialists, this is often not appropriate (as it may not be a social care issue) and their level of communication skill is not always adequate for complex issues. Of greater significance, is the very real disadvantage Deaf people find themselves at through marginalisation in society, the dearth of information available to them in a medium of their choice and restricted availability of communication support for every day matters which might cause annoyance at best but could be life threatening at worst.

The other main areas of concern across the client group relate to relatively poor inter agency working and strategic planning, limited availability of information including about equipment, poor public awareness and provision for children and other client groups where sensory loss is significant.

How Does Somerset Compare?

It could reasonably be argued that the commissioning of this review suggests that the commitment to improving services in Somerset is higher than most other authorities. The commitment to people with a sensory loss, in terms of resources expended on this client group, is a little above average, particularly when compared with other authorities in the South West

In terms of services commissioned, the spend is higher than many other authorities and it appears that the reasons behind the commissioning of services from the third sector is to improve efficiency, service delivery and to respond to central government thinking and national guidelines. That is to be commended, although there is also an absence of on going strategic and inter agency planning to ensure these commissioned services are consistent across the county and are aligned to other service providers, especially health.

Worthy of note, is the part time post working with people who have a dual sensory loss across the county and the specialist social worker working with D/deaf people who have mental health problems across the Somerset Partnership Trust area and funded by the Trust. Both posts appear to represent a recognition of both the varied and complex needs of these client groups and national guidelines.

In terms of the overall number of sensory specialist posts, Somerset fairs quite well, especially when related to the population of the county. Whilst the number of posts is a bit above average, it is noted that most of the post holders are required to work across more than one client group within the specialism and undertake some non-specialist work as well. This is where making comparisons with other authorities becomes more complicated and other measures are needed.

Of the 14 authorities in the South West region nine are known to have specialist management for sensory services but that figure could well be higher. This arrangement clearly finds favour with sensory specialists. Somerset has a sensory lead but that post has very limited managerial responsibility and is not well integrated into management decision-making and strategic planning. Consequently, sensory specialists collectively feel relatively powerless in terms of influencing their roles and the direction of service provision.

No authorities have been identified where the specific needs of people with a sensory loss have been addressed across all client groups with roles clearly defined. In some instances, albeit few, there has been a separation of the role of sensory specialists between children's and adult work but in most authorities the distinction is unclear as it is in Somerset. This does not appear to serve children or adults well, neither is it wholly satisfactory for sensory specialists. Similarly, with other client groups, e.g. learning disability and older people. Here the incidence of sensory loss is particularly high, but the concern is that whilst sensory specialists do work across different areas and different client groups,

they are spread very thinly. Somerset's approach is to broaden the role of sensory specialists to cover more than one client group within the sensory spectrum but this does not find favour with most staff members and is an unusual model.

This raises the issue of specialist versus generic, which is hard to resolve. There are advantages and disadvantages of each model and a lot depends on the geography of the authority. Of greatest significance are the risks attached to a model where roles are not clear and the demands made on workers are too broad. Sensory specialists in Somerset find on occasions that the generic tasks they are asked to perform take a higher priority than their specialist role. The exception to this position is the sole full time rehabilitation worker post, visual impairment, in the county whose role is clearly defined. This contrasts markedly with most other authorities where the greater number of posts are rehabilitation, perhaps acknowledging that the greatest demand is for rehabilitation services for people with acquired conditions.

Having considered and consulted over the above information, the project team has constructed the following model (see Section 9) that responds to the needs and issues identified.

9. Proposed Model for the Future

The purpose of this Section is to address the issues contained in this report and to present a recommended model for the future. The issues have been identified through the GAP analyses which utilises feedback from service users and stakeholders with good practice elsewhere, service guidelines and national legislation acting as benchmarks.

Additionally, the current context shapes the preferred model and in particular:

- “Putting People First”, and the new *Vision for Adult Social Care*, the Government’s transformation agenda
- “Personalisation”
- Reducing resources
- Inclusion and equality

Other, more local, examples of the current context include Somerset’s work streams under “You First”, embracing:

- Delivering Independence
- Transforming community services
- Active lives
- Learning disability futures

Also:

- The lack of organisations of and for D/deaf people
- Lack of user engagement in governance

The preferred model, therefore, has to align with the principles underpinning the governments *Vision for Adult Social Care*. It has to ensure that service users are central to any decisions taken. Services must be tailored to improve prevention, information, advice and advocacy in order that individual people, their families and carers are well informed about their choices and, therefore, empowered to make decisions about independent living and care arrangements. This reflects the likelihood that statutory services will play a decreasing role in support to people. Within this universal offer, it is essential that service users know the limits of any resource allocation. The project team believe that if this offer is appropriate, it will have the effect of reducing the number of people who require

care management, thereby reducing reliance upon statutory services which will allow reconfiguration of current resources where necessary.

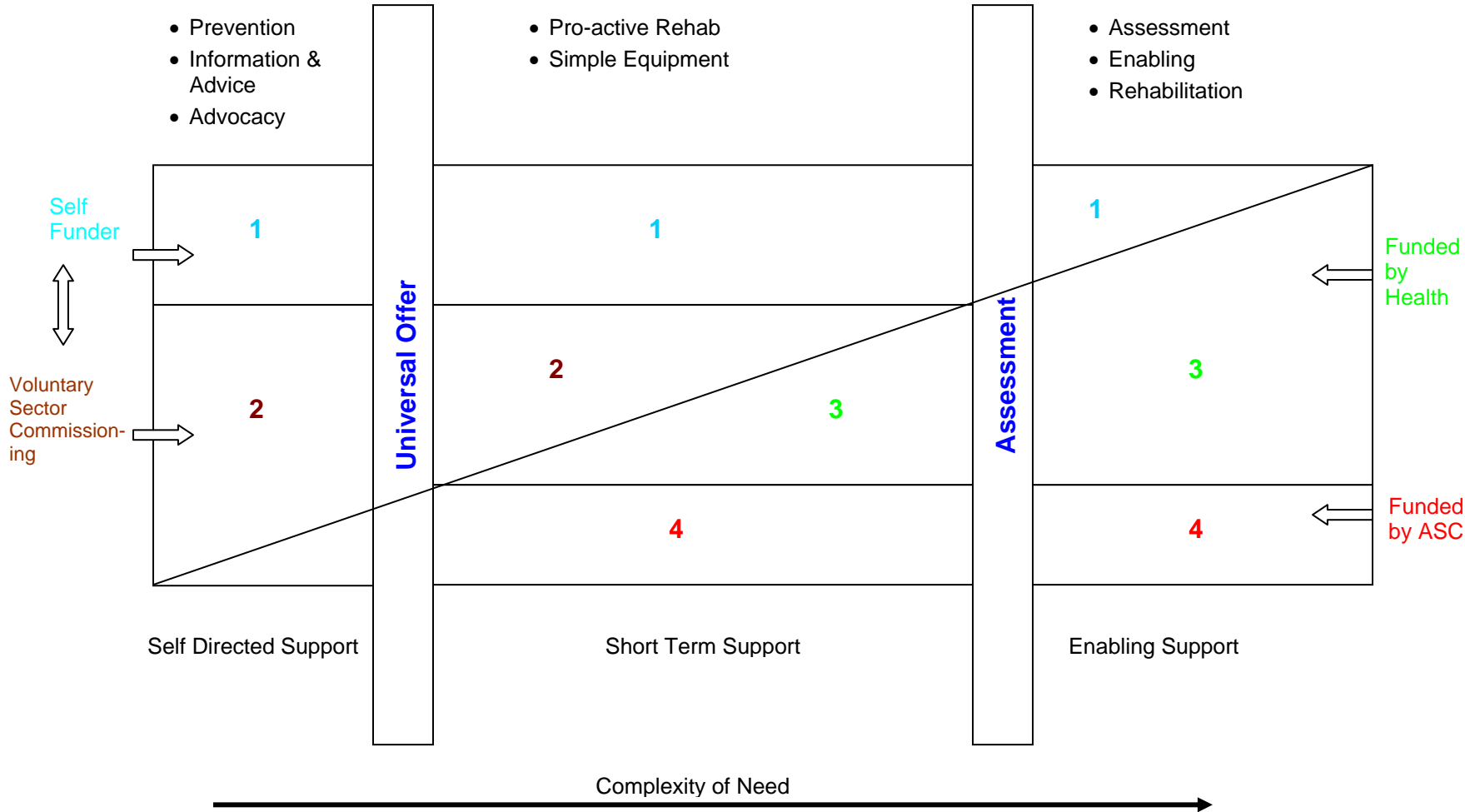
The model is also intended to build on current community engagement, ownership and relationships with other service providers, especially health, towards more clearly defined care pathways. The project team is mindful that the research indicates the potential for very large numbers of people to seek help especially with a growing older population and if the universal offer works effectively, the management of those numbers will represent a challenge. It is anticipated that the model will provide an effective service to a much larger number of people than is currently the case and in a more consistent way.

Client groups, i.e. visual impairment, Deaf, hearing impairment and dual sensory impairment under the heading of “sensory” are distinct but there are also significant similarities and areas of overlap particularly with regard to much of the user feedback, processes relating to treatment/care, legislation/guidelines, psychological impact and rehabilitation. The model, therefore, embraces all sectors of sensory impairment.

In order to best demonstrate the principle of the preferred model, Fig. 9-1 is used to illustrate how the model might work for individual service users and the respective roles for different service providers within the 3 main stages of operation. The principle relies on clearly understood care pathways between stakeholders. The 3 main stages are:

- **Self directed support** – initial contact with a specialist sensory agency or contact centre, the “Hub” providing information, advice and support primarily towards self help
- **Short term support** – access to screening, further information, emotional support, rehabilitation and simple equipment as part of a voucher system
- **Enabling support** – assessment and statutory provision for people with more complex needs, e.g. care management

Fig. 9-1: Future Commissioning Model – Sensory Support



1 = Self funding 2 = Vol. Sector Commissioning 3 = Health Funding 4 = Adult Social Care Funding

The rest of Section 9 describes in more detail what service users might expect from a service that is more community based, integrated, co-ordinated and personalised around the principles of self help wherever possible. The model is based on a universal offer around the categories of self directed support and short term support aimed at everyone for whom it is relevant with access and equality as a high priority.

9.1 Self directed support

We are recommending that the existing voluntary organisations work together as a consortium to provide one point of contact for everyone with a sensory impairment through the provision of a sensory information Hub.

In the vast majority of cases, the sensory Hub would be the first contact with support agencies following medical assessment/treatment whether specialist or general. Individuals would be advised of the support available and access arrangements via community services, especially GPs and specialist health care, e.g. audiology and ophthalmology. Whilst most specialist health care services are based around acute general hospitals, it is crucial that contact can be made locally and easily. This is explained further in subsequent paragraphs about how the model might work.

Upon contact, service users should expect a response from staff, including possibly volunteers, trained and conversant with the general needs of the whole client group. At this stage, up to date information and advice would be available that enables people to decide for themselves how they resolve their particular needs whether they self fund, seek further assessment or support from another organisation as part of the universal offer. This might include specific opportunities, e.g. emotional support groups and communication skills groups. The Hub itself would be responsible for co-ordinating such arrangements, thereby ensuring coherence and consistency for service users.

Alongside robust information delivered by competent staff, equipment could also be accessed whether on site, on line or by contacting another provider set up to respond.

In terms of prevention, this model should be part of a care pathway, offering early support and access to further help if needed, This reduces the likelihood of injury to people, (there is a high incidence of falls amongst people with a visual impairment, particularly soon after onset) improves independence potential and psychological well being resulting in a reduced likelihood of people needing more intensive forms of care at a later stage.

An important additional element to the model is access to specific services including advocacy and communication support. Both have a cross cutting function for this client group and represent a significant inroad to a personalised and empowering service.

9.2 Short term support

For people whose needs cannot be met at the initial contact stage or who are unable to self help even with information and advice, the universal offer should extend to screening and/or simple assessment. The purpose of the assessment would be to determine needs and aspirations, to ensure consistency and appropriate provision but it is aimed at those with non complex needs. Registration could be included. At any stage of the process an individual can decide to refer themselves for a full assessment via Somerset Direct and they should be informed of this.

Where needs can be easily identified and agreed, simple service provision should be invoked with a resource allocation. Such services would include those that are specific or prescribed including access to group activities, e.g. emotional support and communication skills. Other services available should include: further information, rehabilitation and equipment. Equipment could be provided using a voucher system as defined by the resource allocation.

It is envisaged that the support given would be in various settings including resource centres and people's own homes according to need and circumstances but the emphasis would be on developing local delivery where a number of people might be seen in a given day. Examples include "living with sight loss" courses, simple daily living skills and communication groups. Such support could be developed through more generic and community services, e.g. active living centres and their very existence would likely increase awareness of support available and greater community engagement.

Whilst the skill base for such provision might come, to some extent, from a reconfiguration or existing sensory specialists, it is envisaged that ownership of such provision would be within the voluntary sector. However, expertise is an essential ingredient in this equation as there are risks attached to insufficiently trained personnel providing certain services. Recourse to more in depth assessment and the provision of certain services, e.g. mobility and orientation training, by suitably trained specialists is essential.

9.3 Care management and enabling support

Some people will access this stage directly via Somerset Direct but the intention is that stages 1 and 2 will screen out the majority. Those who do receive a care management assessment will in the main, be those with more complex needs which may result in brokerage, packages of care and/or personal budgets. Whilst responsibility for assessment and commissioning of individual services, including the use of personal budgets, may rest with statutory services, service provision itself could be commissioned from the independent sector, thereby building on the services included within the universal offer.

Essential, therefore, are sensory specialists able to undertake assessments of a more complex nature including people with multiple disabilities and those whose needs are more generic. These posts would be ring fenced to ensure the necessary skills are available and whilst their roles would necessarily include some FACS eligible provision, e.g. intensive rehabilitation, mobility and orientation training, most specialist sensory rehabilitation services would be commissioned from those developed as a result of the consortium of service providers and the stages described above.

9.4 How will this be achieved?

The consortium of existing independent service providers would be commissioned to operate the Hub, to ensure accessibility and the availability of relevant sources of support including rehabilitation, as referred to above. Although it is tempting to suggest the Hub be virtual, it is important to recognise, from consultation, that many people with a sensory loss prefer and/or need face to face contact for effective communication. This may not be realistic across the whole county but serious consideration about access is needed.

Local access points could be based around established community services, including libraries and health centres. The consortium would ensure the availability of appropriate skill levels, up to date information, on line web site access and links to other sites. For the hub to operate to its potential, it would need to be integrated wherever possible with other community services with open channels of communication to avoid reliance on pathways from specialist health care in the interests of information and support being available as early as possible. The consortium would ensure other community services were kept updated with relevant information.

The member organisations constituting the consortium would continue to run and develop their own services in their own right but they would be coordinated through the hub. Developments would be required to improve local delivery in particular.

In Summary, the commissioned service would be required to:

- Ensure the role of the Hub is widely known about across all client group services, especially older people and facilitate pathways
- Make comprehensive information about sources of support, locally and nationally available to all sensory client groups and carers, both specialist and non specialist
- Maintain information supplied by the Hub to other non specialist stakeholders and service providers, e.g. Age UK and Active Living Centres
- Provide awareness training, with partner agencies, to other agencies
- Co-ordinate service development and provision within the consortium
- Develop specific services, e.g. advocacy
- Act as an access point with the necessary access facilities for specific services, e.g. communication support for D/deaf people
- Engage service users in the governance of the Hub and the consortium

10. Phase 2 Consultation – testing out the proposed model

The purpose of this Section is to explain the consultation undertaken as part of Phase 2 of this review after the adoption of the Interim Report in October 2010. The first Section details some of the views expressed followed by the themes that emerge. For details of consultation events and interviews conducted see Appendix 9.

10.1 Methodology

Each consultation event was divided into 2 parts, the first to present findings as explained in the Interim Report and to seek confirmation of their accuracy. Secondly, to consider the proposed new vision/model for a service, including a universal offer, with recommendations in response to:

- Phase 1 consultation
- “Putting People First” approach
- Emerging financial climate
- Appraisal of current services
- Legislation and guidelines
- Practice models elsewhere

10.2 Summary of Consultation

During the course of the process a small number of inaccuracies and omissions were raised and discussion ensued to ensure these could be correctly presented but there was no significant dissent as to the overall content of the Interim Report from service users, voluntary organisations or professionals.

As regards the proposed new vision/model for the service, it received general approval with no objectors and a large majority indicating their support for the way it will better respond to needs identified.

A number of questions were raised about the operational side of the model including funding, personnel, role of health, relationship with Somerset Direct, service standards and the role of rehabilitation. A small number of possible

alternative permutations were also considered but there were no counter proposals. Of particular note was the extent to which the model finds favour because of the way it responds to people's need for specialist information and support at an early stage i.e., at the time of onset or diagnosis with the potential for more "joined up" service provision especially between health and other providers.

Some varying views were expressed about qualifications needed and skill levels of personnel within the proposed Hub. There was a majority view that some of the work of the Hub could be undertaken by unqualified staff or even volunteers for certain tasks as long as personnel have the appropriate skills and are suitably supported. The complex needs of some people, especially those with multiple conditions was also highlighted and the need to maintain a skilled workforce within ASC.

The following represent the content of individual comments from the consultation. Some received support from others present but none were generally endorsed. Very few counter proposals or views were forthcoming and overall, consultation meetings evoked little debate or controversy:

- A sensory Hub, run by voluntary organisations, would need help in setting up
- Signposting has merits, but some service options resulting from the signposting may have cost implications that some people cannot meet
- The value of specialist information and support was highlighted by many people and the view expressed by some that it should be available to everyone
- Lack of NHS input/engagement causes concern
- Model must align to other initiatives such as the business process review, RAS (Resource Allocation System) trial, review of FACS eligibility, direct payments/individual budgets, "equipment before care" and developments around re-ablement
- Qualified sensory specialists are essential within ASC including those with a high level of skill in BSL
- Model satisfies numerous calls for a higher profile of sensory issues and a more centralised point of contact for sensory need/referrals
- Proposals for "joined up" services are welcomed
- Some people still need a home visit
- Model must embrace people of all ages and those with additional disabilities such as learning disability and mental health
- Support for carers should be included
- Early intervention/prevention is particularly supported

- Service users experiences strongly suggest their involvement in governance would greatly benefit service provision
- Local access points would be welcomed. Community hospitals were considered a possibility
- A virtual Hub suits some people but others, especially Deaf people, prefer a service that can be accessed in person
- Independent provision is supported by the majority subject to operational, structural, financial and management concerns being resolved
- Model responds positively to concerns about the number of people who receive specialist health care but are unsupported thereafter
- The model would improve general awareness/profile of sensory loss
- Some people of working age wish services to be available at weekends
- Improved access to equipment and how to fit/use it would be a great bonus
- A minority of people with particularly negative views of current services and the application of eligibility criteria expressed their support for proposals on the basis that they must be an improvement

10.3 Emerging themes

The following are intended to bring together the main themes from the consultation to help with identifying priorities and recommendations for future planning:

- The proposed vision/model addresses the need for more uniformity of services
- Proposals also address the need for preventative services and availability of information and support at the right/critical time
- Many of the services provided by ASC, whether “in house” or commissioned, are well thought of but they reach a small percentage only of people with a sensory loss. The vision would reach a much higher percentage of people affected by sensory loss
- The model gives greater confidence that inter agency working will improve but greater health engagement is essential
- Although in the minority, some people feel that the breaking of bad news by health personnel is poorly handled
- There is very limited consistency as to how people access suitable equipment and information relating to it and whether they have to pay for it

- A high percentage of need relating to non complex rehabilitation needs can be carried out through the provision of a service based largely on self assessment and self help where suitably trained personnel are engaged and safeguards exist
- If the Deaf community can be enabled towards greater self governance, access information in the language of their choice and obtain communication support, their need of sensory specialists would reduce
- Support/rehabilitation services commissioned by Somerset Sight and deafPLUS are greatly valued
- Although there has been a mixed response to the prospect of equipment no longer being provided free of charge, there have been no strong or concerted objections
- Experiences are varied but there is a level of dissatisfaction with the services offered by Medequip

Service users themselves have a unique experience of the onset of sensory loss and resulting treatment. These experiences could be well utilised in ensuring services are relevant and fit for purpose.

10.4 Universal Offer for People with a Sensory Loss

One of the four themes of Putting People First is about universal services and ensuring people have fair access to a wide range of services avoiding the need to become dependent upon statutory services. During consultation with local stakeholders, the project team explored what a universal offer should consist of.

Listed below are the services which people with a sensory loss said they wanted or are a priority and could be accessed without the need for a formalised Single Assessment Process:

- Information in suitable formats
- Signposting/agreed pathways
- Registration
- Communication support
- Provision and promotion of sensory awareness training
- Access to rehabilitation groups including emotional support and communication
- Access to equipment including trial, loans, purchase and fitting
- Availability of experience/expertise

11. Making Best Use of Resources

11.1 Existing Investment

Somerset County Council (Adult Social Care) investment in existing sensory services across the whole of Somerset is approx £866,200 based on 09/10 budgets. This investment is broken down broadly into three elements:

- Area based staff resources 56%
- Commissioned Services 35%
- County –wide staff resources 8%

In addition there is a significant investment made by the NHS as outlined in paragraph 5.5 and a more difficult to quantify investment made by the Community and Voluntary Sector.

Fig. 11-1: Showing the allocation of resources in each area compared with population

Area	% of Population	% of staff hours allocated	% of staff budget allocated
Taunton	21%	20%	20%
South Somerset	30%	33%	29%
Sedgemoor / West Somerset	28%	27%	32%
Mendip	21%	20%	20%

Source: Data supplied by Somerset County Council ASC

In monetary terms approximately 56% of the area based staff resources are committed to supporting people with visual impairment with 44% allocated to Hearing Loss. See Fig. 11-2 below. Currently each of the four area utilise specialist sensory staff differently making benchmarking difficult. Taunton has separate hearing and visual impairment workers, whilst Mendip, Sedgemoor and West Somerset tend to use staff who work across both specialisms with South Somerset using a combination of both approaches. Despite these differences the allocation of resources both of terms of money and hours is broadly in-keeping with the population in each area.

Fig. 11-2: Showing the breakdown of specialist staff by area

Area	Visual Impairment Qualified	Visual Impairment Unqualified	Hearing Impairment Qualified	Hearing Impairment Unqualified	Dual Impairment Qualified	Dual Impairment Unqualified
Taunton	24%	31%	18%	28%	0	
South Somerset	27%	28%	0	18%	9%	
Sedgemoor & West Somerset	0	0	0	0	36%	
Mendip	0	0	0	0	46%	

Source: Data supplied by Somerset County Council ASC

Detailed referral data is outlined in paragraph 5.2 above. Based on this data it appears that 95% of all contacts progress to a formal referral. The referral rate is 1.1% of the total estimated sensory loss population. However, the quality and reliability of this data is so variable that it has been difficult to benchmark and to use as a comparator.

11.1.1 Commissioned Services

Currently £306,203 is invested in commissioned services primarily from the Community and Voluntary Sector which represent approx 35% of the total sensory budget. Of this investment £148,856 (52%) provides services for people with visual impairment with £139,302 (48%) supporting people with a hearing loss. The table below categorise the investment made in sensory services by the headings used in the proposed model in order to model the proposed changes in investment. These categories are as follows:

- Category 1 includes preventative services such information, advice and advocacy
- Category 2 includes rehabilitation and equipment
- Category 3 includes assessment, enabling via social work intervention

Fig. 11-3: Showing % investment across hearing and visual impairment

Service Type	% spend on Visual Impairment services	% spend on Hearing Impairment services **
Information, advice and advocacy incl. prevention	32%	22%
rehabilitation and equipment	20%	22%

Service Type	% spend on Visual Impairment services	% spend on Hearing Impairment services **
Consultation	1%	1%
	53%	45%
Area based assessment & social work management	56%	44%
Source: Data supplied by Somerset County Council ASC		
** does not include 2% for Guide Communicator Service added to care management figures		

The population of Somerset is approx 534,100 of which it is estimated 18% of people have some form of sensory loss (see Section 4). Approx 3.7% of people are estimated to be experiencing sight loss and a further 14.7% hearing loss. Despite people with hearing loss accounting for almost four times the number of people with visual impairment there is a disproportionate investment in commissioned services for visual impairment. A similar situation exists when considering the proportion of area based staff resources devoted to each group

In the year Aug 09 to August 10 just over 1100 referrals were received from all contacts made via Care Direct of which 95% went on to be formal referrals. With an estimated 96,408 people experiencing some form of sensory loss the number of referrals made in the last year accounted for 1.1% of the sensory population. Despite this fact, area and county based specialist staff account for over 63% of the total investment in sensory services.

11.2 Modelling of proposed changes

Given the difficult financial climate facing local government it would unrealistic to expect any additional investment from ASC. Therefore any changes proposed need to be funded from savings elsewhere in the current system.

Outlined below are costs associated with developing the proposed model set out in Section 9 of the report. The modelling of costs is based on existing data which has it limitations for the following reasons:

- The accuracy of the most recent census data
- Accuracy of financial information on current level of referrals, estimated budgets and allocated hours
- Doubts over estimated number of people with sensory loss in Somerset
- Activity levels for contracted services difficult to determine
- Modelling relates to ASC spend and excludes NHS budget contributions

- Does not include any TUPE related costs or staff travel costs
- Excludes the cost associated with the county lead post as this is funded separately from commissioning
- An assumption that qualified staff are involved in complex cases providing social work support.
- The modelling assumes a 5% loss of budget to children's services
- Assumes an increase in workload throughout the model to support people with Learning Disability

11.3 Commissioning improvements to existing service

The report suggests a number of recommendations which will result in significant changes in existing commissioning. These are summarised as follows:

- Greater emphasis on prevention, information advice and advocacy
- Redirection of current investment in unqualified specialist staff into prevention and rehabilitation
- More creative uses of equipment with emphasis on flexibility and choice.
- Rebalancing of investment in qualified specialist staff within area teams to focus on working with complex cases and support mainstream social work teams

The reinvestment in preventative services will, in part, be achieved by the commissioning of a new Sensory Hub which will create a single point of contact plus a range of services for people with a sensory impairment (described in Section 9). The Sensory Hub will:

- Be a specialist point of contact for all people with sensory loss via face to face contact, literature, websites and telephone support
- Compliment the advice already provided by Somerset Direct
- Provide an information network across all communities with appropriate signposting to relevant agencies
- Undertake screening assessments and access to equipment with onward referral where appropriate
- Be responsible for the development and support of carers groups
- Be responsible for marketing and advice in respect of specialist equipment

There are no examples nationally where all aspects of this suggested model have been deployed and which can be evaluated. However, the suggested model builds on existing best practice in Somerset and adds learning from other areas.

The intention in this Section is to create a basket of funding from various sources to form a commissioning fund from which new services can be supported. The commissioning fund will be made up of three elements:

- Redirection of existing resources
- Decommissioning of services
- Accessing alternative funding sources

11.3.1 Redirection of existing resources

Perhaps the most significant change would initially affect unqualified specialist staff. The report recommends that this role should no longer be part of the care management function but instead focus more on rehabilitation and prevention as part of the Sensory Hub. This role will include providing information and advice as well as equipment. These changes need to be carefully monitored to avoid community teams being under resourced during the development of the Sensory Hub. However, what is important to stress is that the provider of the Sensory Hub will be able to deploy these resources flexibly and in such a way as to best meet people's needs both now and in the future. This could release approx £233,225 for reinvestment.

The report also recommends the retention of specialist qualified staff line managed within community teams but with additional professional support. These posts would be ring fenced to prevent the specialisms being eroded overtime.

It is anticipated that increases in referrals from learning disability services may initially lead to an increase in workload. However, it is recommended that the current investment in qualified staff of £252,661 should be adjusted as follows:

- Reduction in funding of 5% (£12,633) to be transferred to children and families services
- The remaining staffing resources be re allocated using the following formula 80% (£192,022) hearing loss and 20% (£48,005) visual impairment

The timescale for the development of the Sensory Hub may be a factor that would influence the sequencing of any changes.

11.3.2 Decommissioning of services

The consultation with stakeholders raised concerns about the availability and effectiveness of some existing services. Initially some of the existing services /

relationships for services may continue prior to the development of the Sensory Hub. However, subject to further consultation it is suggested the following services be decommissioned and the funding released re-invested into funding the Sensory Hub:

- Deaf-plus mobile unit auditory service is seen as predominately a health function and the funding responsibility should be transferred to NHS Somerset releasing £40,144 for reinvestment
- Communication classes should be provided by mainstream learning & skills service funded through fees releasing £20,543 for reinvestment
- Similarly talking books are available on most high streets or via mainstream libraries. Withdrawal of funding from this service would release £23,700 for reinvestment
- Current rehabilitation programme would be retained but would form part of a newly commissioned service contributing £97,185 to newly commissioned rehabilitation / enabling services
- Other than in support of complex cases it is recommended that eligibility for equipment should no longer be determined by FAC criteria but instead be linked to rehabilitation and available from the Sensory Hub, possibly using an allocation from someone's personal budget. The current investment in all forms of equipment across both groups is £80,000. Purely for the purpose of modelling the recommendations it is suggested that 75% of this investment (£60,000) be released to fund the Sensory Hub

11.3.3 Accessing alternative funding sources

One of the attractions of re-commissioning this new service is that community and voluntary sector organisations may be able to attract additional funding sources not normally available to the statutory sector. It has not been possible to estimate the extent of this funding and therefore no assumptions are made about this. However, other factors to consider include:

- The better co-ordination and a realignment of existing services under the control of the Sensory Hub should also generate some efficiency savings in terms of administrative costs (indicative sum 10% suggested post procurement process)
- There could be some efficiency savings by greater integration of any new information network into mainstream resources such as libraries, post offices and supermarkets.
- There may be some limited potential to attract funding through commercial sponsorship or commission on sales of equipment
- It reasonable to expect that a proportion of the 97,000 people with some degree of sensory impairment will have access to private funding to purchase equipment, training etc.

11.4 Sustainability

It is anticipated that the general population in Somerset will increase by 87,000 by 2029 from 2001 base. An increase in general population of 3,000 people per year would generate another 540 people with some degree of sensory loss.

Based on current referral rates this would generate an additional 6 referrals per year. Improved preventative and rehabilitation service may, in the longer term, reduce the number of referrals, raising the potential for savings from the investment made in specialist qualified staff.

It is therefore suggested that the proposed changes which are based on existing budgets are sustainable in the medium to long term.

Fig. 11-4: Summarising the proposed changes in investment

Re investment re commissioning fund	Investment released
Unqualified specialist staff	£233,225
Re balancing of specialist qualified staff <ul style="list-style-type: none"> • 80% (£192,022) hearing loss - 20% (£48,005) visual impairment. • Funding of county wide post be designated for the professional development / support of the specialist team 	Nil
Deaf-plus mobile unit funding responsibility transferred to NHS Somerset	£40,144
Communication classes provided by mainstream learning & skills service funded through fees	£20,543
Reduction in funding qualified staff 5% transferred to children and families services	(£12,633)
Talking books funding withdrawn for reinvestment.	£23,700
Rehab programme retained but commissioned as part of new rehabilitation / enabling services.	£97,185
The current investment in all forms of equipment across both groups is £80,000 it is suggested that 75% of this investment (£60,000) be released to fund the Sensory Hub	£60,000
Potential efficiency savings following procurement process	(£47,479)
Total	£427,318

11.5 Benefits and Risks

Summarised below are the benefits and risks associated with the proposed changes. The aim throughout this appraisal has been to build on existing good practice and where appropriate suggest ways of improving the current system to deliver better outcomes for carers.

Fig.11-5: Summary of benefits and risks associated with proposed new model of sensory services in Somerset

Benefits associated with proposed model	Risks associated with proposed model
1. Elements have a proven track record of improving outcomes for people in other areas	1. Potential to destabilise existing providers / networks
2. Key aspects identified and supported by recent consultation	2. Potential to lose local knowledge of specialist carer workers
3. Provides people with a single information point which is up to date and responsive	3. Sensory Hub needs to link with Carers Hub, Active Living Centres, Extra care housing units, Mobile Libraries etc to meet the needs of people in rural communities
4. More customer focused with better access for people with sensory loss and greater engagement potential with Black and Minority Ethnic Communities	4. Needs to link with and be supported by specialist teams such as mental health, learning disabilities and other specialist sensory services especially health
5. Greater flexibility and efficiency regarding use of resources- e.g. increased value for money by better co-ordination, reduced duplication and potential to raise funds independently.	6. Deterioration in performance (numbers and quality) of assessments due to proposed changes
7. Improved communication and information particularly across rural areas	7. Information needs to kept updated across many agencies potentially, requiring significant organisation and manpower
8. Greater choice regarding accessing services in a non institutionalised way particularly re equipment purchase	8. Loss of current ways of working , some of which work quite well
9. Greater levels of participation, scrutiny and recognition for people with sensory loss	9. Engagement of people with the right skills and provision of training as necessary
10. Enhanced role for Community & Voluntary Sector	10. Additional work involved in organising a service, attracting personnel and funding

11.6 What effect will the model have on Somerset Direct?

The model described above is intended to enhance the role of Somerset Direct by the introduction of a service that is specific to people with a sensory loss. Fig. 5-5 suggests the number of people who contact Somerset Direct with a sensory query which they can answer is quite small. Most queries to Somerset Direct of a sensory nature tend to generate a referral.

Once suitable care pathways are established, a high volume of people requesting information and advice from the Hub is expected, far greater than the numbers who currently contact Somerset Direct. However, with larger numbers of people, better informed of what is available, it is likely that demands made on Somerset Direct will also increase.

Some people with sensory needs will inevitably contact Somerset Direct first where they should receive improved information as a result of the existence of the sensory consortium which would be responsible for ensuring information is updated and establishing pathways. In essence, the two services should complement each other and together significantly enhance access to sources of information and advice proportionate to need.

12. Recommendations

Given the evidence contained in this report from research, mapping, consultation and analysis the project team recommends adoption of the following:

12.1 Equality of Access

Improve access to support in the interests of prevention and early intervention by the establishment of a sensory Hub. The Hub would be run by a consortium/co-operative of existing, and potentially new voluntary agencies, commissioned to:

- Provide a range of services linked to other service providers, both specialist and non specialist
- Review audible access to SCC's website for visually impaired people
- Establish corporate county council funding for communication support for Deaf and hearing impaired people and facilitate access via the Hub

12.2 Advice & Information

The Hub would be responsible for the development of comprehensive information in a range of accessible formats for people with a sensory loss and their carers close to their local community and via a web based information system. This should include:

- A single sensory website including information in BSL with links to other sites
- The engagement of a range of community based organisations, e.g. libraries and active living centres
- Common information adopted by all agencies
- Information, advice and signposting which must dovetail with Somerset Direct

12.3 Advocacy

The Hub to be responsible for raising awareness of the availability and benefits of advocacy and how to access it.

12.4 Sensory Hub Development

The Sensory Hub to be developed as a focal point for people with a sensory loss and their carers across Somerset. It would:

- Act as a specialist, central point of contact for enquiries via telephone, websites, text or face to face contact
- Provide an information network across all communities via other organisations with appropriate signposting to relevant agencies
- Support people recently diagnosed with a sensory loss through listening, information, advice and access to equipment as part of a universal offer
- Negotiate and establish pathways to ensure the free flow of information and uniform support to people
- Offer people opportunities to self help or a screening assessment
- Provide access to a range of co-ordinated rehabilitation services such as guide communication and communication support groups
- Ensure service user engagement in service governance
- Lead on raising awareness of sensory issues and encouraging other organisations to make appropriate adjustments
- Actively engage with other user organisations such as the stakeholder group
- Sensory services to be reconfigured to provide additional expertise within the Hub for rehabilitation services including emotional and practical support. See Section 11.

12.5 Resources

Adoption of the proposals set out in Section 11 above to facilitate reconfiguration of sensory services with resources, except those required within community teams, allocated to the Hub.

12.6 Assessment and Care Management

Assessment should be proportionate to the needs of people experiencing sensory loss. A simple screening tool should be developed and utilised within the Hub that will complement the SAP at a later stage.

12.7 Emotional Support

Planning for care pathways must consider emotional need. The Care First counselling service should be extended to include people with a sensory loss and their carers. Its existence should be more widely publicised.

Other resources for emotional support which are available via NHS Somerset and Somerset Partnership NHS Foundation Trust should also be better publicised.

12.8 Governance

Consideration should be given to the stakeholder group, set up for the purposes of this review, taking a governance role to ensure appropriate development of the proposed model and that service users are engaged at all levels and stages of development. The same group should also take on a governance role with services commissioned for other client groups where there is a significant incidence of sensory loss as well such as learning disability and older people.

Organisations commissioned to provide services should be required to evidence how service users are engaged in the management of their services.

12.9 Strategic Planning

As part of the adoption of this review, it is suggested that the Adult Services Management Board be asked to ensure appropriate opportunities are made available for the strategic development and regular review of health and ASC sensory services. This should be aligned to a plan of implementation with timescales.

12.10 Workforce

Clarify the role of sensory specialists and model of service by:

- Distinguishing between the social work and rehabilitation role
- Concentrating the work of qualified sensory specialists in local community teams on complex needs, i.e., those within the critical or substantial threshold of FACS

- Enhancing skills by individual workers undertaking one area of specialist work only and some generic work
- Using the information in Section 11, determine how resources are to be apportioned between social work and rehabilitation provision both within local teams and the Hub
- Measuring the current scale of children's work and transferring resources to children's services, ring fenced to meet sensory need
- Applying the principle above to work with other client groups where specific expertise is required such as learning disability services. This model aligns with that for services to Deaf people with mental health issues
- Promoting the role of sensory specialist social workers with Deaf people through improved training opportunities. This should reduce occasions when interpreters might otherwise be engaged
- Making specialist workers part of a county specialist group with a lead from a senior practitioner
- Using the senior practitioner role to ensure with senior management support, that the model of working is achieved, developed and adhered to as well as having a professional support, policy and training development function.

12.11 Rehabilitation

- Rehabilitation should remain central to sensory services but resources converted to more easily accessed support in the community strongly linked to the universal offer
- Rehabilitation support must also continue to be available as part of local community team provision for cases of more complex need
- Ensure sensory services and the needs of people with a sensory loss are considered as part of the development of a new model of reablement across health and ASC
- The universal offer should be described as providing rehabilitation support primarily for those able to self help through the provision of advice, information, sign posting and access to equipment
- Funding for rehabilitation services commissioned from Somerset Sight and deafPLUS should be reinvested in the universal offer

12.12 Registration

- Responsibility should rest with the Hub
- Certification leading to registration of people with a visual impairment should continue to be directed to a central point, being the Hub
- Registration should be promoted, especially for people who are Deaf, hearing impaired or dual sensory impaired
- Through partnership working, identification of people with dual sensory loss should significantly increase

12.13 Equipment

- Contracts with deafPLUS for the provision of a mobile unit displaying equipment should be re-negotiated. Consideration is needed, alongside health, for the decommissioning of this service as a significant element of its function relates to the maintenance of hearing aids
- Equipment should only be provided free of charge to people who meet the designated threshold for the FACS criteria, either as part of a rehabilitation programme or simple equipment provision by screening, using a voucher system or direct issue from the Hub
- Access to equipment whether purchased or FACS eligible should be via the Hub and resources allocated accordingly

12.14 Guide Communication

An alternative provider for this service should be sought and value of contract considered in the light of current expenditure.

12.15 Carers

Feedback suggests that carers of people with sensory loss are not particularly well supported or represented by the existing arrangements. It is therefore recommended that the newly developed Somerset Carers Partnership Board should include carers of people with a hearing and visual impairment.

It is further recommended that the Carers Hub be tasked with ensuring that carers of people with a sensory loss have access to mainstream carers support groups and other benefits.