NHS STANDARD CONTRACT
FOR SPECIALISED MENTAL HEALTH SERVICES FOR DEAF PEOPLE (ADULTS)

SCHEDULE 2 THE SERVICES – A. SERVICE SPECIFICATIONS

Service Specification No.	C04/S/a
Service	Specialised Mental Health Services for Deaf People (Adults)
Commissioner Lead	
Provider Lead	
Period	2013/14
Date of Review	

1. Population Needs

1.1 National/local context and evidence base

Mental Health services for Deaf people are included in the Specialised Services National Definition Set (SSNDS 3rd Edition No. 22) and it refers to the specialised mental health service for the deaf as including inpatient, outpatient, and community services including assessment and treatment services for deaf people and advice to general mental health services on the management and treatment of deaf people with mental illness.

Seven per 10,000 people in the general population (approx. 70,000 people in the UK) have severe to profound deafness with onset before language has been established and of these 50% may experience mental health difficulties at some time in their lives.

This ranges from mild depression to psychosis (Evans 2003) with an increased prevalence of severe mental disorders such as psychosis, co-morbid visual impairments, language dysfluency and other neurodevelopmental disorders.

Research has consistently found deaf people to be at a higher risk of mental illness

than the general population (McClelland et al. 2001).

The Department of Health document 'Sign Of The Times: Modernising Mental Health services for People who are Deaf (2002)' makes a clear case for the need to have specialist services for Deaf people who have mental health problems to improve access to culturally appropriate mental health services and achieve better outcomes for service users. In doing so, it also highlights the geographical nature of the service provided by the three specialist units in London, Birmingham and Greater Manchester. It was identified that:

- Deaf awareness is very important.
- Good mental health services for Deaf people will cost more.
- A Deaf person is more likely to get better in a signing environment.

Further epidemiology and best practice information can also be found in the following publications:

Department of Health (2005) Mental Health & Deafness – Towards Equity & Access: Best Practice Guidance (DOH 2005)

Fellinger J, Holzinger D, Pollard R, (2012) Mental Health of Deaf People, www.thelancet.com, 379 1037-1044

2. Scope

2.1 Aims and objectives of service

Aim of the Service

To provide a cost effective, quality of life and recovery focused, culturally sensitive, linguistically accessible mental health service to severe or profoundly deaf and deaf-blind people aged 18 years and above, who have a wide range of communication and language needs and who need a deaf environment. The service will effectively use resources to provide accurate diagnosis, and specialist treatment.

Objectives

- Provide expert understanding of mental illness and developmental disorders in deaf people and associated co-morbidity
- Have an expert understanding of resources available for deaf people
- To promote deaf service user access to their local deaf services and independent advocacy
- Promoting deaf awareness and providing specialist advice.

- Ensure that deaf people can be reliably assessed and treated in a way that is appropriate for them.
- The service will develop expertise in how significant mental health difficulties manifest in deaf people, methods of assessment and communication, and an understanding of deaf culture.

The service will:

- Provide a culturally sensitive and communicatively accessible multi-disciplinary mental health service to severe or profoundly deaf and deaf-blind people
- Provide a service for deaf people with complex and enduring mental health problems associated with multiple developmental deprivations, physical health conditions and negative psychosocial experiences
- Aim to reduce or prevent relapse
- Involve service users in service development and all aspects of their care in an empowering way, with access to independent deaf advocacy
- Offer training and development to staff in the deaf mental health speciality, including training in British Sign Language (BSI). Will strive to recruit more deaf staff into the service
- Provide continuous development and delivery of education programmes to multi-disciplinary agencies involved in health and social care, including regular workshops and training sessions promoting deaf awareness in the context of positive mental health
- Offer advice and support to the service users home area services
- Operate a recovery and social inclusion approach to service provision

Local services will continue to hold the care co-ordination responsibility for patients, unless otherwise agreed, and are care co-ordinators in respect of obligations under the Care Programme Approach (CPA).

2.2 Service description/care pathway

Specialised Mental Health Services for the Deaf include inpatient, outpatient and community services.

The specialised service is provided to deaf service users who have significant mental health difficulties and have been unable to access culturally appropriate assessment and treatment services, or have not responded to treatments or require inpatient admission for assessment. The service will offer advice and support to care co-ordinators from the service users' home area and may provide consultation and advice via teleconferencing facilities.

The services provide expertise in the assessment, treatment and recovery of people who are deaf, likely to use British Sign language and have a serious mental health problem. Services may also specialise in the support of those people who are deaf and offend (Secure Services). The service can provide assessment, treatment, and care including long-term rehabilitation and short-term treatment.

Communication

Research shows that from a deaf perspective, hearing people's use of sign language is closely associated with demonstrating personal respect, value, and confidence. In environments where the participation of deaf people is vital, and in environments that aim to deliver services to deaf people, Sign Language is an important medium of communication to be used in service delivery and engagement of the patient.

To provide a culturally sensitive, linguistically accessible service to severe or profoundly deaf and deaf-blind people, communication skills in BSL as well as other modes of communication (e.g. deaf-blind manual hands-on signing) are of vital importance, to enable clear communication and reciprocal understanding in the language and cultural framework of the service users themselves. Knowledge and experience of deaf culture and the unique mental health issues that are associated with deafness, enable services to respond to deaf patients" needs more effectively, and to support mainstream mental health and social care staff to do the same.

The aim is to train all non- clinical staff to level 1 BSL, clinical staff to level 2 BSL and expert clinical staff i.e. therapists to be trained to level 3. BSL interpreters are used as a matter of course when required. The service can be accessed by videophone, SMS text messaging, text phone, e-mail and minicom. The services can advise other services to produce appropriately accessible patient information geared to deaf patients who may have limited ability to access written English.

Summary of the Patients Journey

Pre admission - Referral Administration

- Pre-admission Assessment

In Patient Phase – Admission

- Assessment phase
- Initial treatment phase
- On-going treatment phase
- Discharge planning
- Maintaining treatment phase
- Discharge and transition plan

- Discharge
- Post admission - Out patient follow up
- Liaison with local services

In Patients

Inpatient services function 24 hour/365 days per year. Care is provided by a mixture of deaf and hearing professionals supported by BSL interpreters. Hearing staff within the inpatient service are supported in developing 1, 2 & 3 Level BSL. On admission patients are allocated a case manager, care is provided within the Care Programme Approach (CPA) framework and based on a Recovery Model. All patients are encouraged to develop their own recovery plan.

Patients have access to:

- Medical Staff
- Nursing staff
- Occupational Therapy
- Cognitive Behavioural Therapy (CBT)
- Speech and Language Therapy (SALT)
- Social Work
- Psychological Therapies

Specialised Mental Health Services for the Deaf Community Services

These specialised teams operate 5 days per week. Unless specifically agreed otherwise and where a patient has a high level of complexity, community mental health and learning disability teams hold the care co-ordination responsibilities for patients. All staff are supported to develop BSL level 2 as a minimum and desirable to be trained to level 3. Opening times of the service will be determined by the commissioner and provider but some flexibility will be required to ensure access to the service by those people in employment as well as enabling close working relationships with deaf groups in the community. The specialised deaf community service has formal links with one of the three inpatient units and operates a hub and spoke model. The specialised community services will provide alternative care to hospital admission that is culturally accessible.

Interventions:

- Signing Environment
- Culturally and Linguistically accessible
- Specially designed unit with adapted environment
- Psychiatric assessment and treatment

- Psychopharmacological interventions
- Advice on medication management
- Psychological assessment treatment, consultation and advice
- Assessment and treatment by speech and language therapists, occupational therapists
- Community Care assessments, development of packages of support as well as advice on appropriate placements
- Carers assessments where appropriate
- Family support
- Development of a positive Deaf identity and integration in the Deaf community
- Social and recreational groups
- Assessment and development of Activities for Daily Living (ADL)
- Support in access to deaf services, information, and advocacy
- Employment and education support
- Advice and support to other mental health and social service

These interventions are enabled by all staff having communication skills in BSL and other modes of communication (e.g. deaf-blind manual, hands-on signing) with the support of fully qualified registered BSL interpreters with experience in mental health where appropriate. They will have a sound knowledge of deaf culture and of the impact on psychosocial and educational development, physical and mental health of being deaf in a hearing world.

Discharge Criteria and Planning

It is expected that the local secondary care services lead on CPA or other local arrangements and that planning and preparation for discharge starts at the point of admission.

If the service user requires further services the deaf service makes recommendations to the local team care coordinator for onward referral and will provide supporting reports.

Discharge will be considered when:

- Clinically appropriate
- A service user is fully engaged with local services
- A service user has finished an assessment or treatment package
- For informal inpatients, discharge will occur if a patient requests to leave and they are not considered detainable
- Detained service users may be discharged at Manager or Tribunal Hearings

Discharge Routes

Service users may be discharged to:

- Local Community Mental Health Team or Community Learning Disability Team
- To another part of the Specialised Deaf Service e.g. Specialised Community Team, psychological therapies or to standard care as outpatients under the care of a deaf service mental health professional
- In some circumstances, patients may be discharged back to the care of their GP
- Voluntary Agencies

Encouraging and Promoting Service User and Carer Involvement

Weekly in-patient community meetings are held. User Voice Forums provide patients the opportunity to influence service development. Access to Deaf advocacy is actively supported.
Each service user has their own individual care plan which they will have participated in producing.

2.3 Population covered

The service outlined in this specification is for patients ordinarily resident in England* or otherwise the commissioning responsibility of the NHS in England (as defined in Who Pays? Establishing the responsible commissioner and other Department of Health guidance relating to patients entitled to NHS care or exempt from charges)

* Note for the purposes of commissioning health services, this excludes patients who, whilst resident in England are registered with a GP practice in Wales, but includes patients resident in Wales who are registered with a GP practice in

England. Specifically, this service is for:

Adults aged 18 and over who are deaf or deafened and likely to use manual methods of communication and have a serious and acute mental health problem which would meet criteria for referral to secondary care mental health services.

2.4 Any acceptance and exclusion criteria

Referral Processes and Sources

The services are specialised tertiary services and referrals will only be accepted from secondary care mental health services

It is expected that the local secondary care services lead on CPA or other local arrangements and that planning and preparation for discharge will start at the point of admission.

It is expected that where possible a pre-admission assessment will be undertaken (This will only be possible where specialised Community Mental Health Services for the Deaf are available).

The local care co-ordinator is expected to maintain contact and be involved in the discharge planning process. This is in line with recommendations from the Department of Health Sign of the Times and Towards Equity and Access reports.

New presentations will not be accepted as emergency referrals.

The service will accept referral's for patients who meet the following criteria

- That a patient is deaf or deafened and likely to use manual methods of communication.
- That the person has a serious and acute mental health problem which would meet criteria for referral and treatment to a secondary mental health service or has complex presentations where there is significant evidence of an acute and/or enduring serious mental illness and a specialist assessment is required for a definitive diagnosis.
- That a patient is deaf and has been in secure care and no longer needs medium or low security and requires a time limited period of rehabilitation.
- That a patient is oral deaf and would benefit from a specialised deaf mental health service.

Criteria for exclusion for in-patient admission

Mild or no hearing loss

The patient does not have a significant mental illness

A patient has current high risk behaviours which cannot be managed safely within the Inpatient unit

A patient requires conditions of high, medium or low security

A patient has a learning disability and the extent of that disability means that patient would be best placed in a service for severe and profound learning disabilities

This service specification does not cover the highly specialised services previously commissioned by the National Specialised Commissioning Team. These include the Mental Health Service for Deaf Children and Adolescents (CAMHS) – in patient service and the outreach service

This specification does not cover the High Secure Deaf service at Rampton High Secure Hospital.

2.5 Interdependencies with other services

Interdependent

The service will work closely with the service users local services.

The service will provide regular training in diagnosing and treating mental illness with those providers where appropriate.

The service will accept referrals from secondary care mental health services and will work with those agencies to develop care plans for service users.

The service will work closely with the referring team and will plan care jointly with them and agree clarity about the responsibilities of each party identifying leads and actions points. This will need to include links with Clinical Commissioning Groups (CCGs) where funding for additional care packages may be required.

Where a patient has been admitted from another region, the service will work with the service users' home area agencies to develop care plans for patients after discharge.

Related

The service will work closely with local sensory social work services and voluntary (third sector) services for deaf people.

The service will provide regular training in diagnosing and treating mental illness with these providers.

The service will work with the national Deaf CAMH service around transition issues with the National Deaf CAMH service for those young people who will need to move from the children's service to adult services as they approach their 18th birthday.

The services will be part of a deaf providers network which will also include the high secure service at Rampton Hospital, Nottinghamshire Healthcare NHS Trust.

3. Applicable Service Standards

3.1 Applicable national standards e.g. NICE, Royal College

It is mandatory that staff need to be appropriately trained to provide therapeutic services to people who are deaf.

Designation Framework for Specialised Mental Health Services for Deaf People (non Secure), June 2011, developed by the North East Specialised Commissioning Team – see Appendix 1

National Institute for Health and Care Excellence (NICE) Guidance for Mental Disorders.

The Royal College of Psychiatrists are working towards developing a quality network for Specialised Mental Health Deaf services in 2013/14.

4. Key Service Outcomes

The service will work to improve the service user's mental health with optimum functioning and quality of life:

- Greater psychological functioning or well-being
- Appropriate level of personalised care tailored to the individuals needs
- Development of a placement profile with recommendations about accommodation, staffing needs. Continuing psychiatric and psychological treatments and support
- Discharge planning with the referrer including relapse prevention, crisis contingency, and recovery planning
- Provide comprehensive appropriate assessment where it's not been feasible to do otherwise
- Establish needs where it's not been possible
- Training supervision and development of mainstream mental health services
- Support local teams
- Signpost
- In-reach work
- Outreach work
- Individual treatment/ psycho-educational groups
- Skilled communication
- Reduce incidences of misdiagnosis
- Improve diagnosis

Supporting training and development of deaf staff to gain professional qualifications (sustainable workforce).

5. Location of Provider Premises

The current inpatient services are based in three locations:-

- London
- Birmingham
- Manchester

The current specialised community services are located :-

- London
- Birmingham
- Manchester
- Bristol
- North East
- Nottingham
- South Yorkshire

The High Secure Hospital Service is located:- Rampton High Secure Hospital Nottinghamshire Healthcare NHS Trust. This service is commissioned as part of the High Secure Hospital services provision and falls outside the remit of this service specification.

APPENDIX 1

Designation Framework

Specialised Mental Health Services for Deaf People (Non-Secure)

Produced by	North East Specialised Commissioning Team (NESCT)
Version No.	Final Draft June 2011
Date	June 2011
Review Date	April 2016 (tbc)

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1. Specialised Mental Health Service for Deaf People

Foreword

This designation framework has been developed for the designation of specialised mental health services for deaf people. This includes inpatient care and outpatient and community care.

For specialised commissioners to designate non secure specialised mental health services for deaf people there is a need to understand the context in which the services are delivered.

Specialised mental health services for deaf people for England, Wales and Scotland are provided across a small network of three NHS hospitals

- Old Church at South West London and St George's Mental Health NHS Trust.
- Jasmine Suite , The Barberry, at Birmingham and Solihull Mental Health NHS Foundation Trust
- John Denmark Unit at Greater Manchester West NHS Foundation Trust.

The specialised mental health services for deaf people are integrated within local NHS mental health services, two of which are regulated by Monitor and NHS Foundation Trust code of governance.

Deaf people have the same mental health problems as hearing people, but because of their communication, social, educational and linguistic needs require specialised services. The standards in this framework are therefore in addition to standards expected by hearing patients in mainstream mental health inpatient services.

This designation framework concerns adults of 18 year and over who are profoundly deaf and probably use manual methods of communication such as British Sign Language.

Specialised mental health services for deaf people operate twenty four hours seven days a week for inpatients and five days a week for outpatient and community services. This designation framework concerns performance standards expected in inpatient service settings as well as the outpatient or community teams that the provider offers.

2. Designation

2.1 Current specialised mental health services for deaf people are provided by three NHS mental health services.

2.2 At the present time, in each Strategic Health Authority (SHA) region there is a Specialised Commissioning Group (SCG) aligned to each SHA. SCG's were established following the Review of Commissioning Arrangements for Specialised services (Carter, 2006) and commission specialised services on behalf of Primary Care Trusts within SCG regions. Within the newly proposed arrangements, SCG's will be merged into four clusters which will mirror the SHA arrangements and will be accountable to the newly formed National Commissioning Board from April 2012.

2.3 The providers of specialised mental health services for deaf people work across neighbouring SCG regions, and as thus make up three supra regions across the UK.

2.4 Within each supra region the provider works with lead commissioners from each of their SCG regions.

2.5 The lead commissioners from within each supra region nominated a lead to carry out the designation process with the provider that is based in their supra region. The nominated lead then reports on the designation standards to the National Specialised Services Group.

2.6 It is the responsibility of SCGs to designate specialised services within their geographical patch on behalf of the other SCG's.

2.7 Designation is the formal process of ensuring that each specialised service provider meets the required service quality standards as well as being equipped to meet specific demand in a safe and cost effective manner.

2.8 The Department of Health (DH) requires that all specialised services are designated by the end of 2011.

2.9 Designation is not an isolated activity - it is part of the commissioning process to ensure fair access to clinically effective, high quality, cost effective services.

2.10 National guidance has been written to support the designation process for national services and is available on the NHS NSCG website.

2.11 Specific standards inform practice for a specialised mental health service for deaf people. They are identified as:

- "Valuing People Now: A Three Year Strategy for People With Learning Disabilities" DH (2009)
- "Mental Health and Deafness – Towards Equity and Access: Best Practice Guidance" (2005).
- No Health Without Mental Health DOH 2011
- Standards for Better Health 2007

2.12 These documents identify and inform an agreed set of quality principles to guide specialised commissioners and those wishing to provide Mental Health Services.

2.13 This designation framework will therefore acknowledge and base its' assessment process on the above documents (which have national standing and have involved commissioners, service users and the Royal College of Psychiatrists in their development).

2.14 Service providers must also be able to deliver services within (or comply with the requirements of) :-

- The service standards
- The patient pathway
- The patient access and egress criteria (e.g. clear processes locally agreed)
- The currency and classification
- The cost
- Information reporting
- Designated services will have to measure two outcome focussed objectives. One patient satisfaction measure and one clinical outcome measure, e.g. Health of Nation Outcome Score each year.

3. Service Model

3.1 The deaf persons will have a mental health problem which would meet normal criteria for referral to a secondary mental health service or has complex presentations where there is significant evidence of impaired functioning in everyday living and requires specialist treatment to attain and maintain optimal functioning.

3.2 The aim of specialised mental health services for deaf people is to ensure deaf people can be reliably assessed and treated in a way that is appropriate for them. The service nurtures expertise in how mental

health problems manifest in deaf people, methods of assessment and communication, and an understanding of Deaf culture.

3.3 The service follows a recovery approach which puts the deaf person at the centre of their support, and is a culturally sensitive and accessible multi-disciplinary service.

3.4 Treatment models will be fully supported by evidence based practice and clinical research.

3.5 The care programme approach will be integral to care delivery and evaluation

3.6 Care pathways to and from specialised mental health services for deaf people will be clearly identified and active links evident to enable smooth care pathways.

3.7 The patients are deaf and male/female and from a diverse group with common themes:-

- Language
- Culture
- Developmental Difficulties
- Mental Disorder

3.8 Patients who are profoundly deaf or with significant hearing loss will have a range of communication and language needs. They may have minimal language skills and will be expected to benefit from being treated in an environment that is able to meet their communication needs.

3.9 There is no one model which is the 'right way' and different models have developed based on evidence and research to achieve high quality service delivery.

4. Standards

Deaf Standards for Specialised Mental Health Services for Deaf People

Standards to meet the needs of deaf patients have been drawn up from a combination of service standards already adopted by the [NAME OF PROVIDER] and through a fact gathering visit of the patient or staff needs.

Ref	Standard and measures	Essential or Desirable	Evidence	Performance Rating (traffic light)	Evidence sought in TBC (depends on full or partial licence period)
1.0	**Policy – observing and implementing policies aimed at meeting the needs of Deaf patients and deaf staff**				
1.1	All policies (current and new) used by the specialised mental	E			

	health service for deaf people are deaf aware and deaf friendly.				
1.2	Deaf job applicants are supported to ensure they can fully access the recruitment process, and are guaranteed an interview if they meet the minimum criteria for a post	E			
1.3	Posts that would benefit from having the culturally competent skills of a deaf person are advertised through appropriate communication channels to access the Deaf community. Job descriptions and person specification are written in plain English/Easyread and	E			

	interpreting support is fully available for use during interviews				
1.4	All policies used by deaf service users, deaf staff and volunteers are written in both plain English and EasyRead/Widget format.				
1.5	All policies/statutory information that must be formally explained to the service users are	E			

	produced as DVDs with sign language inserts and captions. EasyRead/Widget and plain English text information on the same policy/statutory information is also available				
1.6	Deaf staff are represented at all business development fora in relation to deaf services	E			
1.7	Existing videos or DVDs used internally for training purposes, which do not have sign language inserts or captions need to have full access arrangements made – whether through using a plain English	E			

	transcript or a sign interpreter, or both, depending on the requirements of the staff				
1.8	There is good evidence that feedback from all training (face to face, group, on line, in house of external etc) provided to deaf staff and deaf volunteers is used to ensure satisfaction with the communication support used during the training is rated as high, and that where it is not, actions are taken to improve the rating	E			
1.9	The provider of the specialised	E			

	mental health service for deaf people has a page on their website that includes a video clip in sign language, giving an overview of the service to all those who access that website. The video is presented by a Deaf signer				
1.10	All interviews panels have a representative from either the deaf service users or from the deaf staff.				
1.11	The arrangements for deaf service advocacy will ensure deaf service users have the opportunity to choose use an independent advocacy worker who	E			

	1) is deaf, or, 2) is hearing and signs to level 3. Or, 3) is hearing and signs to level 2 and uses a registered qualified interpreter				
1.12	Deaf service users can at any time during office hours get the support they need to make contact with advocacy services	E			
1.13	Deaf service users have full access to appropriate education courses that would benefit them and there are no issues around the availability of interpreters or Deaf Support Workers(or similar) preventing them from accessing those courses	E			

1.14	The specialised mental health service for deaf people uses a speech and language therapist who can sign at least level 2, and has a background in working with deaf clients	E			
1.15	Manuals and visuals used during therapy sessions are provided in plain English and Easyread/Widget. Multimedia materials include sign language inserts	E			
1.16	On the ward there are readily accessible individualised care plans and emergency plans/guidance/questions available in Easyread/Widget for deaf staff and service users to use	E			

1.17	Deaf service users should not be prevented or delayed in accessing therapy (individual or group) because of the lack of availability of interpreters	E			
2.0	**Practice – managing the development and implementation of best practice**				
2.1	The use of portable loop systems are promoted widely throughout the service, and made available to anyone who	E			

	requires it				
2.2	Text phones are in full working order and accessible in suitable settings for deaf service users and staff to use	E			
2.3	All staff in the specialised mental health service for deaf people use Typetalk and are confident in using the service, and explaining it to others. Induction training on using Typetalk is provided to all staff who are not familiar with this service	E			
2.4	Flashing beacons are available throughout the premises alongside the audible alarm. This applies to offices,	E			

	bedrooms, communal areas, toilets and meeting rooms for the benefit of deaf staff, service users and deaf visitors. Deaf members of staff have a paging device to inform them that the alarm has been activated. The evacuation plan is tested regularly with staff and service users				
2.5	A flashing light is used to alert deaf members of staff that there is a visitor to the ward	E			
2.6	Any lift used by deaf staff or unoccupied deaf visitors has a visual alarm installed in them together with clear instructions on what action needs to be taken should the alarm go off	E			

2.7	The specialised mental health service for deaf people will register with the quality network	E			
2.8	The service adheres to principles of clinical governance via in-house and national audits and benchmarking (within and between deaf services), presentation and publication of clinical governance data, active sharing of information nationally and internationally.				
3.0	**Process – supporting processes that address the needs of the Deaf patients**				

3.1	Deaf Awareness training is provided to sufficient numbers of front line staff, such as security staff, receptionists, customer service staff, call centre staff and health and safety managers so that during any shift, a deaf service user, deaf member of staff or deaf visitor, who comes into contact with front line staff will experience no barriers when dealing with them. Sufficient numbers means that at any one time there is at least one person on the service who has had the training and is best placed to communicate with the deaf visitor, carer, volunteer or member of staff	E			
3.2	Staff based in the specialised				

	mental health service for deaf people who have not previously had BSL training, receive deaf awareness training within three months of commencing their post. Equally deaf staff will receive hearing awareness training or working with hearing people training within three months of commencing their post.	E			
3.3	Staff based in the specialised mental health service for deaf people who carry out non clinical engagement work and are in direct contact with deaf BSL service users, achieve Level 1 Certificate in British Sign Language as a minimum, (Accredited by Signature). In-house training may only	E			

	supplement, and not substitute this qualification				
3.4	Staff based in the specialised mental health service for deaf people who engage on a regular clinical basis with deaf BSL service users achieve Level 2 Certificate in British Sign Language, (accredited by Signature), as a minimum.	E			
3.5	Deaf service users, staff or carers who require communication support that is not in sign language (lip speakers, note takers, speech to text) can receive this if they wish	E			
3.6	Only registered qualified	E			

	interpreters are used to interpret in any clinical meetings or settings. These interpreters are qualified to Signature's BSL level 4, or at university post graduate level. They are a member of the National Registers of Communication Professionals working with Deaf and Deafblind people www.nrcpd.org.uk,				
3.7	At the beginning of every shift there will be an assessment of communication needs and appropriate interpreting provided. It is the responsibility of the service to ensure that there is access to appropriate communication level. Signing staff should not be used when an interpreter is needed.	E			

3.8	The service is able to receive and provide appropriate individual or group clinical supervision to al members of staff, including freelance interpreters.				
3.9	Staffs in the team keep up to date with professional practice standards by attending necessary training.				
4.0	**People - promoting equalities and involvement**				
4.1	All new training, promotional, staff videos and multimedia CD ROMS have a sign language insert and captions so any deaf	E			

	service users or staff can access the information				
4.2	There is an inclusive policy in place during and outside of office hours. This means at all times deaf service users, deaf staff and deaf volunteers may not feel excluded when in company with specialised inpatient provider who communicate without using sign language	E			
4.3	Deaf service users are individually approached every six months and asked to rate the service's deaf awareness, access to information and communication support etc.(checklist to be created)	E			

4.4	Deaf service users are able to give feedback at monthly forums on their own agenda to voice their views on the service and discuss any issues that they are not happy with on the ward, including communication support.	E			
4.5	Deaf service users, staff and volunteers are asked to give specific feedback during supervision meetings, on the service's deaf awareness, access to information and communication support (checklist to be created)	E			

4.6	In line with standard 1.14, deaf patients have access to the same and recreational facilities' as hearing patients and on an equitable basis. Records should be held on database to compare levels of access (patients numbers and activity levels) between the deaf and hearing service users, and any gaps are either justified or actively addressed as necessary				

Standards for Specialised Mental Health Services for Deaf People

A standard for Better Health (2007) identifies core standards for mental health and learning disability services. These standards are required to be met for designation purposes. The seven domains are safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.

5. Safety

Patient safety is enhanced by the use of overall healthcare processes, working practices and systemic activities that prevent or reduce the risk of harm to patients.			
Core Standard		**Evidence**	**Performance Rating (traffic light)**
5.1	Healthcare organisation protect patients through systems that: (a) identify and learn from all patient safety incidents and other reportable incidents, and make improvements in practice, based on local and national experience and information derived from the analysis of incidents; and (b) Ensure that all patient safety notices, alerts and other communications concerning patient safety which require action are acted upon within required timescales.	SUI reporting systems and processes	
5.2	Healthcare organisations protect children by following national child protection guidance within their own activities and in their dealings with other organisations.	Safeguarding policies	
5.3	Healthcare organisations protect patients by following NICE		

	Interventional Procedures guidance.		
5.4	Healthcare organisations keep patients, staff and visitors safe by having systems to ensure that: (a) the risk of healthcare-acquired infection to patients is reduced, with particular emphasis on high standards of hygiene and cleanliness, achieving year-on-year reductions in MRSA; (b) all risks associated with the acquisition and use of medical devices are minimised; (c) all reusable medical devices are properly decontaminated prior to use and that the risks associated with decontamination facilities and processes are well managed; (d) medicines are handled safely and securely; and (e) The prevention, segregation, handling, transport and disposal of waste is properly managed so as to minimise the risks to health and safety of staff, patients, the public and the safety of the environment.	Modern matrons Infection control policy Waste management	
5.5	The service is compliant with the Health and Safety at Work Act 1974		
5.6	The service operates under the Safety and Security Directions 2000 / 2009.		
Developmental Standard		**Evidence**	**Performance Rating (traffic light)**
5.7	Healthcare organisations continuously and systematically review and improve their activities	Transition policy Admission and Discharge policy	

	that directly affect patient safety and apply best practice in assessing and managing risks to patients, staff and others; particularly when patients move from the care of one organisation to another.	Transfer policy	

6. Clinical and Cost Effectiveness

Clinical and Cost Effectiveness Patients achieve healthcare benefits that meet their individual needs through healthcare decisions and services based on what assessed research evidence has shown provides effective clinical outcomes.			
Core Standard		**Evidence**	**Performance Rating (traffic light)**
6.1	Healthcare organisations ensure that: (a) they conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care; (b) critical care and treatment are carried out under supervision and leadership; (c) clinicians continuously update skills and techniques relevant to their clinical work; and (d) Clinicians participate in regular clinical audit and review of clinical services.		
6.2	Healthcare organisations co-operate with each other and social care organisations to ensure		

	those patients' individual needs are properly managed and met.		
Developmental Standard	**Evidence**	**Performance Rating (traffic light)**	**Developmental Standard**
6.3	Patients receive effective treatment and care that: (a) conform to nationally agreed best practice, particularly as defined in National Service Frameworks, NICE guidance, national plans and agreed national guidance on service delivery: (b) take into account their individual requirements and meet their physical, cultural, spiritual and psychological needs and preferences; (c) are well co-ordinated to provide a seamless service across all organisations that need to be involved, especially social care organisations; and (d) is delivered by healthcare professionals who make clinical decisions based on evidence-based practice.		
6.4	Systems are in place to record admissions, length of stay, treatment outcomes, discharges, refusals and waiting lists		

7. Governance

GOVERNANCE

Managerial and clinical leadership and accountability, as well as the organisation's culture, systems and working practices ensure that probity, quality assurance, quality improvement and patient safety are central components of all the activities of the healthcare organisation.

Core Standard		Evidence	Performance Rating (traffic light)
7.1	Healthcare organisations: (a) apply the principles of sound clinical and corporate governance; (b) actively support all employees to promote openness, honesty, probity, accountability and the economic, efficient and effective use of resources; (c) undertake systematic risk assessment and risk management; (d) ensure financial management achieves economy, effectiveness, efficiency, probity and accountability in the use of resources; (e) Challenge discrimination, promote equality and respect human rights.		
7.2	The service is regulated by the Care Quality Commission		
7.3	The service reports and achieves the targets against the performance		

	standards set for the quarterly performance management meeting with the Specialised Commissioning Group.		
7.4	Healthcare organisations support their staff through (a) having access to processes which permit them to raise, in confidence and without prejudicing their position, concerns over any aspect of service delivery, treatment or management that they consider to have a detrimental effect on patient care or on the delivery of services; and (b) Organisational and personal development programmes which recognise the contribution and value of staff, and address where appropriate, under-representation of minority groups.	Whistle blowing policy	

Core Standard		**Evidence**	**Performance Rating (traffic light)**
7.5	Healthcare organisations have a systematic and planned approach to the management of records to ensure that, from the moment a record is created until its ultimate disposal, the organisation maintains information so that it serves the purpose it was collected for and disposes of the information appropriately when no longer required.	Record keeping policy	
7.6	Healthcare organisations: (a) undertake all appropriate		

	employment checks and ensure that all employed or contracted professionally qualified staff are registered with the appropriate bodies; and (b) Require that all employed professionals abide by relevant published codes of professional practice.		
7.7	Healthcare organisations ensure that staff concerned with all aspects of the provision of healthcare (a) are appropriately recruited, trained and qualified for the work they undertake; (b) participate in mandatory training programmes; and (c) Participate in further professional and occupational development commensurate with their work throughout their working lives.		
7.7	Healthcare organisations which either lead or participate in research have systems in place to ensure that the principles and requirements of the research governance framework are consistently applied.		

Developmental Standard		**Evidence**	**Performance Rating (traffic light)**
7.8	Integrated governance arrangements representing best practice are in place in all healthcare organisations and across all health communities and		

	clinical networks.		
7.9	Healthcare organisations work together to: (a) Ensure that the principles of clinical governance are underpinning the work of every clinical team and every clinical service; (b) Implement a cycle of continuous quality improvement; and (c) Ensure effective clinical and managerial leadership and accountability.		
7.10	Healthcare organisations work together and with social care organisations to meet the changing health needs of their population by; (a) having an appropriately constituted workforce with appropriate skill mix across the community; and (b) Ensuring the continuous improvement of services through better ways of working.		
7.11	Healthcare organisations use effective and integrated information technology and information systems which support and enhance the quality of safety of patient care, choice and service planning.		
7.12	Healthcare organisations work to enhance patient care by adopting best practice in human resources management and continuously improving staff satisfaction.		

8. Patient Focus

PATIENT FOCUS

Healthcare is provided in partnership with patients, their carers and relatives, respecting their diverse needs, preferences and choices, in partnership with other organisations (especially social care organisations) whose services impact on patient well-being.

Core Standard		Evidence	Performance Rating (traffic light)
8.1	Healthcare organisations have systems in place to ensure that: (a) staff treat patients, their relatives and carers with dignity and respect; (b) appropriate consent is obtained when required for all contacts with patients, and for the use of any patient confidential information; and (c) Staff treat patient information confidentially, except where authorised by legislation to the contrary.		
8.2	Healthcare organisations have systems in place to ensure that patients, their relatives and carers; (a) have suitable and accessible information about, and clear access to, procedures to register formal complaints and feedback on the quality of services; (b) are not discriminated against when complaints are made; and (c) are assured that organisations act appropriately on any concerns and, where appropriate,		

	make changes to ensure improvements in service delivery.		
8.3	Where food is provided, healthcare organisations have systems in place to ensure that; (a) patients are provided with a choice and that it is prepared safely and provides a balanced diet; and (b) patients' individual nutritional, personal and clinical dietary requirements are met, including any necessary help with feeding and access to food 24 hours a day.		
8.4	Advocacy services are easily available and will include IMHA advocates.		
8.5	Healthcare organisations make information available to patients and the public on their services, provide patients with suitable and accessible information on the care and treatment they receive and, where appropriate, inform patients on what to expect during treatment, care and after-care.		
8.6	The special needs of patients and carers from different ethnic, cultural or religious backgrounds are reflected in the service policies		

Developmental Standard		**Evidence**	**Performance Rating (traffic light)**
8.7			

	Healthcare organisations Continuously improve the patient experience, based on the feedback of patients, carers and relatives.		
8.8	Patients, service users and, where appropriate, carers receive timely and suitable information, when they need and want it, on treatment, care, services, prevention and health promotion.		

9. Accessible and Responsive Care

ACCESSIBLE AND RESPONSIVE CARE

Patients receive services as promptly as possible, have choice in access to services and treatments, and do not experience unnecessary delay at any stage of service delivery or of the care pathway.

Core Standard		Evidence	Performance Rating (traffic light)
9.1	The views of patients and their carer are sought and taken into account in designing, planning, delivering and improving healthcare services.		
9.2	Healthcare organisations enable all members of the population to access services equally and offer choice in access to services and treatment equitably.		
9.3	Healthcare organisations ensure that patients with emergency health needs are able to access care		

	promptly and within nationally agreed timescales, and all patients are able to access services within national expectations on access to services.		
9.4	The service has the capacity to admit deaf men and women with Mental Health, Personality Disorder and Learning Disabilities, based on individual need.		
9.5	Where appropriate, there are established links with Her Majesty's Prison Service, Ministry of Justice, Courts and Medium/Low Secure Services to ensure seamless admissions and discharges.		
9.6	There will be a specialist referral/admission panel that comprises of clinical staff with specialist skills and training for deaf people		
9.7	The service has clear, written criteria and policy for admission		
9.8	The Code of Practice least restrictive principle and Reed recommendations will be evidenced to ensure deaf people are always admitted and treated in lowest level of security required.		
9.9	Patients have an assessment of their needs and risks, which is regularly reviewed under the Care Programme Approach.		

Developmental Standard		Evidence	Performance Rating (traffic light)
9.11	Healthcare organisations plan and deliver healthcare which; (a) reflects the views and health needs of the population served and which is based on nationally agreed evidence or best practice; (b) maximises patient choice; (c) ensures access (including equality of access) to services through a range of units and routes of access; and (d) Uses locally agreed guidance, guidelines or protocols for admission, referral and discharge that accord with the latest national expectations on access to services.		
9.12	Information is provided to referrers on the process of referral and admission.		
9.13	Information is available for referrers and other related professionals.		
9.14	Within 72 hours of admission a patient will be seen by a Dr and physical healthcare assessment offered and undertaken with patient agreement.		

10. Care Environment and Amenities

CARE ENVIRONMENT AND AMENITIES

Care is provided in environments that promote patient and staff well-being and respect for patients' needs and preferences in that they are designed for the effective and safe delivery of treatment, care or a specific function, provide as much privacy as possible, are well maintained and are cleaned to optimise health outcomes of patients.			
Core Standard		**Evidence**	**Performance Rating (traffic light)**
10.1	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being: (a) a safe and secure environment which protects patients, staff, visitors and their property, and the physical assets of the organisation; and (b) Supportive of patient privacy and confidentiality.		
10.2	Healthcare services are provided in environments which promote effective care and optimise health outcomes by being well designed and well maintained with cleanliness levels in clinical and non-clinical areas that meet the national specification for clean NHS premises.		
	Developmental Standard	**Evidence**	**Performance Rating(traffic light)**
10.3	Healthcare is provided in well-designed environments that; (a) promote patient and staff well-being, and meet patients' needs and preferences, and staff concerns; and (b) Are appropriate for the effective and safe delivery		

	of treatment, care or a specific function, including the effective control of healthcare associated infections		

11. Public Health

PUBLIC HEALTH **Programmes and services are designed and delivered in collaboration with all relevant organisations and communities to promote, protect and improve the health of the population served and reduce health inequalities between different population groups and areas.**			
Core Standard		**Evidence**	**Performance Rating (traffic light)**
11.1	Healthcare organisations promote, protect and demonstrably improve the health of the community served, and narrow health inequalities by (a) co-operating with each other and with local authorities and other organisations; (b) ensuring that the local Director of Public Health's Annual Report informs their policies and practices; and (c) Making an appropriate and effective contribution to local		

	partnership arrangements including Local Strategic Partnerships and Crime and Disorder Reduction Partnerships.		
11.2	Healthcare organisations have systematic and managed disease prevention and health promotion programmes which meet the requirements of the National Service Frameworks and national plans with particular regard to reducing obesity through action on nutrition and exercise, smoking, substance misuse and sexually transmitted infections.		
11.3	Healthcare organisations protect the public by having a planned, prepared and, where possible, practiced response to incidents and emergency situations which could affect the provision of normal services.		

11.4	Healthcare organisations: (a) identify and act upon significant public health problems and health inequality issues, with primary care trusts taking the leading role; (b) implement effective programmes to improve health and reduce health inequalities, conforming to nationally agreed best practice, particularly as defined in NICE guidance and agreed national guidance on public health; (c) protect their populations from identified current and new hazards to health; and (d) Take fully into account current and emerging policies and knowledge on public health issues in the development of their public health programmes, health promotion and prevention services for the public, and the commissioning and provision of the above services.		

12. Minimum Service Requirements Checklist

Standard for Specialised Mental Health Services for Deaf People

Deaf Standards

	Section	Core Standard	Desirable Standard

Section No.			
1.0	Policy – Objectives and implementing polices aimed at meeting the needs of deaf patient		N/A
2.0	Practice – managing the development and implementation of best practice		N/A
3.0	Process – supporting processes that address the needs of the Deaf patients		N/A
4.0	People - promoting equalities and involvement		N/A
5.0	Safety		
6.0	Clinical and Cost Effectiveness		
7.0	Governance		
8.0	Patient Focus		
9.0	Accessible and Responsive Care		
10.0	Care Environment and Amenities		

11.0	Public Health		

13. Outcome Measures

13.1 The Service should ensure they agree to provide clinical outcomes for each patient using:-

- (HONOS) Outcome measures used as part of the Health of the Nation Outcome Scores

- At least one other clinical measurement framework as defined in the NHS Multilateral Contract or Service Specification as agreed with commissioners

13.2 The service must also deliver service improvements based upon an agreed Quality Improvement Plan at service level.

13.3 The service must capture user defined outcomes for each patient based on:-

- Narrative testimony (using service users words, experience, observations, comments, stories)
- Key outcomes (rehab and recovery)
- Recovery rating, scale based on:-
  - Purpose and meaning
  - Relationships
  - Hope and esteem
  - Independence, choice and control
  - Citizenship
  - Stability and consistency

13.4 Services must also be able to evidence, as a minimum, two improvements per year that has been made as a result of a patient's suggestion

Designation Checklist

Service agrees to use Health of Nation Outcome Scores

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14. Designation Report

To be completed following classification visit by responsible commissioner(s)

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