2019/20 PSS CQUIN Scheme

Indicator Template

[Section B to be completed before insertion in contracts.]

PSS6 D/deaf Communications Assessment

Indicator Name	***Using communications assessments to enhance care pathways in D/deaf MH Services***
A. SUMMARY of Indicator	
Indicator Sponsor (with email address)	Victoria.Man@nhs.net alexanderhamilton@nhs.net
QIPP Reference	n/a
Duration	2 years
CCG Complementarity	n/a

Problem to be addressed

[*Briefly characterise the shortfall in quality or efficiency that the indicator is designed to address; detailed evidence should be placed in section D1****]***

Deaf people with mental health problems face significant challenges in accessing and benefiting from mental health services. Not all D/deaf people have the same communication needs; difficulties in communication make diagnosis and management challenging and lead to conceptual deficits, which in turn can lead to significant mental health problems.

D/deaf inpatient services have long lengths of stay; this has been attributed in part to the complexity in treating D/deaf people. In order to reduce length of stay for D/deaf inpatients, it is important to ensure services have appropriate tools to enable effective communication with patients.

The Communication Sunburst Tool has been developed by clinicians in adult Deaf mental health services as a means of assessing and recording the communication strengths and weaknesses of a D/deaf person. The Communication profile has been developed in Deaf CAMHS. Embedding these into the management of D/deaf patients will enable better assessment of communication needs of D/deaf people and comparison between D/deaf people.

Change sought:

[Specify what change in behaviour is sought in general terms, with detailed specification set out in section C4.]

- The implementation of the Communication Sunburst Tool/ Deaf CAMHS Communication Profile as the standard assessment approach across all mental health and D/deafness services

- Communication Sunburst Tool/ Deaf CAMHS Communication Profile used as part of wider approach using All About Me/ framework including Communication Profiling and Communication Passports
  - Reduced lengths of inpatient stays where delays are attributable to unresolved communication difficulties
  - More effective transfers of care at discharge and service transition points
  - Needs of D/deaf patients appropriately identified and adaptations made to support effective communication
  - Improved clinical and patient reported outcomes

B. **CONTRACT SPECIFIC INFORMATION** *(for completion locally, using guidance in sections C below)*

B1.Provider (see Section C1 for applicability rules)	*[Insert name of provider]*
B2. Provider Specific Duration. What will be the first Year of Indicator for this provider, and how many years are covered by this contract?	2019/20 2020/21 *[Adjust locally]* One/two years *(Adjust locally)*
B3.Indicator Target Payment (see Section C3 for rules to determine target payment)	Full compliance with this CQUIN indicator should achieve payment of: Target Value: *[Add locally ££s]*

B4. Payment Triggers.

The triggers, and the proportion of the target payment that each trigger determines, and any partial payment rules, for each year of the indicator, are set out in Section C4.

Relevant provider-specific variation, if any, is set out in this table.

[Adjust table as required for this indicator – or delete if no provider-specific information is required.]

Provider specific triggers	**2019/20**	**2020/21**
Trigger 1:		

Trigger 2:		
Trigger 3		

B5. Information Requirements	
Obligations under the indicator to report against achievement of the Triggers, to enable benchmarking, and to facilitate evaluation, are as set out in Section C5.	
Final indicator reporting date for each year.	Month 12 Contract Flex reporting date as per contract. *[Vary if necessary.]*

B6. In Year Payment Phasing & Profiling

Default arrangement: half payment of target CQUIN payment each month, reconciliation end of each year depending upon achievement.

[Specify variation of this approach if required]

C. INDICATOR SPECIFICATION GUIDE: STEP CHANGE INDICATORS	
C1. Providers to whom Applicable	
Nature of Adoption Ambition*:*	All providers of D/deaf services (Adult/CAMHS)
List of Providers for whom Indicator is Applicable	GREATER MANCHESTER MENTAL HEALTH BIRMINGHAM & SOLIHULL MH NHS FT SOUTH WEST LONDON & ST GEORGE'S MH TRUST ELYSIUM HEALTHCARE (*FORMERLY ST GEORGES HEALTHCARE GROUP)* CYGNET HEALTHCARE ST ANDREWS HEALTHCARE NOTTINGHAMSHIRE HEALTHCARE NHS FT DUDLEY AND WALSALL MH PARTNERSHIP NHS TRUST LEEDS AND YORK PARTNERSHIP NHS FT SOMERSET PARTNERSHIP NHS FT
C2. Provider Specific Parameters	
The indicator requires the following parameters to be set for each provider in advance of contract, in order to determine precisely what is required of each provider, and/or to determine appropriate target payment (as per C3.)	n/a
C3. Calculating the Target Payment for a Provider	

The target overall payment for this indicator (the payment if the requirements of the indicator are fully met, to be set in Section B3 above) should be calculated for each provider, according to the following algorithm:

The total value of the scheme is calculated as 1.25% of the baseline value of the provider contract for this service.

Provider payment is split against the scheme triggers in Section C4 below. The % split for each trigger is also set out in Section C4 below

See Section D3 for the justification of the targeted payment, including justification of the costing of the indicator, which will underpin the payment.

C4. Payment Triggers and Partial Achievement Rules

The interventions or achievements required for payment under this CQUIN indicator are as follows:

Descriptions	First Year of indicator	Second Year
Trigger 1	Q1 and Q2 Using guidance in appendix, each provider • Establish baseline service position of team skills and capabilities to undertake communication assessments and implement All About Me Recovery Tool and/or the Deaf CAMHS Assessment and identify change required • Complete baseline quantitative and qualitative audit of patient communication assessments • Establish service/organisational governance infrastructure, reporting, engagement and communication processes needed to oversee and deliver service change programme over years 1 and 2 • Evidence of work with national deaf provider network and Deaf Advisory Group to enable sharing of national intelligence and development of inter-organisational working, design and delivery of national training programme • Agree the required local service change programme including local training plan, outcome metrics, delivery mechanisms/approach and resources to deliver improvements against baseline in each service.	Q1 and Q2 Provider to demonstrate • Active implementation of refreshed change programme building on learning from year 1 • Evidence of progress made against programme deliverables including demonstration of changes made at corporate, service and patient level and impact on service baselines • Active contribution to work of National Deaf Advisory Group and National Provider Network including production of final versions of national communication assessment and training tools • Communication assessments completed for 50% of existing patients and 100% of new admissions in previous quarter • All About Me Recovery and/or Deaf CAMHS Assessment planning used for >50% of existing patients by end of Q4 and 100% of new patients admitted in previous quarter • Minimum of 50% existing staff and 100% of joiners in previous quarter undergone training in communications skills
Trigger 2	Q3 and Q4	Q3 and Q4

	Using guidance in the appendix, provider to demonstrate • Active implementation of change programme including use of All About Me and/or Deaf CAMHS Assessment, team training and delivery of communications assessments against agreed programme metrics • Evidence of active contribution to work of National Deaf Advisory Group and National Provider Network • Sunburst Tool Communications assessment/CAMHS Communication Profiles completed for >25% of existing patients by end of Q4 and all new admissions in previous quarter • All About Me Recovery planning used for >25% of existing patients by end of Q4 and 100% of new patients admitted in previous quarter	• Re-audit against baselines to identify changes update implementation plan in line with findings • Communication assessments completed for 100% of existing patients and 100% of new admissions in previous quarter • All About Me Recovery and/or CAMHS Communication Assessment planning used for >100% of existing patients by end of Q4 and 100% of new patients admitted in previous quarter • Evidence communications assessment training included as part of induction and mandatory training programme • Repeat Complete baseline quantitive and qualitative audit of patient communication assessments
Trigger 3	• Evaluation of impact and refreshed change programme reflecting outcome for implementation from Q1 year 2 • Annual report co-produced with patients, staff and carers/families – reflecting on changes made and impact with recommendations for continued action in year 2	Final co-produced evaluation report with recommendations for further action.

Target payment per trigger

The following table sets out the target payment that is payable on achievement of the payment triggers

Target Payment per Trigger	First Year of indicator	Second Year
Trigger 1 (Q1 and Q2)	10%	45%
Trigger 2 (Q3 and Q4)	80%	50%
Trigger 3 (Q4)	10%	5%
TOTAL	100%	100%

Partial achievement rules

Not applicable

Definitions

C5. Information Flows: for benchmarking, for evaluation, and for reporting against the triggers.

To be determined by the Deaf Advisory Group
Reporting of Achievement against Triggers:
Information for Benchmarking:
Audit information generated
Information Governance:
No patient identifiable information to be used
Reporting Template requirement:
n/a
C6. Supporting Guidance and References
Further details on implementation, and references to documents that will support implementation: https://www.ntw.nhs.uk/content/uploads/2018/02/All-About-Me-Deaf-Recovery-Package.pdf The Sunburst Communication Assessment Tool and the Deaf CAMHS Communication Profile are included in the **Appendix** at the end of this document. The Sunburst Tool ***Outcome Assessment Template*** and a ***Completed Example*** are to be found alongside this template, here: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/

D. Indicator Justification and Evaluation
D1. Evidence and Rationale for Inclusion
Evidence Supporting Intervention Sought Historically, mental health services have used a variety of means and approaches to assessing D/deaf patient's communication skills and understanding. There is an argument to standardise this assessment process, ensuring best clinical practice across the all services to facilitate and improve the patient's experience of services and transitions between each element of the pathway. The Communication Sunburst tool and Deaf CAMHS Communication Profile compliment the All About Me Recovery Package and Deaf CAMHS Assessment by providing a framework for assessing and understanding all domains of the patient's communication needs. The Communication Sunburst Tool has been piloted nationally in adult inpatient services and has received positive feedback from multi-disciplinary colleagues. The Communication Profile has been rolled out nationally in Deaf CAMHS and received similarly positive feedback from professionals and families alike. The aim is to further refine the tool and the staff training required to support implementation and embedding into everyday clinical practice.
Rationale of Use of CQUIN incentive **CQUIN as an instrument is justified if net costs beyond normal service requirements are incurred by providers whilst benefits and cost savings accrue to patients and commissioners.**

The approach to assessing and understanding individual patient's communication approaches and capabilities will vary, this has an impact on how staff and others may interact with them, how services assess and plan to meet their needs and how transitions between services are managed. The benefits of the Sunburst Communication Tool/Communication Profile scheme include

i. Leading the service team to be aware of how, where, when, and with whom a person communicates at their best. The Sunburst/ Communication Profile allows for direct comparison between variables which impact level of functioning enabling consideration to be given to how care and support can be individually tailored to that person
ii. Supporting diagnosis making and clinical formulation.
iii. Understanding different reasons for long lengths of stay for D/deaf inpatients and to allow differentiation between patient groups (communication deprived/limited compared to patients with good communication skills).
iv. Supporting transition between services and minimising disruption to continuity of care.
v. Supporting appropriate and timely adjustments to care and treatment by identifying communication functioning in relation to interventions, relapse signatures or progression of a condition.

D2. Indicator Duration and Exit Route

The appropriate duration of an indicator depends upon how long CQUIN support is required before the change in behaviour sought can be embedded in services specification or otherwise.

On completion of the 2-year period the use of the Sunburst tool will be fully embedded in all providers a part of routine practice. Organisations will be expected to include training in the use of the tool as part of their mandatory staff induction and refresher training programmes.

D3. Justification of Size of Target Payment

The evidence and assumptions upon which the target payment was based, so as to ensure payment of at least 150% of average costs (net of any savings or reimbursements under other mechanisms), is as follows:

Target payment covers costs of establishing the scheme and the associated organisational and service structures, processes and delivery mechanisms including training and equipment requirements.

Scheme costs will vary by provider and individual service reflecting organisational differences for example against a single or multi-site provider, linking the value of the scheme to the value of the contract baseline ensures equity in approach.

D4. Evaluation: Approach, data and resources

Evaluation Approach:

To be determined by the Deaf Advisory Group

Information for Evaluation	To be determined
Resources for Evaluation	To be determined

APPENDIX

Salford Royal NHS Foundation Trust
University Teaching Trust
safe • clean • personal

Communication Sunburst

NHS
Greater Manchester Mental Health
NHS Foundation Trust

Name

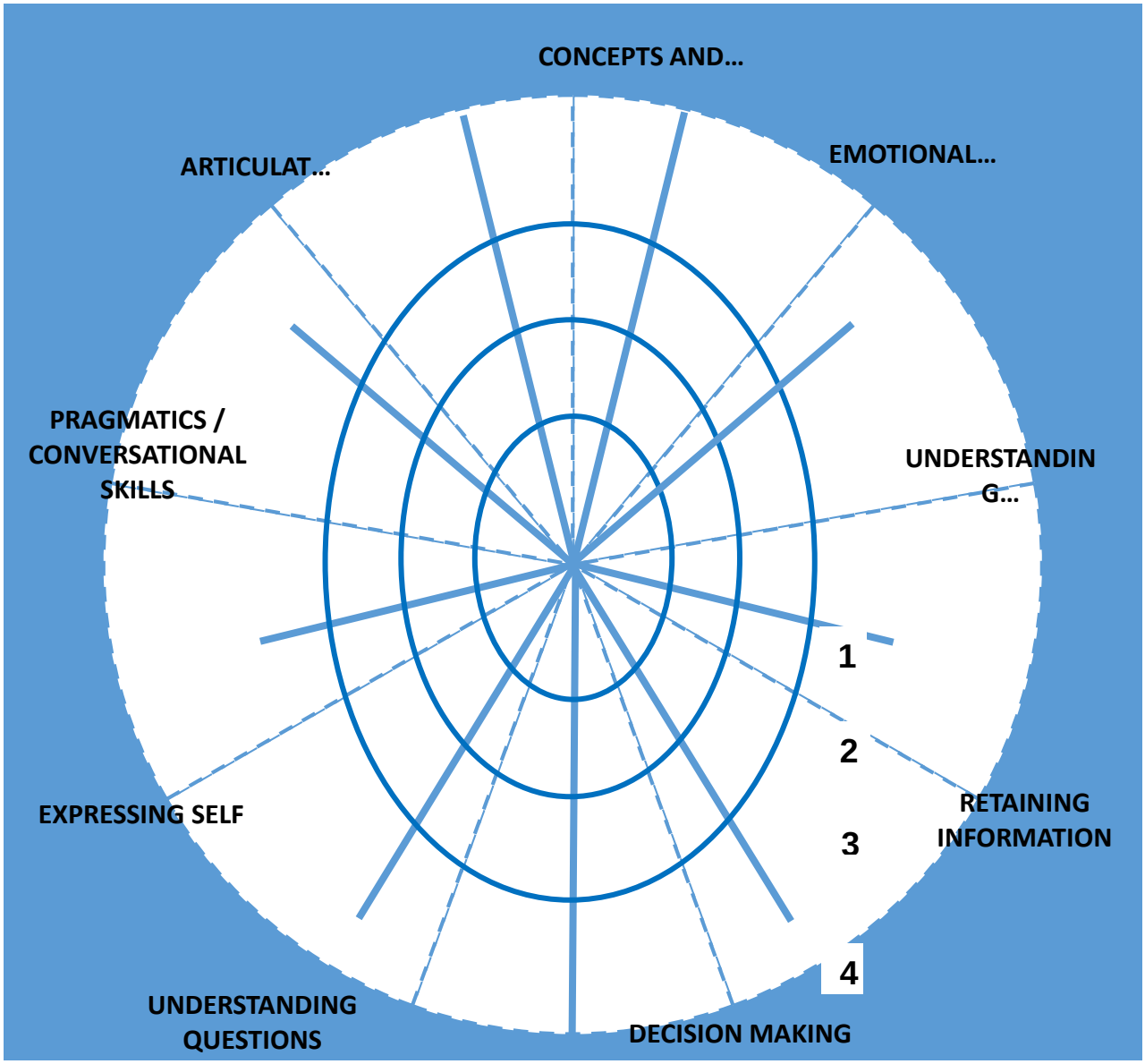
Date of Birth

Date of Assessment

Planned Review Date

	Score	Score
Articulation		
Concepts and Vocabulary		
Emotional Vocabulary		
Understanding Information		
Retaining Information		
Decision making		
Understanding questions		
Expressing Self		
Pragmatics		
Total		

Comments



Language Aspect *(circle appropriate number)*	**Comments**
CONCEPTS AND VOCABULARY 1. Limited BSL (home signs/gesture) or limited English 2. Adequate concrete everyday vocabulary within own experience 3. Some abstract concepts (e.g. *think, responsible*) and ability to talk about some things outside of own experience. 4. Wide ranging vocabulary, including high level abstract concepts across a range of topics.	

EMOTIONAL VOCABULARY 1. Own emotions are only demonstrated with spontaneous facial expression and behaviour 2. Able to recognise and label own and others' basic feelings e.g. *happy, sad, angry.* 3. Able to discuss feelings at a higher level with support and extra time. 4. Understands and is able to talk about own and others' feelings even when complex.	
UNDERSTANDING INFORMATION 1. Relies on gesture, pictures, demonstration and routine 2. Understands some very short basic information outside routine 3. Understands longer multi part information e.g. a set of instructions 4. Understands narrative level information e.g. stories and explanations	
RETAINING INFORMATION 1. Unable to repeat back basic information that has just been given. 2. Retains new information over a few minutes only. 3. Retains new information over an hour. 4. Retains new information from one day to another with minimal prompting	
DECISION MAKING 1. Passive and willing to be directed by others/acts impulsively 2. Indicates a here and now preference when offered tangible choices e.g. *outfits, snacks.* 3. Able to consider choices based around familiar experiences. 4. Able to evaluate new information and arrive at an informed decision about future significant life events.	
UNDERSTANDING QUESTIONS 1. Responds appropriately to routine or gestured yes/no questions *2.* Responds appropriately to basic questions in the here and now e.g. *Where is the nurse? Who is your nurse?*	

3. Responds appropriately to a range of questions including everyday cause and effect e.g. *When did that happen? Why were you late?* *4.* Responds appropriately to complex abstract questions e.g. *How does your mental illness affect your life?*	
EXPRESSING SELF 1. Relies on gesture, vocalisation and a few disjointed home signs/words or talks/signs fluently but with little or no meaningful content 2. Able to talk/sign briefly about own experiences here and now at a concrete level, using some grammatical cohesion e.g. basic placement, directional verbs or word order. 3. Able to talk/sign more extensively around a limited range of topics using more structured BSL / English. 4. Able to talk/sign at length around a wide range of topics, including hypothetical situations and unfamiliar information using sophisticated language.	

PRAGMATICS / CONVERSATIONAL SKILLS 1. Either is not motivated to participate in conversation beyond communicating basic needs or dominates conversation with non-meaningful information. 2. Has some conversational skills but communication is limited because of difficulties e.g. with turn taking or eye contact 3. Generally participates well in everyday exchanges but needs support from other person to maintain and extend the conversation. 4. Uses available language skills effectively so that conversation flows appropriately to the context and occasional misunderstandings are repaired. Information is given in a fluent well organised way with awareness of the other person's needs.	
ARTICULATION 1. Struggles to sign/speak in an intelligible way e.g. because of a stroke or cerebral palsy. 2. Signing / speech is mostly intelligible to familiar people (who have "tuned in") 3. Signing / speech is mostly intelligible to new people. 4. Signing / speech is clearly articulated.	

Examples given in descriptors will not be equally relevant to everyone. When this is the case, consider:

4 = no difficulties or support needs
3 = a little difficulty noted / support needed on occasion
2 = marked difficulty / consistent support needed day to day
1 = significant difficulties impact conversation.

An Overview of the process

1. Within an MDT discussion, consider how the person functions within each domain. Where appropriate, involve the person in this conversation. Look for evidence of skills as well as examples of difficulties. Everyone forgets words and signs, misunderstands and has difficult conversations from time to time, so think about how often any difficulties occur and how much of an impact they have. It may be valuable to consider the person's skills when supportive environmental adaptations are not being made in order that communication needs are identified clearly for future care planning. A comparison can be made between unassisted and assisted communication

2. It may be possible for everyone present to reach consensus around how to score a domain.

3. If a domain cannot be scored because of lack of information or lack of consensus, identify key staff with optimal communication skills and appropriate opportunity to gather the required information.

4. The team may wish to make a comparison between different aspects of communication across the domains. (See

5. Set a time scale for information gathering that fits with clinical need and set a date for discussion e.g. the next ward round.

6. Discuss the observations at the next MDT meeting and agree final ratings for each of the nine domains.

7. Completing the Sunburst is not an end in itself. Where areas of need are identified, the MDT should think about what strategies support the person in this area. These may be immediately apparent and easily facilitated. However, some children and adults have more complex language and communication needs and a more detailed and formal assessment is indicated. On some occasions, the team may decide to refer to Speech and Language Therapy.

8. Once appropriate strategies have been identified, these can discussed with the individual where appropriate and shared with supporters and carers.

9. Review the Sunburst when clinically helpful – CPAs, discharge, transition, annually. This will depend on your service and the individual's needs.

What are the considerations for scoring children?

Extra care must be taken when scoring children in NDCAMHS. Children who are still developing cannot be expected to have acquired a full range of adult skills. In addition, a child may not have had exposure to an adequate language model to be functioning at an expected age appropriate level.

Special consideration needs to be given to the range of contexts in which a child communicates, the different modes used across these contexts and the variation in their skill levels between modes. For example, a child may predominantly use fluent BSL at home in everyday conversation and but more oral/written skills at school or conversely may only use signing at school.

For children rating at a low level, the MDT should consider whether this poses a clinical concern for that child.

How can we make differences in communication skills visible on the Sunburst?

Each domain can be bisected to allow comparisons to be made along a range of linguistic, contextual or clinical parameters. Colour coding or shading can differentiate between parameters and these can be identified in the key on the diagram. For example:-

INSIGHT	A person may disagree with the team about his/her skills.

LANGUAGES/MODES	• BSL *versus* spoken communication • written *versus* signed communication • English *versus* Urdu Such a comparison may highlight the nature of the communicating environment that a person needs to function at their best.
SETTINGS	For example: • dining room *versus* lounge • home *versus* school
CONVERSATIONAL PARTNER	For example: • family member *versus* staff • friend *versus* professional.
MENTAL STATE DETERIORATION	For example, mental illness relapse, onset of dementia.
PHYSICAL DETERIORATION	For example, CVA (stroke), tumour, diabetes, cataracts.
RESPONSE TO INTERVENTION:	A person's communication may be seen to improve in response to therapeutic management e.g. a medication or adaptations to the environment. The Sunburst may also capture plateaus in recovery or negative responses to intervention.

Who can use this tool?

Within both Adult and NDCAMHS services, scoring the domains should be undertaken by the Multi-Disciplinary Team comprising both Deaf and hearing clinicians and practitioners. A good mix of skills and perspectives will give better quality observations. For example, some staff may have developed a therapeutic relationship with the individual, some may use the same native language as the person, some may have more formal clinical observation skills. Sign Language Interpreters who have worked with the person may also provide useful observations.

When should we use it?

At or shortly after initial assessment is suggested as a starting point with reviews throughout the person's contact with the service to monitor changes in presentation. This can be at the discretion of the clinical team dependent on factors such as commencing a new medication regime or moving into a new residence.

Why is the information helpful?

When we are aware of our patients' communication strengths and needs and we adapt our own communication accordingly as clinicians, we are more likely to deliver effective therapeutic interventions. If we overestimate or underestimate a person's communication skills, we may prevent him or her from engaging optimally in recovery.

The domains of the Sunburst may provide relevant supporting evidence to particular questions of capacity.

Decisions arising from completion of the Sunburst will support the recording requirements of the Accessible Information Standard.

Will this generate more work for me?

The Sunburst is not intended to create an additional assessment process. The information needed should be observable within everyday routines. However, some targeted exploration of areas of functioning may be useful to illuminate areas of strength and need.

The Domains

- **Articulation**

  Articulation is the movement of hands, arms, mouth, face and body to produce speech or signing and not the language itself. Is speech slurred, mumbled or jumbled? Are handshapes lax, in the wrong place or do hands move in the wrong way? Do not forget to observe non manual features as well – does the face and body move expressively with hands? If you can see what the person is signing or hear what the person is saying clearly, even if the intended meaning is unclear, then articulation is scored highly. By contrast, a person who has a clear message to communicate but cannot do so because of movement difficulties (perhaps because of a stroke or cerebral palsy) scores low in this domain.

- **Concepts and vocabulary**

  Guard against making premature assumptions about a person's range of vocabulary. Try to step out of a person's more rehearsed and favoured topics. A person may converse eloquently

around his/her life story or information that has been covered repeatedly in therapy. Try discussing a news story or other new information.

- **Emotional vocabulary**

  Some people talk more easily about their own feelings than those of others. Conversely, some people feel inhibited or confused when talking about their own feelings but can label and explain emotions shown in pictures, role plays and film clips. A nurse's one-to-one session or talking about an episode of a soap opera are both useful ways of exploring this domain.

- **Understanding information**

  Think about how a person understands such things as the activity timetable or rights under section or medication leaflets. To what level do they need information repeating or simplifying if at all? In comments, you may want to add if written, drawn or symbolised information makes it easier for the person to understand. This is particularly pertinent to the Accessible Information Standard requirements.

- **Retaining information**

  How well does the person recall previously given information about medication management, appointments or other day to day routines? If unable to recall, does s/he recognise the information when it is presented again? How many times is it necessary to repeat information before the person remembers it independently?

- **Decision making**

  Consider different kinds of decisions, from choosing between two outfits laid out on the bed, to weighing up a range of less tangible factors around a life changing decision such as whether or not to have an operation. Does the person ask relevant questions? Does s/he independently think about potential consequences or generate other options?

- **Understanding questions**

  Consider everyday conversational questions as well as more complex questions arising in clinical settings. Often, *Who? Where?* questions are the easiest to answer, followed by *When?*

  Why? and *How?* are likely to be the most difficult for a person to process. Questions that require retelling or justification of events are the most challenging.

- **Expressing self**

  This domain may vary considerably dependent on context. When thinking about how briefly or elaborately the person signs or speaks, consider their relationship with the other person, the place, whether it is a group or a one to one conversation, needs led or social, formal or informal.

- **Pragmatics/conversational skills**

  This domain is concerned with how well a person works with the other person to hold a smooth conversation. Observing the person's skills in action is key e.g. in Occupational Therapy groups or in the dining room. However, talking about pictures of social situations can also give a good indication of what a person understands about conversational behaviour. Look out for how well the person initiates conversation, joins others' conversations, takes turns to talk, contributes and responds, ends the conversation and respects interpersonal space, touch and body language.

[Cite your source here.]

Date:

Name of child/young person:

DoB:

Deaf CAMHS Communication Profile - CHILD

Planned Review Date:

If the Communication Profile did not happen, explain why:

Present at the Appointment:

Name	Relationship to Child

Child/YP's Communication Profile

Productive:

Oral		Lip-Speaking or Lip Reading	
BSL		Deaf-blind manual or Hands on	
SSE		Other Language:	
Cued Speech			

Receptive:

Oral		Lip-Speaking or Lip Reading	
BSL		Deaf-blind manual or Hands on	
SSE		Other Language:	
Cued Speech			

Preferred Language / Mode of Communication:

Access Needed

Speech		Deaf-Blind Manual Interpreter	
BSL Interpreter		Picture And Written	
SSE Interpreter		Deaf-Blind Hands-On Interpreter	
Lip Speaker		Spoken Language Interpreter	
Other			

Information

(Describe communication of child e.g. Conversational skills, eye contact, turn-taking, get attention, features of language, did they understand). Also, if child is in residential school accommodation, explain communication here.

Identity & Culture

Additional Needs

(e.g. Diagnosed Visual problems, learning disability)

Technical Aids

Extra Information

(Deaf when, Cause of deafness, when got hearing aids/implants, when started to sign/speak, how many words/sign together now, SALT how often/when saw)

Communication needs for Intervention with NDCMAHS – Child only:

(e.g. With a deaf staff member/ With a hearing staff member)

Interpreters Comments

Recommendations

Preferred Format

Writing to child, (if appropriate):

Letters:

If Other, please specify:

Longer Documents:

Completed By:

Role

Date

Translated from BSL to English by:

NRCPD No:

Deaf CAMHS Communication Profile - FAMILY

Child Name:

Date:

Re:

DoB:

Planned Review Date:

If the Communication Profile did not happen, explain why:

Present at the Appointment:

Name	Relationship to Child

Family Communication Profile

Productive:

Oral		Lip-Speaking or Lip Reading	
BSL		Deaf-blind manual or Hands on	
SSE		Other Language:	
Cued Speech			

Receptive:

Oral		Lip-Speaking or Lip Reading	
BSL		Deaf-blind manual or Hands on	
SSE		Other Language:	
Cued Speech			

Preferred Language / Mode of Communication:

Access Needed

Speech		Deaf-Blind Manual Interpreter	
BSL Interpreter		Picture And Written	
SSE Interpreter		Deaf-Blind Hands-On Interpreter	
Lip Speaker		Spoken Language Interpreter	
Other			

Information

(For each family member and child: Preferred communication (receptive/productive), level of deafness/hearing, aids and how do they communicate with each other?)

Identity & Culture

(Identity & Culture of all family members inc. child)

Additional Needs

(eg. diagnosed visual difficulty, learning disability of any family member inc. child)

Technical Aids

(Environmental aids in the home)

Extra Information

(eg. If parents/carers are deaf, their history of deafness, which school they attended, if they learned to sign & when, contact with extended family if appropriate)

Communication Needs for intervention from NDCAMHS - Parents/carers and siblings only

Interpreters Comments

Recommendations

(What is good and suggested improvements and why)

When writing to Parents/Carers:

Preferred Format

Letters:

If Other, please specify:

Longer Documents:

Completed By:

Role

Date

Translated from BSL to English by:

NRCPD No:

Deaf CAMHS Communication Profile - SCHOOL

Child Name:

Date:

Re:

DoB:

Planned Review Date:

If the Communication Profile did not happen, explain why:

Present at Appointment:

Name	Relationship to Child

School Observation

School:

Class Teacher:

Support Staff:

Teacher of the Deaf:

What did you see?

(Lesson & Break-time: How access class content? Type of support? How communicate with other children)

Health & Educational Care Plan

Do they have a Health & Educational Care Plan: Y/N

What Support?

How Often?

Last HECP review date:

Next HECP review date:

Technical aids in school

(Aids in school -child and environment) & use of aids)

Additional Information

(eg. Information from the Teacher)

Interpreters Comments

Recommendations

(What is good & suggested improvements and why)

Completed By:

Role

Date

Translated from BSL to English by:

NRCPD No: