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Practical guide to implementing the Social Services and Well-being (Wales) Act 2014 for deafblind people

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**Who is this guide for?**

This guide is intended to support all health and social care professionals working with deafblind people to achieve their well-being outcomes under the Social Services and Well-being (Wales) Act. The guide will support senior managers and policy makers involved in implementing the Act to understand the key aspects that have a bearing on care and support that promotes the well-being of deafblind people and people with sensory loss and additional needs. It will be particularly useful to anyone working on the frontline in care and support – including social workers, care staff, support workers, primary care practitioners – to understand how the Act will impact on their day-to-day work. It is not intended as a detailed guide to all the provisions of the Act, merely to draw out the key points in relation to deafblind people. This guide is part of the suite of [Getting in on the Act](http://www.ccwales.org.uk/getting-in-on-the-act-hub/) training and information, which includes further detailed guidance on specific areas of the Act.

The guide highlights the points in the Act’s regulations and codes of practice that make specific reference to deafblind people, as well as examining other areas of the Act with particular relevance for this group, including guidance on working with disabled children, older people and people with learning disabilities. The guide covers first the specific duties in relation to promoting the well-being of deafblind individuals throughout the care journey and then factors to consider in relation to the general duties on local authorities that will impact on deafblind people. Where the guide quotes from the code and uses the word “must” this refers to a statutory requirement. Quotations using the word “should” are guidelines and should only be departed from in exceptional circumstances. Quotations from the Act’s codes of practice include the part of the Act under which the code has been issued and a paragraph reference number from within that code.

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**What is deafblindness?**

The term deafblind covers a wide range of different conditions and situations. For the purposes of the Act people are regarded as deafblind if they “have sight and hearing impairments which, in combination, have a significant effect on their day to day lives” (Section 18, SSWbA).

A combination of sight and hearing loss is usually described in one of three ways:

* Deafblind
* Multi-sensory impaired (usually for children and young people or people born deafblind)
* Dual-sensory impaired or dual-sensory loss

Deafblindness can cause problems in three primary areas: communication, access to information and mobility.

Recognising the impact of a person’s dual sensory loss at an early stage and providing appropriate support is in line with the Act’s preventative agenda. Early intervention provides the best opportunity of improving a person’s well-being. Getting things right first time will save time and cost to the local authority in the long term. Involving the right specialist in the assessment and care planning process will ensure that needs are met appropriately.

Deafblindness is a low incidence condition. Most deafblind people have some remaining hearing and/or sight, though this is not true of all deafblind people.

Deafblindness can be acquired – where a hearing-sighted person acquires dual sensory loss throughout the course of their life – or congenital – when a person is born with Multi-Sensory Impairment.

The most common cause of deafblindness is older age and most older deafblind people communicate using clear speech. However all will have difficulties in communication, accessing information and mobility caused by the interaction of the two impairments.

Children and young people with Multi-Sensory Impairments (MSI), or adults who were born with MSI, often have additional needs and require input from a variety   
of professionals across health, social care and education. Children can be born deafblind as a result of premature birth, rare genetic conditions or maternal illness during pregnancy. People with MSI may not have acquired formal language and so the care and support they require to attain well-being will be different from that for people with acquired deafblindness.

Even professionals with expertise in a single sensory loss do not necessarily understand the way that a loss of both distance senses – hearing and vision – interact to cause unique difficulties. Many deafblind people are unable to use services designed for people with a single sensory loss or mainstream services.

**Communication:** Deafblind people use a range of communication including clear speech, sign language and tactile communication based on the alphabet. People born deafblind may have little or no formal communication. See Appendix A for detail on deafblindness and communication.

**Access to information:**  This includes difficulty with written information such as timetables, websites, bus numbers, use by dates on food; spoken information such as train platform announcements; environmental information such as the layout of a room, finding a seat on public transport, busy traffic, potholes, obstacles on pavements, etc.

**Mobility:**  This refers to the ability to safely move around the home and outside   
the home. A deafblind person may appear to have no difficulty in moving around   
a familiar place or taking a regular journey, but be unable to safely manage an unfamiliar journey or cope with a change such as a blocked pavement on a usual route. A deafblind person’s ability to move safely out of doors can also vary depending on light levels, for instance between daytime and at night.

**Deafblind duties**

The codes of practice under the Act make specific reference to local authorities and local health boards’ responsibilities to provide appropriate care and support for the deafblind people in their area. We call these the ‘Deafblind duties’. The duties within the Act and codes replace the National Assembly for Wales circular ‘Social Care for Deafblind Children and Adults’, often known as the ‘Deafblind guidance’, which was issued in 2001. The new duties on local authorities are dispersed throughout the Act and codes, and are referred to in their contexts in detail further in this guide. For ease of reference, the Deafblind duties have also been brought together here.

Under the Act local authorities are required to ensure:

* The **Director of Social Services must have overall responsibility** for deafblind services within his/her responsibilities (Code 4, 71).
* A local authority must **establish and maintain a register** of the people ordinarily resident in the authority’s area who have sight and hearing impairments which, in combination, have a significant effect on their day-to-day lives (SSWbA, 18, 1c).
* In discharging their duties under Section 18 local authorities must **identify and make contact** with all people who have both sight and hearing impairment including those who have multiple disabilities including dual sensory impairment (Code 2, 392).
* When an **assessment** of the needs of a deafblind person is required or requested, it **must be carried out by a specifically trained person/team**, equipped to assess the needs of a deafblind person – in particular to assess the need for personal contact and social interaction, assistive technology; support with mobility; communication; emotional well-being; habilitation/rehabilitation learning skills for life and future needs (Code 3, 31).
* A local authority must ensure that **services** provided to deafblind people **are appropriate, recognising that they may not necessarily be able to benefit from mainstream services** or those services aimed primarily at blind people or deaf people who are able to rely on their other senses (Code 4, 71).
* Local authorities mustensure that deafblind people are able **to access specifically trained one-to-one support workers** for those people they assess as requiring one (Code 4, 71).
* Local authorities mustprovide deafblind children and adults with **information, advice and assistance in formats and mediums accessible** to them and to ensure they have access to specifically trained one to one support workers, if this is required (Code 2, 325).

**Identification**

The first step in ensuring that all deafblind people are able to access the rights and entitlements afforded to them by the Act – and for local authorities and local health boards to comply with their duties and responsibilities under the Act to promote the well-being of their population – is to ensure that the deafblind population within each area is identified.

The Act itself sets the precedent for this at Section 18 by explicitly requiring for the first time that local authorities maintain a register of all deafblind people – or people who “have both sight and hearing impairments which in combination have a significant effect on their day to day lives”. The codes of practice elaborate:

For the register of both sight and hearing impairment, an individual does not need to be separately registered on the sight or hearing impairment registers (Code 2, 390).

This means that a deafblind person will not require Certification of Visual Impairment to be included on this register. This is because the register of deafblind people takes a functional approach – it’s concerned with the impact of combined visual and hearing needs on a person’s well-being – rather than the medical model which is determined by reaching a certain level of impairment.

It is also worth bearing in mind that a person could be included on more than one register if they choose.

Registration is always optional and subject to the individual’s choice. However, people should be made aware of the benefits of registration in contributing to their well-being, which include:

* Better and more streamlined access to social care
* Improved access to welfare benefits and entitlements

The local authority must also proactively:

**Identify the linguistic circumstances of all those people in the relevant register. This would include individual preferences for communication, for example British Sign Language or Braille, or through the medium of Welsh** (Code 2, 392).

This requirement should support the provision of accessible care and support for deafblind people.

The [Active Offer](http://www.wales.nhs.uk/sites3/Documents/415/WG20766_Active%20offer%20More%20than%20words_13%20a4%20leaflet_E_WEB.pdf) of Welsh language care and support to all people should likewise be made to all deafblind people, or people who the professional may suspect has a sensory loss or impairment. Deafblind people have the same right to access Welsh language services, and to access these in accessible formats. Accessing services in your language of choice is central to maintaining well-being. This may be particularly important for deafblind children and older people who may have a Welsh language need.

**Registering children and young people with MSI**

The requirement to register all deafblind people applies to both **adults and children**. Until the Act, the general practice was to maintain sight and hearing impairment registers for adults only.

Children and young people with MSI should also be included on the local authority’s

Register of children who are within the local authority’s area and who are disabled, have a physical or mental impairment which gives rise, or may in the future give rise to, needs for care and support (Code 2, 391).

When discharging this duty, local authorities should consider all of a child or young person’s needs or disabilities, not only their primary or major need. For example, many children and young people with MSI will have a learning disability and it is common for their sensory needs to be overlooked or forgotten at the expense of their primary diagnosis. Children and young people with MSI will need to be on both the register of disabled children and the register of combined sight and hearing impairment if these registers are kept separately.

**Making contact**

The Code makes specific provision in the case of deafblind people to not only identify and maintain a register but also to:

**Make contact with all people who have both sight and hearing impairment including those who have multiple disabilities including dual sensory impairment** (Code 2, 392).

This means that local authorities will need to proactively approach the deafblind people in its area to determine whether a well-being assessment under the Act is the appropriate way forward.

**Assessment**

The Act shifts the assessment conversation between the professional and the person from ‘What’s wrong with you?’ to ‘What’s important to you?’. This is a fundamental shift to a more enabling approach to social care.

Sometimes this conversation will need to happen between the person and a specialist assessor. The Act’s regulations on assessment set out requirements for the involvement of specialists in an assessment. They state that:

**When carrying out an assessment, a local authority must consider whether the nature of the person’s needs calls for the involvement of   
a person who has specialist skills, knowledge or expertise** (3(2)).

**If the local authority decides that such involvement is called for, it must either consult with a person who it considers will be able to provide those skills or that knowledge or expertise or arrange for the assessment to be carried out by a person with the required specialist skills, knowledge or expertise** (3(3)).

The Deafblind duties included in the Code of Practice on Assessment note:

**When an assessment of the needs of a deafblind person is required or requested, it must be carried out by a specifically trained person/team, equipped to assess the needs of a deafblind person** (Code 3, 31).

This means that local authorities must always arrange for the assessment of a deafblind person to be carried out by a person with the required specialist skills, knowledge or expertise.

The Code also notes:

**Where a specialist assessment has been carried out, the presumption is in favour of the expert opinion in cases where the expert and generalist practitioner do not agree** (Code 3, 30).

This means that, in the case of conflicting observations, the opinions and recommendations of the specialist assessor carrying out the assessment of a deafblind person will carry greater weight than supporting information from other generalist practitioners contributing to the process.

**What level of training is appropriate to ensure that an assessor has the required specialist skills, knowledge or expertise?**

The Code sets out what level of training is appropriate:

**The type and degree of specialism required for assessing a deafblind person should be judged on a case by case basis according to the extent of the person’s condition and their communication needs. Specialist assessors for deafblind people should be trained in deafblindness at a minimum of OCN or QCF level 3 or above where the person has higher or more complex needs** (Code 3, 53).

This means that, for instance, a deafblind awareness course would not give sufficient knowledge of deafblindness for assessing a deafblind person. Nor would a Level 3 qualification in deafblindness or sensory impairment be sufficient for assessment of   
a person born deafblind. Level 3 is also not sufficient for someone whose acquired deafblindness is complex, for instance for someone whose needs are changing and need to adapt their communication or need to learn a new method of communication, such as moving from BSL to hands-on signing. Conditions such as dementia or brain injury also impact on communication and so make assessment more complex.

Currently the highest level qualifications in deafblindness are the Diploma in Deafblind Studies, which is a QCF level 5 course accredited by the Open University, and the University of Birmingham postgraduate diploma in Multi-Sensory Impairment. There is also a level 4 Certificate in Deafblind Studies.

A person carrying out an assessment of a deafblind person would also need to meet the training and experience requirements set out in the regulations and Code on assessments more generally. This would include meeting the specific requirements associated with assessing a child or young person, where this is applicable.

A person with a level 3 qualification in deafblindness or dual sensory impairment, for instance, is likely to meet the level 3 deafblind specialist qualification requirements   
of the guidance, but unless they have other training or experience in carrying out assessments would not be a suitable person to carry out an assessment.

It is unlikely that the minimum level of training at level 3 will be sufficient for assessing most deafblind children or young people since having dual sensory impairment from a young age is likely to result in more complex needs. Appropriate qualifications would include:

* The Advanced Certificate in MSI or deafblindness
* Bachelor of Philosophy in MSI or deafblindness
* Postgraduate Certificate/ Diploma in MSI or deafblindness
* Master of Education in MSI in or deafblindness

**What should the training cover?**

The Code also sets out the minimum areas that the training and expertise should include:

* **Assessing the need for personal contact and social interaction**
* **Assistive technology**
* **Mobility**
* **Communication**
* **Emotional well-being**
* **Habilitation/rehabilitation and learning skills for life and future needs** (Code 3, 31)

There are a range of courses available that meet these requirements. Local authorities should ensure that their assessors have a qualification which meets both the level and the range required by the codes and regulations. It is unlikely, for instance, that a course for people with no prior knowledge of deafblindness could cover all the areas outlined above to level 3 in one day.

**Assessing a deafblind person – case studies**

All the staff in the sensory team in local authority A have received a basic deafblind course which covered deafblind awareness and how to identify deafblind people. They are all qualified social workers and have a range of other qualifications in either hearing or sight loss. However, the basic deafblind awareness course did not cover the full range of areas required by the Act, in the level of detail required for an assessment. Local authority A therefore would need to contract externally to enable them to assess a deafblind person.

Local authority B employs a deafblind specialist within the sensory team. She has   
a level 3 qualification related to supporting deafblind people and several years’ experience managing a Communicator Guide service. She carries out the majority   
of assessments of deafblind people in local authority B. However a level 3 course would not be sufficiently detailed to enable her to assess a person born deafblind with profound and multiple needs, nor a complex acquired deafblind case. For these more complex assessments local authority B has a contract with a local voluntary organisation with staff holding the University of Birmingham postgraduate diploma   
in Multi-Sensory Impairment and the Diploma in Deafblind Studies.

Local authority C has a member of staff who has completed the diploma in deafblind studies, which gives a wide range of knowledge and understanding of the range of different needs. The staff member has only level 2 sign language so when assessing a person who uses BSL always books an interpreter.

Note that the above applies to any assessment of a deafblind person, regardless   
of whether they have had a previous assessment. This includes reviews and   
re-assessments. Assessments must be proportionate to need, but regardless of the format or detail required, a specialist assessor must be used.

**The five elements of assessment**

**A person’s circumstances**

Examples of presenting needs would be:

* A young person with MSI is unable to access age-appropriate recreational and social activities
* An older deafblind person’s social support systems are at risk
* A deafblind person is unable to access work opportunities
* A young child with MSI is unable to access play opportunities

**Personal outcomes**

Personal well-being outcomes must relate to the national well-being outcomes set out in the [National Outcomes Framework](http://gov.wales/docs/dhss/publications/160331ss-outcomesen.pdf).

Examples would include:

|  |  |  |
| --- | --- | --- |
| **Definition of  well-being in the Act** | **National well-being outcome** | **Personal well-being outcome** |
| Physical and mental health, and emotional well-being | I am healthy | To be able to cook my dinner independently and safely |
| Domestic, family and personal relationships | I have safe and healthy relationships | To be able to maintain my family relationships by learning a new method of communication |
| Contribution made to society | I can engage and participate | To be able to engage with the people in my local community |

**Barriers**

For most deafblind people their combined hearing and vision impairment, which impacts on their communication, access to information and mobility, will be considered a barrier to meeting their personal well-being outcomes.

**Risks to meeting personal outcomes**

The Code of Practice states:

**It is possible for individuals to have several low risk elements which in themselves would not pose threat to achieving personal outcomes, but the combination and how the risks interact will result in a more serious threat** (Code 3, Annex).

For an older person with reduced vision who is also hard of hearing this could mean several low risk actions – difficulties cooking safely, reluctance to walk to the shops alone, difficulties communicating – leading to a greater risk of restricting food intake and becoming malnourished.

**Strengths and capabilities**

People will have personal skills and capabilities that can enable them to meet their well-being outcomes. They may also have support from family or friends. An assessment will also consider what support is available in the community, such as through preventative services.

**A day in the life – a deafblind person’s perspective**

**Anna**

Anna, aged 42 from Abergele, is a BSL user with poor English skills. She has some central vision in one eye and is blind in the other. She is profoundly deaf in both ears. With hearing aids she can hear some loud sounds but finds it hard to understand speech. She is unable to communicate using the telephone, including textphone or text relay. She relies on SMS text messages and emails to communicate with non-BSL users but ideally would communicate using online video calls with people proficient in BSL. If emails or texts are to be used, then they need to be written in BSL English or plain English.

Anna requires a Communicator Guide or a Personal Assistant to help her deal with correspondence and communication with services. She also needs support for shopping and social activities. Without these she’d be isolated from her community and would not be able to access the services she needs, such as health and housing, to maintain her well-being.

**Martin**

Martin, aged 51 from Caerphilly, is profoundly deaf but English is his first language. He is now registered severely sight impaired due to progressive optic atrophy. Martin struggles with text and face recognition. In one-to-one situations Martin can often communicate well, provided the environment is suitable (quiet, no echo, no visual noise). In one-to-one situations Martin would need to be close to the speaker and there should be light on the speaker’s face. Supporting speech with gestures and fingerspelling can help Martin. In group settings Martin would need Speech to Text Reporters and they would need to have very large high contrast text on their screens.

Martin relies heavily on technology to communicate and maintain his independence. He uses a large smartphone to make calls via Next Generation Text Relay. He also uses CCTV magnifiers to read letters and information.

Martin is unable to drive and relies on public transport. He struggles to see where buses and trains are going and finds it hard to know where to get off transport in unfamiliar places or when it is dark.

**Fluctuating needs – a consideration in determining strengths   
and capabilities**

Deafblind people’s needs may fluctuate for two reasons. Firstly their condition may fluctuate, for instance people’s sight loss is often more severe when they are tired or stressed. But it may also fluctuate due to environmental conditions. For instance, people with Usher syndrome will have more severe problems with mobility after dark. An assessment carried out during summer would have to take account of the impact of longer hours of darkness during winter. A person with Usher may find they have no issues accessing necessary services and facilities in the community during summer, but in winter need to access facilities during hours of darkness and so are eligible for support, or for more support, at different times of the year.

**Considerations when assessing a deafblind person**

* What level of knowledge of deafblindness will the assessor need? Is level 3 sufficient, or is a higher level needed?
* Does the local authority have access to an appropriately trained assessor?
* Does the person need information in an accessible format?
* Does the person need an interpreter or any other type of communication support? If so, what specific skills will the interpreter or communication support professional need?
* Will the person need an advocate? What specific skills will the advocate need to work with this person?

**Involving deafblind children and adults in assessments and care and support planning**

Underpinning the Act is the principle of co-production and the belief that an adult   
is always best placed to determine the care and support they need to meet their   
well-being outcomes. Article 12 of the United Nations Convention on the Rights of the Child also sets out that children have a right to be listened to and heard when decisions are made that affect them. This means that the person has the right to exercise voice and control and to act as an equal partner to the professional throughout assessment and care and support planning processes and throughout the delivery of care and support. For this reason the Act sets outs overarching duties on professionals to:

**Ascertain and have regard to the individual’s views, wishes and feelings, in so far as is reasonably practicable** (SSWbA, Section 6(2)(a)).

**Have regard to the importance of providing appropriate support to enable the individual to participate in decisions that affect him or her to the extent that is appropriate in the circumstances, particularly where the individual’s ability to communicate is limited for any reason** (SSWbA, Section 6(2)(d)).

Professionals are required to ensure that a person’s views, wishes and feelings are considered and that assessment and care planning is a two way process. Enabling a person to set and meet their personal well-being outcomes is at the heart of this Act. This means that involving the person in all aspects of the care and support process is essential. Making this a reality means that the professional leading the process must be able to communicate with the deafblind adult or child, including being able to communicate in an age appropriate way, and to make provision if the person lacks capacity. In the case of a child under 16, the assessment and care planning processes must also consider the family’s views, wishes and feelings.

**Interpreters**

Appropriate communication could include the need for a qualified interpreter   
with training appropriate for the deafblind person’s communication, where this is applicable. For instance, where the person uses British Sign Language (BSL) adapted for a person with a visual impairment (e.g. visual frame or hands on BSL) the interpreter must be experienced in using this form of BSL. See Appendix A on communication methods for more information on this.

It is not normally appropriate to use a family member as an interpreter because the person should feel free to speak their mind freely and to focus on their own personal well-being outcomes, as well as there being a risk that interpretation by a family member could be less accurate than a professional. An exception might be where no interpreter exists, e.g. where the person uses idiosyncratic communication. Local authorities will need to ensure that they have access to sufficient qualified interpreters to meet the likely needs of their deafblind population.

**Accessible information**

In order for people to participate as equals in the assessment and care planning processes they must be fully informed and this means having access to information in a format that’s accessible to them.

The codes of practice explicitly state that:

**Local authorities must provide information in formats and methods that are accessible to deafblind people** (Code 4, 90).

This should include providing information to people in a range of formats, such as braille, large print, audio, electronically or by BSL (in person or by video). In exceptional circumstances a person may only be able to receive information in deafblind manual. For these few people it will be necessary to provide the information in person.

Information in accessible formats should be made available through the medium of Welsh or English, in line with the person’s language preference or language need.

Where authorities have support materials which are designed to be user-friendly through the use of graphics and visual aids, this will not be accessible to those with little or no sight, so alternatives must be provided.

Accessibility is not only related to formats. Because deafblind people have difficulty accessing general information about the world around them, there may be gaps in their knowledge which mean they need more support to understand the information provided. The codes also make reference to the requirement on local authorities to:

**Ensure that deafblind people are able to access specifically trained one-to-one support workers, where this is required** (Code 3, 40).

A specialist one-to-one support worker, such as a Communicator Guide or Intervenor, may be able to support the deafblind person to access the information available to them and to participate in the assessment and care planning processes.

**Advocacy**

The Act requires that:

**Local authorities must arrange for the provision of an independent professional advocate when a person can only overcome the barriers to participate fully in the assessment, care and support planning, review and safeguarding processes with assistance from an appropriate individual, but there is no appropriate individual available** (Code 10, 47).

Barriers to participating in decisions about personal well-being outcomes, and how to meet these, will include issues and situations that may impact on a person’s ability to:

* **Understand relevant information**
* **Retain information**
* **Use or weigh information**
* **Communicate their views, wishes or feelings** (Code 10, 55)

Some deafblind people will be in this position, for instance if they have a learning disability or dementia. They may also have limited knowledge because of their difficulty accessing information and so need additional support to understand their choices. In all these situations a person will require the support of an advocate who is able to appropriately support them. Not all advocates will be able to support those with communication difficulties. It is essential that the advocate employed has an appropriate understanding of communication and sensory loss otherwise they will be unable to fulfil the role of advocate.

A deafblind person who faces a barrier to participating solely because of communication barriers and accessing information caused by their sensory needs will not require an advocate. A person who can engage with the process with appropriate communication support or accessible information should be provided with this. They will only require an advocate if they are unable to engage with the process even with such support. It is possible that a person may require both an interpreter and an advocate.

**Eligibility**

Once the assessment has been completed, the next step is to determine whether the person meets the eligibility criteria. This should also be carried out by a person with training and expertise in deafblindness to ensure that the impact of those needs on outcomes and well-being is fully understood.

Children and young people with MSI, as disabled children and young people, will always be presumed to have eligible needs. Local authorities will always work from:

**The presumption that a disabled child has needs for care and support in addition to, or instead of, the care and support provided by the child’s family** (Code 4, 12).

This does not necessarily mean that a child or young person is automatically eligible for care and support provided by the local authority as the family’s willingness, ability and resources to provide care and support will form part of the decision. Again, this will be a dialogue between the person and professionals.

Every person is different and the assessment and determination of eligibility to access care and support provided by the local authority will need to be judged on   
a case-by-case basis, dependent on the five areas of assessment. The Care and Support (Eligibility) (Wales) Regulations 2015 set out that eligibility is dependent on:

* Not being able to meet the need with the support of others or through accessing services in the community
* For adults, the person requires the local authority to provide or arrange care and support to be able to meet the needs
* For adults, the need relates to specific areas of life set out in the regulations

Examples of how deafblindness, and the associated difficulty with access to information, mobility and communication, are likely to cause needs relating to the specific areas of life set out in the regulations on eligibility are:

* **Ability to carry out self-care or domestic routines:**  Being able to make use of the home safely can be a challenge. Trips and falls are a risk if lighting is not adequate and appropriate. Specialist equipment such as vibrating smoke alarms and door bells may need to be fitted, home adjustments such as better lighting may be necessary. Support may be required to use kitchen equipment safely and answering the front door safely may be problematic.
* **Ability to communicate:**  Deafblind people may communicate using languages and formats that are little used by the majority of the population. This means that deafblind people can become isolated and find it difficult to find a peer group using the same form of communication as them.
* **Involvement in work, education, learning or in leisure activities:**  Mobility, access to information and communication all present barriers to this type of involvement.
* **Maintenance or development of family or other significant personal   
   relationships:**  Communication difficulties can be a barrier to developing and maintaining relationships. Families may need support to learn new ways of communication.
* **Development and maintenance of social relationships and involvement   
   in the community:**  Mobility and communication difficulties can be a barrier to developing and maintaining relationships as they impact on essential activities such as travelling to visit friends, holding a conversation, using   
  the telephone or accessing correspondence. Challenges to accessing the community include accessing information about timetables, opening times and services, getting to the facilities and making use of them once there if moving around safely and communicating with strangers are difficult.
* **Fulfilment of caring responsibilities for a child (for an adult):**  For a deafblind person many aspects of parenting can be difficult. Deafblind older people may wish to provide support to their family by caring for grandchildren.
* **Achieving developmental goals (for a child):**  A child with MSI may not be able to access play opportunities that support development because of mobility and communication issues.

A person is considered unable to achieve an outcome if it is possible but causes significant pain or distress; it would take significantly longer than normal or would put the person or others in danger (Eligibility regulations, 6). This will apply to many deafblind people, who, for example, may find travel to unfamiliar places theoretically possible but the stress of navigating the environment and communicating can be severe. This is particularly true of people who have previously experienced difficult   
or dangerous situations when travelling alone. Many of the outcomes will take significantly longer than normal because of, for instance, very slow communication methods.

Many of the conditions which cause deafblindness are progressive, so even where a person is not deemed eligible it will be important for the professional to consider the preventative benefit of early intervention and for the person to understand that they can ask for another assessment if their condition changes.

**Case scenarios to illustrate approach to eligibility of needs**

**Sensory Impairment**

Mr Davies recently presented with a serious sight impairment (blind) and may need to develop mobility, communication and life skills (e.g. meal preparation) from a rehabilitation officer. He may need some emotional support to come to terms with   
the fact there is no further treatment available to improve his sight. He may also need specialist equipment. Where each of these can be provided by community based services – supporting Mr Davies’s capacity to self-care – then Mr Davies will not be regarded as having eligible needs. Should any of these services not be available or be insufficient to help Mr Davies to meet his personal outcomes, then that need will become an eligible need and services will be provided through a care and support plan.

**Dual sensory impairment**

Iris, 78, has acquired deafblindness – she is hard of hearing and partially sighted. Following a specialist assessment for deafblind people by a suitably qualified assessor, Iris’s personal outcome is identified as: I can socialise and engage with people in my local community.

They conclude that Iris will require a care and support plan, alongside accessing preventative community services, to enable her to meet her personal well-being outcome. Iris’s deteriorating hearing and eyesight mean that she will require one-to-one support from a specialist support worker trained to work with deafblind people to support her in using transport to reach the town centre. She attends a weekly social group for older people at the community hall in her town and requires her specialist support worker to make social engagement at the group accessible to her (Code 4, Annex 1).

**Care and Support Planning**

The codes of practice state that:

**A specialist involved in an assessment should also be involved in care and support planning under Part 4 of the Act** (Code 3, 53).

Where possible, this should be the same person to ensure continuity for the individual. This is to ensure that the person has support from someone who understands what type of support options, including specialist support, are available to a deafblind person. It should, for instance, mean that they have information about technology or other support services of which generalist professionals may be unaware. This will also apply to reviews of care and support plans, since the same processes should be followed for these. However, the principle of co-production should continue to be central to the process – the involvement of a specialist is not intended to override the deafblind person’s ability to make their own decisions about their care and support. On the contrary, it should mean that they have access to the relevant specialist information they require to make those decisions.

Local authorities who commission external providers to support care planning will want to ensure that those providers are able to make their support accessible to deafblind people. Alternatively, local authorities may wish to retain responsibility for support for deafblind care and support planning, for instance in the sensory team.

**Appropriate provision**

The Code makes specific reference to the need for local authorities to provide appropriate services specifically for deafblind people:

**A local authority must ensure that services provided to deafblind people are appropriate, recognising that they may not necessarily be able to benefit from mainstream services or those services aimed primarily at blind people or deaf people who are able to rely on their other senses** (Code 4, 71).

This may mean the provision of a specialist one-to-one support worker, such as a Communicator Guide for a person with acquired deafblindness or an Intervenor for   
a person born deafblind (see Appendix C for explanations), if this is the most appropriate way of enabling them to meet their personal well-being outcomes. The Code states:

**Local authorities must ensure that deafblind people are able to access specifically trained one-to-one support workers for those people they assess as requiring one** (Code 4, 71).

To ensure that a deafblind person does not experience a delay in accessing the care and support they are entitled to, the local authority should make sure they have access to suitably qualified specialist support workers or are able to access these through organisations such as Sense Cymru.

**Specified accommodation and out-of-county or cross-border placements**

Where we live can have a huge impact on well-being – this includes being close to family, friends or in an area where we can be part of the community. For this reason, when a deafblind person is assessed as specifically requiring care home accommodation to meet their care and support needs, as set out in ‘The Care and Support (Ordinary Residence) (Specified Accommodation) (Wales) Regulations 2015’, they will need to have a conversation with their care and support plan coordinator about the location of the care home they will live in. This will include supporting the person to exercise choice and control over which area – in Wales or across the UK – will best contribute to meeting their well-being outcomes. The local authority in which the person is ‘ordinarily resident’ will be responsible for meeting this care and support need, no matter where in the UK that person is accommodated (Code 11, Chapter 2).

**Direct Payments**

Deafblind people may choose to take control of their care and support through opting for direct payments from the local authority. The level of direct payments provided should be calculated in a way that ensures there is sufficient money to meet the cost of the deafblind person’s care and support including specialist deafblind support.

Deafblind people can face significant barriers to managing direct payments, and in some cases this means they do not wish to do so. In such cases the direct payments can be made to a person acting on their behalf. Direct payments should not be refused for a deafblind person purely on the grounds that they are unable to manage their payments.

Local authorities should also take all reasonable steps to provide those who wish to use direct payments with the support they would need to do so. Local authorities will need to ensure that whatever direct payments support services they provide are able to support deafblind people appropriately. Sense has a series of [factsheets on deafblind people and direct payments](https://www.sense.org.uk/content/direct-payments).

**Direct payments and family members**

Local authorities may authorise direct payments to pay a relative of the recipient living in the same household if they consider it is necessary to promote the well-being of that person. This is where the relative provides care and support to the recipient or manages the direct payments on their behalf. Situations where a relative of a deafblind person may be the best person to provide support could be where they are able to use British Sign Language, as there is a shortage of suitable BSL users able to provide support. Another is where the deafblind person has idiosyncratic communication, where only family members are able to understand the person’s communication.

**What good social care looks like – deafblind people’s perspectives**

**Aled, 35 from Llanelli:**

“A good social care system will be fully accessible to deafblind people and at the same standards as any other person accessing social care. For example, my progress through the system should not be delayed because I need communication support or information in an accessible format.”

**Beth, 23 from Llandrindod:**

“The social care service would ideally be delivered by someone who fully understands deafblindness – preferably someone who is deafblind – and that social care is tailored to meet my unique needs. Things like being able to go out and meet friends without relying on my parents and recognition that my vision is affected by the seasons – when it’s dark in winter I can’t stay out on my own as long as I can in the summer.”

**General duties on local authorities**

Recognising the importance of strategic leadership for services for deafblind people, the Code of Practice states:

**The Director of Social Services must have overall responsibility for deafblind services within his/her responsibilities** (Code 4, 71).

**Population Needs Assessment**

Local authorities and their partner local health boards are required to compile a combined Population Needs Assessment Report, as well as individual assessments for each local authority area. This will lead to better care and support provision and improved well-being for the population in the longer term.

The Population Needs Assessment Report should include:

* The assessment of needs – including the extent to which there are people in the area who need care and support and the extent to which there are people whose needs for care and support are not being met
* The range and level of services required to meet those needs, including in a preventative way

The Code states:

**Section 1 of the population assessment report must include specific core themes dealing with:**

* **children and young people**
* **older people**
* **health / physical disabilities**
* **learning disability / autism**
* **mental health**
* **sensory impairment**
* **carers who need support**
* **violence against women, domestic abuse and sexual violence** (Code 2, 123)

Sensory impairment is recognised as priority area and local authorities must report on both the extent and the level of services available to people with sensory impairments, including dual- and Multi-Sensory Impairment.

In order to do so, local authorities should consult their registers of people who have sight and hearing impairments which, in combination, have a significant effect on their day-to-day lives, as required by the Act (Section 18c). The Code does, however, warn that local authorities and Local Health Boards should not solely rely on registers in relation to disabled children, disabled people and those with sensory loss (Code 2, 100).

Data held on registers may not always be accurate and up-to-date because they often rely on self-referral. To support the production of the Population Needs Assessment Report’s findings on sensory impairment local authorities should also consider:

* The estimate of prevalence of deafblindness among the general population. Research by Professor Emmerson will help local authorities estimate the [likely deafblind population of different ages in their area](https://www.sense.org.uk/content/regional-data-future-deafblind-population).
* Collating information from initial assessment data. The national minimum core data required as part of the assessment includes:

**Preferred Language / Communication method / Accessibility requirement** (Code 3, 59)

Which may provide some useful information for these purposes.

* Supporting colleagues in primary and secondary care and social care to better identify people with dual sensory loss and to record and share this information effectively, bearing data protection considerations in mind.

There is a duty to plan based on the Population Needs Assessment. The local authority should therefore take action to ensure that all needs – including those noted as unmet – are taken forward. This should include noting how sufficient high quality services in their area are made available to meet the identified care and support needs. Local authorities will need to consider low incidence conditions, such as deafblindness, and specialist services within this assessment.

It is crucial that the action taken to meet the duty to plan based on the Population Needs Assessment also considers the appropriateness of the services, not only their availability. Many deafblind people will not be able to access mainstream services, including those available as part of the local authority’s suite of preventative services. For example, a young person with MSI should not be expected to use a service designed for older people as this will not provide an appropriate peer group and is unlikely to offer age-appropriate activities for that young person to enable them to meet their personal well-being outcomes. Moreover, mainstream learning disability services may not be suitable for congenitally deafblind people. Likewise, mainstream older people’s services, including those aimed at people with a single sensory loss, may not be accessible to people with a dual sensory loss unless they have been designed with this in mind.

Local authorities may need to invest in training for specialist staff or commission in a way that enables providers of specialist support to be confident their services will be sustainable in the long term.

The highest incidence of deafblindness is among the older population so local authorities should commission services for older people in a way that ensures sufficient support which is accessible to deafblind people.

**Information, advice and assistance**

The Act requires that a local authority establish a service for providing information and advice to people about the care and support available in the area, and assistance, where this is needed, to access that care and support. There is a section in the Code that requires local authorities to ensure that the service is accessible, which specifically references accessibility for deafblind people:

**Local authorities must provide an information, advice and assistance service which includes the provision of:**

**h) accessible information, advice and assistance to specific groups including one to one support workers if this is required, for example, deafblind children and adults** (Code 2, 300).

Appendix B provides information about a range of accessible formats and Appendix A lists a variety of communication methods that deafblind people may use.

The Code notes that a deafblind person may require a specialist one-to-one support worker, such as a Communicator Guide, to support access to information and advice.

Information, advice and assistance service planners and staff should also be aware that deafblind people may require specialist information from sources that take account of their needs as a deafblind person. Information, advice and assistance services should know how to refer people to specialist organisations such as [Sense Cymru](http://www.sense.org.uk/) or organisations working on a specific condition. The Sense website has a list of [conditions and the relevant support groups](https://www.sense.org.uk/a-z-of-conditions).

Local authorities will also need to consider how a deafblind person will make contact with an authority since telephone contact may be difficult or impossible. Local authorities should ensure there is a range of ways for people to make contact with them. Telephone or online only, for instance, will not be accessible to many deafblind people. Some local authorities allow a range of contact methods including SMS, fax and Skype to ensure accessibility. Local authorities should involve their sensory team in planning their first contact arrangements to ensure that they are accessible to deafblind people.

**First contact with information, advice and assistance**

There are implications for the training of first contact teams within the information, advice and assistance service in relation to deafblind adults.

Firstly, first contact teams must have the ability and confidence to identify a deafblind person.

* The group most likely to be misidentified by first contact teams is older people who have acquired dual sensory loss. Older deafblind people who approach the local authority for support may not consider themselves deafblind, or even recognise that their sensory loss is an issue, since they may see it merely as an inevitable part of ageing. Dementia may mask sensory loss and other conditions such as stroke may result in dual sensory loss.
* People with learning difficulties may also not be recognised as having a dual sensory loss as they are often not able to access hearing and sight tests. Learning disability teams should ensure that they have considered the possibility that people they work with also have a sensory loss.
* Children and young people with MSI may not be identified as such if they also have a range of health or other disabilities or if they have a specific diagnosis that is recorded at the expense of other needs, such as sensory needs.

Deafblind awareness and identification training and supporting materials can be obtained from [Sense Cymru](http://www.sense.org.uk).

Secondly, first contact teams at the information, advice and assistance service are required to carry out an initial assessment when providing advice or assistance. First contact teams should all know how to refer for a specialist assessment after identifying the person’s deafblindness.

**Early intervention and a preventative approach**

Prevention and early intervention, with the intention of reducing higher level needs further down the line, is at the heart of the Act. Providing prompt and appropriate support to a deafblind person can have a preventive effect. For instance, deafblind people are more likely to have a range of physical and mental health conditions and to be isolated and lonely than the general population. Difficulties with accessing healthy food, keeping in touch with friends and family, getting exercise, being involved in the local community will all contribute to poor well-being.

**Specialist preventative services**

Most of the preventative support for deafblind people will be support for those who already have a care and support need but who, with support, can either reduce their need for care and support or prevent it from becoming greater. This might include:

* Accessing specialist community groups to support young people with MSI to develop independent living skills and to transition to adulthood.
* Mobility training to enable an adult or child to make some regular journeys without a guide, meaning their need for a Communicator Guide or support from a parent-carer is reduced.
* Teaching a person and their spouse to use deafblind manual to communicate, meaning they need significantly less external support if their spouse is willing and able to provide support.
* Teaching someone daily living skills, such as how to cook, after losing their sight, meaning the person is able to continue living independently.
* Ongoing support, such as from a Communicator Guide or Intervenor, can prevent severe isolation or challenging behaviour which would lead to higher support needs.

As with other services, deafblind people may not be able to access mainstream prevention services and will need something specifically tailored to take account of their dual sensory loss. For example, not all Rehabilitation Officers for visually impaired people (see Appendix C) have an understanding of the impact of hearing loss on mobility skills, for instance.

**Case scenario – prevention**

Mary is an elderly deafblind woman who had good hearing and sight for most of her life. She is now profoundly deaf and blind. Mary became increasingly confused due to her deafblindness and her brother who helped with her care found he was unable to cope.

**Scenario 1: Not taking a preventative approach**

The decision was made against Mary’s wishes to place her in residential care but this has not been a success. The staff at the home do not know how to support her and she is isolated, frustrated, anxious and angry.

**Scenario 2: Taking a preventative approach**

Mary was given two hours per day of support at an early stage to help her to readjust to her sensory impairments and thereafter three hours, twice a week, of Communicator Guide support. She remains in her own home and lives as independently as possible.

**Reablement and habilitation**

**Reablement is about helping people to do things for themselves to maximise their ability to live life as independently as possible with an appropriate level of support… It is an outcome-focused, personalised approach where the person using the service sets their own goals and is supported by a reablement team to achieve them over a limited period. It supports a person’s physical, sensory, social and emotional needs and aims to reduce or minimise the need for ongoing support after reablement** (Code 2, 183).

**Habilitation is central in enabling children and adults with a disability to live as independently as possible with the right level of support as it is key to acquiring and developing skills that otherwise would have been learnt incidentally** (Code 2, 185).

Local authorities and local health boards will jointly commission reablement and habilitation services for adults and children in their area. Reablement for up to six weeks, aimed at enabling people to develop skills to live independently often following a hospital admission, will be provided for free.

Rehabilitation programmes for deafblind people, which is a specific form of reablement, and habilitation for children and young people with MSI are similarly outcomes-focused. However timescales are likely to be longer than six weeks. For instance, learning new mobility skills, or to communicate using deafblind manual rather than speech (see Appendix A), can take months rather than weeks.

Reablement and habilitation services for children will be provided for free. Local authorities, in determining whether to charge for reablement for deafblind adults extending beyond six weeks, may wish to consider the short-term investment leading to long-term prevention, savings and outcomes for people brought about by reablement services.

**Preventative services in the community**

Preventative services in the community that some deafblind people may benefit from could include accessible befriending, social groups and social support. Local authorities and local health boards may consider the appropriateness of undertaking social prescribing schemes aimed at people with sensory loss. Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the third sector.

Local authorities will want to ensure that support in the community is fully accessible. Some preventative services available more generally may be inaccessible to deafblind people. Many interventions for loneliness rely on people being able to access the telephone or communicate in groups. In particular, continuing to engage in social activity can be a challenge since communication in a group or a noisy environment is too difficult. Being in a room full of people but unable to communicate is an extremely isolating experience.

One way to address this might be the provision of a Communicator Guide or specialist technology to assist the person in accessing the mainstream preventative service. This would be provided through more formal support set out in a care and support plan. Another way to address this would be to arrange a similar service but tailored to the needs of deafblind people. This might be social groups or activities in venues with good lighting, acoustics and a hearing loop. The group could also be run by staff or volunteers with some understanding of deafblindness, and where the speed of communication is more appropriate. A befriending scheme might need volunteers with training in deafblind communication and guiding to enable them to support those with these needs.

**Checklist**

**Population Needs Assessment and action plan**

* Do we understand the size of our deafblind population and their likely characteristics? [Research](https://www.sense.org.uk/content/regional-data-future-deafblind-population) on the estimated deafblind population in each authority area will help with this.
* Have we considered multiple sources of information on our deafblind population, including registers of dual sensory loss and disabled children?
* Have we considered the likely need for specialist services for people born deafblind with complex needs? This is likely to be a small number of people.
* Is the support available for older people in our area appropriate for the likely numbers of older people with dual sensory loss?
* Have we considered the need for appropriate support for older deafblind people with more complex needs?
* Do we commission older people’s support with sensory loss in mind?

**Specialist staff**

* Have we involved our sensory team in planning how to implement the Act?
* Have we assessed the likely need for specialist input to assessment, and support planning resulting from this population?
* Do we know where we will access staff to carry out assessments, including staff suitably qualified to carry out complex assessments?
* Do we have sufficient staff with the relevant levels of training in-house or will we need to contract out?
* Do all our first contact team know how to identify a deafblind person and how to refer appropriately?
* Can we access advocates with communication skills where necessary?

**Meeting needs**

* Do we have appropriate care and support planning support available for deafblind people?
* Is our direct payment support service able to support deafblind direct payments recipients? Are they aware of the Sense factsheets?

**Information, advice and assistance**

* Is our information, advice and assistance service accessible to deafblind people and would staff know how to provide information in a range of formats?
* Do staff in our information, advice and assistance service know how to refer people with specialist needs to relevant national specialist information services?

**Preventative services**

* Have we assessed our preventative services for their suitability for deafblind people? Do we have rehabilitation suitable for those with sensory loss and access to specialist skills development for deafblind people?
* Are our community prevention services such as befriending accessible to people with dual sensory loss?
* Do we understand the preventative benefits of support such as Communicator Guides and Intervenors, and do we commission those services with prevention in mind?
* Do we have access to skilled rehabilitation workers to support deafblind people to develop new skills?

**Appendices**

**Appendix A. Deafblind people and communication**

**Speech based communication**

### Clear speech

Speaking clearly is one of the most effective and common ways of communicating with deafblind people who have some remaining vision and a hearing loss.

### Lipreading

Lipreading involves the deafblind person watching the lip shapes, gestures and facial movements of the person they are talking to so that they get a fuller understanding of what they are saying.

### Tadoma

Tadoma involves a deafblind person placing their thumb on a speaker’s lips and spreading their remaining fingers along the speaker’s face and neck. Communication is transmitted through jaw movement, vibration and facial expressions of the speaker.

**Speech to Text Reporting**

Speech to Text Reporting (STTR) is a method of communicating using trained palantypists and stenographers to produce verbatim text on a screen for the deaf or deafblind person to read the speech dialogue being communicated. This method can be used by deafblind people with some residual vision as the STTR provider is able to adjust font size, colours and contrasts to suit the individual.

**Electronic notetaking**

Speech can be converted to live text by electronic notetakers. The notetaker produces a summary of spoken dialogue on a screen. This method is also useful for producing printed notes for a deafblind person who may be using other methods of communication support such as a lipspeaker or BSL interpreter.

### Letter based communication

### Deafblind manual alphabet

The deafblind manual alphabet is a method of spelling out words onto a deafblind person's hand. Each letter is denoted by a particular sign or place on the hand. It is straightforward to learn but is more complex to receive.

### Block

Block is a manual form of communication where words are spelled out, using capital letters, on to the palm of the deafblind person's hand.

### Braille

Braille is a system of writing and printing for people with sight loss, in which arrangements of raised dots representing letters and numbers are identified   
by touch. Braille can now be used as a digital aid to conversation, with some smartphones being paired with braille displays, and computer braille displays allowing access to instant messaging software, Skype or chatrooms.

### Moon

Moon is similar to braille in that it is based on touch. Instead of raised dots, letters are represented by 14 raised characters at various angles. It is less commonly used than Braille, but easier to learn and feel.

**Signed communication**

### British Sign Language or BSL

BSL is a language in its own right, with its own word order and grammar. It uses hand signs and facial expressions as a visual form of communication. For people with visual impairment it can be adapted in two ways:

1. Visual frame signing – someone using BSL will sign within the restricted visual field of the person so that they can see it.
2. Hands-on signing – some people may use tactile or ‘hands-on’ signing by placing their hands over the hands of the signer, so that they can feel the signs being used.

### Sign-supported English and Welsh

Sign Supported English and Welsh uses BSL signs but in the order they would be used in spoken English.

### Haptic communication

This is becoming more recognised. It consists of tactile signs describing the environment, emotional responses, descriptions of people and other additional information that would otherwise be provided by sight. The signs are given through touch, commonly to the back, but it can be anywhere on the body that doesn’t interfere with other communication methods being used that the recipient is comfortable with.

### Makaton

Makaton uses signs, symbols and speech to develop communication, language and literacy skills.

### Symbol systems

Symbol systems are often used to assist deafblind people to communicate. Photos, pictures and objects can be added to other structured forms of communication.

### Objects of reference

Some congenitally deafblind or multi-sensory-impaired people learn to use particular objects to symbolise a significant activity. For example, a towel may indicate swimming, or a fork may be used to show that it is time for a meal. This method allows people who are deafblind to make choices and enables others to let them know what is planned.

### Picture symbols

Picture symbols are sometimes used to support the development of language, either accompanying text or in their own right. There are a number of symbol sets available including [Widgit](http://www.widgit.com/) and [Mayer Johnson](http://www.mayer-johnson.co.uk/?ctt_id=8956208&ctt_adnw=Google&ctt_ch=ps&ctt_entity=tc&ctt_cli=2x15381x64072x1583555&ctt_kw=Mayer-Johnson&ctt_adid=11052901504&ctt_nwtype=search&s_kwcid=TC|16135|Mayer-Johnson||S|p|11052901504&gclid=COuV3vmqpa4CFe4htAodYkoqRw).

### Non-verbal communication

Many congenitally deafblind and multi-sensory-impaired people with no formal verbal communication methods will use non-verbal improvised forms instead. Through observation it is often possible to understand the meaning of these unique methods of communication and to learn how to react to, and interact with, the deafblind person.

### Total communication

The total communication approach is about using the right combination of communication methods for an individual to ensure the most successful forms of contact, information exchange and conversation. For example, an individual may receive information via speech and signs while expressing themselves via signs and symbols.

**Appendix B. Making information accessible**

Check with the deafblind person how they prefer to receive information. Your information service will need to be able to access transcription into the different formats as required.

### Large print

No single size is suitable for everyone, but most people prefer their large print in the range of 16 to 20 point. Ensure that you record the preferred size and not just the fact that the person needs large print. Arial is an example of a clear font. You can word process simple large print documents yourself. Some people will also prefer a particular colour paper or paper with a matt finish. Words should not be printed on to graphics or patterns.

### Braille

Documents can be transcribed into braille through a transcription service. However, many people who use braille prefer information electronically. With a braille display, emails, word documents and web pages can be accessible to braille users, provided they are designed accessibly. Check with the person how they prefer to receive information before arranging for transcription. You can find a list of transcription services from the UK Association of Accessible Formats ([UKAAF](http://www.ukaaf.org/)).

### Moon

Moon is a much less commonly used system of tactile written information, based on raised versions of the alphabet, and transcription services are in the minority.

### Audio

Transcription services can produce Audio tape or disk versions of written documents. Some people will have screen reader software on computers and be able to access electronic documents in audio.

### Telephone

Ensure information services have access to text phones and/or staff know how to use text relay (which allows a text phone user to communicate with a voice phone user through an operator).

### Email and electronic documents

For people with access to computers, email and word documents can be the easiest way to access information as they can adapt the font size and colours to their preference. Documents should keep formatting to a minimum and pdf documents should be avoided where possible. RNIB Cymru has [guidelines](https://help.rnib.org.uk/help/employment-work/accessibility-at-work/accessible-documents) on creating accessible electronic documents.

### Face-to-face

For a small number of people, face-to-face communication is the only way to access information. This may be because their only way to receive information is through deafblind manual.

### Sign language

Some people who use British Sign Language (BSL) find written English difficult to understand. For many BSL users a signed video is easier to understand. Professionals BSL services are required to produce good quality BSL versions of information.

### Easy read

For some deafblind people who have some vision but an additional learning disability, easy read will be required.

**Appendix C. Glossary**

### Communicator Guide

Communicator guides offer guiding skills, practical help and communication support – such as helping with shopping or dealing with mail – to enable deafblind people to continue to live independently.

### Intervenor

An intervenor works one-to-one with deafblind individuals. For example, children are encouraged to develop new skills through co-active play and tactile stimulation; adults are helped to develop their communication and independence skills and use local community resources.

### Mobility

In the context of deafblindness, mobility refers to the ability to safely move around the home and outside the home. A deafblind person may appear to have no difficulty in moving around a familiar place, or taking a regular journey but be unable to safely manage an unfamiliar journey or cope with a change such as a blocked pavement on a usual route. A deafblind person’s ability to move safely out of doors can also vary depending on light levels, for instance between daytime and at night.

### Rehabilitation and Rehabilitation Officer for people with Visual Impairment (ROVI)

Rehabilitation workers for people who are blind or partially sighted are qualified professionals who design and provide programmes of rehabilitation for people losing their sight or people who have always had poor sight but need to adapt to new personal circumstances. Their service usually include orientation and mobility training, for example, learning how to navigate road crossings and using public transport, daily living skills training, communication skills, such as learning Braille or learning to use magnifiers, or assessing for lighting adaptations. This will often sit as part of a local authority’s reablement team.



**About Sense Cymru**

Sense Cymru is a national charity that supports and campaigns for children and adults who are deafblind or who have sensory impairments and additional needs. We provide tailored support, advice and information to individuals, their families, carers and the professionals who work with them.

We believe that each person has the right to choose the support and lifestyle that is right for them; one that takes into account their long-term hopes and aspirations. Our specialist services enable each individual to live as independently as possible, offering a range of educational, developmental and leisure opportunities.

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