

We are responding as a group of lecturers on the Postgraduate Diploma / MEd in Deaf Education, the Scottish course at the University of Edinburgh which qualifies teachers to teach deaf children.

CONSULTATION QUESTIONS

1. The strategy outlines a care pathway (page 10).

(a) If you are a service user and/or carer, please tell us what difference you believe the implementation of the pathway will make to the services you experience.

(b) How can we best ensure that services and support meet your needs?

(c) If you are a care provider, what changes will you need to make to implement the pathway?

We think that the language of care pathways is not particularly helpful to deaf and visually impaired people. We prefer to think in terms of empowerment and access, to language, goods and services. We accept that care pathways may be appropriate for elderly people who have lost their sight and /or hearing.

(d) How will you make these changes?



2. The strategy identifies key factors that need to be in place to ensure the pathway is successful (Page 11 para 6.7).

(a) Which of the key factors are most important for a successful pathway?

The consultation has been set up to use the pathway metaphor, so for the time being we will co-operate.

1. Referral routes

It is very important that health, education, social services and the voluntary sector work closely together. It will help deaf / visually impaired people if there is a clear outline of the services available and the routes for accessing them. There are often so many people involved that the parent / carer / individual is overwhelmed.

The NHS has established paediatric audiology standards, and these are monitored well on a joint assessment basis between health boards with a panel including parents of deaf children. However, the government did not consider the early educational needs of deaf children when introducing newborn screening, which is why the Scottish Sensory Centre worked between 2008 – 11 to produce the Scottish Early Years Standards for Deaf children and their families. The Early Years Standards for Deaf children and their families sets out values and an overriding ethos by which services should work. Embedding a system around values rather than terminology such as pathways may be a more productive outlook.

2. Including sensory impairment in generic assessments

We can see the benefit of this for social workers, particularly for those working with older people.

Within the school system, it is important at transition meetings that there is an awareness by practitioners to refer on to specialist services. This is important because a secondary impairment may not be initially diagnosed.

3. Maximise basic screening by (non-specialist) staff

The Universal Newborn Hearing Screening service is operated by specially trained staff and is crucial as the first step in early identification of deafness. Many children become deaf during childhood, or have a fluctuating loss. When UNHS was introduced the Health Visitor screen at 5 in school was ended. This leaves diagnosis rather haphazard, and some children are more likely to be identified after birth than others. We would like to see the reintroduction of a screen at 5 conducted by Health Visitors, but they would need additional training. The previous screen at 5 was ineffective because HVs did not receive proper training in how to do the test, and the test conditions in schools were very variable. Minimum acoustic standards could be set. It is important to identify children with all levels of deafness category including mild, as research at Moray House has shown there is no significant difference in the degree of educational effect of deafness between any of the deafness categories from mild to profound, including young people with CIs. In addition all new arrivals to Scotland under the age of 18 should also be offered a screening test within their first few weeks of living here.

Identification is only the start of the process; it is the way that this is organised that will remain with families for the long-term. It is also about the model of support that is provided and the values it is based upon that are as important as any pathway. Devising a chart that sets out how services interface is not as important as the ethos that drives them. Does it have the family as an active member of a team or are they included to meet a standard, checklist or pathway? Are deaf people involved and listened to rather than allocated the 'deaf role model' status? It is essential that there are systems put in place to make sure that nobody is missed out. All missed appointments should be followed up by sympathetic staff who do not adopt a blame approach.

4. Single point of access

Parents of deaf children will appreciate having a single point of access to services. It should be under their control who that person will be; someone they can relate to easily. At present information sharing between health, education, social services and the voluntary sector is very poor in many areas.

5. Local SI care pathways easy to navigate agreed by key stakeholders

Stakeholders here includes young people themselves who are deaf / visually impaired and the adult community of d/Deaf, deafblind and visually impaired people. It is equally important that these people feel valued and respected as key people and not in a tokenistic way. Ease of access and communication will be essential to guarantee success. This means agencies need to consider linguistic access for deaf / deafblind people'

6. Consistency across Scotland

This is crucial in deaf education. There is very little consistency across Scotland as recent research from the SSC by Weedon et al (2012) has demonstrated. It would be good to see recommended ratios of the number of specialist teachers of deaf children related to the size of the local authority population. Historically some local authorities have much better staffing available and are therefore able to work with a wider range of deaf children. Our own research at Moray House (Deaf Achievement Scotland) suggests that the category of deafness does not make any significant difference on educational outcomes: all deafness categories experience difficulties in the education system. Yet only some local authorities provide support to the full range of deafness categories. More research is needed into the different styles of working with a wide range of deaf learners in inclusive settings from class teachers, specialist teachers of deaf children, health service staff and specialist support staff.

7. Awareness raising for frontline staff

Part of the role of local authority services for deaf children is to provide deaf awareness training for school and college staff. Unfortunately some services don't implement this, usually because they are not adequately staffed. There needs to be a particular focus on the access needs and learning strategies which work well with deaf learners. All new trainee teachers should have awareness raising about sensory impairment as part of their initial teacher education. We would recommend a minimum of 2 hours input for teachers on a 4-year education degree and one hour during PGDE with one hour during the probationary year for student teachers on the PGDE route.

8 Trained staff

The demographics of the workforce mean that we are sleepwalking into a situation that no one intended. We need to ensure that there are trained teachers of deaf children and educational audiologists that are of a high calibre, motivated and supported by appropriate training. There needs to be a national succession planning system put in place – the data is out there. We do not need another audit but instead action: national funding for places on training courses for staff to become teachers of deaf children and / or educational audiologists. One way local authorities could recruit more and younger teaching staff is by offering all staff interested taster sessions and awareness raising, which could lead to their secondment to the service for deaf children after appropriate application and interview.

9 Training

Each profession listed in any pathway has their own additional specialised training. However, in an area such as the early years we need the opportunity to train as a group of professionals in a course that meets all our needs. A Supporting Deaf Children birth to 3 three postgraduate course would be beneficial to a range of professional groups and would also allow the groups to study together. What better way to embed partnership working than through a training programme, nationally funded that brings a range of professionals together? As a course team we have the potential to develop such a course, but we know in the present financial climate that a post-qualifying course would be unlikely to recruit. We propose a Postgraduate Certificate programme of 60 credits with courses on: Working with Families of Deaf Children (0-3); Early Language Development and Deaf children (0 – 3); Early audiological issues (0 – 3). We would like support from the Government to develop this course using blended learning and weekend workshops, with input from d/Deaf and hearing professionals and parents.

(b) Which are the most challenging to put in place?

We think the screening at the age of 5 is the most difficult to introduce because it requires good liaison between the Health boards and local councils, and it requires new training for the Health Visitors.

A change of ethos and values can be hardest to change. People and professionals can hold entrenched positions and these can be hard to erode. We are sure funding will be an issue but planning for succession and a training course are small sums in relative terms. We need to adopt a Keynesian approach – invest to achieve returns which will ultimately reduce costs.

(c) Do you think that any key factors have been missed?

For deaf people **linguistic access** is a key factor. For deaf children this means the right to develop a first fluent language under the age of 5. We see this linguistic right as linked to the United Nations Convention on the Rights of the Child (especially articles 12, 13, 23, 30 and 40) and the UN Convention of the Rights of Persons with Disabilities. Compliance with these conventions has consequences for options available in each local authority in Scotland.

Secondly, linguistic access means good quality access in schools, colleges and universities, including providing qualified access staff and properly adapted buildings. We are a very long way off having good linguistic access for deaf young people in Scotland today.

Strategy for the **early years** as discussed above including a **multi-agency training programme** that is nationally funded.

Succession planning for staff.

Looked after children are often overlooked. The priority has often been to provide them with a safe, secure and nurturing environment. But the cost is that care staff often lack specialist knowledge: appropriate communication strategies, hearing aid / cochlear implant care and maintenance, deaf awareness.

3. The strategy identifies areas for action that should be addressed going forward (Page 13-16)

(a) Which of the areas for action will be the most challenging to implement?

1. An audit and realignment of spend

We are not sure what the basis of the realignment will be. The main issue is to ask people who experience a sensory impairment for their views first. The BSL and Linguistic Access group has rightly highlighted the importance of this in their response to this consultation. We can't understand why people with sensory impairments can only receive money already allocated to other people with sensory impairments. For example the Government could decide to cut defence spending and reallocate resources.

2. Local partnerships should consider basic sensory screening

It would be better if there were a national policy on a hearing test at 5, or all new arrivals of school age. Children who receive education otherwise, such as home tuition or travellers should also be able to access a screening clinic and be followed up by local authorities / health boards.

3. There should be mandatory training in sensory awareness and assessing for non-complex needs across staff in health and social care settings, targeted in the first instance on older people's services.

We agree with this. Sensory awareness should where possible be led by people with personal experience of these impairments.

4. *Local partnerships (in this instance local statutory social and health care agencies, and third sector agencies) should be able to evidence that their service planning reflects the need in their area.*

Again, these partnerships should be led by people with sensory impairments, including children. There are many organisations working on behalf of deaf and visually impaired people who regard themselves as stakeholders, and so influence the policy in this area disproportionately.

5. *There should be robust systems for maintaining information locally, and sharing this between agencies, in relation to people who have received a diagnosis of a sensory impairment at any time from birth onwards.*

It is crucial to share information in a much better way between agencies. At present there are large gaps, e.g. babies screened at birth who are not seen by deaf education services till the age of 3. Involving the third sector is also very important – and not just organisations for deaf people but of them too. There are disparities in the access different third sector organisations have to joint planning: for example, NDCS has very close relationships with health, whereas the BDA is not invited in to early years partnerships. This has an effect on what services are provided to families. Confidentiality and the Data Protection Act should be used to help not hinder joint working.

6. *Compliance with the Equality Act 2010 should be scrutinised in relation to sensory impairment, particularly in relation to communication, and consideration given as to what future action may be required.*

This is very important.

Linguistic access in schools depends on:

- a. **Improving classroom acoustics systematically**, e.g. implementing minimum acoustic standards for all schools in Scotland on a rolling programme, not just for new schools. This would also benefit many other children, e.g. children with language disorders or English as an Additional Language. It need not cover all rooms, but at least one room could be treated in each school at first, and re-timetabling could allow this room to be used for classes containing a deaf child.
- b. **Providing effective linguistic access in the classroom**, e.g. properly qualified notetakers and educational interpreters. At present there is a course at the SSC to train notetakers, but no Scottish local authority has ever sent anyone on this course because they don't employ notetakers. Similarly colleges are employing untrained notetakers, unaware of professional standards. Heriot Watt University now has a degree in BSL / English interpreting. Only 3 local authorities in Scotland currently employ registered interpreters as access staff for deaf children. The new curriculum is based on group work, but hardly any local authorities use group FM systems which would maximise the deaf student's involvement in class discussion.
- c. Providing **communication classes** for peers to participate in so that they can communicate effectively with deaf peers / family members. This would mean that isolation and low self esteem can be reduced by simple means: the deaf child feels valued and respected in their own right.
- d. Teachers of deaf children **specialising in monolingual or bilingual support**. For bilingual support they must achieve a minimum of BSL NVQ 3 or better before working with deaf children who sign, or who might want to sign. Mainstream staff to have the opportunity to access basic communication strategies they can use with their deaf pupil.

- e. **Allowing time for the class teacher to meet with specialist** or peripatetic teachers of deaf children for joint planning. More specific training for school teachers who have deaf children in their class in how to develop the English vocabulary of deaf children (which will also help many other groups of children).
- f. Specialist teachers of deaf children being fully trained in **assessing the language development** of deaf children in speech and sign language, so that they can devise appropriate educational plans.
- g. Each local authority considering setting up **resource base schools** at nursery, primary and secondary level. Currently 47% of the Scottish population (20 local authorities) do not have this on offer, which drastically reduces the choices available to deaf young people at school.

Linguistic access for deaf children in *early years* depends on

- h. Some teachers of deaf children, audiologists, speech and language therapists and parents receive **additional training in early years** so that the Scottish Standards can be implemented. i.e. a PG Certificate in Early Years with the families of deaf children.
- i. **the cochlear implant centre working much more closely with local authorities** so if they reject a child for implant (e.g. on the grounds of living in poverty or in a 'chaotic' family – their words) that the local authority prioritises other ways to provide culturally appropriate early support so that the deaf child can develop a fluent language by 5.
- j. Each local authority area having a plan in place to **provide real choice** to the parents of deaf children, including the possibility of their deaf baby acquiring BSL in a sign-intensive nursery environment, with support for the extended family in learning to sign. This option is hardly currently available in Scotland.

In our view each of these points a – j is linked to the Equality Act and reasonable adjustments to prevent discrimination against deaf children.

b) Which of the areas for action will make the biggest difference and why?

- a. **Classroom acoustics**, because at present there are no regulations in Scotland about school acoustics. In England there are BB93 regulations, but they only apply to new-build. We need clear guidance on this in Scotland and for all schools and nurseries, particularly in the light of the Curriculum for Excellence which encourages much more group work, and therefore more challenging listening environments.
- b. Providing **effective linguistic access** in classrooms, because at present support staff working with deaf children in educational settings are usually completely unqualified, paid the minimum wage, on term time only contracts and have no time to liaise with teachers. Consequently the service they provide is very poor. A change of attitude is required – these people are likely to be graduates, and will need graduate level salaries. Providing these staff with training and qualifications essential.
- g / j. **Sign intensive environments**, because at present this option is not offered in many local authorities and it results in deaf children having a very late start with a first language, with consequent effects on their learning and school achievement. The children who experience the worst effects of the current approach are families living in poverty, looked after deaf children, and deaf

children with an additional disability.

A coordinated strategy is required in the area of the Early Years. We still have a very muddled approach at present without a coherent vision for the way forward. We have groups such as the Cochlear Implant Team discouraging families from signing based on unsubstantiated research. We have some teams within hospitals wanting to refer families that opt for a non-audiology / sign language model to be referred to child protection. A culture is challenging to change and we need joint training opportunities and meaningful partnership working to achieve it.

(c) Are there any other areas for action that you would like to see included within the strategy?

Strategy for the early years.

Multi-agency training programme that is nationally funded.

4. Please comment on the current provision of sensory impairment services as either a service provider or service user. If you have any experience of sensory impairment services, please let us know what you think of them: this should include any experience of one-stop shops.

As already mentioned, service provision is very patchy in deaf education. The Early Years Standards are important to implement on a national basis, so every local authority signs up to them. Further detail in the standards for deaf children would ensure that some were qualified to minimum levels necessary in BSL (NVQ 3 or above) and all specialist teachers of deaf children were qualified to monitor the language development of deaf children.

There is a lot of good practice within the different regions but one of the challenges is recognising and defining what it is. A strategy based on shared values that would be determined locally is one way forward. Instead of audits we need a national debate about what the values and ethos should be for deaf children.

5. What difference will the implementation of the strategy make to your life?

We would be even busier, but if our suggestions are accepted, able to work more productively.

Scottish society would be healthier and wealthier as these young people move from a dependency world to an included world, respected and valued as citizens.

6. Does this strategy properly reflect the current climate and developments in policy and practice for children and young people particularly in relation to the Getting it Right for Every Child approach and the Doran Review?

We feel that there could be duplication with Getting it Right. The Doran Review 'kicked the issue into the long grass' by not addressing the funding of grant maintained schools. This issue still remains to be publicly discussed.

7. Do you have anything you wish to add to the Sensory Impairment Strategy or any other general comments that have not been covered by the questions?

Yes. Health input to Individual Education Plans is very erratic across Scotland. Many deaf children have on their IEP or ASP that **Speech and Language Therapy** will be provided, but in practice there is none. Because these plans are non-statutory (although recorded by schools and the government) parents and deaf young people don't easily have any form of redress. It appears that SALT input is determined by whether the therapist judges that the deaf child can make progress over a 10-week period. The way SALT is provided in short blocks also mitigates against deaf children receiving Co-ordinated Support Plans, where parents would have more rights to maintain the additional support.