# Feedback from BADHOGS members who are profoundly deaf, deaf/blind & BSL users

**Have you experienced any barriers to getting great care?**

- There is often very little awareness of the needs of deaf & deafblind patients, & BSL knowledge is still very rare amongst NHS staff. Many do not understand British Sign Language is a separate language, and is either a deaf person's first or preferred language. Deafblind patients who use BSL require specific extra skills from an interpreter, such as signing within a specific visual frame or tactile "hands-on" signing.
- Although registered as deaf, patients are still directed to use the phone! Use of text (which would be preferred to phone) is limited, and usually doesn't allow for replies. Emails and text involve English, and deaf people vary considerably in their ability to read and write English.
- Patients have had appointments cancelled because they have been unable to respond or have had to go to the surgery themselves to confirm, or change appointment dates. GP receptions vary greatly in their awareness of deaf people's communication needs and skills.
- Deaf patients can be expected to lipread English (which may not be their first language) despite feeling unwell, and with no thought given to the fact that the person speaking may have a full beard, for example or a strong accent, or simply not speak clearly. Lipreading is very difficult and much may be missed, especially words or terms not known to the patient.
- Positioning is also very important for both lip reading and signing – e.g. a person's face will be in shadow if the sun or light is behind them, there is an optimum distance for lipreading, and so on. Few NHS staff have had "deaf awareness" training.
- Lack of deaf awareness, and little knowledge of BSL (which uses facial expressions as part of the language's grammar), can result in BSL users being seen as 'aggressive' or 'rude'. Also staff are not always comfortable with hearing/assistance dogs accompanying some patients.
- Lack of knowledge of BSL fingerspelling, or poor and cumbersome use of fingerspelling, which is used for names, for example, but which can also aid understanding.
- Interpreters used in medical settings should be registered and qualified (not just in language skills but also in interpreting skills). Even where an English-BSL (or other sign language interpreter) is provided at hospitals, they are often not permitted in theatre, so deaf patients won't be able to receive instructions, ask questions etc. So the patient may not be properly prepared for details of procedure/treatment. A number of different staff can be involved, from pre-surgery, surgery, post-surgery and discharge, not all of whom are aware of the communication needs of the patient. A patient is likely to be lying down, so communication should be completed while they are sitting up and can easily see the interpreter and those speaking.
- Although booking appointments online is preferable for those who are deaf & comfortable with using technology, and using English, this may not be true for all deaf/hard of hearing. Additionally, the process can be overly complicated & appears to require a lot more information being input than would be expected.
- There are a number of different agencies who supply interpreters, and their quality is variable and some don't always recognise British Sign Language as a specific language which needs supporting, and for which there are clear routes to qualification and

registration. Some agencies when tendering for a contract do not take into account the fee guidance and terms and conditions used by most accredited BSL interpreters. Nor do they realise BSL interpreters need to be booked at least a fortnight in advance. Patients arrive for an appointment to find no interpreter has been booked or are told none is available.

- Furthermore, there are an increasing number of different sign languages needed (e.g. Nepalese, SL, Portuguese SL, American SL, Irish SL) which may need to be catered for. It is understood that NHS change agencies every 2-3 years which leads to inconsistencies/deterioration in service.
- Admin staff at GP surgeries/hospitals etc aren't always familiar with the process – that it is the surgery's responsibility to book and arrange payment for a BSL interpreter.
- There is very little mental health support available for deaf patients – ideally counsellors should have BSL skills, or be themselves deaf and BSL users, rather than involving a 3rd party as an interpreter. (See, for example, the services provided by SignHealth, the charity for deaf people and their health).

**What are your top priorities when receiving health and care services in your community? What improvements would make the biggest difference to you?**

- Having admin staff at GP surgeries/hospitals who are deaf aware, ideally with BSL skills, and know the communication needs of patients so that they are able to arrange & supply requisite interpreter etc.
- Employing more deaf people with appropriate skills (BSL, lip reading, the use of what is called "international sign language" (this is a more gestural-visual sign language largely based on ASL) or what is called SSE (sign supported English)).
- Having dedicated and qualified BSL interpreters available, including specific support for deafblind patients. Deafblind patients who use BSL require specific extra skills from an interpreter, such as signing within a specific visual frame, or tactile "hands on" signing. Time should be allowed for the interpreter to familiarise themselves with the patient's concerns and language style or needs prior to the appointment. Surgeries and hospitals should book double-time appointments to allow for the extra time needed interpreting between a spoken and a signed language.
- Having BSL taught in schools, enabling more people to become deaf aware and BSL capable
- Having more staff aware of basic BSL and fingerspelling.
- Increased usage of video for appointments (with appropriate BSL support) & use of text/WhatsApp for communication with patients with hearing loss; but bear in mind with video that screens are small and two-dimensional, so they suffice for making appointments and short interchanges but not for full medical conversations with a patient.
- Recognition & provision of requisite support for deafblind patients – face-to-face communication with specific needs such as tactile "hands on" support is required.