

Deaf people's access to health and social care services in Shropshire

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Abstract

In the UK it has been documented that in health and social care settings, Deaf people whose first language is British Sign Language do not always get access to British Sign Language/English interpreters for face-to-face consultations; they report of difficulties in accessing contact systems based on auditory language and comprehending the written English used in health and social care information/correspondences. There is a perception amongst many Sign language users that providers have little appreciation of their communication needs and how to accommodate Deaf people. The purpose of this study is to present the views and experiences of the Deaf Community in Shropshire when accessing health and social care services. Qualitative data were collected from members of the Shropshire Deaf community (N=16) by means of focus groups, interviews, and observations of health and social care service delivery. Findings suggest that many of the communication barriers documented in other areas can also be identified within Shropshire, moreover, by virtue of providers working closely and in partnership with the local interpreting service, the community report of fewer access problems in relation to primary carer, outpatient and social care services. Inpatient and A&E provision was identified as requiring better awareness and a more proactive approach from staff members in supporting Deaf patients' communication requirements.

The Deaf Community

It is estimated that within the UK there are around 10 million people with some degree of hearing loss, and it has been proposed that between 30,000 - 70,000 of these can be described as being profoundly Deaf with British Sign Language (BSL) as their first or preferred means of communication. (Ringham, 2012). Most would have experienced a pre-lingual and profound hearing loss, and for many, even after prolonged and intensive tutoring, the acquisition and mastery of oral communication can be extremely difficult to achieve at any functional level. Meadow, (1980, p17) Indeed, it has been documented that a high proportion of Deaf adults (18 -19-year-old students) do not read above the levels generally attained by 9 -10-year-old non-deaf students. (Paul and Quigley, 1994, p.155) And recent data even suggest that this pattern still persists in that English attainment for UK deaf children as measured by GCSE achievement of A* - C grades remains lower (around fifty per cent) when compared with non-deaf children (NDCS, 2015). So, for a

significant proportion of deaf individuals, particularly those with a pre-lingual; and profound hearing loss spoken language cannot be considered a viable option, and in many cases a signed language becomes the only feasible and natural means of communication - oral language in both its written and spoken forms is often considered by 'signers' as a second and somewhat foreign language and that navigating a world dominated by English can be extremely challenging.

Populations of sign language users are often referred to as the 'Deaf Community' - a term generally used to differentiate between individuals with a hearing loss who choose to use spoken language as their preferred and only means of communication from those who use a signed language and primarily interact exclusively with other sign language users. Baker-Shenk & Cokely, (1980) developed a model describing the membership characteristics of the American Deaf Community, which identifies four key routes to membership: (a) the use of a signed language; (b) having a hearing loss; (c) participation in the social life of the group and (c) engagement in the political interests of the community. Brennan (1992) suggests that these criteria provide a useful template for describing the British situation; with the use of BSL potentially being the most central element of British Deaf community membership and identification. With this in mind, Deaf communities can be seen to share many of the characteristics of other minority groups such as immigrant communities where the use of a native language and a unique culture distinguishes them from the majority/host culture. Indeed, there have been moves within Deaf academia to emphasise the linguistic and cultural essences of sign language using communities by aligning them with other linguistic minorities. Lane et al (1996) - thus giving rise to the notion of Deaf spelt with a capitalised 'D', which has been used to emphasise the centrality of the use of sign language in the expression of a Deaf identity and Deaf Communities as distinct linguistic and cultural groups.

Despite these similarities, Deaf communities are faced with added audiological and linguistic barriers (a visuospatial language and limited/no access to the auditory environment), which by definition make the Deaf experience markedly different from that of other minority groups; whose populations can generally learn the spoken host languages and participate independently on this level. This becomes most apparent when considering the ways in which wider societies, within which Deaf communities are embedded, are generally structured around the use a dominant spoken/written language. Ultimately, when Deaf people need to engage with goods, services and other facilities it is often a consequence of language (spoken) and mode of communication (oral/written, including telecommunications) that, without intervention or adjustment can place them at a disadvantage.

Deaf people's access to health and social care services

(i) Face-to-face consultations

It has been widely described that even within health and social care settings the predominance of auditory modes of communication can place limitations on how Deaf people are able to access services and information. Reynolds (2007) warns that without proper access to healthcare information Deaf people tend to rely on others within the community for this - This can produce mixed and inaccurate ideas founded on lay perceptions significantly restricting Deaf people's capacity to take actions such as initiating and attending medical consultations, even in circumstances where, without medical intervention, their health can be put at serious risk. (Polard et al; 2009, Meador and Zazove, 2005) Similarly, Harmer (1999) warns of the risks to Deaf people's health and wellbeing if these barriers (particularly inappropriate communication and insufficient provider awareness of Deaf people's needs) are not addressed. She also highlights the effects on patients' knowhow and willingness to seek timely medical assistance and the dangers of potential misdiagnosis by practitioners. D/deaf people also tend to show less compliance in engaging with treatment and follow-up care due to not fully appreciating practitioners' instructions. Conversely, individuals able to communicate effectively with practitioners showed greater compliance and responsibility for their own healthcare. A study by Signhealth (2014) serves to highlight the impact these restrictions can have on Deaf people's physical wellbeing: Although Deaf people tended to lead relatively healthy lives in terms of alcohol consumption and smoking, the findings do indicate that there were higher incidences of being overweight, high blood pressure and diabetes amongst Deaf British populations. Interestingly, a high proportion of participants showed no awareness' of pre-existing conditions until screened as a part of this study - the authors suggest that limited access to healthcare information and ineffective communication was a causal factor driving this phenomenon.

Deaf populations are therefore faced by a number of factors that constrain D/deaf people's access to healthcare services, which in turn serve to diminish the knowledge and understanding required to effectively take an informed responsibility for one's own health and wellbeing. From this, two underpinning factors can be identified that seem to drive and maintain the barriers faced by D/deaf patients: (i) insufficient communication between practitioners and patients, and (ii) practitioners'/providers' lack of understanding of Deaf people's cultural and linguistic needs.

For all deaf people the cornerstone to quality health and social care is effective communication, and for BSL users this takes the form of consistent access to the services of NRCPD registered Sign Language Interpreters and within the English health and social care sectors it would seem that Deaf people do not always get access to interpreters for consultations. Indeed a survey commissioned by Action on Hearing Loss found that 68 per cent of requests for an interpreter in healthcare settings were met with no provision. (Ringham, 2012) Historically it has been purported that there is a national shortage of BSL/English interpreters in the UK, with current numbers standing at 895 Registered Interpreters serving a population of between 25,000 - 70,000 (Ringham, 2012; Signature, 2015) - rendering one interpreter for every seventy-eight BSL users. Moreover, in healthcare

settings this thirty-two per cent fulfilment rate cannot be explained by interpreter-to-Deaf person ratios alone. The perception amongst some Deaf populations is that this lack of provision can be more accurately attributed to providers such as GP surgeries and hospitals refusing to book interpreters citing cost as the reason. And in some areas provision for optician and dental appointments has ceased. (Healthwatch Kirklees 2014; Healthwatch York, 2013).

Within recent times there have been financial pressures placed upon providers to be mindful of the cost of using interpreting services often resulting in generic spoken language agencies winning centralised tenders to supply both spoken and BSL services. The British Deaf Association (2012) acknowledges this and warns of the risk to services for Deaf people (uninsured and unqualified signers) where 'specialist Deaf' suppliers loose out to these larger organisations. A finding by Healthwatch Kirklees (2014) suggests that since larger national organisations have become suppliers of BSL interpreters, this specialist expertise and local knowledge of Deaf communities' requirements has been lost often resulting in mismatched or no provision. Contractual constraints can also restrict access to interpreters when providers are obliged to use only the contracted supplier. In the event of them not being able to fulfil service requests, providers are barred from sourcing services from local specialist agencies even when they have interpreters available. (Sign Lingual UK, 2014; Reynolds, 2007) also highlights that a lack of knowledge by Deaf patients and providers on how to access interpreting services offers another explanation as to why Deaf people do not always receive interpreting services at medical appointments.

Other ways in which Deaf people feel that they are in receipt of a poor service in respect of their communication needs manifests itself in the use of staff who have some sign language skills; having to resort to using family members (due to length of wait times for interpreting services) and being offered on-line alternatives. The latter, although staffed by qualified interpreters is not always deemed sufficient due to dialectical differences and unreliable connectivity. (Healthwatch York, 2013; Lacey-Davidson, 2012) There are also tendencies to rely on pen and paper instead of supplying interpreters, which presents sign language users with an unfamiliar and often inaccessible vocabulary and English based syntax. (Sign Lingual UK, 2014; Healthwatch York, 2013). Lacey-Davidson (2012) goes on to suggest that some of the factors underpinning this is that providers lack awareness of their obligations under the Equality Act (2010); staff not knowing of their responsibilities to book interpreters; and contracted 'generic' agencies not fully understanding the standards for BSL interpreting i.e. the use of RSLIs.

(ii) Making contact with service providers

Besides issues associated with face-to-face consultations, Deaf people can also face barriers when needing to make contact with Healthcare establishments. The general experience in England seems to be that when a Deaf person needs to either seek advice or initiate an appointment with a

healthcare practitioner often the only contact option is telephone. For BSL users, telephone systems present immediate barriers resulting in many individuals having no option other than attending surgeries in person to book appointments. However, this is not always without its problems due to reception staff's reported lack of awareness of D/deaf issues and how to communicate with D/deaf people, even on a rudimentary level. (Healthwatch York, 2013) The Choose and Book system for booking hospital appointments is also telephone based rendering many BSL users having to rely on hearing family or friends to make calls. (Healthwatch Kirklees 2014) Similarly, the way in which patients are expected to obtain test results is by calling the surgery and once again there is a documented reliance on hearing family and friends. For many Deaf people having non-professional third parties acting in these ways has the effect of diminishing their independence and taking away any privacy. (Healthwatch Kirklees 2014) It would seem then that the structures of health and social care services can be predisposed to, albeit, inadvertently disempower Deaf people by fostering a dependency on non-professional others to access the system. Reynolds (2007) warns that these others (including some professionals such as social workers) can become the 'gatekeepers' of Deaf people's health care rendering them ill-equipped to manage their own health needs. This is contrasted by the feelings of empowerment and understanding reported by those Deaf individuals who have consistent access to BSL/English interpreters when engaging with services.

It would seem that the state of health and social care provision for many Deaf populations in the UK is viewed by them as insufficient in terms of meeting their health and social care needs primarily due to: systemic and structural factors; inappropriate communication between practitioners and patients; and a general lack of awareness of Deaf people's access needs by staff on all levels. This can lay the foundations for a poorer understanding of health and social care issues, which in turn can leave Deaf populations more vulnerable to poorer health and wellbeing.

The Deaf community of Shropshire is composed of around thirty adults between the ages of thirty to seventy-plus-years matching the profiles and characteristics outlined by Baker-Shenk & Cokely, (1980); (NDCS, 2015); Paul and Quigley, (1994). And like any other Deaf community, they have cause to access local health and social care services that are ostensibly designed and structured in a similar way to those in other localities. With these two factors in mind, it could be assumed that Deaf people living and using services in Shropshire would articulate experiences and views commensurate with other national/international populations as outlined in the literature.

Research aims

- (i) Document the specific experiences and views of the Shropshire Deaf Community as they accessing health and social care services.

- (ii) Outline how providers engage with their Deaf patients/service users.
- (iii) Ascertain the Community's recommendations for any further development of services.

Methodology

In order to capture and account for the depth and complexity of individuals' experiences and views on current health and social care practices, this study adopts a qualitative approach informed by ethnographic and phenomenological principles. These research traditions are designed to document social phenomena and describe real-life events from actors' own standpoints. Reynolds (2007, p.68) advocates the suitability of such an approach when exploring the belief systems and experiences of the Deaf community - particularly in relation to health issues. Although the literature suggests that in general British Deaf communities tend to experience difficulties when accessing Health and Social Care services - this study takes as its starting point those experiences specific to the Shropshire Deaf Community. To this end an inductive bottom-up approach is favoured with the literature used to guide data collection and interpretation.

Data collection and analysis was principally carried out by one lead researcher employed as an in-house BSL/English interpreter employed by VISS Ltd the local interpreting service. This facilitated access to respondents and 'real-life' incidences of Deaf people receiving health and social care services. The researcher's role as interpreter working closely with this community in health and social care settings afforded the study with a unique insider/outsider perspective (Hammersley and Atkinson, 2007, pp. 86-87) on emerging issues - thus facilitating the delineation of respondents' experiences from their standpoints combined with the more objective stance brought about by not being a full community member.

Sampling and access

Initially the database of clients held by VISS Sign language Interpreting Service (Shropshire) Ltd was used to sample individuals for the focus group. From this, eleven individuals attended the session primarily representing the older members of the population. This led to a more targeted approach during interviews to capture the views of those representing the younger end of the spectrum and those individuals who felt uncomfortable speaking in a focus group setting. In total a representative sample of around fifty per cent of the population was engaged.

Data collection and validation

In this current study focus groups are used to construct a generalised/shared community perspective on how Deaf patients/service users currently access health and social care services; ad hoc conversations/interviews allow respondents to describe and express firsthand opinion on specific incidences and observational fieldwork enables the documentation of real-life patient - provider interactions. Focus group data took the form of video recorded discussions in BSL on a range of topics with minimal guidance/probing from

the researcher. This was transcribed into written English for analysis. Interview and observational data took the form of field notes written up during and immediately after events. Data collection was conducted over the period of one year.

In order to test the validity of the findings, methodological triangulation and respondent validation are used in the form of: (a) comparing focus group data with that of interviews and observations, and (b) a debriefing focus group where preliminary findings are presented back to respondents for comment on whether the interpretation faithfully represents their views and allowed space for reflection and additional comment.

Data Analysis

The analytical framework used in this study is based on the principles of grounded Theorising as originally proposed by Glazer and Strauss (1967), in which the research process is essentially inductive, taking the data as its starting point with which to build theories/explanations of phenomena. With this in mind, the focus group transcript was initially coded to highlight any emerging themes indicative of the accounts and perspectives held by the group. Second, this served to identify other avenues worthy of subsequent investigations and analysis during the interviews and field observations, which in turn underwent the same process. Finally, all of the indicators were used to generate broader descriptions of the health and social care issues believed to be pertinent to this community.

Ethical considerations and consent

All focus group participants were handed an information sheet outlining the aims of the study, how the data would be used, measures taken to ensure anonymity and their right to withdraw at any time - this was translated into BSL by the researcher. Once all participants were confident that they had an informed understanding of the study and what was expected of them, they were asked to sign a consent form. Interview participants were given the same information prior to being interviewed.

Findings

Deaf People accessing a hearing world: generic underpinning factors

This section identifies the underpinning features and practices that cut across all areas of current health and social care service delivery within Shropshire. There are strong similarities with the documented experiences of Deaf populations in other regions of the UK suggesting that the British Deaf experience is to some degree universal when accessing these types of services.

Environmental/structural factors

A key theme emerging from the literature and the work undertaken for this current study is that the environments within in which services are delivered are generally structured around the use of spoken and written English. There is a perception amongst the Shropshire Deaf community that this creates barriers when Deaf individuals wish to access such services: a

phenomenon, they assert, not experienced by their non-deaf peers. The following section outlines the key environmental and structural factors identified by respondents.

Difficulties in understanding and responding to written communication

Deaf people frequently receive communications from a range of services in written form: appointment letters, results notifications, treatment information, surveys, general information/instructions etc. Often the English registers used within these documents are too formalised and populated with specialist terminology making comprehension difficult for BSL users. This renders them at a significant disadvantage.

I often get correspondences that I don't understand - it goes right over my head due to my lack of English. I need to get these translated into BSL so I can respond if needed, or just to understand what the letters are saying.

Similarly, postal healthcare information and circulars can cause misunderstandings and concern if not immediately accessible to BSL users:

Bowel screening equipment is routinely sent to individuals over a particular age and contains pictorial representations of the procedure accompanied by written instructions. Upon receipt of this kit a BSL user found it difficult to understand these procedures with any confidence, despite these visual cues. Ultimately, these instructions were translated by a BSL/English interpreter using the added visual resource of an online NHS video - resulting in a complete understanding of what was expected.

A BSL user received a satisfaction questionnaire from a health organisation and was confused as to the document's purpose. Thinking it might be important and relating to their immediate healthcare it was brought into the interpreting service for clarification regarding why they had received it and what it related to. Once it transpired that it was in fact a general voluntary survey sent out to all patients they were relieved that it was nothing too serious or needing immediate attention.

Having effective translations of written materials is recognised by members of the Community as crucial when dealing with these types of communications: this is becoming increasingly more important as many organisations are moving towards more online/written means of conducting their activity:

I live on the outskirts of the county and find it difficult to travel to the interpreting service for translation work and interpreted telephone calls. I therefore have a monthly session with an interpreter at my home, which is an invaluable service as it gives me the means with which to independently conduct my personal business. I use this time to have letters and forms translated, respond if I need by composing emails or letters in English translated from my BSL. This

is a vital service for me but sometimes I worry that I may miss deadlines due to it being monthly.

Community recommendations:

The Shropshire Deaf Community should continue to have a local interpreting service for the translation of health and social care written material and assistance in any subsequent actions/responses.

Making contact with and accessing services

In addition to the difficulties Deaf people face with written materials, services' current telecommunication practices present similar barriers when BSL users wish to make contact with providers or providers with their Deaf patients/clients:

My surgery has no other means to make contact other than the telephone - I have to attend in person just to book an appointment: they have no text messaging facility or email and as for using a text phone (mini-com); I no longer have one! I would prefer a way of contacting the surgery by SMS or email instead of having to visit in person each time.

Simple actions such as making emergency related appointments on the same day or being notified of test results can be difficult if not impossible to manage for BSL users due to the telecommunication barriers.

A BSL user was attending a dental appointment with an interpreter. It emerged that the patient should see their GP for a related matter later that same day, to which the patient displayed apprehension as to how they would manage this and get an interpreter for the appointment. The attending interpreter suggested that they refer this back to the Interpreting service's office to arrange an emergency consultation with a GP, which was subsequently arranged and the patient was seen promptly with an interpreter.

When I have blood tests etc. they always say to ring for the results, but this is not possible as I am unable to use the phone and have nobody to call on my behalf.

The most effective means by which Deaf people are able to make and arrange health and social care related appointments is to use the interpreting service as an interface between them and providers. This lessens the impacts that these structural barriers can have on BSL users when attempting to make contact with providers and is seen by the community as the most viable option available.

A Deaf patient contacted the interpreting service via FaceTime regarding an injury at work - an appointment was arranged later the same day with an interpreter. The patient expressed relief and gratitude that this had been arranged at such short notice as they

were in great discomfort and would not have been able to make contact with the surgery and express themselves otherwise.

Making appointments is easy for us via the interpreting service - all I have to do is email them when I am available and they arrange an appointment with an interpreter and my preferred GP. It's also useful when appointments have to be moved: the Interpreting service manages this too - we would not be able to cope ourselves, without this life would be impossible for us Deaf people!

This aspect of the interpreting service's provision is a popular means by which Deaf people are able to easily and confidently make contact with providers, however, some would prefer a more direct means of contact.

I feel strongly that NHS services should have a text only option for Deaf people who need to be contacted by Health Care Professionals and that staff should be trained in how to use this and adhere to it as a protocol for communicating with Deaf people.

Although making initial contacts can be extremely difficult for BSL users, there is a general feeling that front-line staff at surgeries tend to know their regular Deaf patients and how best to accommodate them. This is very much appreciated by the community generating a sense of being respected and accommodated.

Reception staff know me well and are amenable to my needs - they know to book double appointments and are aware that interpreters will be attending.

The staff at my surgery are really nice; they are patient, give me plenty of time and always accommodate interpreters.

Another frustrating environmental feature identified by the community is the use of intercoms for accessing premises and other no-visual means of communication when inside.

At the maternity unit at the hospital, I really struggled to get into visit my friend as the only option was an intercom; they did seem to have a camera but because I didn't respond with speech they seemed to ignore me.

After having problems accessing the premises for my blood test due to an intercom. I had no idea that my number had been called and was waiting about one and a half hours! It's hard in a crowded waiting room for a deaf person to know they are being called - perhaps booked appointments would be better.

When I go to the surgery for something simple that doesn't need an interpreter I find it difficult to know when I'm being called as there are no visual displays' - they just call your name. Really they should

have something in place, and for hard-of-hearing people too as they never go with interpreters who normally alert you to your turn.

The features of life that hearing people seem to take for granted are often not afforded to Deaf people which can leave them feeling isolated and marginalised.

I was an inpatient at the hospital and wanted to watch the TV, but there was no subtitling facility on it, which was disappointing as it's boring when you're stuck in a ward with nobody to talk to. I ended up just sitting quietly reading magazines - I was there for three days!

These accounts demonstrate that structural/environmental issues faced by other Deaf communities throughout England are indeed present in Shropshire with particular reference to telecommunication practices and the prevalence of spoken and written English as the default means of communication. Although Deaf individuals have strategies to overcome these barriers such as using the interpreting service as an interface (discussed in more detail below) there is clear evidence that these practices make accessing and using services awkward. One overarching suggestion emerging from the community and one that resonates with other Deaf populations is that providers should have a greater understanding and awareness of Deaf people's requirements, particularly at the initial points of contact.

Community recommendations:

SMS and email contact options should be put in place for health and social care services; however, staff would require training in how to compose responses appropriately for Deaf BSL users with limited English competencies. For consultations requiring interpretation, utilising the interpreting service to arrange appointments is the most effective means.

Some providers demonstrate a poor understanding of Deaf people's communication requirements.

Deaf people feel that they need more time for their consultations due to interpretation but also for them to feel they are getting a quality service from providers. This can impact on how providers are perceived by the Deaf community in terms of professionalism and general attitude towards them as individuals. Alternatively, when more time is allocated and their needs are seen to be taken into account, the experiences are perceived to be so much better.

Hospital staff just tried to write things down for me, this was no good as I really needed an interpreter.

I was at an eye test and the optician seemed to be in a rush; changing the lenses before I'd had time to think. It made it hard for the interpreter to do their job properly - I really think there is a need for

awareness about how to work with Deaf people and what our needs are.

I too had that optician: he was very quick and had no time to communicate any detail of what he was doing. Then 2 years later I had a different optician who was lovely; making me feel involved by explaining that migraines were not affecting my eyesight, she took time to get my medical history, was much slower - I felt she did her job properly and in fact my eyesight seemed to have improved.

A BSL user attended a GP appointment and after waiting for twenty-minutes no explanation was offered by reception staff, which caused a little annoyance. However, in the consultation the patient was asked the reason for the visit, to which they replied it was a follow up for an existing problem, the GP consulted the patient's records, described the problem and that the best treatment was medication and its dosage. Plenty of time was given for the patient to clarify points and ask questions leaving them clear about their situation and to which they expressed gratitude for the way in which the consultation had been conducted.

My hospital appointment went smoothly, staff were accommodating with the interpreter, which made things very easy - obviously without an interpreter and writing things down it would have been impossible; I wouldn't have been able to understand at all. Having the interpreter there made all the difference, I was able to fully understand and felt confident in my understanding and my treatment/investigations.

Community recommendations:

New staff members should be made aware of Deaf people's communication needs and how to make use of the interpreting service. Also, particularly within the NHS, there should be a wider awareness of the interpreting service and the benefits that using NRCPD registered interpreters can bring to both Deaf patients, healthcare professionals and services as a whole.

Effects and risks of substandard access and poor communication services

Amongst the community there is a strong feeling that without proper communication, their capacity to manage their own health and social care can be seriously impaired. This can result in relying on third parties to facilitate communication, resort to note writing or lip-reading, often resulting in a lack of privacy and self determination, or even confusion and anxiety caused by not understanding. It should be noted that within Shropshire interpreting support is available for all Deaf people at the point of delivery and that respondents were merely expressing their

acknowledgement of the importance and benefits of effective communication and the risks associated with the substandard/no provision.

Having had experience of accessing Health and Social Care services in two other areas I can say that there is a big difference from that of Shropshire in terms of Deaf awareness and accessibility of services. In one area there was no means of getting interpreters for medical appointments and consultations and no accessible way of contacting surgeries. Also contacting social services was difficult where I used to live - I had to resort to asking my mother to make calls for me for things like equipment, which isn't good.

Moving from another location to Shropshire the difference was massive: and for the better! It's great here as you can have interpreters for all of your medical appointments, where before there was no access at all - we had to write things down, which was not suitable as we still didn't understand and it left us confused, worried and anxious! It [using interpreters] took a bit of getting used to at first but we now get full access to what is happening regarding our health care. It's a brilliant service.

I used to go to the dentist on my own, but thought I'd try with an interpreter. It was so much better with an interpreter as I was able to get much more detail as to what was going on with my teeth and able to take better care of my oral hygiene. I have used interpreters ever since.

It is essential that interpreters attend appointments with GPs as it's very difficult to lip-read and I need to get a full understanding - with interpreters I feel safe!

For Hospital appointments it's exactly the same - with interpreters you have that feeling of safety and it is especially important during pre op, for example my wife had to go recently with an interpreter and it was essential that the right information was translated correctly as it can be serious.

Having access to an in-county interpreting service

Respondents identified that having an interpreting service with a base in the county as an accessible first point of call is essential for them to navigate a complex and structurally inaccessible system of services. In addition to the translations of written materials, the community uses the interpreting service for making initial contacts with providers, which has proven to be particularly useful in urgent situations where Deaf people need to see health/social care professionals with interpreters but where provider communication systems are not accessible. There was a sense of empowerment and independence expressed by respondents in that they need not rely on friends and family to deal with such matters.

A BSL user contacted the interpreting service via FaceTime complaining of increasing shoulder pain after an injury at work. It was suggested that a GP appointment be made to which they agreed would be the best option - an appointment was made later the same day with an interpreter where a treatment plan was devised with a pre-booked provisional two-week follow-up appointment in the event of no improvement.

In Shropshire Health and Social Care services are fully accessible in that Deaf people can use the Interpreting Service as an interface with other services (health, social care, schools, benefits etc.) to make/change appointments and book interpreters, which saves me having to physically attending venues or asking hearing friends to ring.

Having a local service with known personnel engenders a feeling of trust born out of a perception of high professional standards particularly in terms of confidentiality.

VISS is always there for us when we need to access services, they are responsive, professional and totally confidential, nothing has leaked out - this setup is invaluable to us.

Again the interpreting Service make communicating with the Council easy where as in another area I had to get my mother to phone Social Services to make arrangements to see someone.

Views on specific services

In addition to the generic factors identified in the previous section, the community also hold views specific to particular services and providers throughout the health and social care sectors. These can be broken down into (i) acute hospital services (out patients and in patients); (ii) primary care services and (iii) social care services. In the interests of clarity and expounding the wider context within which services are situated, generic factors have thus far been treated as a separate entity distinct from these more specific service related matters. Moreover, it should be bore in mind that these factors should be seen as an integral part of wider the context within which services are delivered.

Hospital Services

The Royal Shrewsbury Hospital NHS Trust (RSH) is the main provider of acute care across Shropshire and all of the respondents in this study use this as their main hospital for acute/ongoing healthcare. Although run by the same trust; inpatients, outpatients and Accident & Emergency departments were perceived to deliver varying levels of service for Deaf patients particularly in terms of the degree of sensitivity to the communication /cultural needs of this group.

Outpatient consultations

Out patient experiences are reported as being very positive, with most respondents expressing satisfaction and confidence that their needs are taken into account particularly in terms of professional communication support during consultations.

In situations where patients may be worried about their conditions, clinical staff generally respond to these concerns sensitively giving adequate time to explain conditions, treatment plans, and answer questions. This often results in patients feeling more reassured that they have an understanding of the situation and what is to be expected in terms of treatment, risks/benefits and prognosis.

I found my overall experience of RSH Lingen Davies services very supportive and reassuring. I was very concerned about radiotherapy and the possible side effects; however, the weekly reviews were a good opportunity to ask any questions. I was able to have things clarified and any concerns allayed as an interpreter attended these sessions. Initially, I attended sessions with family members for support, but later felt more confident to go on my own with interpreter support when required. I now have a greater understanding of the condition, its symptoms and how to manage it and I would recommend anyone else in a similar situation to immediately go to their GP at the onset of symptoms.

During the referral stage from primary to acute service Deaf patients can require more support in understanding their conditions and coming to terms with having to undergo medical procedures. This can often occur outside of direct consultations and provides patients with the time and space with which to digest and process what can be quite novel information.

I was under RSH for radiotherapy and feel they saved my life, so I'm very thankful to them. Initially I didn't want to go ahead with treatment due to me being afraid of the invasiveness and possible side effects such as damage to other areas of my body - particularly the biopsy procedure. Luckily I was able to get less rushed and more focussed explanations from the interpreting service which involved attending the office and having NHS internet pages on the condition translated/explained coupled with videos of the procedure and others' experiences. This convinced me of the urgency and importance to accept treatment.

In line with primary care the community recognise the advantages of having professional communication services for hospital consultations and are acutely aware of the dangers of not.

For Hospital appointments it's the same [having interpreters] with interpreters you have that feeling of safety and it is especially

important during pre op, for example, my wife had to go recently with an interpreter and it was essential that the right information was translated correctly as it can be serious.

The most successful healthcare outcomes and satisfactory experiences from patients occur in situations where clinical staff work in conjunction with interpreters.

A Deaf patient attending the clinic post operation was given information regarding the success of the procedure measured by self-reported improvements in their condition and the likelihood of a need for a repeat procedure in the future; as this was their second. They were able to ask questions and get answers thus gaining a confidence in their understanding of the current condition. The clinician took time to ensure that the patient, via the interpreter, had a clear understanding of the condition, treatment and prognosis.

My hospital appointment went smoothly, staff accommodated the interpreter, which made things very easy - obviously without an interpreter and writing things down it would have been impossible! I wouldn't have been able to understand at all. Having the interpreter there made all the difference, I was able to fully understand and felt confident in my understanding and my treatment/investigations.

My asthma care was diagnosed quickly and efficiently taking into account my needs as a Deaf person, unlike the bad old days when you didn't get interpreters - I remember a road traffic incident I was injured in years ago when I had absolutely no communication support!

On occasions where clinical staff are not as accommodating in making adjustments for Deaf patients needs, interpreters are viewed by the community as being instrumental in ensuring that understanding is realised.

I had investigations for bowel cancer and the consultant spoke so quickly I would not have been able to follow - however, the interpreter did make the whole communication feel 'normal' and I was satisfied that I understood and was being understood. And at pre-op the interpreter ensured that communication felt natural.

The community reported that the type of interpreter can affect the dynamics and fluidity of medical consultations, particularly in terms of individual interpreter's familiarity with local dialectical forms of BSL. This can was identified as a factor in influencing comprehension and patient confidence that they are being understood and gaining a full understanding of health care professionals' advice.

I went to the hospital for a scan regarding dizzy spells I was having. The first interpreter I had was unfamiliar to me and I was left confused and had little faith in their abilities. The hospital requested that the appointment be repeated - I then had different interpreter

whom I was familiar with and they seemed to be better suited to the situation giving me much more information and I was much more confident this time. It was terribly frightening not understanding especially in medical situations - the nursing staff were better this time around too.

Once appointments are arranged, there is a general satisfaction amongst respondents regarding the levels of services received as out patients. However, slight dissatisfaction has been expressed relating to the length of time taken between initial referral and consultation.

Sometime I have had to wait a long time to be seen at RSH, however, at the local Community Hospital I am seen very promptly for a range of appointments - overall the service is very good and I have no major issues.

In summary, the general feeling amongst the community is that outpatient services at RSH are of a high standard and that their communication needs are taken into account in terms of engaging interpreting services and working with interpreters during consultations and treatment. However, the primary means by which the interpreting service is notified of outpatient appointments is via patients contacting the interpreting service to request an interpreter to attend - referrals are seldom received directly from hospital departments. This patient initiated system of referral has proven to be effective in that patients have a degree of confidence that appropriate interpreters will be present for consultations taking the onus off of clinical/hospital administrative staff.

Community recommendations:

The hospital departments could take measures to ensure that the interpreting service is notified of appointments for Deaf patients, although the current system of patient referral has proven to be relatively failsafe.

Inpatient experiences and Accident and Emergency

Inpatient and Accident & Emergency services, when compared with outpatient services, are perceived by the community to be not as sensitive to Deaf people's needs and less motivated to be accommodating. During emergency attendances where patients are not in a position to notify the interpreting service of a need for communication support, interpreting provision is often absent. It has been reported that despite providing clinical staff with the interpreting service's details contact is frequently not made. This renders Deaf patients unable to understand what is being said and asked by clinicians, unsure whether they are being fully understood, and feeling disenfranchised from their own health care.

Recently, I was rushed into to RSH by ambulance after collapsing at home and upon arrival I requested an interpreter by showing a card given to all Deaf people containing the service's contact information. A lady took at it but the interpreting service was not contacted even

though it was only about 2:30pm. I had no interpreter and found it extremely difficult and frustrating not understanding what was being said to me by medical staff - I was totally left in the dark and worried about what was happening and what my condition might be. It was only the next day after an overnight stay that my spouse contacted the interpreting service and an interpreter came for discharge. I had no communication throughout and was fuming in how I was treated by having an interpreter denied! This is not the first time this has happened, I complained a few years ago but nothing was done, so when I'm in a better state I will put in another complaint - it's just not right that I and other Deaf people are treated like this.

The effects that not having any means by which to participate in one's own health care can exacerbate already worrying situations causing increased anxiety and a sense of little control.

I wasn't provided with interpreters when I was admitted a few years ago; I had some idea of what was wrong with me but no detail and kept thinking of the worse. It turned out that my condition was treatable, but without access to the full information my mind just took over - I literally thought my time was up!

The general feeling amongst the community is that they hold a shared and determined desire to be party to their health and wellbeing on all levels, even seemingly simple matters such as being informed about plans of action.

I was never informed that I was due to be discharged - I should have been kept in the loop so I could prepare for going home (packing clothes etc.), it was just sprung on me - hearing people I'm sure are kept in the know.

We need to have interpreters available 24 hours a day so they can attend when hospital staff need to let us know of anything.

The root of this type of feeling amongst the community centres on ward/emergency staff not being proactive in engaging interpreting support as soon as a Deaf person presents themselves. On occasions where interpreters have been present from the initial admittance, particularly in emergency contexts, Deaf people report a heightened level of understanding and sense of control over their situation. There is a tendency for Deaf people's perceptions of the quality of care to be sullied or overridden by the effects of not understanding - the frustrations born out of having a clouded notion of clinical processes and a feeling of being denied access. All respondents expressed a wish that medical staff would simply contact the interpreting service to book an interpreter upon their arrival:

I gave them the interpreting service's card and all they had to do is ring and an interpreter would be found - but nothing!

Community recommendations:

Both inpatient wards and Accident & Emergency need to change their practices in order to make the experiences of Deaf patients equal to that of non-BSL users. There needs to be more awareness amongst staff that interpreters are an essential element of Deaf patients' healthcare and that alternative means such as note-writing, lip-speaking are no substitute. It was suggested that contact details for the interpreting service be held by ward staff and A&E booking-in points and that staff are made aware of how to contact the service and it becoming mandatory that they do so if requested.

Primary care

GP and medical practices

Generally the community felt that the current system for accessing medical practices for GP and nursing services is working extremely well. Interpreters and appointments are generally arranged via the interpreting service's office - thus presenting Deaf patients with an accessible means by which to make these initial contacts and ensuring interpreting support. (As outlined in the above section concerning making contact with services)

There is a high degree of satisfaction with the provision and level of care afforded to this group by GPs and nursing staff, and healthcare professionals seem adept at accommodating Deaf patients in terms of their communication needs and allowing time to ensure that a full understanding is reached.

A Deaf patient attending a GP appointment was given a comprehensive consultation, on this occasion the GP was unfamiliar with the patient and took measures to gain a clear and accurate medical history by involving the patient before proceeding with their diagnosis and treatment. The patient was given a full explanation of their condition, its causes and treatment options, with a provisional review appointment should symptoms persist. The individual commented on how caring and thorough the GP seemed to be.

Similarly, on another occasion at the same practice a Deaf patient received an equally thorough consultation centred on the patient's needs in terms of time given for clarification and questions ensuring a deep understanding of their condition and its treatment.

Although generally the community feel extremely satisfied with GP and nursing services from medical practices, dissatisfaction was expressed in not being informed if practitioners are running late. They can feel anxious and worried that their appointment has not been checked-in properly or indeed if a mistake has been made.

Upon the interpreter's arrival, the patient was already in the waiting room and mentioned that the automatic booking-in system was not working, which caused a little concern. The interpreter then approached the desk to explain that the patient had arrived and was subsequently booked in by that means - the patient expressed relief in the knowledge that they had not missed their appointment.

Interpreter and client attended but had to wait over one hour to be seen and it was only upon asking at reception that the patient was notified that the doctor was running approximately one hour behind. The Patient expressed annoyance of having to wait and not being told that there was such a long delay - he suggested that there should be a system to notify patients of this and offer an explanation (on the electronic booking-in device or verbally) rather than just booking them without explanation.

Moreover, healthcare professionals do offer apologies when patients are eventually seen, however, there is a strong feeling amongst patients affected that it would be courteous and less worrying to be notified beforehand.

Generally, Deaf patients are able to get timely appointments with GPs or nursing staff, however, it was noted by one individual that this is not always the case and having to wait can cause concern and frustration.

Because of the cutbacks I get the feeling that I have to wait: sometimes it's about two weeks times to get an appointment with my GP.

Opticians

Respondents briefly commented on their experiences with opticians, with most attending Specsavers for their biannual sight tests. It was felt that the services are generally of a high standard, where practitioners accommodate interpreters coupled with a good level of guidance when selecting frames. Concerns were raised in terms of some practitioners showing a tendency to rush through examinations not giving patients enough time to respond to lens changes - causing anxieties about possible errors in the prescription. As touched upon above, the community believe a greater understanding and awareness of Deaf people's needs would be beneficial in these situations.

Dental Services

Overall dental services are perceived to be of a high standard - there is a mix of patients attending NHS and private practices with the weighting slightly higher towards NHS services. In Shropshire a proportion of Deaf patients attend the Shropshire Community Health NHS Trust Dental Service, which is a referred services for patients with more specialised needs. Those registered with this service express deep satisfaction with the way in which their needs are taken into account in terms of time taken during

appointments, sensitivity to potential anxieties and general patient centred consultations.

I used to attend another NHS dental practice in town and I felt the dentist was rough and didn't have enough time to make sure I was comfortable and they never explained things to me properly - I was often in a lot of discomfort. Now at the new dentist it's so much better, reception staff are nice and friendly and know me, and the dentists I have seen have been much more caring.

A number of Deaf patients also receive hygienist/therapist treatments along with dental care. These services are generally of a high standard resulting in high levels of satisfaction in that the advice and preventive treatment enables patients to become more aware of their oral hygiene and take better control of it themselves. The treatment is generally of a high standard with practitioners being sensitive to Deaf people's needs.

Hygienist apologised for the delay in calling in the patient and explained the reasons why. She outlined each process of the treatment and explained any possible consequences relating to what may happen if no treatment was given. A dental instrument fell on the floor, which she ensured was replaced by a sealed one. The patient was involved in all of the processes, time was taken to ensure that information was effectively communicated and that they were able to ask questions. Advice was given on how to clean difficult areas where food can easily get trapped including cleaning techniques and which brushes were best suited for which task. The dental nurse was also proactive and conscientious.

Community recommendations:

More D/deaf awareness and visual alerting devices in some practices

Shropdoc and 24 hour access to medical services

Shropdoc is an out-of-hours service providing urgent medical services and advice when surgeries are closed. Essentially a telephone based service GPs would often advice Deaf patients to use Shropdoc as a first point of contact outside of surgery opening times, often assuming that a hearing person would be able to make the call, when in fact most households consist of two Deaf adults. In light of this a project involving the Deaf Community, the local interpreting service and Shropdoc resulted in a designated text (SMS) line exclusively for Deaf people. This ensured that Deaf people needing out-of-ours medical attention could access this service and if needed receive interpreting support on a 24 hour basis.

Since its inception, the service has been used on a number of occasions mostly for simple advice and has proven successful. Moreover, individuals did stress the importance of ensuring interpreters are booked for all callouts especially Deaf parents with children.

Shropdoc is a good system now it has a texting facility for Deaf people, what is crucial is that interpreters are booked when Deaf people make contact.

Social Care

Social worker support

Within Shropshire, social care for Deaf people has changed significantly from having a named specialist Social Worker for the Deaf who was tasked with dealing with all aspects of the community's social care needs. This included general social work activities, completing forms (benefits etc.) attending appointments to facilitate communication, assisting with telephone calls, explaining written communications and undertaking visits to check on Deaf people's welfare needs. The current system makes use of generic social workers (with no specialism in deafness) working with interpreters as and when Deaf people require this type of support. Moreover, since the interpreting service was established in 1994, the Deaf community has used this as the first point of contact for a host queries including those that are of a social care nature. This has resulted in a proportion of the work that Social Workers for the Deaf would have undertaken taking on more of an interpretation/translation orientation, particularly in relation to telephone interpretations and sight translations of document etc.

There is a general feeling held by the community that the current system is successful in meeting their social care needs and there is little reported desire for a specialist Social Worker for the Deaf, although certain 'pastoral' elements are lamented by some individuals who perceive the current system as affording them a lesser service, particularly when compared with other groups.

In the past there was good support from social workers, one social worker was a great help when my daughter had an operation out of county and had to stay there for six months. They'd take me to and from the hospital for visits. Also another social worker was very good, they'd visit to see if we needed any support - however, a new social worker took over who could sign but not that well, which made me feel uncomfortable, so we'd always go to VISS as this new person wasn't very helpful.

There is no nominated Social Worker for Deaf People, why is this? Physical disabilities, visual impairment and mental health patients seem to have one.

I work in a care home and disabled children have a lot of support from social workers - what about us Deaf people?

This sense of being treated differently from other disability groups in Shropshire can be compounded by a perception that Deaf people living in other regions have a better level of service due to having nominated Social Workers for the Deaf.

Other areas have good social worker and interpreter support for example I know in Derby and even Telford they have Social Workers for the Deaf.

Moreover, despite these observations there seems little actual requirement amongst the community for specialist social worker services anymore, indeed the biggest direct contact with social care services takes the form of the acquisition and maintenance of alerting equipment.

I only really use social services for equipment, which is useful as my pager device is effective in waking me up at various times for work and the new devices work at a distance. It's good that this is still free for Deaf people

Social services are very good at supplying equipment and keeping it updated.

The services from the Sensory Impairment Team by way of the equipment like door bells is very good, If it's broken I can take it in and if they are not there not there I can leave it with VISS to pass it on.

The work that the interpreting service undertakes regarding telephone interpretation and sight translations is a frequently used service and provides Deaf people with a means with which to take direct control over a range of matters. However, by virtue of interpreters' primary role as dialogue interpreters, there is a perception that this in some way detracts interpreters from their main duties and that the community are in some sense over burdening the interpreting service.

I go to VISS for phone calls, letters etc. but their main role is interpreting for our face-to-face appointments; perhaps social services should undertake phone calls letters etc? In the past a social worker would visit to see if we needed any support - now we have to go to VISS and I feel is probably too much for them as they're too busy and we have to wait sometimes to see an interpreter.

Although the current system functions effectively and Deaf people seldom need direct support from social workers, a feeling still circulates within the community that a return to having a specialist social worker, possibly working in conjunction with the interpreting service would be desirable. Moreover, there are concerns surrounding the communication competence of workers and whether their BSL skills would be sufficient to meet the needs of all Deaf people.

It would be better for VISS and Social Services to share an office/premises and work in partnership, Social Services could do the letters, counselling, advice etc. and VISS help out with translations if the Social workers struggle.

Social workers working with Deaf people should have BSL skills to the level of the previous workers we had who signed extremely well, plus I think we should have a say in who we feel we can work with and get on with as well.

An acute sense of boundary was expressed regarding the extent to which social workers should act in a communication/interpreting capacity, suggesting that the community acknowledge the need for social worker support whilst recognising that interpreting is, and should be a distinct activity.

Social workers should not go to the GP etc. as they're not qualified to interpret also it would be a good idea to have male and female social workers.

Advice and advocacy

By virtue of there no longer being a specialist Social Worker for the Deaf, BSL users can obtain initial support via Signal's outreach worker (Signal being a Shropshire based charity supporting D/deaf and Hard-of-Hearing people) who is able to deal with some issues and fields more complex cases to the interpreting service to arrange more specialist support primarily from Citizens' Advice Bureau. With this in mind, Shropshire Council recognise the importance of Deaf people having access to a robust system of advocacy, advice and support for a range issues that could have an impact on their wellbeing and fund interpreted support with advisors. The community highly value this service and feel that the Bureau are extremely responsive to their needs.

CAB in Shropshire are very open to supporting Deaf people - they have a BSL section on their website with information videos and say if we need an interpreter to let them know. VISS are good at signposting and referring our problems to CAB and other agencies if needed.

With the current changes from Disability Living Allowance (DLA) to Personal Independence Payment (PIP) a number of Deaf people have contacted the interpreting service to make the initial telephone call to claim and subsequently attend CAB to complete the application form. One BSL user attended CAB with an interpreter to complete the application form as the English rendered it inaccessible; the advisor was sensitive to the needs of BSL users and had worked with interpreters supporting Deaf clients before. The session lasted for an hour where the advisor ensured that all of the sections were completed correctly and highlighted parts where further information was required which the client hadn't brought to the appointment.

The client felt that the support was thorough and of the highest standard; commenting that had this support not been available they would have had no means by which to complete the form.

Conclusion

The findings for this study reveal that Deaf people living in Shropshire encounter the same types of dilemma when accessing health and social care services as other Deaf Communities, both inside and outside the UK. The data suggest that the underpinning factor driving this is the predominant use of oral language and communication methods designed around an assumed competence in the use of written and spoken English. For Deaf individuals whose first language is British Sign Language navigating a world by the means of English alone is often arduous and prone to causing misunderstandings between all parties. Respondents identified key areas of difficulty faced by Deaf individuals within Shropshire when dealing with communications based on spoken/written English: Written communications

Written communications in the form of letters, information leaflets, web-based information, surveys, screening information, results notifications etc. were reported to cause concern and induce anxiety if not fully understood, particularly with healthcare correspondences. The way in which BSL users in Shropshire address this is by presenting correspondences to the interpreting service for interpreting staff to produce sight translations/explanations of content and facilitate any subsequent actions if required.

Spoken communications were categorised: telecommunications or face-to-face interactions with frontline staff/consultations with healthcare professionals. The latter was largely deemed satisfactory in that consultations were always conducted with BSL/English interpreters; moreover, there was a sense that the default means of contacting GP practices, hospitals etc. was by telephone with no other viable non-spoken option. Initial contacts for appointments are generally made via the interpreting service after notification by patients, which functions effectively, in that, appointments can be arranged in accordance with patient, healthcare professional and interpreter availability. Respondents did stress that in the interests of autonomy and flexibility that other non-spoken contact options would be welcomed for instances of obtaining results or booking appointments where interpretation is not required.

In line with other Deaf populations in the UK there was a feeling expressed that service providers in Shropshire could have a greater understanding of Deaf people's communication requirements. This includes the factors outlined above coupled with an increase in visual alerting systems as opposed to auditory announcements when attending without interpreters. However, on the whole the community felt that healthcare staff demonstrated an understanding of their needs and were keen to accommodate Deaf patients during consultations in terms of working with interpreters and giving sufficient time to ensure understanding, which left

them feeling more valued and able to participate. Similar sentiments were expressed regarding social care services.

Outpatient hospital services were generally perceived as being extremely satisfactory, accessible and sensitive to the needs of BSL users. During consultations sufficient time is given to gain an understanding of conditions and treatment, and staff work well with interpreters. The way in which the interpreting service is notified of appointments is generally via the patients making contact to make sure that an interpreter will be in attendance. This approach is successful in that the interpreting service is able to liaise with clinics to check details and facilitate any changes between patient and clinic.

Inpatient services and Accident & Emergency were described as largely unsatisfactory. There was a perception amongst respondents that staff members show little appreciation of the importance of using interpreters in emergency and inpatient settings, which exacerbates an already worrying situation. Although, when contacted, the interpreting service is able to source an interpreter, there were reports that even when supplying hospital staff with the service's details there is a tendency not to make contact rendering the patient unsure they have been understood and what is being communicated to them by medical staff. The impact that this has on Deaf patients is a sense of being disenfranchised from their own healthcare, anxious about the unknown and frustrated in having their only avenue to participation refused.

Primary care services including GPs, Practice Nurses, Opticians, Dentists, Chiropody etc. were all described as extremely satisfactory. Appointments are easily booked and managed via the interpreting service, healthcare staff are adept in accommodating interpreters, with ample time given to ensuring that Deaf patients have a clear understanding of their conditions/treatment.

Services relating to social care we described by the community as being of a high standard. These include specialist equipment issued by Shropshire Council's Sensory Impairment Team, advice and guidance via Citizens Advice Bureau and telephone interpretations/document translations via the interpreting service. With these systems in place there was a feeling that no specialist Social Worker for the Deaf was needed or indeed any contact with social services.

Overall the situation for Deaf people living in Shropshire accessing health and social care services can be described as satisfactory in that providers, on the whole, are sensitive to this group's communication requirements and work in conjunction with the interpreting service. There are certain sectors where more work needs to be done to ensure that accessibility is achieved in all areas of service delivery. One of the central factors emerging from this study is that by virtue of having an interpreting service situated within the county Deaf people have the means by which to confidently manage their

own health and social care matters on an equal footing to that of their non-deaf peers.

Further study

This study set out to capture the views of Deaf people receiving services, describe the current models of delivery, and outline recommendations for further improvement from a Deaf user perspective. These findings suggest that the Shropshire Deaf community have a good relationship with health and social care services, moreover as a counterpoint; further study may wish to investigate how providers view their capacity to service their Deaf patients/clients.

Appendix 1.

Summary of participants' recommendations

The Shropshire Deaf Community should continue to have an in-county interpreting service for the translation of health and social care written material and assistance in any subsequent actions/responses.

SMS and email contact options should be put in place for health and social care services; however, staff would require training in how to compose responses appropriately for Deaf BSL users with limited English competencies. For consultations requiring interpretation, utilising the interpreting service to arrange appointments is the most effective means.

New staff members should be made aware of Deaf people's communication needs and how to make use of the interpreting service. Also, particularly within the NHS, there should be a wider awareness of the interpreting service and the benefits that using NRCPD registered interpreters can bring to both Deaf patients, healthcare professionals and services as a whole.

The hospital departments could take measures to ensure that the interpreting service is notified of appointments for Deaf patients, although the current system of patient referral has proven to be relatively failsafe.

Both inpatient wards and Accident & Emergency need to change their practices in order to make the experiences of Deaf patients equal to that of non-BSL users. There needs to be more awareness amongst staff that interpreters are an essential element of Deaf patients' healthcare and that alternative means such as note-writing, lip-speaking are no substitute. It was suggested that contact details for the interpreting service be held by ward staff and A&E booking-in points and that staff are made aware of how to contact the service and it becoming mandatory that they do so if requested.

More D/deaf awareness and visual alerting devices in some practices.

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