NHS
Liverpool
Clinical Commissioning Group

Understanding Experiences of D/deaf People and People with Hearing Loss in Getting Information and Communication Support from the NHS in Liverpool

2nd May 2018 Engagement Meeting Report

1. Introduction

In February 2018 NHS Liverpool CCG (LCCG) were made aware of a number of issues faced by D/deaf[1] people in the city in getting the health care they need. NHS Liverpool CCG invited D/deaf people and local healthcare organisations to a meeting on 2nd May 2018 with the following aims:-

- Share clarity on the information and communication support patients are entitled to in the NHS
- Understand patient experiences of information and communication support in the NHS eg sign language & lip speaker interpretation
- Understand how the local NHS provides services
- Identify action to ensure a good quality service
- Clarify the role of interpretation in supporting quality of care and how improvements will be reviewed

The meeting was publicised widely, as follows:-

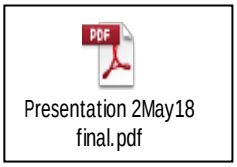
- Email invitations were sent to local Voluntary Community and Social Enterprise (VCSE) groups including those working with D/deaf people
- Email invitations were sent to people previously involved in LCCG engagement / consultations
- Merseyside Society for Deaf People encouraged their Wednesday group to attend
- A BSL version of the invite was produced by MSDP and circulated by email, social media and shown in GP surgeries.
- Invitations were sent by post to known D/deaf contacts without email addresses.

The meeting was attended by 66 members of the public who are either D/deaf, or who directly support this community either personally or professionally. The meeting was interpreted by 6 BSL interpreters from MSDP and by 2 lip speakers. Also present were 11 staff from NHS Liverpool CCG and 14 staff from the following NHS employers:

[1] Many deaf people whose first or preferred language is British Sign Language (BSL) consider themselves part of the Deaf community. They may describe themselves as Deaf with a capital D to emphasise their Deaf identity. In this report we aim to reflect issues as they affect D/deaf people and people with different degrees of hearing loss.

- Clatterbridge Cancer Centre
- Aintree University Hospital Trst
- Lancashire Care
- Liverpool Women's Hospital
- Mersey Care
- Royal Liverpool & Broadgreen University Hospital Trust
- Sefton CCG
- The Walton Centre

LCCG's Chief Officer opened the meeting with a short presentation about patients' rights, known issues to date and the aims of the meeting.
The meeting then split into 4 groups to discuss people's experiences in more detail. Feedback on the meeting itself is in Appendix 1.



2. Issues Raised

Feedback from the groups and issues submitted to NHS Liverpool CCG in the run up to the event are summarised below:-

A. KNOWING WHAT YOU ARE ENTITLED TO

In general the extent of the regulations/ obligations on NHS organisations to provide reasonable adjustments and meet the information and communication needs of D/deaf people was not widely understood. While some people knew their entitlement to interpreters, others were not so clear about what support they were entitled to. In many cases it was evident NHS staff were not clear that patients are entitled to support in all instances.

B. HAVE INFORMATION AND COMMUNICATIONS NEEDS BEEN IDENTIFIED BY NHS SERVICES?

There wasn't a picture that people had routinely had their information and communications needs discussed and recorded or that the 5 steps NHS staff are required to follow were being undertaken. It was a small number of people who expressed positive experiences of GPs knowing their needs; the experience of their needs then being passed on at referral stage was even less.

C. MAKING AN APPOINTMENT

People expressed significant difficulty with the NHS expectation to use the phone. GP access was noted as particularly difficult as many GPS require early morning phone calls to secure an appointment. Some patients wanted to go to the GP surgery in person to make the appointment, but weren't allowed to, many wanted texts and many said Type Talk isn't very good. Some hospital departments/GPs have persisted to use telephone calls rather than texts, sometimes refusing to make the required change. Appointment communications routinely don't state whether an interpreter can/has been booked. There was agreement that this should be automatic and the name and gender of the

interpreter included. People's preferences for interpreters of a specific gender, or a named preferred/not preferred individual were very rarely met.

People explained that an appointment for something relatively minor needs an interpreter just as much as for something major, but often NHS staff had suggested an interpreter wasn't necessary for routine appointments.

There was limited awareness that a lip-speaker service is available and can be requested and also limited understanding in the NHS of the difference between sign language and lip speaking.

It was related that appointments were sometimes scheduled to suit the interpreter not the patient, due to work for example.

On occasion people described having been called by an unknown number which turned out to be NHS, relating to an appointments or results. A hearing family member was often then used to return the call, whereas texts for example would have enabled direct, independent communication with the patient which is preferred and an entitlement.

The Community podiatry service was noted to always require patients to call for an appointment, so someone always has to do this on the patient's behalf.

Most people said that their GPs were better at supporting them than hospitals, because they knew them / had an ongoing relationship there, but some reported having to wait about a week for a GP appointment.

One patient reported that information regarding planned surgery had arrived by letter the day before the operation, as the patient's preferred communication method of text had not been used by the hospital department.

Difficulty was experienced in booking interpreters for children's appointments such that patients were trying to find and pay for interpreters themselves.

D. WRITTEN INFORMATION

From letters about appointments, to information about a condition, diagnosis or treatment, it was widely reported that written information is not accessible for those whose first or only language is BSL. Written communication is not readily understood and for those who can read English, the language used was often too complex and terminology was not explained. This lack of cultural understanding was reported to leave Deaf people embarrassed and ashamed.

Participants commonly reported difficulties with consent to treatment including not being able to understand consent forms and interpreters being asked to read and sign the consent forms rather than themselves. One patient referred for an oncology scan,

had delays to the scan because the appointment couldn't be matched to an available interpreter. When finally the appointment and interpreter appeared to have both been aligned, there was no interpreter present for the appointment. The patient told the receptionist but felt they weren't helpful, making the patient feel difficult. The patient reluctantly decided to go ahead but had to sign the consent form without understanding what they were consenting to.

Patient registration was noted to be difficult for some patients and interpreters often are not booked for the first appointment with the GP. Letters from GPs have been given to patients that are for onward referrals or treatment, but the patient has not understood this on leaving the appointment or until an interpreter or family member has translated the letter. Offers of translation/other formats often don't include BSL offers, or not prominently.

Residents of Knowsley reported taking written letters to deaf organisations in Liverpool to be translated into BSL but not being able to get translation help due to not having a Liverpool address.

Information regarding medication was reported not to be clear.

E. NO INTERPRETER LEADING TO DELAYED APPOINTMENT

Multiple experiences were relayed of people having delays to appointments, diagnosis, tests and treatment as a result of interpreters not being booked.
People had experience where they have been asked to lip read only. "I can only at best understand 80% of what is being said".

There was widespread, frequent experience of GP practices and hospital staff not knowing how to book an interpreter.

Evenings were noted as difficult for getting interpreters, but it was not clear if this is because they weren't booked or there was less availability. Some reports were made of staff saying interpreters weren't booked for evenings as it was too expensive.

Refusal to book an interpreter due to cost/inconvenience was cited by many at both GP and hospital visits. Often this was relayed as 'we don't book interpreters'. On 1st May 2018 a patient was told by one hospital that they were stopping interpreters to save money.

One parent resorted to booking their own interpreter for a child following multiple serious delays and rescheduled appointments as a result of no interpreter being booked.

Interpreters are frequently reported to be booked for too short a slot and have to leave. Appointments can be interrupted, put on hold or put back while another interpreter is found to finish the appointment/treatment.

F. FAMILY/FRIEND INTERPRET FOR ME

There were widespread experiences of families being asked to interpret in lieu of an interpreter; sometimes rather than book an interpreter, sometimes because the interpreter had not been booked and in some instances because the health professionals have allowed this to be common practice for a patient. It was often noted that if a family member starts to interpret then no effort is made to book an interpreter by the hospital/GP. Failure to book interpreters led to several reports of appointments being facilitated by a family member via facetime.

Ongoing use of children as interpreters for parents in medical appointments was raised; an example included a child interpreting for their parents in a diagnosis. One patient made multiple trips to hospital for gynaecological appointments however due to lack of an interpreter the patient's 11 year old child was used as an interpreter.

Family members were often noted to be the only point of contact for a patient throughout a stay in hospital. Family members were reported to have had to interpret before and following surgery and other treatments as interpreters weren't booked. Often medical staff don't adjust their consultation in order to allow patients to lip read – this was cited as a reason family members attend appointments and interpret even though the patient could lip read.

A young person who is deaf and has learning disabilities is regularly supported by their parents at hospital appointments, however neither parent has BSL to a level required to ensure accurate communication and the patient also has lost their right to independence in their care.

In one instance a very unwell woman was taken to hospital in an ambulance, during the whole process to waiting in a corridor she had no means of communication. Her daughter was called to the hospital but there was no communication for 6 hours as no interpreter was found and the hospital did not want the daughter to sign for her. On the following day when a diagnostic procedure was required and no interpreter was booked, the daughter was asked to attend to interpret.

G. EMERGENCY OR UNPLANNED CARE SITUATIONS

Good availability of interpretation at A&E was described as rare. A patient being transferred to hospital by a paramedic was told there would be no interpreter booked as it was too expensive.

Ambulance services generally don't notify the receiving hospital that an interpreter is needed, doing this was thought likely to reduce delays in getting care.
People reported that staff were usually interested only in the medical condition and not good communication.
Mostly people reported that emergency treatments were carried out but no interpreter was brought in so patients were left for hours/days not knowing what was happening to them and not being able to communicate with the medics.

There was very low knowledge among participants of how to contact 999 in an emergency and low confidence in the SMS service if people were aware of it. (Additionally, in an LCCG Twitter poll carried out during Deaf Awareness Week, none of 16 respondents had heard of the service). One person waited over night with chest pains as they weren't aware how to get 999 help.

A Deafblind person was reported to have been admitted hospital and was to be discharged with no interpreter having been present at any time.

H. DIAGNOSIS / TREATMENT UNCLEAR

GPs and other clinical NHS staff often focus on the hearing impairment rather than the patient's actual health problem (diagnostic overshadowing). Clinicians focus on Deafness as the medical need and there was then considerable concern that other medical conditions can be overlooked.

There were some concerns expressed regarding the use of VRS (video relay services) in hospitals, particularly for diagnostic purposes.
One instance was described where an interpreter led to test results being incorrectly communicated to the patient.

A patient attended for a scan with an interpreter. The patient was asked to remove their glasses and so was then unable to see the interpreter well enough to understand. The interpreter was not allowed in the room for the scan and was asked to leave before the patient understood what was happening. The patient became too anxious to have the test and was told to get tablets from the GP to calm anxiety before rescheduling. The patient is sure that had enough time been spent to ensure they had all the information and been able to ask questions before they took their glasses off they would have been able to go ahead with the scan.

I. INPATIENT CARE

After admission people experienced protracted delays in interpreters being requested. Also there were reports of patients waiting days without an interpreter and in one

instance passing away without an interpreter being present and family members having to interpret at that time.
Patients reported having surgery with no interpreter being present.
A cardiac patient reported having an interpreter for the initial admission and then spending a week feeling very isolated as most of the time they were unable to communicate.

J. MISSED APPOINTMENTS

There were numerous reports of people sitting in waiting rooms but the only system for alerting people that they were ready for their appointment, was by calling their name, so they missed the appointment and were sometimes then told they hadn't attended.

Waiting areas were noted to be difficult for people as it is hard to know when they were ready for the appointment. It was also noted there is no information about support available to people or what they should expect from the NHS.

K. COMPLAINTS

Patients participating at the event don't complain as they find the process inaccessible and difficult and also have no confidence in the complaints process.
Patients stated that PALS does not have text options, therefore, they will not use it.
Where one patient had complained, they had received no response.

L. AGENCIES/ INTERPRETERS

Some interpreter agencies received very positive responses (Action on Hearing Loss). (Language Empire) were universally disliked. Language Empire were noted not to be a BSL specialist, to only confirm bookings 24 hours in advance and to less reliably provide interpreters.
It was noted UK Language Agency do not have qualification requirements for the interpreters they use. It was also noted that foreign language interpretation agencies don't specialise in BSL and often provide unqualified interpreters.
Sub-contracting by some agencies was reported to be taking place more frequently and the increased cost and difficulty of this were raised as concerns by several people.

Prior to the appointment patients would like confirmation that an interpreter has been booked and to know who it is. Confirmation of an interpreter booking prior to appointment was described as getting less common. Some reports were made of interpreters being at the wrong location.

People would prefer to book a known, regular interpreter with whom they have built up a relationship and to have this confirmed in advance of the appointment. People also want to be able to specify male or female interpreter. This is often not made possible.

The trial of “Interpreter Now” (a remote video BSL translation via a phone or tablet app) was generally found to be good and a really useful tool for urgent care where an interpreter can’t be booked in advance.
Many people reported that the interpreter booking has been made twice so two interpreters arrive for the same appointment, often having had no interpreter for a previous appointment. People recognised the problem this causes for cost and availability of interpreters.
People reported not being consulted on change of provider of interpretation services. Involving Deaf patients in appointment panels was raised as a means to improve the quality of agency providers.

With the NHS funding situation, there was concern across groups that services to support them have become more varied in quality, and people expressed fear of losing this service.

M. LACK OF SKILLS IN STAFF

There is a lack of knowledge amongst NHS staff of the cultural issues that impact on D/deaf people, including the fact that BSL is the first language for many Deaf patients and some patients don’t read English. This has a negative impact on patient access and experience. Reception staff at GPs, hospitals and Walk-In Centres, were often described as not able to communicate, showing a lack of warmth, a lack of knowledge of the booking approach for interpreters, failure to recognise how important interpreters are, regularly forgetting to book interpreters and failing to book interpreters for long enough for the particular appointment/treatment. Staff were widely insisting on using phones not text.
Staff were reported to have not booked an interpreter because of cost and particularly in the evenings.
People can be uncomfortable with how to address Deaf people and unclear of the difference between D/deaf and hearing impaired. A patient was made to feel so uncomfortable at a hospital appointment they left in tears and are now reluctant to attend the follow up.
Consultants/GPs need to respect when people are lip reading they were described as focusing on the examination, talking throughout but without turning to the patient.
Staff were widely described as not aware how to provide support, how to try to communicate with D/deaf people or to support lip reading etc..
Care and warmth of reception were stated to be important, remembering to look up at the person and make eye contact.

N. POSITIVES

- NHS 111 has a good online access point via text / video consultation. A participant in a group discussion explained that the service was really useful and that NHS 111

directed them to A&E and informed A&E about the need for an interpreter. However, when the patient arrived at A&E they stated “we don’t book interpreters as it’s a waste of our money, as you could just be here for 10 minutes”. The patient explained being there for 5-6 hours before an interpreter was booked and that this had happened twice.

- Some departments have switched to text communication only for patients.
- Welsh NHS have a mandate for interpreters to attend within an hour
- Action on Hearing Loss was frequently praised for reliability and quality of service.
- One NHS Trust was noted to have a clear policy of not using family members to interpret.

O. POOR INTERPRETER EXPERIENCE

Mostly the poor experience was because an interpreter has not been booked. Some Trusts have changed to new agencies to supply interpretation services who were very frequently cited in problems experienced in both the booking process, failure to book interpreters and in quality of interpretation as well as failure to confirm bookings and meet preferences.

ITL and Empire received significant criticism and Language Line was also noted as problematic. There were frequent experiences of interpreters with these agencies not wearing /showing ID, being rude and unreliable. Patients need to know that their interpreters are qualified and they are in safe hands.

Some people felt that the regional dialect in BSL was a factor. Some interpreting services / agencies book interpreters from outside of Liverpool and this can lead to confusion.

P. OTHER

It was noted that budget for interpretation at VCSEs is very limited so their services are then made inaccessible. There was recognition of the difficulties faced by VCSE organisations where funding has been cut and suggestions made of provision of funding for interpretation to enable access to their services.

Choice of GP was largely irrelevant as patients try hard not to change, even using old addresses if needs be because of a preference to be known and go where it’s familiar.

Poor support was noted in some specific areas e.g. for counselling.

People described a lack of information about wider support available, such as when being told hearing loss would progress and be severe, there was no support to lip read offered or links to community organisations providing support for D/deaf people.

Patients found that cash machines not operating, parking meters not reading cards, background noise, lack of drinking water and healthy food in waiting areas all added to the stress of appointments. Some people also reported overcrowded waiting areas with too little seating as problematic.

Lack of visual notification of firm alarm in CCG offices was noted.

The difficulties of D/deaf people were noted to have been raised before but people described many years of still having the same bad experiences and a really strong feeling was expressed that this has got to change.

3. Learning from Others/National Evidence

A 2015 study reported in the BMJ, (Edmund et al) compared the current health of the signing deaf community in the UK compared with the general population. It found that deaf people's health is poorer than that of the general population, with probable under diagnosis and under treatment of chronic conditions putting them at risk of preventable ill health.

There is an increased risk for people with hearing loss to have poor mental health outcomes and dementia with severe hearing loss meaning patients are 2.5 times more likely to develop depression than those without hearing loss, and are twice as likely to develop dementia, rising to five times for people with severe hearing loss. Estimates suggest that children who are deaf have a 40% prevalence rate of mental health problems compared to 25% in children who are hearing. (NHS E Action Plan on Hearing Loss).

The "Access All Areas?" report by Action on Hearing Loss found the following among BSL users:-

- 68% of respondents had asked for a sign language interpreter to be booked for a GP appointment but did not get one
- 74% of respondents have had to remind GP staff about their communication needs

In the same report, people with hearing loss reported that after a GP appointment:-

- Just over one-quarter of respondents (28%) had been unclear about their diagnosis
- Around one-quarter (26%) had been unclear about health advice provided with
- Approximately two-fifths (19%) had been unclear about their medication.

SIgnHealth produced a report "Sick of It" which highlights a range of health inequalities experienced by deaf people including that they are more likely to have health conditions which go undiagnosed and once diagnosed are less likely to receive the right care, treatment and advice. "Deaf people are twice as likely as everyone else to have high blood pressure and not know it". "More than half of Deaf people with diabetes had inadequate treatment."

The need for excellent access to healthcare and high standards of care is evident.

Below is an Action Plan which attempts to address the issues raised and those known to be problematic. It is proposed as a first step, to be reviewed with the community and all NHS partners and to be updated and revised accordingly.

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Recommendations for Improving Access to Health Care for D/deaf People and People with Hearing Loss

OVERARCHING RECOMMENDATIONS
❖ **GPs - Follow the 5 steps** in the NHS Accessible Information and Communication Standards
❖ **All NHS - Train Staff**
❖ **All NHS - Have a clear interpreter booking system with a good provider**

	Recommendation	Who involved	Who responsible for follow up	By When
	INTERPRETER SYSTEMS			
1	NHS Trusts to review and provide CCG with details of interpretation agencies are they using and contractual period	All Trusts	Jan Ledward, LCCG	31 July 2018
2	Flowchart to be produced showing who is responsible for booking interpreter for each part of patient journey so clear for staff and patients and interpreters. Communicate this across NHS and community.	All Trusts D/deaf people LCCG	NHS Trust Equality Lead Helen Johnson -LCCG	31 August 2018
3	All Trusts to require providers of interpretation services to send confirmations to patients of bookings at least a week in advance where possible, or as soon as possible if it is a late booking.	All Trusts	Jan Ledward LCCG	30 September 2018
4	Produce a guide to which hospital uses which interpretation agency	All Trusts, CCG	Helen Johnson - LCCG	30 Sept 2018
5	All Trusts, walk-ins and GPs to install video interpretation software/system for emergency/unexpected situations.	All Trusts GPs LCCG	Dave Horsefield - LCCG	30 April 2019
6	Review with Ambulance services ensuring crew ring destination hospital to alert them to need for interpreter to assist patient they are carrying	LCCG	Ian Davies – LCCG	30 Sept 2018
7	Review use of video interpretation system with Ambulance service	LCCG	Ian Davies - LCCG	30 Sept 2018

	EQUALITIES ACT AND NHS STANDARD COMPLIANCE			
8	Consider commissioning interpretation services as a system, utilising professionals registered with the National Registers of Communication Professionals working with Deaf and Deafblind People, and only if impossible ensuring BSL level 6 standard. * Hospitals consider having BSL interpreter present at all times	LCCG All Trusts	Equalities Leads Derek Rothwell -LCCG	31 December 2018
9	Bookings systems – GPs and NHS Trusts to review approaches used and introduce a range of ways to book an appointment including text and email.	All Trusts GPs & LCCG D/deaf people	Jan Ledward- LCCG	31 December 2018
10	Review of consent forms, letters and GP registration to be carried out and accessible approaches to consent, letters and registration to be introduced across NHS Trusts and GPs including sign video series.	All Trusts & GPs D/deaf people LCCG	Jane Lunt/Derek Rothwell LCCG	31 December 2018
11	NHS Trusts and GPs to ensure double appointments are booked to allow good communication time.	All Trusts & GPs LCCG	Jane Lunt LCCG	30 September 2018
12	GP practices, hospitals and walk in centres to update and communicate their policies and procedures to ensure that:- - the information and communication standard is met, including that interpreter booking arrangements are clear and confirmed with patients - records are made of needs and these are flagged in referrals - needs are met as required including by use of qualified interpreters - records are kept of failed appointments due to interpreter access and each case is reviewed with remedial action taken	All Trusts All GP Practices GP Federation LCCG	Jan Ledward/Derek Rothwell LCCG	30 September 2018
13	Staff in all patient facing roles, eg receptionists, in Trusts, Walk in centres and GP practices to receive D/deaf awareness training involving D/deaf people. Training plans updated to include in future.	All Trusts All GPs LCCG	Jan Ledward LCCG	31 March 2019
14	Consideration of approach in mental health and dementia services given increased risks for people with hearing loss.	LCCG	Tom Fairclough LCCG	30 September 2018
15	Ensure appointments are announced via visual means as well as audio	All Trusts	Jan Ledward LCCG	30 April 2019

	…preference for numbering system rather than names so that patients can see approximately when likely to be called and to preserve privacy. Training for reception / desk staff needed to support patients.	GPs	Dave Horsfield LCCG	
16	End of Life services – take action to ensure people are not escalated to care homes etc prematurely because of communications needs rather than health need and that communications needs are met within care settings. Discuss how best to meet D/deaf people's needs in care homes.	LCCG community programme	Jane Lunt LCCG	31 December 2018
17	Standardise new patient info form which gathers information on interpretation/communication needs and review how GPs record communication needs – ensure done and reported on	LCCG GPs	Ian Davies/Derek Rothwell – LCCG	30 August 2018
18	Review SMS system for emergency calls	LCCG	Ian Davies - LCCG	30 July 2018
19	Each NHS Trust to have improvement plans in place setting out clear steps to address actions in this report and any other relevant actions.	All Trusts D/deaf people	Jan Ledward LCCG	30 September 2018

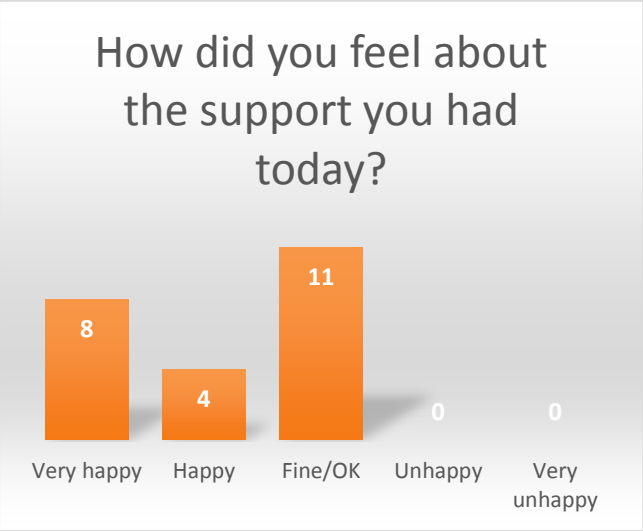
	COMMUNICATION AND ENGAGEMENT			
20	Communicate 5 steps rights and emergency text process widely including GP screens and via NHS Trusts	LCCG NHS Trusts GPs	LCCG Communications and Engagement Team	30 July 2018
21	LCCG to remind all GPs and NHS Trusts of duties and rights of patients – to book interpreters and 5 steps – communication to all staff to be made by GPs and NHS Trusts ahead of full training, including reminding staff of policy and booking procedure for interpreters	LCCG Communications and Engagement/PC GPs	Cheryl Mould - LCCG	31 August 2018
22	D/deaf patients be involved in the development or redesign of services. Plan to achieve this to be prepared to be submitted to LCCG	All Trusts Equality Lead D/deaf people LCCG	Sarah Dewar - LCCG	30 September 2018
23	Include BSL in all information in alternative formats notices	All Trusts & LCCG	Equalities Leads Helen Johnson- LCCG	31 August 2018
24	Gather experience for DeafBlind people	LCCG DeafBlind Patients Deaf support orgs	LCCG Engagement Team	30 September 2018

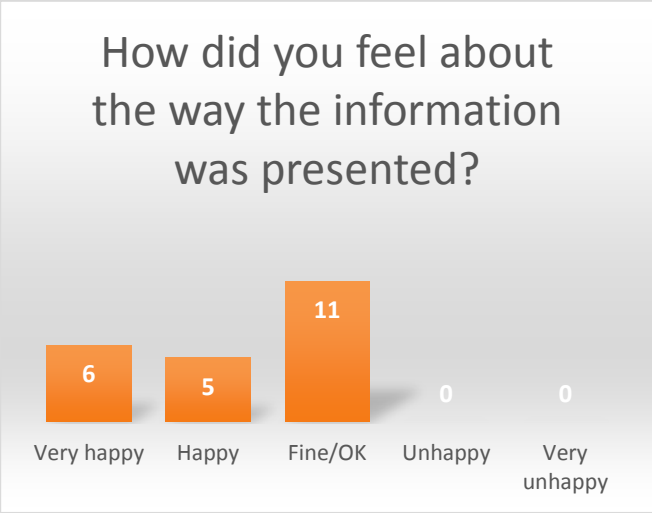
25	Hold a meeting with interpreters to hear their experiences and suggestions	LCCG	LCCG Engagement Team	30 August 2018
26	Hold a further session/s to understand issues for children	LCCG and GPs Patients / families Alder Hey	LCCG Engagement Team	30 September 2018
27	Ask each Trust to form a D/deaf and hearing loss patient liaison group	All Trusts Equality Lead D/deaf people Deaf support orgs	Sarah Dewar - LCCG	30 September 2018
28	CCG to form a D/deaf and hearing loss liaison group – initial agenda items to include booking of interpreters processes, staff training, booking GP appointments, digital support.	LCCG D/deaf people Deaf support orgs	Sarah Dewar - LCCG	30 September 2018
29	A further city wide meeting to be arranged for 6 months' time to follow up on progress made, and experiences of this and identify further issues.	LCCG D/deaf people Deaf support orgs	Sarah Dewar - LCCG	31 December 2018
30	LCCG Digital team involve D/deaf people in assistive technology and how digital plans can support/exclude people (part of LCCG liaison group).	LCCG D/deaf people	Dave Horsfield - LCCG	30 November 2018
31	Promote local support organisations for D/deaf hard of hearing people, especially in audiology/related departments/at points of diagnosis. Confirm arrangements for this to LCCG.	All Trusts GPs MSDP & other VCSEs	Helen Johnson - LCCG	31 August 2018
32	Develop local NHS approach to making the complaints system accessible	All Trusts & GPs Ambulance Service	Sally Anne Hunter LCCG	31 August 2018
33	Create BSL version of this report for circulation	LCCG	Sarah Dewar - LCCG	30 July 2018
34	Report and action plan to be shared with participants and Trusts.	LCCG	Jan Ledward - LCCG	30 June 2018
35	Where appropriate apply lessons to other language support offers to improve experience and consider wider engagement on foreign language interpretation and translation support offered.	LCCG	Sarah Dewar - LCCG	30 September 2018
36	Share report with other CCGs in Merseyside and Cheshire & Merseyside Partnership	LCCG	Jan Ledward – LCCG	30 July 2018

*or SASLI, the Scottish Association of Sign Language Interpreters and RBSLI, the Regulatory Body of Sign Language Interpreters.

Appendix 1

Feedback on the meeting held on 2nd May 2018 regarding experience participating.





This report was written by NHS Liverpool CCGs Engagement Team. LCCG would like to extend warmest thanks to everyone who participated in the meeting, to MSDP and for the generosity of everyone who shared their experiences and offered to continue to help us improve care in the city.

If you would like to share an experience or stay involved please contact

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BSL version at www.liverpoolccg.nhs.uk from August 2018.