Communication Report: for people with a hearing loss 2014

healthwatch Isle of Wight

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Acknowledgements

HealthWatch Isle of Wight would like to express their very sincere gratitude to all those who shared their views and experiences to inform this report.

We would also like to thank those organisations who helped facilitate the distribution of our questionnaire, including Age UK Isle of Wight, East Hill Home for Deaf, the Audiology Department at St Mary's Hospital and especially Action on Hearing Loss[3] who went the extra mile in distributing questionnaires, welcoming us to their many 'drop in's and arranging interviews with individuals who "had a story to tell'. We are also indebted to Island Support Services for inviting us to their See Hear forum and helping to set up interviews with individuals, providing interpreters and even a volunteer to conduct an interview with an individual who did not want to meet with us.

We were also welcomed into many other meetings, including the Sense Forum, the IW Children's Deaf Association and Saturday Club for Deaf Children.

Communication difficulties do not just affect people with a hearing loss and we were keen to find out from others with difficulties what their experiences were too, so our thanks to those blind people who talked to us and The Stroke Association[20] and their service users who welcomed us to their sessions and told us their experiences .

Note on the use of British Sign Language (BSL) interpreters:

HealthWatch Isle of Wight wishes to be impartial in all that they do. For this reason we decided to engage an independent interpreter who was not Island based to facilitate interviews with those people who were BSL users. However, we found that users of BSL were reluctant to engage with us unless we used a known and chosen interpreter. Indeed, one BSL user would not meet with us at all despite expressing an initial interest in sharing their experiences unless we provided a known interpreter and a known volunteer from Island Support Services to conduct the interview. For this reason we used interpreters known to and chosen by the interviewee.

Authors note

From an early age I have suffered from glue ear. For the past 20 years my hearing has worsened and it was only as I started work on this theme that it was deemed poor enough to warrant hearing aids. I was incredibly well supported in taking this forward by a colleague who is profoundly deaf. It was only at this point did I really find out what the issues affecting my hearing really were and it wasn't just glue ear. Hearing aids have changed my life although they cannot restore all my hearing they make the most of what hearing I have left. I can now join in with more conversations, feel more confident and less isolated. I have spent many years at work in meetings, not really following the conversation, but trying desperately hard to, a rising panic when I have to take minutes or respond to something that I have not heard. This experience is what happens to people who are deaf or have a hearing loss every day of their lives. The instances of anxiety, loneliness and depression are much higher for the deaf and hard of hearing than other groups.

When listening to experiences for this theme I was very much welcomed due to my own hearing loss, those who were profoundly deaf recognised that I was deaf long before I told them or showed my aids (one interviewee even helped adjust mine!) they could see I used the same lip-reading techniques as themselves. We also found commonality in the number of times we would apologise for our deafness in a day 'I am sorry I can't hear you' (this too was reflected in the survey results.) All deaf or hard of hearing people have said many times 'I am sorry I can't hear you' and are met with the humorous 'pardon?' Which causes an inevitable reluctance to ask for clearly, repeated speech in order to understand. Deafness and hard of hearing is a largely invisible impairment and a large majority of those people I spoke to thought of their deafness as a nuisance to both themselves and those they had to communicate with, rather than thinking that they had the same rights to expect 'reasonable adjustments' as anyone else. I also found that for some people the wearing of hearing aids was an embarrassment and they were reluctant to wear them. My own personal experience resonates with this, my mother was very reluctant to wear her NHS aids until I had mine, she now wears them every day, and no longer has to save for smaller private aids. The wearing of hearing aids is sometimes perceived as a sign of ageing that people are reluctant to admit, although this does not apply to wearing spectacles with over 74% of the UK population wearing them[1]. The Hearing Loss Commission final Report 2014 [2] finds that of 6 million people nationally who would benefit from hearing aids, only 2million wear them. This means that many people are missing out on making the best of their remaining hearing.

Finally, I became conversant in what the deaf community call the 'deaf nod' when they cannot understand what is being told to them, but are anxious to please and to not be a nuisance or hold the conversation up. I have been doing the 'deaf nod' all my life. It was only when a profoundly deaf woman told me that she had given consent for a major operation , having no idea what was going on as there was no BSL interpreter provided that I realised just how dangerous the' deaf nod' could be.

Introduction

The difficulties in communicating with health and social care professionals was identified as an issue at the HealthWatch Isle of Wight Prioritisation Day held in June 2013. As this is such a broad area, it was decided to focus this on people who were deaf or hard of hearing and experienced more acute difficulties than the general population. Communication and understanding self-care is an ongoing issue for HealthWatch Isle of Wight and has become a priority area for the work plan in 2014/15.

Action on Hearing Loss[3] describes deafness and hearing loss as follows:

People who are deaf

- We use the term people who are deaf in a general way when we are talking about people with all degrees of hearing loss

People who are hard of hearing

- We use the term hard of hearing to describe people with mild to severe hearing loss. We quite often use it to describe people who have lost their hearing gradually

People who are deafened

- People who were born hearing and became severely or profoundly deaf after learning to speak are often described as deafened. This can happen either suddenly or gradually

People who are deafblind

- Many people who are deafblind have some hearing and vision. Others will be totally deaf and totally blind

The Deaf community

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.

Definitions of deafness:

- Your level of deafness – mild, moderate, severe or profound – is defined according to the quietest sound, measured in decibels that you can hear
- The quietest sounds people with mild deafness can hear are 25-39 decibels, while it's 40-69 decibels for people with moderate deafness, 70-94 decibels for people who are severely deaf and more than 95 decibels for those who are profoundly deaf.

If you have mild deafness you will find it difficult following speech in noisy situations. If you're moderately deaf you may need to use hearing aids. You will probably rely on lip-reading if you're severely deaf, even if you wear hearing aids, and BSL may be your first or preferred language. BSL is likely to be your first or preferred language if you are profoundly deaf.

There are a plethora of statistics relating to deafness and hearing loss:

According to Action on Hearing Loss[3] almost 10 million people nationally have a hearing loss. Locally the Census 2011[4] gives 275,000 people deaf or hard of hearing on the Isle of Wight and in Hampshire. The Health and Social Care information Centre March 2010[5] gives the following figures:

Total number registered	1570
Age 0-17	10
Age 18-64	220
Age 65-74	240
Age 75+	1075

The 2011 census[4] finds that on the Island there are 22 BSL users, 6 sign language (other) and sign language (any communication system).

The Isle of Wight Joint Strategic Needs Assessment[6] reports that in 2012/13 there were 29 people registered as deaf on the Isle of Wight, a slight increase on the last report in March 2010, when 25 people were registered.

Since it is voluntary to register as deaf these figures may well be under-reported, but the figures have been verified locally by Action on Hearing Loss[3], as a fair representation. The Isle of Wight has a significantly lower rate of deaf registrations than the England average. In 2012/13 there were 1597 registered as hard of hearing, this is a slight increase on the previous record and according to Action on Heating loss this is likely to be an underestimation, with the figure likely to be close to 2500 based on the number of clients (both active and dormant) that have used their services.

This means that the Isle of Wight is statistically significantly higher for this group than England and is to be expected given the Islands aging population. 51.7% were aged between 18-64 of those registered deaf and 70.8% of those registered hard of hearing were in the 75+ age group. This shows that hearing loss is largely age related and that deafness can be congenital or experienced at any age. The Isle of Wight Children's Deaf Association[7] estimates that there are approximately 60 children and young people who are deaf.

Today 88% of the 8.4 million people in England with mild, moderate or severe hearing loss are aged 50 and over. People with moderate hearing loss can find it difficult to follow speech without support and it is estimated that 5.1 million people aged over 44 in England have a moderate or severe hearing loss (POPPI 2014[8]).

Research has shown that early detection and support for hearing loss can help reduce the risk of depression, anxiety and sadness (National Council on Aging 2000[9]). This is further supported by the Chief Medical Officer's latest Annual Report which acknowledges that appropriate support for hearing loss can have "a substantial impact on quality of life" (Chief Medical Officer2014[10]).

The Sign Health Report 'Sick Of It' 2014[11] makes the following findings based on their 5 year study:

- It is much more common for doctors not to spot and diagnose health conditions in deaf people, and this includes problems that can lead to life threatening illness. For example, researchers found that deaf people are twice as likely to have high blood pressure and not know it. High blood pressure is one of the major causes of heart attack and stroke. They are also less likely to be on medication for it (only 36% compared to 57% in the wider population).
- A survey found that whilst 51% of the general population thought that their doctor was good at listening, this fell to 15% of deaf people. This was even more marked about GP receptionists with 8% of the general population finding them unhelpful compared to 40% of deaf people.
- The NHS Choices website[12] contains around 900 videos, but just ten of them are in BSL, a little over 1%.
- The Health Economics study [13] showed that poor diagnosis and ineffective treatment of deaf people was costing the NHS £30million a year. The suffering caused to deaf people is incalculable.

Further research (Arlinger; International Journal of Audiology 2003; 42:2 S17–2 S20[14]) Negative consequences of uncorrected hearing loss--a review, finds the following:

- Several studies have shown that uncorrected hearing loss gives rise to a poorer quality of life, related to isolation, reduced social activity, and a feeling of being excluded, leading to an increased prevalence of symptoms of depression.
- Longstanding uncorrected hearing loss in the elderly often results in withdrawal from a variety of social activities, which in turn may affect quality of life as well as mental health and wellbeing. Reduced auditory and intellectual stimulation may give rise to changes in the central nervous system, and may affect the development of dementia.

Currently, adults in England, aged 55 and over, who have used NHS hearing care services to get hearing aids or other support are being urged to make their views known about the quality of the service they received.

Health service regulator Monitor[15] has launched a full review into how well the hearing care service model is working, with particular focus on whether the introduction of the Any Qualified Provider (AQP) model[16]. Currently, around half of the health regions in England use this model.

Methodology

Deaf and Hard of Hearing people are very much a hidden community. As the Island has a large ageing population, according to Census 2011[4] data there are 43,900 people aged 60+ out of a population of 138,800, and that hearing loss is largely associated with increasing age (NHS Choices) it was decided to focus our questionnaire on this group.

Age UK Isle of Wight[17] as the leading provider of services for this group were engaged to promote and distribute the questionnaire. Of 500 mailed out to service users, in excess of 120 were returned. Other organisations also helped distribute the survey, they are detailed in the acknowledgements. The survey was also promoted by way of conventional press releases, and electronic media.

Community Engagement was an important aspect of gathering evidence for this study. As with the maternity report, approaches were made to existing contacts forged through the dual role of coordinating the Voluntary Sector Forum and from there a somewhat 'splatter gun' approach was adopted as it was not wished to exclude any specific group or need from the outset but for issues to be identified organically through this approach.

A number of outreach sessions were held alongside Action on Hearing Loss[3] 'Drop-ins' for hearing aid maintenance, together with attendance at key meetings and forums to tell groups about the theme and to gain feedback. A number of individuals came forward as a result of these and in-depth one-to-one semi-structured interviews were conducted.

Not wishing to exclude any group with a hearing loss, community engagement has been wide ranging, taking in those who are profoundly deaf, those who have become deafened or had lost their hearing through ageing, also to include all ages. At the time of writing, engagement activities are continuing to listen to the stories of deaf children and their parents and the experiences that they have had.

Executive Summary

Healthwatch Isle of Wight first identified communication difficulties at their initial prioritisation day held in the summer of 2013. Communication issues affect the whole population when understanding treatment and care from health and social care practitioners, the use of unfamiliar language, the brevity of consultations and sometimes the apprehension of hearing what a diagnosis is, can lead to people not 'hearing' what is communicated to them. Later discussions with stakeholders honed this priority into communication for people with hearing loss or deaf as this group were already at a disadvantage because of their hearing loss.

Evidence gathering is outlined above within our methodology, but also included extensive reading to learn more about communication difficulties and ways to overcome these, as well as the most recent reports and research published in this area.

In the main, those who responded to our survey were older people, with a large proportion being aged over 80, this was to be expected as Age UK had been contracted to send out the survey to their service users. On the whole this group found themselves relatively well treated and had only some difficulty in making appointments and understanding treatment and self –care.

Again this was unsurprising, this group is acknowledged as with what Anna Bradley, Chair of HealthWatch England[18] describes as "grateful patients", 'happy with the service they receive regardless of the safety and quality. This is often because of our national pride in the NHS and admiration for the staff looking after them'. It could also because this group could be envisaged as frail perhaps less able than the younger population leading to staff taking a more compassionate approach with them.

These findings are assumed due to the very different experience by many of the younger deaf, hard of hearing and people with other communication difficulties we spoke to.

Also of note within the survey is the very small numbers of people accessing a National Health Service Dentist. Whilst few comments were received, one person we spoke to said that they could not cope at the NHS surgery they attended as masks were not removed when dentists and nurse were speaking, and music was played leaving them very frightened and disorientated, the commentator left the surgery and since then has been unable to get another NHS dentist.

At outreach sessions alongside Action on Hearing Loss[3], we became aware of another issue which had a very detrimental effect on the lives of some hearing aid wearers. This was when ear wax prevented hearing aids working correctly and the treatments available.

Those people that we interviewed who were profoundly deaf, whether or not they used British Sign Language or another means of communication, told us a very different story about communication and access to services. We carried out a number of focused interviews with this group, using BSL interpreters when this was their method of communication.

We found that the process of making appointments especially with GP surgeries was very difficult. For those that used BSL, without an interpreter it was impossible.

Access to emergency services was also incredibly difficult and we heard several quite frightening stories when partners of profoundly deaf people had been taken very ill suddenly and their deaf partners had to call for help.

Communication – Survey Results

Age is the biggest cause of deafness, it can start to deteriorate from 30-40 years of age and is called age-related hearing loss or presbycusis. By the age of 80 most people will have significant hearing problems (NHS Choices website[12]). For many, a hearing aid is used to help correct the condition, about 1.4 million people regularly use a hearing aid and many more would benefit from them.

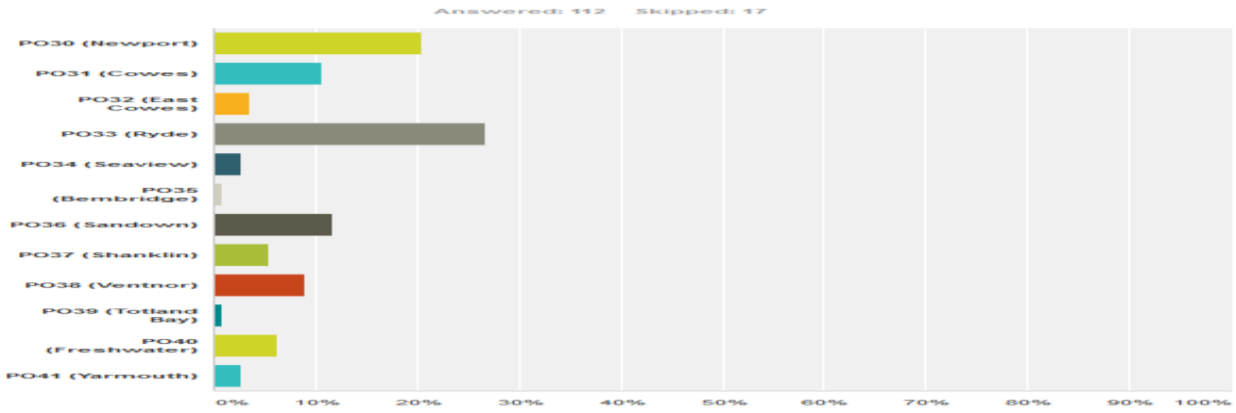
It is this group that HealthWatch Isle of Wight had the biggest response from both for the survey and for community engagement activities.

For people with a hearing loss, common difficulties are outlined below;

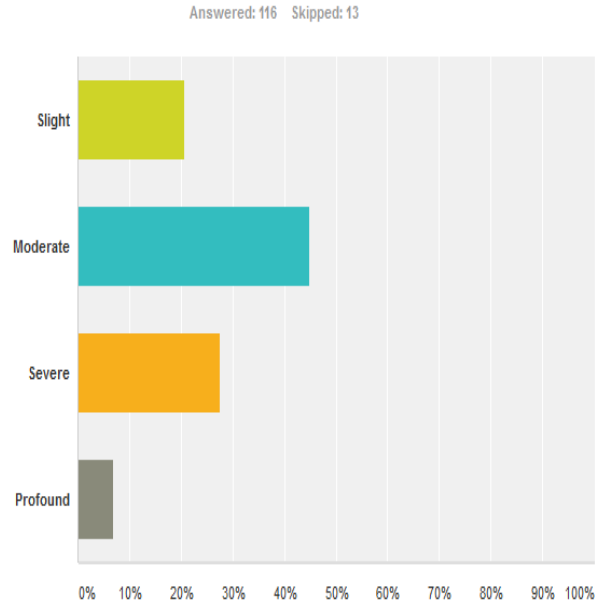
- Others seem to mumble rather than speak clearly to you?
- People often have to repeat things for you before you understand what they say?
- You have difficulty understanding what is being said in noisy places, such as pubs or restaurants, even though other people manage to have conversations?
- You find it hard to keep up with conversations when talking to a group of people?
- You find it tiring to listen to conversations because you have to concentrate hard?
- Others think your television or music is too loud but you cannot hear it properly if they turn it down?
- You often have difficulty hearing on the telephone? [19]

Our survey found that those taking part were mainly older people, with moderate hearing loss and used a hearing aid. There was proportionate coverage from all over the Island.

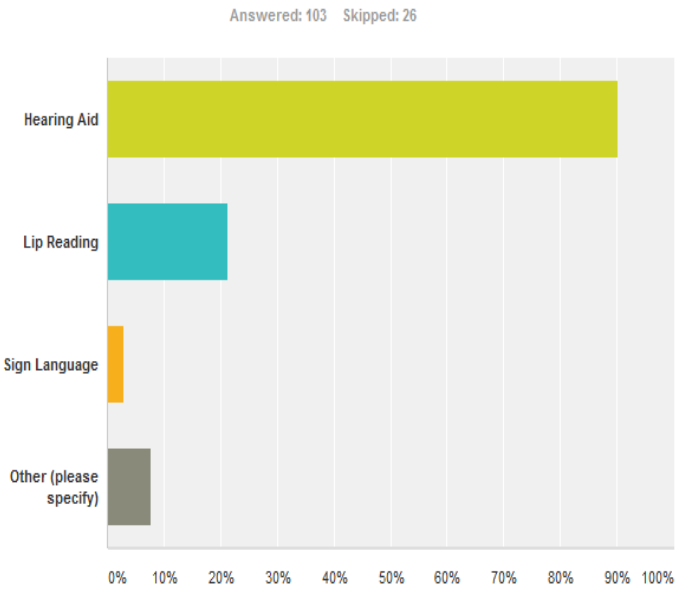
Residential areas of respondents:



Level of hearing loss:



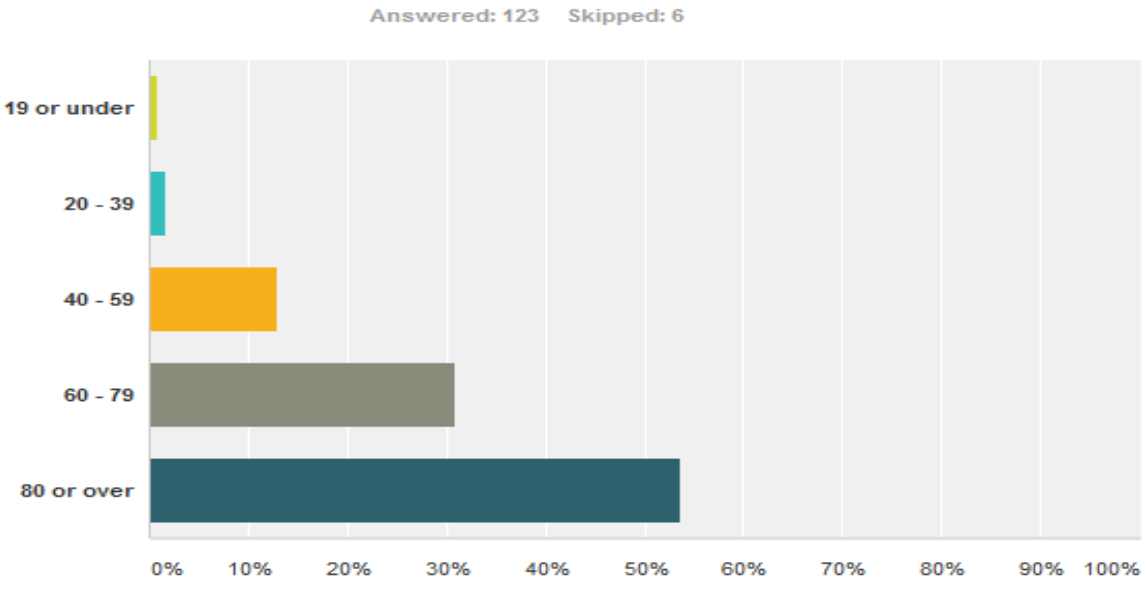
Which of the following used;



Other (please specify)

Cochlear implant x 2
Headphones for TV, door bells
Nothing
Pen and paper
Turning up volume of sound
Untrained lip-reading to support hearing

Age Group:



At the Doctors

Most people who responded to our survey found it very or quite easy to communicate on all levels at the Doctors surgery. Whilst there is good progress being made by all surgeries in offering on-line appointment bookings, no surgery offers mini com or text phone bookings. Mini com or text phone is a phone is linked to a keyboard and enables a person to type a message which appears on a small screen at the other end of the line. We found that a significant number were reliant on relatives or Carers to make bookings for them. Others who could use the telephone found that often this could take a long time as the phone was frequently engaged or they were put on hold for long periods. For many that are unable to use the telephone or on-line booking, making an appointment means making a visit to the surgery to arrange. This potentially has two negative impacts, besides the inconvenience, often we heard that on the day appointments were impossible to arrange. This is because whilst surgeries open for telephone bookings quite early, these had all gone by the time people visited the surgery to arrange an appointment. People also felt that their privacy was damaged as making an appointment face to face with a receptionist in a public area destroyed confidentiality. Some were disappointed with receptionist's attitudes finding them rude and dismissive, asking intrusive questions or simply talking too fast. There were also issues when an announcement was made for waiting patients to attend consultation rooms, as many could not hear them, and sometimes missed appointments, this caused some anxiety for those that it affected. We heard much good practice of doctors and nurses coming to fetch their patients, but this seemed to depend on the compassion of an individual doctor or nurse rather than being adopted as an across the board policy. Others reported long waits after their appointment time, up to an hour was mentioned. Several others mentioned taking someone with them for support.

Comments on the quality of consultation were varied with similar numbers received of both positive and negative. Positive comments were mainly about the helpful, professional manner of doctors, there was recognition that doctors were very busy. Negative comments were focused on direction of speech, the need to remind them of hearing loss, with one finding their surgery 'very hard to talk to and not friendly or helpful.

Another issue that is related that came to our attention was that of ear wax. Ear wax is naturally forming and provides protection to the ear. However, when there is excessive build up, it can cause the hearing aid to become ineffective and to 'whistle'. We came across several people who suffered with this problem, which rendered their hearing aid useless and left them very deaf, frustrated and sometimes in pain.

There are several methods that can relieve this issue, including ear drops, ear irrigation and micro-suction. We were told that ear irrigation can lead to wax building up more quickly and whilst there is no clear evidence that micro suction is a better method, this is often preferred as it can be done more frequently and has fewer side effects.

However, only a handful of GP practices on the Island offer micro-suction, and patients who are not registered with them are denied the opportunity for this option. One man told us that after ear irrigation, his hearing aid worked for one week, before his ear became blocked with wax again, yet he could only have the treatment once every three months, leaving him without hearing for the greater part of every year.

As part of our outreach sessions we spent time with the Stroke Association[20] at their regular moving –on sessions. We talked to many service users who suffered from Aphasia. Aphasia is a condition that affects the brain and leads to problems using language correctly.

People with aphasia make mistakes in the words they use, sometimes using the wrong sounds in a word, choosing the wrong word, or putting words together incorrectly.

Aphasia also affects speaking and writing in the same way. Many people with the condition find it difficult to understand words and sentences they hear or read.

Group members reported that a great deal of determination was required to overcome and that it was likely there would be more success in personal interests, rugby was mentioned, than in trying to communicate with health and care professionals.

Difficulty in finding the right words means that they might inadvertently mislead a doctor with symptoms. Memory affected is both short and long term, so sometimes they cannot remember all symptoms when reporting or remember instruction for self-care. Group members said that they found it easier to find the right words when they were at home and had more time than when they were at the surgery or hospital. In addition, many suffer with fatigue, either in the mornings or afternoons so flexibility in appointments for the best time of day for them is important to get the most out of appointments. A few reported that as they took companions with them for appointments to help them get the most out of these consultations then medical professionals addressed their companions which they found very undermining.

Several people with a range of communication difficulties told us that in order to understand information on self-care and further treatment they needed information written down, the Stroke Association[20] can provide good resources to support this, but we found little evidence that they were being used.

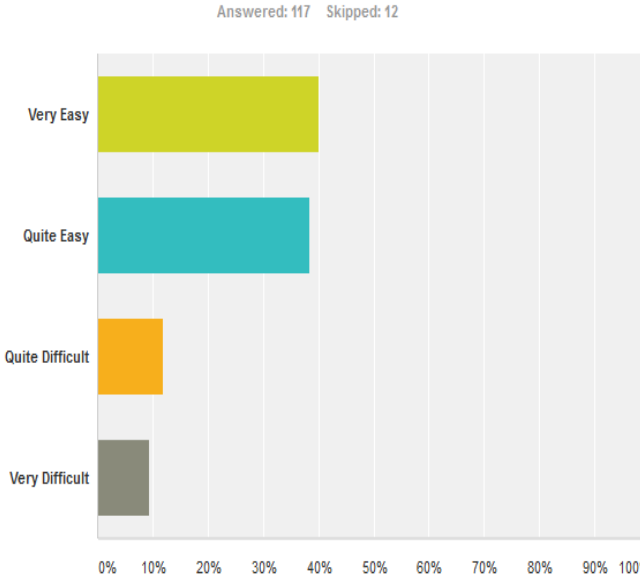
Our work included one interview with a blind person. Our Interviewee reported that at the GP surgery, the receptionist is helpful in checking in and helping to find a seat. However, when the appointment is due, name and room number is called. Interviewee cannot find room without help and this is never anticipated.

When talking to medical professionals, the interviewee is aware that if a companion is present, then the medical professional will often address the companion, as the interviewee cannot make eye contact.

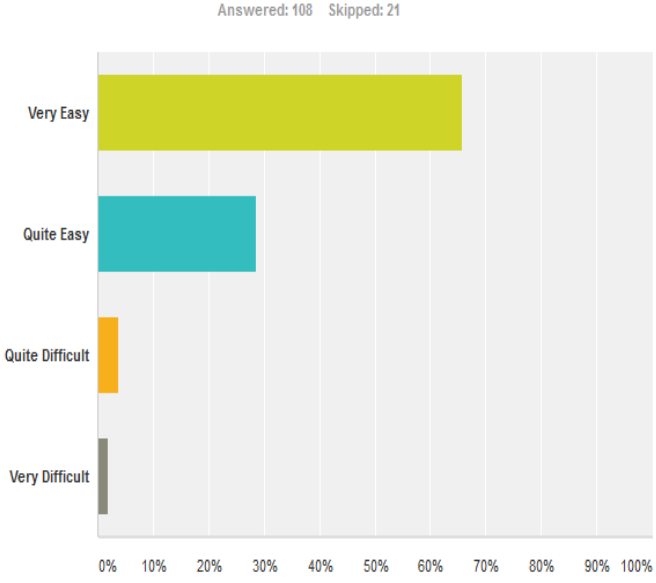
We were also told of an instance where a deaf/blind person was asked to leave their guide dog in the waiting room when called to the consulting room, showing a complete lack of understanding of the guide dogs role.

There were over 30 comments received regarding prescriptions. Some of these were specific to the communication skills of pharmacy staff, generally these were not well regarded, although there were a few positive comments received also. Many of our respondents relied on a relative or Carer to arrange prescriptions, with only one saying they used electronic ordering. There was some confusion with systems changing and accuracy of prescriptions. One worrying remark received was; 'system changed and my prescriptions disappeared. Trying to do without them, it's too much trouble.

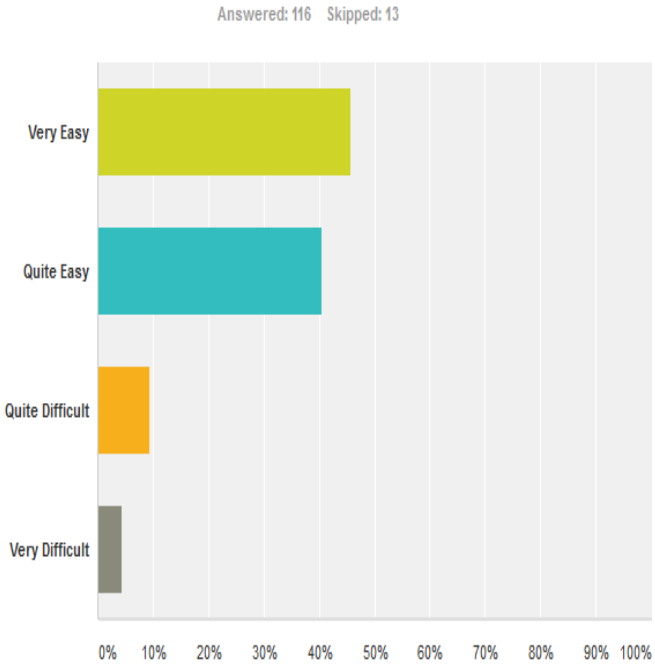
Booking an appointment:



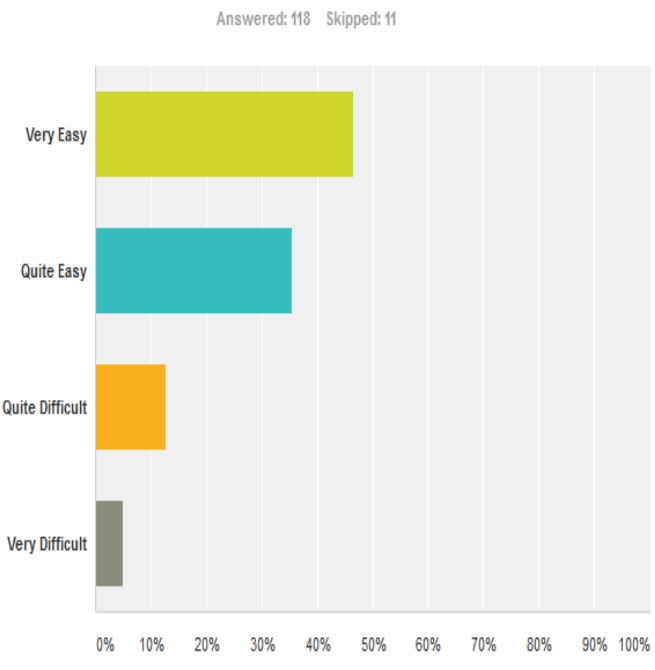
Checking in on arrival:



Communicating with doctor/nurse:



Arranging prescriptions:

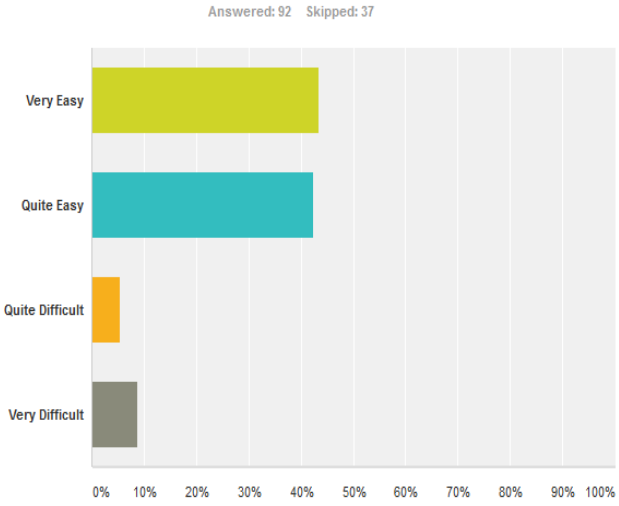


At the Dentists

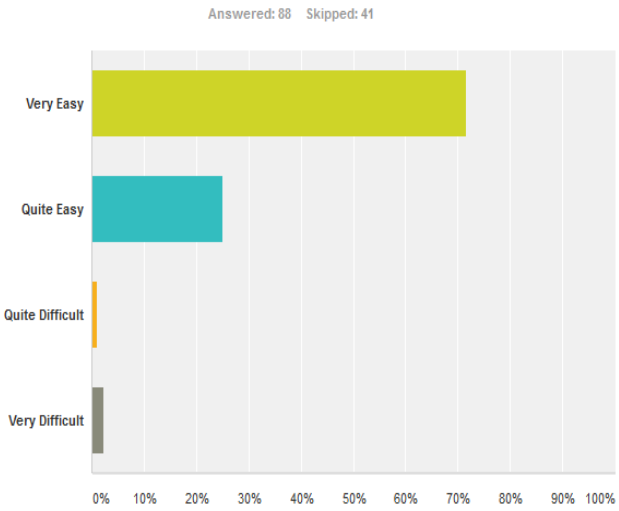
Again, our survey found that communication was generally good for those attending NHS dental surgeries. The only issue of note for this question were the numbers not accessing an NHS dentist, which flags the issue of access to NHS dentists on the Island again. This issue was not further explored by survey questions.

From our interview with a blind person we were told that on the whole the service was better at the dentist surgery than at the GP's. We were told that this is because nurses guide to seat and into the surgery, text message appointments are used and are appreciated as they can be converted to speech. Text messaging and emails seem to be more widely used by dentists.

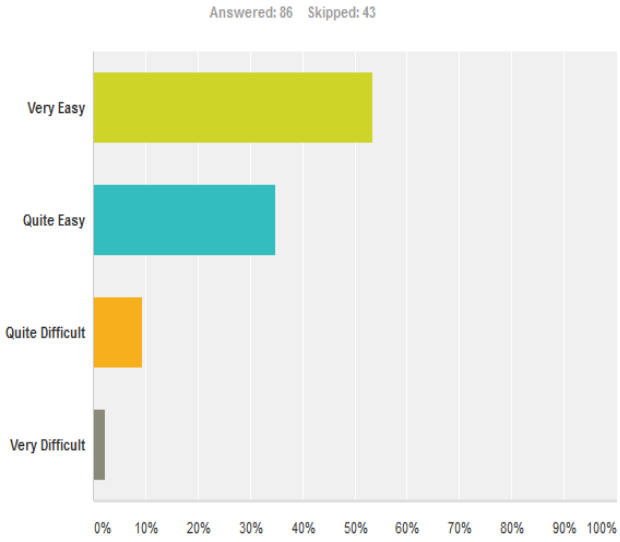
Booking an appointment:



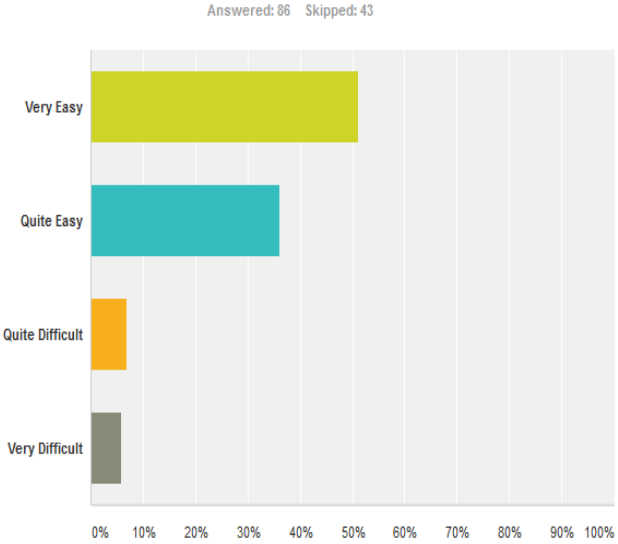
Checking in on arrival:



Communicating with dentist/hygienist:



Understanding treatment & aftercare:



At the Hospital and Emergency Help

Our survey discovered that there were less people finding arrangements and appointments very easy, with a greater number reporting that it was only quite easy. These numbers increased again for understanding self-care, and for arrangements for leaving hospital and further care. Of note, are the many people who relied on lip reading alongside a hearing aid, who found highly accented staff hard to understand.

This was echoed by blind people we were told that that good spoken English is imperative for understanding diagnosis and self-care, as the blind cannot read facial clues or body language.

Feedback received during this period raised concerns in a couple of areas. We were told of an elderly patient with deafness and dementia who was denied the opportunity of a cup of tea as he could not hear staff asking him whether he wanted one. Another told us that whilst they were an in-patient, especially at night when they had removed their aids, staff would address them without ensuring first that they could hear them. A third report of a deaf carer of a deaf elderly relative admitted via A&E said that she had to be most assertive to ensure that doctors faced them when addressing them and spoke clearly.

The issue of deaf and hard of hearing always having to be assertive and having to remind professionals over and over again was a common theme repeated to us through outreach time and time again. 'The onus is always on us' and 'I'd like a badge telling everyone I was deaf' were just two of the comments we received. Many said that in order for appointments to be effective they had to take a friend or relative along with them, there were two undesired consequences of this; quite often the health professional would address the hearing person, rather than their patient. Also taking along a friend or relative destroyed confidentiality and many people reported to us about how uncomfortable they were to take this action but could not see any other way to do it.

The above indicates that deaf awareness training is not carried out consistently across all staff and is again dependent on the compassion of individual health professionals. We did hear of some good practice particularly for visually impaired people at A&E, we were told that 'they really seem to understand disability'

However, the same interviewee advised us that letters from the hospital still arrive in print. This means that interviewee has to ask a friend or family member to read it. This can cause embarrassment and destroys privacy. Audio CD or braille would be preferred. Audio CD could be re-used for others and maybe more useful for those whose sight loss is age related and haven't learned how to read braille. In general, letters should be substituted for phone calls for all blind people.

Also highlighted was that hospital visits are impossible without a companion, and the interviewee has to take a taxi as it goes into the site. Interviewee thinks that a 'meet and greet' service from the bus stops, provided by volunteers would reduce the amount of stress, organisation and expense required for hospital appointments.

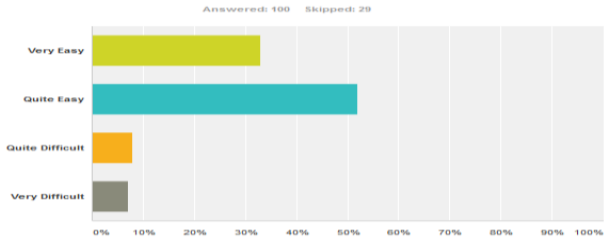
The Audiology department came in for particular praise with many stating that they were well looked after and that a technician would do home visits for those who are housebound. However, during our research it was found that there was a leaflet signposting hearing aid wearers to the Queen Alexandra Hospital in Cosham for re-tubing. It understood that the Audiology department is commissioned from Portsmouth Hospital NHS Trust however this generic use of leaflets could cause anxiety and distress for hearing aid users who are unaware of the services offered by Action on Hearing Loss[3] throughout the Island.

We were also told of an instance where a hearing aid user approached Specsavers to repair their hearing aid as the wait for an appointment was too long, they were pleased to report that the aid was repaired on the day and free of charge. Another told us that when her hearing aids were broken she had a two week wait for an appointment at Audiology, she was then told that there would be a two week wait to have them repaired and that in the meantime there were no replacements available and she would have to do without. She said this made her very afraid to go out with her children, even taking them to school was an ordeal as she couldn't hear traffic when crossing the road. This destroyed her confidence and made her very anxious.

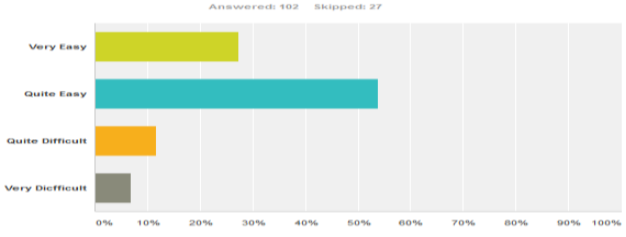
In addition, we heard some relatively historic stories about treatment within this department, with some people having a real mistrust and disappointment in the services they were given. Also this group were very reluctant for us to record their concerns particularly if it concerned a child, this was because of the relatively small numbers affected by hearing loss in this group and the fear of having even an anonymised story recognised.

Issues included were related to a lack of compassion and understanding by senior staff and a lack of appropriate aids and treatment that went undiscovered for some time. Another parent who forgot an appointment was told that her children who are profoundly deaf would be discharged for non-attendance. The parent who has a number of other children, who had other hospital appointments and works, was most distressed, she had not received a reminder of the appointment.

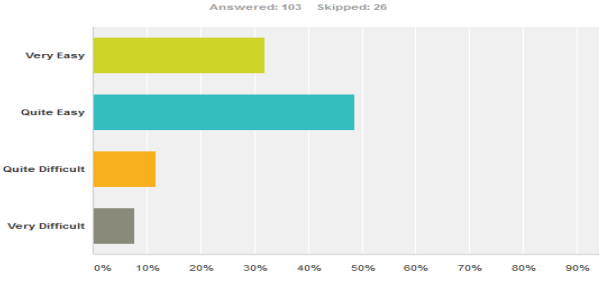
Arrangements before arrival:



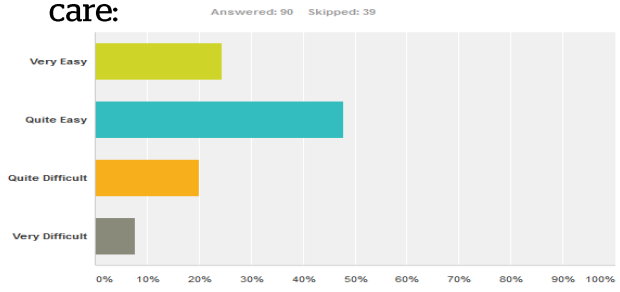
Communicating with staff whilst in hospital:



Understanding treatment & self-care:



Arrangements for leaving hospital & further care:



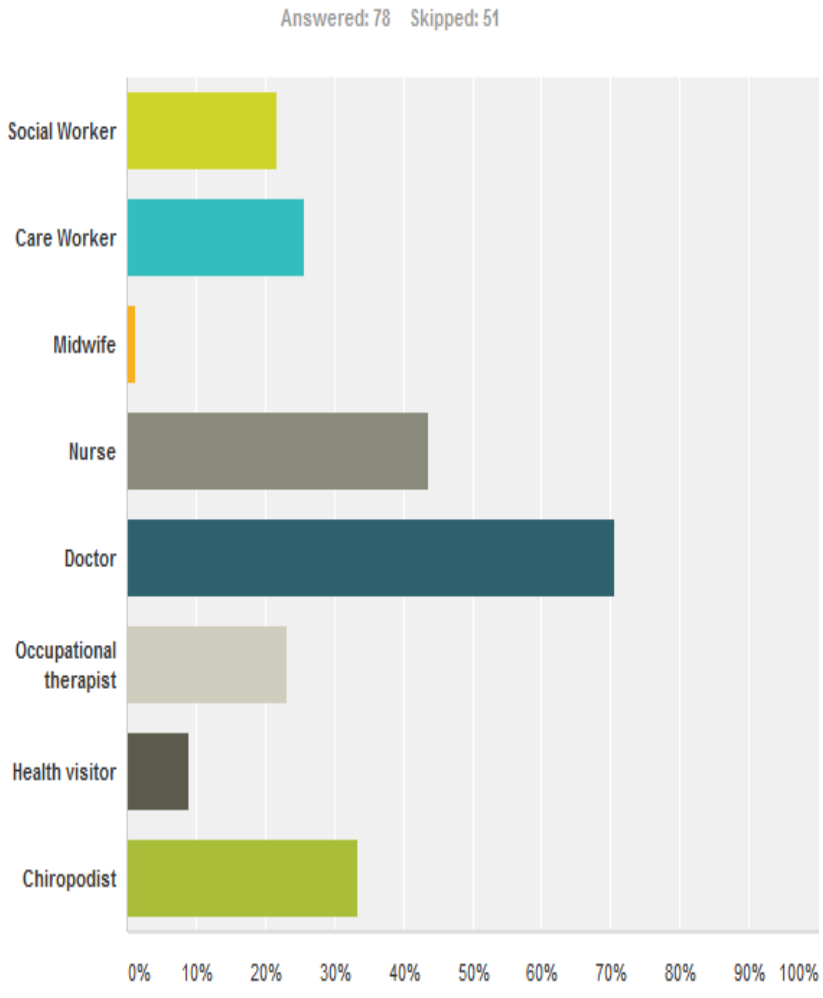
Home visiting

The survey asked whether respondents had health and social care professionals visit them at home, a range of professionals were mentioned, but by far GP's were the most cited, with nurse, social care professionals and occupational therapist second most quoted. Generally, communication was found to be very or quite easy with relatively few saying that they had difficulty with this.

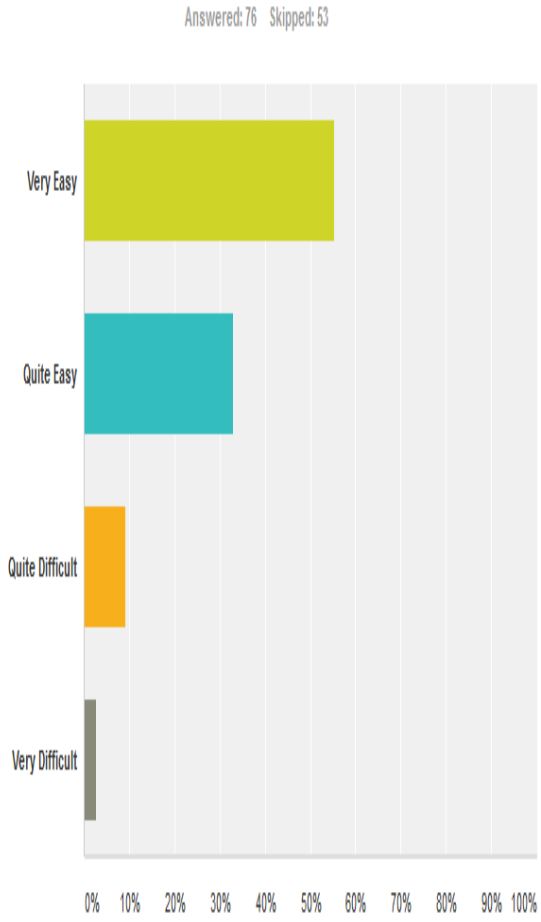
The findings for seeking and receiving emergency care very much echoed the above findings, with very few reporting that this was difficult. Emergency help presented serious concerns for those who were profoundly deaf, the findings of our work in this area are presented later in this report.

Bizarrely, we were told of an instance when a locum doctor asked for a guide dog to be removed from the room when visiting a patient who lived in a bedsit.

Which of the following have visited:



How easy was it to communicate with these professionals:

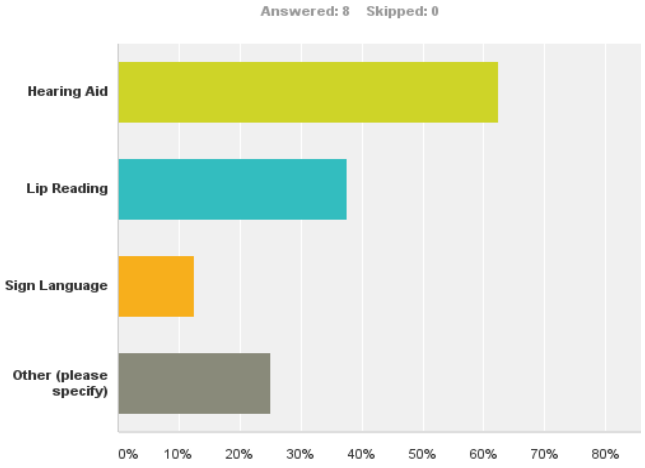


The experiences of the Profoundly Deaf

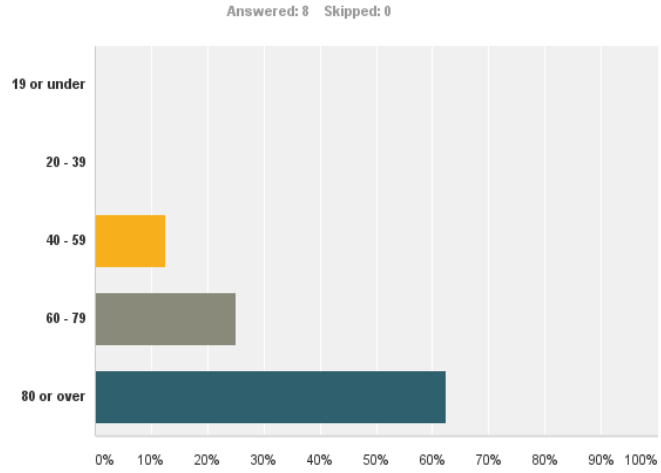
To capture the experiences of the profoundly deaf, those who responded to our survey who identified themselves as profoundly deaf, were collated in a separate report. Alongside the survey, we carried out a number of semi-structured interviews using BSL interpreters where required and in one instance using a familiar volunteer to complete the interview, as the interviewee was unhappy to meet with us as we were not known to them. We also attended a number of meetings to gather on an ad-hoc basis the views and experiences of this group.

The survey results for the profoundly deaf were quite different to those who had identified themselves with a lesser hearing loss. For this group over 70% were hearing aid users, nearly 40% were reliant on lip reading and almost 15% used BSL. The age range was more widely spread from 40-80+, but again more were in the older age group. More respondents lived in more urban areas of the island and there was less of an equal geographical spread.

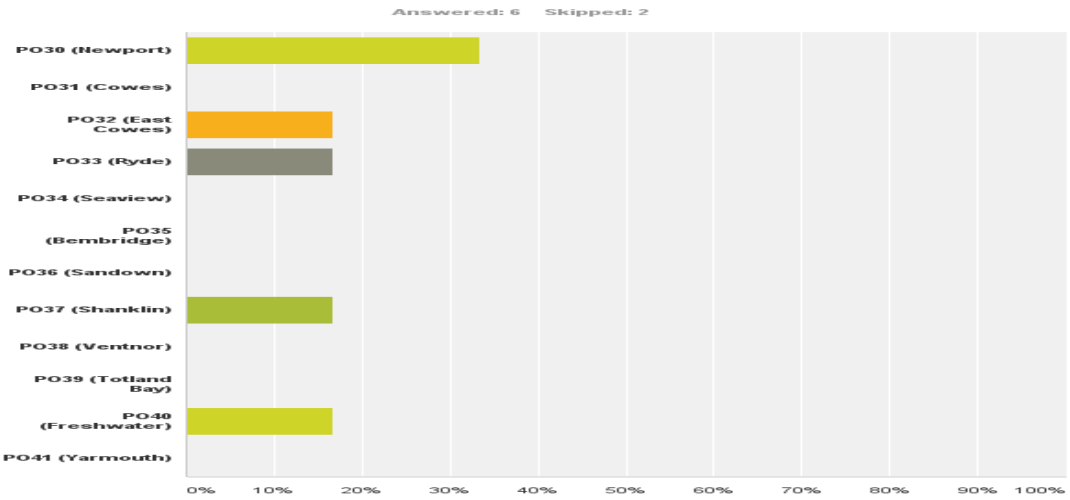
Which of the following used:



Age group:



Residential areas of respondents:



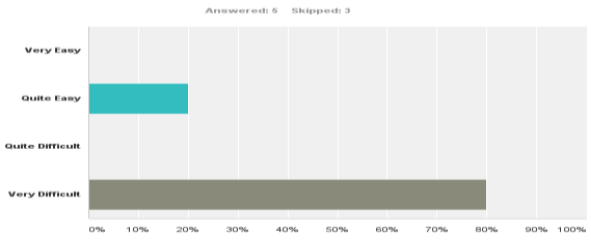
At the Doctors

A shocking 80% found arranging an appointment very difficult, this is because this group is frequently unable to use telephones, previously it has been noted that there is a complete lack of mini-com usage at all GP surgeries. This means that where patients cannot use internet booking systems, the patient is reliant on calling into the surgery, or on a friend, relative or carer to telephone for them. We heard that for one person up to two weeks wait for an appointment had to be anticipated when calling into the surgery for an appointment, if no-one else was available to make a telephone call for them. Several said that they always had to be accompanied to the surgery and that whilst some surgeries were good at arranging for BSL interpreters others were less so. One stated interpreters needed to be familiar to them to aid understanding of complex medical issues. Several said that they found lip reading tiring and difficult particularly when the doctor had a beard.

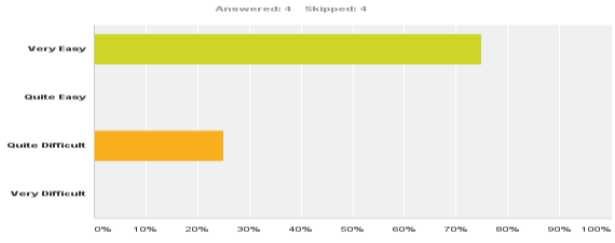
It was more pleasing to note that patients on the whole found checking in on arrival in comparison, relatively easy. This is in part due the increasing prevalence of electronic check-in services.

The success of consultations was often dependent on the availability of a BSL interpreter, but generally consultations were reported as better than arranging appointments. Arranging prescriptions was an area where a lot of concerns were noted. One interviewee told us that they were unaware of changes to a management prescription following a blood test until they collected the prescription. They were told this was because the surgery would not leave messages on answering machines with a generic message and would only try to call once. Several others told us that they always had to ask to be shown the screen to be aware of any changes to medications and that the changes were never explained to them. Another told us that there were frequent omissions to their prescription and confusion to where it was being dispensed, they suspected that this was down to the pharmacy rather than the GP surgery.

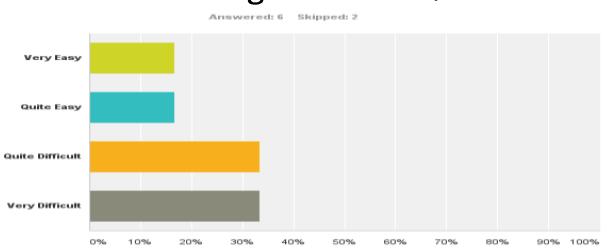
Booking an appointment:



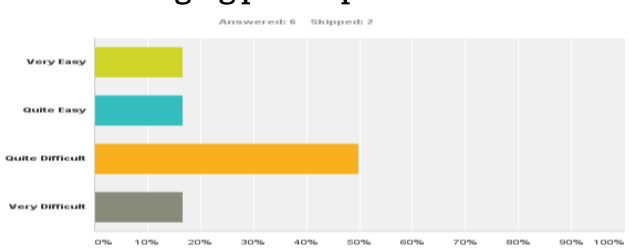
Checking in on arrival:



Communicating with doctor/nurse:



Arranging prescriptions:

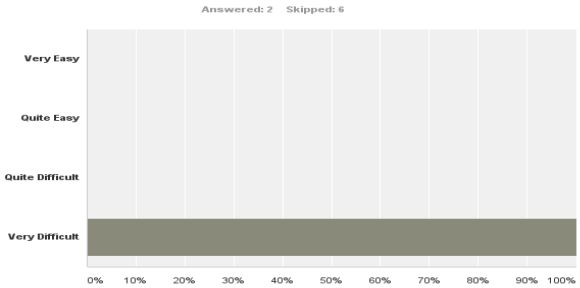


At the Dentist

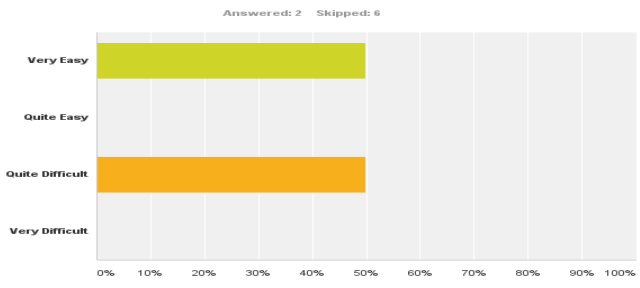
100% of respondents to our survey found making dentist appointments very difficult, with this same number stating that it was very difficult to understand treatment and self-care. Again we were told of people not having an NHS dentist. One story was particularly worrying. We were told that the experience was so overwhelming that the patient had given up her place at the NHS surgery, was unable to get another place and was fearful of getting toothache. We were told that the dentist constantly wore a mask making lip-reading impossible. There were up to 5 nurses in the room, so it was unclear who was talking. The patient had to repeatedly ask; 'Are you talking to me?' They also played background music which just made the situation even worse. Treatment was never properly explained,

Other common issues cited both within the survey and from our interviews found the same problems arranging appointments as with GP surgeries. All have to attend in person to make an appointment or ask a carer or a friend to make appointments on their behalf. For one respondent problems communicating at the reception desk were compounded by a noisy air conditioning unit and background music being played. Where BSL is a first language the use of interpreters is imperative for the success of a consultation. Others who lip read said that they had to constantly remind all staff that they were deaf, to ask them to remove masks when addressing them and to provide written information on after care. They also said that highly accented staff made any communication very difficult. One respondent was in pain for some time before treatment was made available; the respondent was a BSL user and had a suspicion that treatment was delayed because they could not explain symptoms properly without a BSL interpreter.

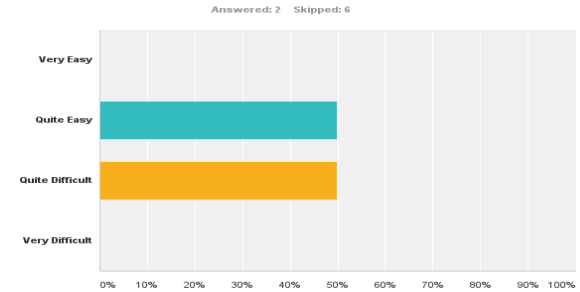
Booking an appointment:



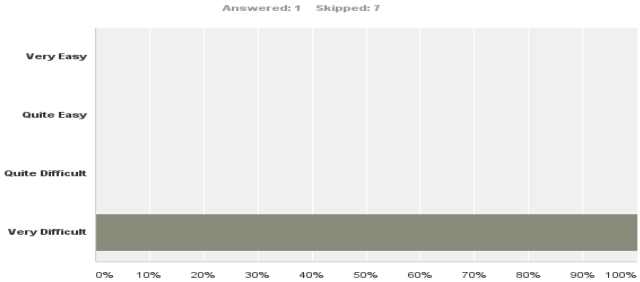
Checking in on arrival:



Communicating with dentist/hygienist:



Understanding treatment & aftercare



At the hospital

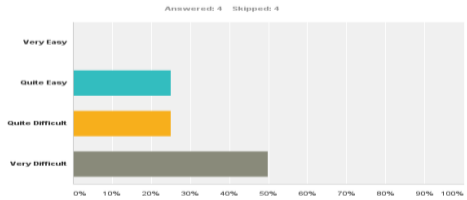
For all the topics covered within this question; arrangements before arrival, communicating with staff in hospital, understanding treatment and self-care, and arrangements for leaving hospital and further care, all found to be very difficult rather than any other category.

Of concern were the noise on the wards, staff shouting to be heard, and highly accented staff (which prevents lip reading as the mouth shapes change), having to explain repeatedly to up to 10 members of staff in an hour, especially when concerns were of a very personal nature, and the lack of written material to explain procedures, treatment and self-care. For those who used BSL interpreters it was reported that unfamiliar interpreters made it much harder to explain ailments as they did not understand each other well. We were told that a great deal of 'chasing' was required to organise BSL interpreters and that frequently they were unfamiliar to those that were habitually used for other situations. The 'chasing' of arrangements for BSL interpreters fell to Carers or loved ones to arrange, even if they were in poor health themselves. A lack of effort by staff to make clear explanations caused confusion and fear, with one respondent being told 'Not to worry' when asking for further clarification, which they found most disrespectful. When BSL interpreters were used, professionals tended to address them rather than their patient which again was found to be disrespectful. Another issue that was raised was when procedures were not clearly explained, through lack of interpreter or an unfamiliar interpreter, interviewees experienced a lot of anxiety as they could not understand what was happening to them and why.

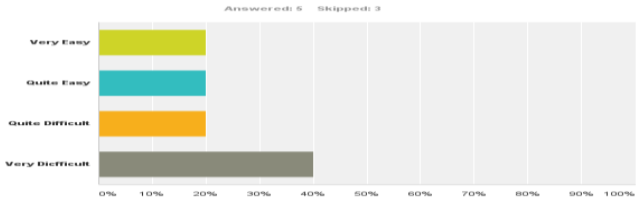
The ticket system for blood tests was highlighted as an example of good practice as it was found to be very accessible and many thought it should be adopted for other areas of the hospital, for one this was the only appointment they could attend independently.

The relationship between a BSL interpreter and BSL user is important. Familiarity leads to increased understanding, BSL is not a simple translation of English to hand gestures. BSL users also reported that it was important that they exercised choice as there were some interpreters that they were unhappy with and did not want them knowing personal information about them.

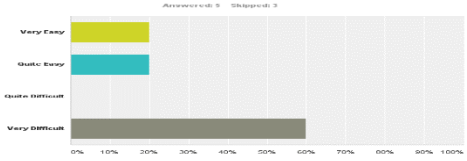
Arrangements before arrival:



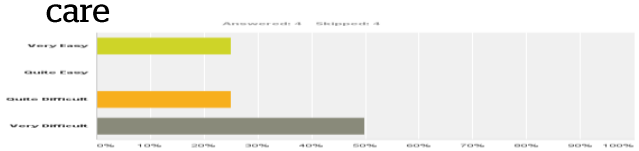
Communicating with staff whilst in hospital:



Understanding treatment & self-care:



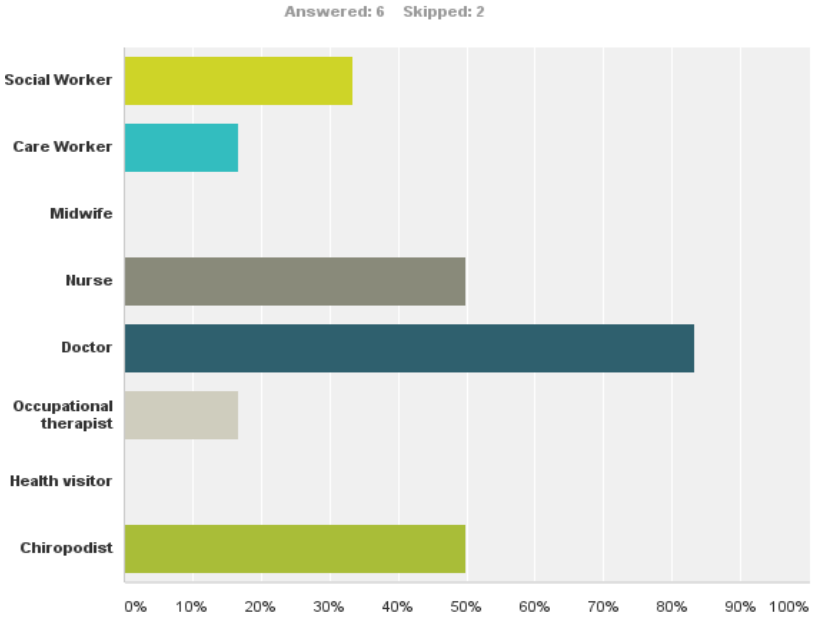
Arrangements for leaving hospital & further care



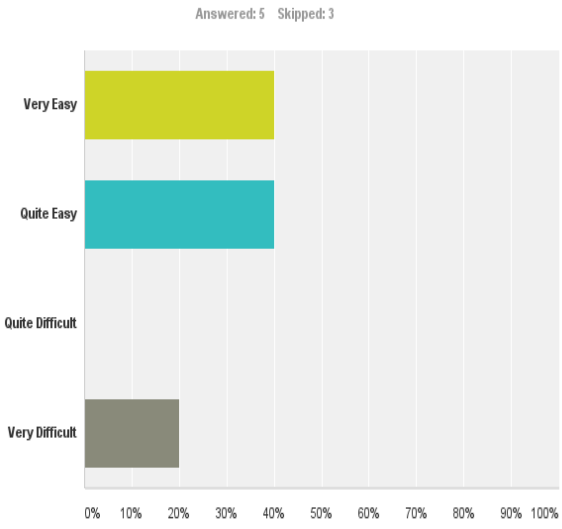
Health and Social Care at Home

As with the main survey results the majority of those responding to the survey and for those taking part in interviews, the chief reason for a home visit was for a GP. More respondents found it easier to communicate at home though some still said that it was 'very difficult'.

Which of the following have visited:



How easy was it to communicate with these professionals:



Specialist support workers were an important aspect in helping with communication with health and social care professionals at home. None of the respondents using BSL reported that an on-call doctor or other health and social care professional came accompanied by an interpreter even if they knew their patient was deaf and used BSL. There was strong positive acknowledgement on the role of specialist support workers, but recognition that their level of BSL was not sufficient for complex medical conditions.

Emergency Health and Social Care services

Currently the IW NHS Trust does not operate the national 999 text relay for the profoundly deaf. Instead if a text to 999 is made this goes to the police, who call the hub, then a clinician makes a phone call to the person who sent the text. Obviously, a person who is profoundly deaf cannot hear on the telephone so this system does not meet their needs. We found that there was no knowledge of this system for people who are profoundly deaf. We have asked the IW NHS Trust to explain what they do to publicise the existing system and if they can change to a standard 999 text relay system. Three of our interviewees had had cause to call the emergency services in the recent past. One interviewee had fallen from her wheelchair and thought that she had injured herself in this fall, in order to call the emergency services, she had to text her Support worker to ring them. The Support worker told us that then she was asked many questions that she could not answer as she was not with her client, leading to more delay in getting the ambulance deployed. This instance also raises the question of what would have happened if the interviewee had dropped her telephone out of reach as and was unable to text her support worker. This interviewee had been offered an emergency call pendant in the past, but had refused, because they rely on speech, also that she perceived them as a device for the elderly.

Our second interviewee had a medical emergency happen to her partner, she had attempted to call 999 and had to keep passing the phone between herself and her partner as she could not hear, this caused a great deal of confusion and panic that made the situation even worse.

Our third interviewee also had a medical emergency happen to her partner, in this case they were with other people who were able to make the call. On a second occasion, her partner was experiencing stomach pains, she called 999 but couldn't communicate, in this instance the police came and they called an ambulance and a doctor. Following this they had put together a plan in case it happened again. The plan was for the interviewee to leave her partner unattended whilst she made the ten minute walk to a friend's house to alert them and get them to make the call to emergency services, clearly this would only work if the friend was at home, it would also mean a long delay in calling the ambulance. The partner of this interviewee raised concerns about the risk of fire at their home, they live in a top floor flat, in the event of a fire and if the partner was incapacitated, then a call for help could not be made.

One interviewee told us of an experience, ten years ago, which happened when she lived on the mainland. She experienced problems with her leg, no interpreters were available, there was no communication with her and she didn't know what was wrong with her or what would happen. In the event, she had to have an operation, when asked how she gave consent for it, she said she didn't know, but thinks she gave the 'deaf' nod. After the operation she awoke very frightened and still no interpreters were available. A physiotherapist came and tried to make her walk, not knowing that she had Cerebral Palsy and used a wheelchair, her lack of reading the notes compounded a very distressing situation.

Other issues

- As toe nail cutting services are now only available to blind/diabetic people, the interviewee who is blind now has to pay £25 every six weeks for a private chiropodist to cut his/her toe nails, and interviewee lacked confidence to do it themselves.

- Bowel, Kidney and Bladder cancer are all concerns for blind people. On the Island there are 300 urological cancers diagnosed every year. Our interviewee was aware of 2/3 other blind people who have died from these conditions as they are unable to make the visual checks that the general population can. A recent press release from the IW NHS Trust 10 July 2014 advised that checking for blood in urine, this is not an option for blind people.

- Interviewee receives a small personal budget, however personal assistant is unable to undertake tasks that are deemed hazardous. This includes using bleach and flea treatment for the guide dog, the interviewee has to rely on family and friends to complete these tasks.

- Parents of deaf children we spoke to said that whilst the teachers for the deaf provided a good service, schools sometimes did not put in place all measures needed to support their children. Also that explanations to other children were not made, one parent reported buying their own resources for teachers to use to explain deafness to the other children in the class.

- Parents also reported that once they had received the diagnosis that their children were deaf, there was no support package offered, they had to find their own way to find support for themselves and their children.

- There were differences in the support offered for hearing aid care. Action on Hearing loss[3] run many drop-ins across the Island for replacement batteries and tubing, but these do not seem to be well publicised by the Audiology department, with some being told they must re-tube themselves and others being given appointments to go to the department to have this carried out.

Conclusion

Communication issues for deaf and hard of hearing residents of the Island show a differing picture with some reporting few problems, but others, notably those that are profoundly deaf whether or not they use BSL, reporting some incredible difficulties. From our research we have found that the onus is always on the deaf person to remind clinicians that they are deaf, there does not seem to be any standard noting on files of this issue.

Many doctors and nurses do show kindness and compassion in helping their patients understand, but for others, they are not deaf aware and do not communicate clearly with their patients. We should be mindful of the 'grateful patients' that maybe do not hear or understand that use the 'deaf nod' whether or not they understand. There is a great deal of evidence that deaf and hard of hearing people have worse health outcomes than the hearing population, there is more to do in both communication and helping patients to understand self-care.

According to the British Medical Journal[21], thousands of profoundly Deaf people still struggle to communicate with healthcare professionals on a daily basis. Research by Action On Hearing Loss found that the level of services Deaf and hearing impaired people receive in both GP surgeries and hospitals often falls short of what they could reasonably expect. For example, 35% of people who are Deaf and hearing impaired had experienced difficulty communicating with their GP or nurse and 32% found it difficult to explain their health problems to their GP.

The issue of clearly spoken English by doctors was raised as an issue for people with both hearing and sight loss. The International English Language Test (IELTS[22]) is recommended for those doctors from outside the EU wishing to work in the UK, as a starting point to the Professional Linguistics Assessment Board Communication skills (PLAB Test).

The IELTS[22] assesses the proficiency of English, in four areas spoken, written, listening and reading. There are band scores from 1-9 with no pass or fail, although a level of 7 to 7.5 is recommended by NHS employers. The PLAB test also covers communication usually through a simulated situation. Areas covered include explaining diagnosis, investigation and treatment.

It also includes involving the patient in decision making, communicating with relatives, breaking bad news and seeking informed consent. Also covered is dealing with anxious patients and relatives, giving instructions on discharge from hospital and health promotion. Each different aspect lasts five minutes. There is a requirement for doctors to check what the patient already knows and what they would like to know.

This explanation should be clear with a level of detail and a pace that a patient can follow, with checks at intervals to see if the patient has understood or has any questions. They are also required to demonstrate checks that the patient has understood.

These tests are not the only routes to check English language proficiency, the following are listed as acceptable in the Language Competency Good Practice Guidance for employers July 2014[23]

- be a national of a majority English speaking country or have worked in an organisation/institution where English was the primary language used
- pursued part of their education in the UK
- hold a degree or relevant educational qualification that was taught in English by a recognised institution abroad
- lived in a multi-lingual household in which a relative or a carer used English as their primary form of communication

The General Medical Council gives guidance in this area (Good Medical Practice 2013 Domain 3 Communicate Effectively Para 31-34[24]) It is recommended that they 'Give patients the information they want or need in a way that they can understand' Further that, 'doctors must have the necessary knowledge of the English language to provide a good standard to practice and care in the UK'. At the time of writing we have made enquiries to the IW NHS Trust as to what level doctors practicing at the hospital have (with regards to English language proficiency) and await their response.

The increasing usage of on-line bookings for appointments and electronic check-ins are positive moves for the many deaf people who can use a computer. However, some elderly people we spoke to were fearful that this would mean that they could no longer telephone or call into the surgery to make routine appointments. Waiting rooms also increasingly have screens calling for patients which is positive for deaf people, but of no use for people with sight loss. A combination of two methods would go a long way to meet the needs of these groups and also decrease their dependence on friends and Carers. Of good practice also was the ticket system for blood tests used at the hospital. In other situations, people are reliant on the knowledge that their doctors know them and will come and fetch them from the waiting room.

Another key issue that was raised was the use of micro-suction for those suffering with ear wax. There is an inequality across the island where some surgeries have the equipment and other don't. We were told that at hospital a trained nurse carried these out on a daily basis, however, our respondents told us that they could only get an appointment on a quarterly basis.

Most disturbing of all our findings was that the majority of our respondents were not aware of the 999 text service. Whilst Island support Services who support many profoundly deaf people had notified the Hub of all their service users, this still meant that they could not call independently. Other areas of the country have implemented 999 text relay for many years and it is embedded in their systems. We have been told that the facility for this system is available to the Hub but is not yet being used.

For those that use BSL, there was a mixed picture with some reporting that services were good at arranging interpreters, others reporting that they had to 'chase and chase' to get one arranged. There is a legal right for people who use BSL to have interpreters at all health appointments.

For people who used lip reading, they were more likely to report that doctors and nurses did not explain issues properly to them, lip reading is tiring and hard work for those who use it and unfamiliar terminology and accents make this even harder for them.

The National Community Hearing Association (NCHA) [25]aims to work with partners across the health, social care and charity sectors to support 'better hearing for all'. The NCHA supports policies that put patients at the heart of how hearing care services are delivered. The NCHA provides its members with single voice so they can engage with all stakeholders to:

- ensure hearing loss is recognised as a public health issue
- work towards equal access for all those who can benefit from hearing correction
- develop a National Hearing Plan which properly reflects need, especially for older patients whose needs can often go undetected and unmet
- improve collaboration between community and hospital services so that the service you and your family receive is designed around your needs
- encourage more joined-up approaches across primary care where community hearing providers pharmacists, opticians and GPs all work more closely together to improve outcomes and maximise health, well-being, independence and social inclusion for all.

The Isle of Wight is not signed up to the above aims.

The Chief Medical Officer's latest annual report[10] acknowledges that appropriate support for hearing loss can have 'a substantial impact on quality of life'.

Healthwatch Isle of Wight would endorse the recommendations made by the Action on Hearing Loss report[3] 'Access All Areas' for GP surgeries.

Recommendations

Healthwatch Isle of Wight Recommendations for:

IW NHS Trust, Local Authority, GP Surgeries/Dentists and the CCG:

1. Provide deaf awareness training for all frontline staff. Comprehensive training should cover effective communication tips (Look at the patient while speaking and listening, For lip-readers, face the patient in good light. Speak clearly but not too slowly. Don't exaggerate your speech or shout (this distorts lip movements). Don't look at the computer while talking). It should also cover the types of communication support available and good practice.

2. Extend the use of technology that can help improve the patient experience for people with hearing loss, such as visual display screens in waiting rooms and induction loop or infrared systems.

3. Ensure that patient records clearly indicate when a person has a hearing loss and include basic information about their preferred method of communication and any communication support requirements.

4. Have policies and procedures in place to enable communication support to be booked as and when required including BSL interpreters, using only communication professionals who are fully qualified to deliver interpreting services in a healthcare setting.

Further practical advice is provided by the website www.Patient.co.uk

5. Ensure that all frontline staff have a good enough level of spoken English so that they can be understood by all deaf people especially those that use lip-reading.
6. The IW NHS Trust, GP Surgeries and the Local Authority to sign up to the aims of the NCHA to improve the experiences of all deaf and hard of hearing people on the Isle of Wight. As in other areas of healthcare early identification and intervention lead to more effective and cost-effective outcomes. Health and Wellbeing Boards (HWBs) and Clinical Commissioning Groups (CCGs) should therefore embrace initiatives that help people with hearing impairment access support as early as possible.

Whilst those aged 45 and over with moderate or severe hearing loss will increase by 775,510 between 2012 and 2020 the greatest growth in demand for hearing services will come from a new generation of older people. This generation will not see disability as inevitable and will expect technological correction and support as a normal part of life. This change in social attitudes, if supported by HWBs and CCGs, has the potential significantly to improve both public and population health. http://www.the-ncha.com/media/16652/Adult-Hearing-Services-in-the-Community-Commissioning-Guidance-June-2014.pdf

Healthwatch Isle of Wight Recommendations for:

IW NHS Trust, GP Surgeries/Dentists:

1. Meet their legal obligations set out in the equality act 2010[26] to provide a range of ways for patients to contact their GP surgery/Health Clinic and ensure that practice staff are trained in how to use these methods. For example, allow booking of appointments by text/SMS, text phone, internet or email and use similar methods when leaving messages for patients.

2. Ensure patients have the opportunity to see the same doctor/nurse/dentist in order to achieve continuity of care.

3. Back up the consultation with written material such as patient information leaflets. And utilise the free online BSL interpreting from SignTranslate.

Healthwatch Isle of Wight Recommendations for:

GP Surgeries:

1. Support patients to improve their communication - e.g., with hearing aids or lip-reading classes and encourage those more likely to have a hearing loss, for example the elderly to have hearing tests and hearing aids fitted where necessary. Promotion of lip reading classes and counselling along with other support services should be a high priority for those newly diagnosed as deaf and their families and carers.

Healthwatch Isle of Wight Recommendations for:

GP Surgeries and CCG:

1. Ensure that micro-suction for ear wax is available at all GP surgeries to enable fair access to it.

Healthwatch Isle of Wight Recommendations for:

IW NHS Trust:

1. IW NHS Trust to utilise the 999 text relay system and publicise its use.

Review:

A follow up on all the recommendations and actions will be carried out by HealthWatch Isle of Wight during the autumn of 2015.

Appendices

Communication Survey – People with Impaired Hearing

Healthwatch IOW is an independent local "watchdog" and signposting service. It works with decision-makers and service providers to help improve health and social care services on the Island. It is one of 152 local Healthwatch organisations in England.

"Communication" is one of Healthwatch IOW's priority themes for 2014. We would like people with impaired hearing to tell us their experiences of communicating with the local NHS.

Please take a few minutes to fill in this questionnaire. We want an up-to-date picture, so in all questions please answer **only about your experience since the beginning of 2013.**

Just fill in as many parts of the questionnaire as are of interest and apply to you. We are pleased to receive all responses, Thankyou.

This survey is open until Friday 11th July 2014

If you need this form in another format or version, please contact Healthwatch IOW on 01983 608608 or visit www.healthwatchisleofwight.co.uk

Part 1 – About you

To help us understand who has replied to this survey we invite you to give us the following information:

Your level of hearing loss:	Slight	☐
(please tick one)	Moderate	☐
	Severe	☐
	Profound	☐
Which of the following do you use to help with communication?	Hearing aid	☐
(please tick as many as apply)	Lip reading	☐
	Sign Language	☐
	Other *(please describe)*	
	……	
Your age-group:	19 or under	☐
	20 – 39	☐
	40 – 59	☐
	60 – 79	☐
	80 or over	☐

Part 2 – At the Doctor's Surgery

Name of G.P. Surgery ……

How easy is it to communicate with the surgery on each of the following:

Booking an appointment:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Checking in on arrival:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Communicating with the doctor or nurse:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Arranging prescriptions:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Part 3 – At the Dentist's Surgery

Name of Dental Surgery ……

How easy is it to communicate with the surgery on each of the following?

Booking an appointment:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Checking in on arrival:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Communicating with the dentist or hygienist:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Understanding treatment and aftercare:

Very easy ☐ Quite easy ☐ Quite difficult ☐ Very difficult ☐

Comments……

Part 4 – At the Hospital

How easy was it to communicate on each of the following?

Arrangements before arrival:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Communicating with staff whilst in hospital:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Understanding treatment and self-care:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Arrangements for leaving hospital and further care:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

this section continued overleaf…

Part 4 – At the Hospital (continued)

If you would like to tell us more about your experiences with communication whilst at the hospital, please use one or more of the boxes below:

Name of ward/clinic……..

Comments:

Name of ward/clinic……..

Comments:

Name of ward/clinic……..

Comments:

Part 5 – Health or social care at Home

Which of these professionals have visited you at home?

(please tick all that apply)

Social worker	☐	Occupational therapist	☐
Care worker	☐	Nurse	☐
Doctor	☐	Health Visitor	☐
Midwife	☐	Chiropodist	☐

Other (please name)…….

How easy was it to communicate with these professionals in your home?

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Is there anything that could have improved communication with these professionals?

Comments……

……

P***art 6 – Emergency health or social care services***

Type of emergency help received……..

How easy were each of the following?

Calling for emergency help:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Communicating with those providing emergency transport:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Indicating your immediate need for help:

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Indicating your own specific needs

Very easy	Quite easy	Quite difficult	Very difficult
☐	☐	☐	☐

Comments……

Please tick the box to let us know the first part of your postcode:

	Please tick one:
PO30 (Newport)	
PO31 (Cowes)	
PO32 (East Cowes)	
PO33 (Ryde)	
PO34 (Seaview)	
PO35 (Bembridge)	
PO36 (Sandown)	
PO37 (Shanklin)	
PO38 (Ventnor)	
PO39 (Totland Bay)	
PO40 (Freshwater)	
PO41 (Yarmouth)	

Please return this form to the following address, once filled in:

Freepost RTGR-BKRU-KUEL
Healthwatch Isle of Wight
Riverside Centre
The Quay
NEWPORT
Isle of Wight PO30 2QR

This is an anonymous survey – the names of people taking part will not be recorded.

If you would like to find out the results of this survey, please fill in the attached sheet and return to Healthwatch IOW at the above address. Your contact details will be kept secure and not shared with any other organisation.

References

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