healthwatch

Recommendations for commissioning BSL interpretation services in South West London GP practices

A report by Healthwatch Croydon, Kingston, Merton, Richmond, Sutton, and Wandsworth

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Executive summary

This project builds on our South West London Accessible Information Standard engagement. Shortly after our engagement concluded in September 2024, a new interpretation service, DAL (formerly known as DA Languages) was rolled out across South West London GP practices. We reached out to BSL users and to GP practices again to see if this service change addressed the concerns we had heard.

Our engagement with BSL users and GP practice staff did not demonstrate a consistent preference for DAL versus Language Line, the former provider. Instead, patients and carers emphasised that genuine accessibility requires more than changes to interpretation services. Participants highlighted the need for consistent, high-quality interpretation alongside broader improvements across the entire patient journey - from booking appointments to receiving information after consultations - in line with the NHS England's Accessible Information Standard. [1]

These findings echo the concerns raised in our earlier engagement and are reinforced by national research. **Patients and carers stressed that the same issues have been raised for over a decade, with little meaningful progress.** This lack of improvement continues to drive health inequalities for d/Deaf and deafblind people, driving up costs for ICBs nationally.

Drawing on local insights and national evidence, we have developed recommendations for ICB commissioners to improve and rigorously monitor communication and information accessibility, as well as to better involve people with lived experience in the design, delivery, and governance of BSL interpretation and health services more broadly. **Of note, the lessons are highly relevant to other ICBs and NHS services across the country, and across service providers.** We are also publishing a related report specifically for GP practice staff.

This report complements the long-anticipated updates to the Accessible Information Standard (published 30 June 2025) [1] as well as health and social care guidance from the UK government's BSL Advisory Board (published 27 November 2025). [2] It is critical that in South West London we add to the national momentum to drive improvements to accessibility and care for BSL users.

A note about scope

Our recommendations focus on improving BSL interpretation, but many d/Deaf, deafblind, and hard of hearing patients rely on other forms of communication support, including hearing loops, speech-to-text reporters, notetakers, lipspeakers, and communicator guides. The South West London ICB should ensure that these services are commissioned and promoted in provider organisations. They can draw from NHS England's AIS Implementation Guidance (section 'Support for people who are d/Deaf or have some hearing loss' here) and on RNID's accessibility guidance, available here and here.

Terminology [3] [4] [5]

This report primarily uses the term 'BSL users,' to be consistent with service user preferences.

There are also references to 'd/Deaf and hard of hearing people' throughout. The first group is a subset of the second. 'Deafened' people are also mentioned.

The term 'deaf' (lower case 'd') refers to people who have hearing loss, either at birth or acquired later through injury, disease, or with aging. They may communicate orally or use sign language.

'Deaf people' (upper case 'D') are deaf individuals who belong to the Deaf community and are fluent in its culture and communicate almost exclusively in sign language. Many Deaf people are not proficient in written English communication.

'Deafblind people' are those with a degree of both hearing and vision loss that affect communication, mobility, and ability; one or both sensory conditions may be congenital or acquired over time, and it includes people within and outside of the Deaf community.

'Hard of hearing people' are those who have lost some, but not all, hearing.

'Deafened' usually refers to people who became deaf as an adult.

Background

d/Deaf, deafblind, and hard of hearing people's access to health services

National context

An estimated 87,000 people in England and Wales use British Sign Language (BSL) as their first or preferred language. [6] Their right to equitable access to health care is protected by law. The Equality Act 2010 requires organisations to make "reasonable adjustments," [7] while NHS England's Accessible Information Standard (AIS), first published in 2016 and updated in June 2025, sets out six clear steps for providers of NHS and publicly funded social care to meet people's information and communication needs. [1] These include identifying, recording, flagging, sharing, meeting, and reviewing communication needs so they are consistently addressed.

Despite these protections, BSL users continue to face significant barriers to healthcare. Research by South West London Healthwatch, alongside national studies by charities, academics, and the UK government's BSL Advisory Board, shows that patients who use BSL encounter obstacles at every stage of the journey: from booking an appointment, to registration and knowing when they are being called from the waiting room, to the consultation itself and follow-up care. [2] [6] [8] [9] [10] These barriers contribute to missed or delayed appointments, misdiagnosis, poor treatment, and distrust of services, which collectively worsen health outcomes. [2] [6] [11] [12] Of note, deafblind people, who have combined hearing and sight loss, are at especially high risk for social isolation and exclusion. [2]

The scale of the problem is stark: nationally, **84% of d/Deaf, deafblind, and hard of hearing people report difficulties accessing healthcare**. [8] In 2014, health economists at the University of East Anglia estimated that misdiagnosis and poor treatment of d/Deaf patients cost the NHS £30 million annually. [11] Adjusted for inflation and wider associated costs, the figure today is likely between £80–100 million each year. [12]

South West London context

While there are no census estimates of the number of BSL users in South West London – and demographic findings from NHS England's GP Patient Surveys are likely to underestimate the population if d/Deaf patients- the ICB has collected data that show that they received 878 requests for BSL interpretation provision from GP practices between October 2025 and June 2025 (multiple requests may have come from the same individual). Of these requests, most came from

Wandsworth (n=466), followed by Croydon (n=185), Sutton (n=72), Merton (n=68), Kingston (n=61), and Richmond (n=26). Wandsworth has a higher per capita d/Deaf population in its borough in part due to the presence of two Achieving Together care homes (Harding House and Huguenot Place) that serve d/Deaf residents as well as the Oak Lodge School, a specialist day school with residential provision for students aged 0-19 with hearing, speech, language, and communication needs.

BSL interpretation provision – state of the sector

There is a shortage of BSL interpreters locally and nationally. In London, there are an estimated 45,000 d/Deaf BSL users [13] but only 210 registered BSL interpreters [14]. There is also evidence that interpreters are leaving the sector more quickly than they are being replaced.

According to a 2015 national consultation by the Department of Work and Pensions with BSL interpretation providers and a separate consultation of the BSL workers' union, the reasons for the shortage include long and expensive training time (7 years on average) as well as deteriorating pay caused by interpretation agencies driving down fees, operating under 'framework agreements' that can result in unpaid interpreting hours, and asking interpreters to cover more of their travel costs. [15]

Nationally, all-language interpreting agencies, which offer BSL alongside foreign language interpretation, tend to win commissioning bids, as they can usually offer the most competitive rates. However, research by the Royal Academy for Deaf People suggests that freelance BSL interpreters tend to prefer to work for specialist d/Deaf agencies because they offer greater consistency and familiarity with patients or clients, and research from this charity and others also suggests that patients prefer interpreters from these agencies as they can offer wrap-around support. [16] Commissioning these smaller, specialised services may therefore help preserve the BSL workforce as well as provide a better service to patients. See recommendation 3B and case study 2 in this report for more information.

Our previous work

This project builds on our South West London-wide engagement on the implementation of the AIS in GP practices, conducted in partnership with local charities of/for Disabled people. [10] Through surveys, interviews, and focus groups with 144 d/Deaf BSL users and other people with a range of disabilities that affect communication, we found that awareness of the AIS was very low – 73% of patient and carers had never heard of it.

BSL users expressed deep dissatisfaction with Language Line, the BSL interpretation provider commissioned at the time in GP practices. Patients

reported frequent cancellations, long waits of up to two weeks, and poor communication about service changes. One participant also raised privacy concerns, noting that a small pool of interpreters served this relatively small community, though we do not know of any breaches of confidentiality.

Importantly, patients also identified accessibility challenges beyond interpretation services. These included practices failing to communicate in patients' preferred formats (for example, ringing a patient rather than using SMS or email), not providing information in plain English, and inconsistent adjustments in waiting rooms to alert patients when they were being called to be seen by the health provider (for example, some practices had a screen that display patients' names when it is their turn – which works well – while other practices verbally call in a patient without visual cues).

New BSL interpretation provider in South West London GP practices

Our 2024 engagement with BSL users concluded in September. The following month, South West London Integrated Care Board (ICB) rolled out DAL (formerly DA Languages) as the new provider of both BSL and foreign language interpretation across GP practices.

DAL's subcontractor, Sign Solutions, provides patients and carers with the following service (this is their routine offer and is not specific to South West London):

- pre-booked in-person interpretation
- on-demand video interpretation
- a video relay service to contact GP practices
- translation of documents into BSL.

Notably, on-demand video interpretation was not readily available under Language Line, though GP practices have been equipped with the technology to use video interpreting since the pandemic.

Distinctions between legal protections and needs of BSL users versus people who require foreign language interpretation

Although the ICB commissions DAL to deliver both spoken foreign language and BSL interpretation, it is important to recognise that the protections and needs of BSL and foreign language speakers are distinct.

Firstly, the legal context differs. The Equality Act and the AIS provide d/Deaf and deafblind people with specific rights to communication support, while foreign language speakers are not covered under these laws. [17]

In addition, according to SignHealth, a national charity that advocates and provides services for d/Deaf people's health and wellbeing, BSL users often have a greater need for in-person interpretation, as the language is partially expressed through 'non-manual features' like facial expressions that are much easier to communicate face-to-face (personal communication, 15 August 2025). The visual nature of the language also means that communication is more susceptible to interruption from internet connectivity issues, and patients cannot default to telephone interpretation or turning their cameras off to accommodate low bandwidth as they would with a foreign language interpreter.

That said, both groups share similar challenges in navigating health services, and both experience disproportionately poor outcomes. [18] [19] The NHS Constitution commits to "promot[ing] equality through the services it provides, focusing on groups where improvements in health are not keeping pace with the rest of the population." [20] Healthwatch advocates that all patients should have their communication preferences met. **We draw out the distinctions here not to undermine the needs of foreign language speakers, but to ensure that commissioning and service provision reflect the unique needs of both groups.**

Methods

Patient and Carer Engagement

We used a mixed-methods approach - combining surveys, focus groups, and an interview - to capture the experiences of d/Deaf and deafblind people who use BSL and their carers.

Survey

To maximise accessibility, the survey was available in both written English and BSL video formats. Information about the change in interpretation provider and the purpose of the study was uploaded to local Healthwatch websites (see an example here) and promoted through charities, local councils, and other organisations that serve d/Deaf people in South West London.

Participants were invited to share their experiences of the new service, either by completing a short online form or by submitting a video response in BSL. The survey ran from April to June 2025, 6-8 months after the rollout of the new interpreter provider. All respondents were asked to confirm that they were BSL users, or the carers of BSL users, who had accessed interpretation support through their GP practice since 1 October 2024. To encourage participation, eligible respondents were entered into a prize draw for a £50 gift card.

Focus Groups

We held two focus groups to gather more in-depth perspectives:

Achieving Together's Harding House (Wandsworth), 4 April 2025: A virtual session was conducted with staff from a specialist residential care home supporting 10 d/Deaf adults with a wide range of health needs. The group included both hearing and d/Deaf staff, with interpretation provided by a member of the care home team. While participation was not limited to those who had used the new interpretation service, the session focused on staff members' personal experiences of DAL's provision and their recent experiences supporting residents to access GP care.

Croydon, 4 June 2025: A community focus group was organised and promoted by the Royal Association for Deaf People (RAD). This group was specifically promoted to BSL users who had accessed the new interpretation service since October 2024. Consent forms were distributed by South West London Healthwatch staff, and interpreters worked with participants to ensure understanding. Participants each received a £15 gift card in recognition of their time. In line with agreed conditions, the session was not recorded.

Interview

We had a single patient interview with a person referred to us from a charity partner.

GP Practice Staff Engagement

To capture the perspectives of GP practice staff, we circulated a short survey across South West London GP practices, open from April – June 2025. The survey invited staff to reflect on their experiences of arranging or using BSL interpretation services through DAL.

In addition, we gathered feedback directly from practice managers through existing professional forums, including July and August 2025 manager meetings in Wandsworth and Sutton, respectively. Engagement also took place at the South West London Training Hub's "Hot Topics" GP Update event on 23 April 2025, where Healthwatch hosted a booth for GP practice staff to provide feedback.

Findings and recommendations

Case study 1

A charity partner connected us with a woman seeking support accessing an in-person BSL interpreter at her GP practice, which is located within the North West London ICB footprint. **While her experience occurred at a practice outside the South West London ICB,** we include her story as it illustrates the importance of allowing **patient choice** in accessing in-person or remote interpreting, even though NHS England guidelines do not require commissioners to provide both options. It also illustrates the importance of **double appointments** regardless of whether an interpreter is providing an in-person or remote service (this is already explicit within NHS England guidance, but not always done for remote provision according to our research). [1]

The patient told us that half the appointment was taken up just setting up for the interpretation call.

She was seeking care whilst wearing a splint on her arm, forcing her to sign one-handed and reducing her confidence that the interpreter, and therefore, her doctor, understood her. These communication challenges were compounded by internet connectivity issues.

She left the appointment understanding that she should take her tablets for two days. However, the instructions from her pharmacist differed – she was in fact prescribed the pills for one month - confirming her fears that that there was miscommunication during the appointment.

She told us that she would feel more confident that she had been understood, offered proper treatment, and was appropriately managing her own care if she could have accessed an in-person interpreter. The GP practice has listened to her concerns, but have said they are limited in what they can do as the North West London ICB only commissions online BSL interpretation.

Overview

In total, we heard from **39 people** with relevant experience of using BSL interpretation in South West London GP practices. These included:

- **21 patients and carers** through focus groups (We did not have any responses to the patient and carer survey)
- **17 GP staff** through surveys, practice manager meetings, and a training event
- **1 patient from North West London** whose story, though outside our target area, provided useful lessons for commissioning (see **case study 1**)

Key Messages from Patients and Carers

Patients and carers did not express a strong preference between DAL and Language Line. **Instead, they repeatedly emphasised their frustration with persistent language and communication barriers that they have been raising for years.** Many said that progress feels "stuck," highlighting that while improvements to interpretation are necessary, they must be matched by training and cultural change among GP practice staff to ensure consistent adherence to the AIS.

Compared with our 2024 engagement, there was **less focus on long delays** for interpreter appointments, possibly reflecting DAL's introduction of an on-demand video option. However, patients continued to report problems with:

- the reliability of interpreters
- lack of notification when interpreters cancel
- interpretation needs not being carried forward into referrals to secondary and tertiary care
- broader concerns about lack of compliance with AIS, including the need to constantly repeat communication needs and these needs not being met

GP Staff Perspectives

GP practice staff gave mixed views of DAL compared with Language Line. Some valued DAL's simpler booking system, while others raised concerns about reliability, especially for in-person interpreting. One staff member highlighted DAL's flexibility in enabling a patient to see the same interpreter consistently, which was seen as good practice.

Using our recommendations

From these insights, combined with patient-centred evidence from national research and guidance, we have developed a set of recommendations.

The recommendations are divided into two sections. **Section A** describes priorities for improving BSL provision and overall accessibility across ICB services, and **section B** is specifically for commissioners of BSL interpretation services. *A separate, related report has also been published with recommendations for GP practice staff.*

Our **target audiences** include anyone at the South West London ICB who can help instil a d/Deaf aware culture throughout the organisation and its provider organisations, including, but not limited to:

- those in leadership positions (Recommendation A1);
- teams leading health improvement and health equity initiatives (A1, B1);
- those working to improve information sharing, and collaborative commissioning between primary, secondary, and tertiary care (A2, B3);
- patient engagement and communication professionals (overall engagement with people with lived experience, B6, B12);
- commissioners of BSL interpretation service across the ICB footprint, especially, but not limited to, those in primary care commissioning (all of section B)

Crucially, any changes to commissioning should be developed and iterated in collaboration with local people with lived experience, and with attention to the impact on the local BSL interpreter workforce. d/Deaf and deafblind people told us they want to be directly involved in shaping services. However, their views are often mediated through interpreters or third parties, creating a risk of distortion. Commissioners should establish direct routes for BSL users to engage with decision-makers, using BSL interpreters as appropriate. For as long as we continue to operate, Healthwatch and d/Deaf and deafblind charities can facilitate introductions and co-design processes that respect Deaf culture and communication needs.

A. Recommendations for commissioners and leadership working across provider organisations

The following recommendations aim to create a d/Deaf and deafblind-aware culture across the South West London ICB and to help provide continuity of BSL services across the patient journey.

1. Ensure Delivery of the Updated Accessible Information Standard

The June 2025 update to the Accessible Information Standard (AIS) increases commissioner responsibilities (see section 'The role of commissioners'). [1] ICBs are themselves subject to the Standard and must ensure that all organisations they commission comply. This includes embedding AIS requirements into procurement processes, service specifications, and provider contracts. According to the update, commissioners should also ensure that each NHS organisation identifies an AIS lead and that board-level accountability for compliance is explicit (see section 'Implementing the standard: an overview').

2. Improve sharing of communication needs across providers

Sharing communication needs with other providers is a key step in implementing the AIS. As a result of not sharing communication needs upon referral, patients in South West London and nationally said that they often arrive at hospital appointments to find no interpreter present, and must either cancel their appointment or rely on a family member or carer. [21]

We are aware that a 'reasonable adjustments' flag was introduced in South West London GP practices' electronic medical systems in December 2024 to help address this issue, but as of spring 2025, acute hospital staff told us that the IT had not been set up to receive this data. Are there plans to address this promptly, if not done so already? The ICB may also consider how else information sharing about patient and carers' communication needs can be improved.

B. Recommendations for BSL Interpretation and Translation Service Commissioners

National research, as well as our own engagement with d/Deaf and deafblind BSL users, their carers, and GP staff emphasised ways for commissioners to ensure interpretation services are reliable, equitable, and responsive to patient needs.

Collectively, the intention of these recommendations is to:

- highlight what aspects that are important to patients and carers are already in place in South West London GP practices, and how these can continue to be improved
- identify needs of patients that are not currently being met
- identify where to monitor performance rigorously
- inform equality impact assessments

- emphasise the need for continuous engagement with d/Deaf and deafblind people

Our recommendations should be **consulted alongside** NHS England's Guidance for Commissioners: Interpreting and Translation Services in Primary Care (2018) [17] and NHS England's Accessible Information Standard Implementation Guidance (2025) [22].

As we are aware that the South West London ICB primary care commissioning team primarily uses NHS England's 2018 guidance to inform BSL interpreting procurement decisions [17], we have created a table in the **Annex** to compare our recommendations with this guidance.

As noted earlier, while these recommendations were developed primarily with primary care interpretation commissioners in mind (given the focus of our research on experiences in GP practices), we believe that commissioners in acute and mental health trust settings will also find them useful.

Our recommendations are:

1. Include d/Deaf and deafblind people on BSL interpretation procurement panels and seek their views when conducting equality impact assessments and reviewing the quality of the service

Direct patient engagement will help ensure that services procured are accessible and meet people's needs. We also learned from our work on this project that many people with lived experience are keen to support work to make health services more accessible.

2. Continue to maintain and strengthen infrastructure for video interpreting

We understand that South West London ICB has already made significant progress to ensure quality infrastructure for video interpreting. However, there may be some areas for improvement:

- According to practice managers, some clinicians lack confidence using video interpreting equipment during physical assessments, and require further training.
- Patients emphasised the importance of large, clear screens to understand BSL. (We did not hear any complaints about screen size specific to GP practices, but we would encourage commissioners to consider whether such screens are widely available.)
- Bandwidth and screen-freeze issues remain a concern in GP practices in South West London and nationally. [8]

The ICB should support practices to address these challenges by continuing to invest in equipment upgrades, clinician training, and backup internet solutions (e.g., secondary routers, mobile hotspots). Importantly, this equipment should continue to accommodate movement around the examination room, for example, when a patient requires a physical examination (a shortcoming that was identified nationally [8], though we did not hear specific complaints about this in our South West London sample).

3. Consider collaborative models of commissioning that provide interpretation service across South West London ICB

In South West London, there are different commissioners, and different service providers, for primary care, mental health, and acute trust providers.

National research suggests that commissioning at the ICB footprint level increases patient satisfaction, especially when patients can access the same interpreter across their care pathway. **Case study 2** provides an example.

Of note, UCLPartners is currently recruiting ICBs in London to participate in a pilot of an ICB-wide, in-person BSL interpretation provision model, and commissioners may wish to contact the project manager to learn more: (elizabeth.graham@uclpartners.com).

In addition, commissioners may wish to consider procuring BSL-specific interpretation services to complement their existing offer, particularly those that offer enhanced social support for d/Deaf people. Procuring such services can also help preserve the BSL workforce as evidence shows interpreters tend to prefer to work at such organisations (see 'BSL interpretation provision – state of the sector' above), and the increased investment in services that provide wrap-around support and advocacy may be offset by decreases in health costs resulting from communication lapses. [8] [21]

4. Continue to offer patients the option of in-person or remote interpretation

We understand from conversations with the South West London ICB that there is tension between providing patients with unrestricted access to face-to-face interpreting and reducing wait times for an interpreter and managing costs. GP practice managers told us that the ICB has recently instructed them to begin limiting the availability of in-person provision across BSL and foreign language interpretation, with in-person provision 'triaged' at the discretion of the provider.

The case for triage

The rationale for this change is pragmatic. The ICB told us that providing in-person interpreting means that interpreters spend time travelling that could otherwise be spent supporting additional patients remotely – helping to reduce wait times. It is also much less expensive, as travel costs do not need to be

reimbursed. Given interpreter workforce shortages, maximising the availability of individual interpreters is important, and a remote option also means that interpreters who live far from South West London can offer services, adding to the pool of available staff and addressing any confidentiality concerns among the tight-knit Deaf community about sharing the same medical interpreters.

The case against triage

Despite the advantages of remote interpreting provision, we and others have found that most patients prefer in-person interpreting. Experts tell us that BSL is a 3D language that loses nuance over video. [21][personal communication with SignHealth, 15 August 2025] Poor internet connectivity can also cause misunderstandings (see **case study 1** presented in this report, as well as case studies captured on page 35 of SignHealth and RNID's 2025 report [8]). In addition, reliance on remote interpreters – particularly from large multi-language interpretation companies like DAL- could unintentionally drive further decreases to the BSL workforce (see 'state of the sector' section above). **Overall, the consensus is that remote interpreting can be an excellent option for urgent medical needs** [23]**, but is particularly inappropriate for sensitive conversations and face-to-face procedures and is extremely vulnerable to technological glitches.**

Furthermore, national NHS England guidance does not align with the ICB's directive to practice managers. Within its 2025 AIS implementation guidance, NHS England specifies that "remote services [for d/Deaf people] are not a total replacement for face-to-face interpretation or communication support and may not be appropriate in some circumstances (for example, longer appointments). Where possible, and for routine care, **individuals [rather than providers]** should be given the option of remote or face-to-face interpretation." [22]. In addition, while NHS England's language interpretation commissioning guidance does not specify which interpretation formats must be offered, it does state that "On registration with a primary care service (or subsequently if their needs change), patients requiring language support should be made aware of the different types of interpreting available to them (e.g. face-to-face, telephone, video remote interpreting / video relay services)" – suggesting again that patients should be involved in choosing their preferred format. [17]

What can the ICB do to protect its resources and patients?

- **Procure a specialist BSL service**, either in future procurement cycles or to complement current provision by DAL, to help secure the availability of more in-person interpreters. Typically d/Deaf-led, these organisations tend to attract high numbers of freelance BSL providers (see recommendation 3B, **case study 2**, and 'BSL interpretation – state of the sector' sections of this report)

- **Patient-informed triage**. For the reasons described above, Healthwatch does not endorse that providers triage in-person interpreters.

  However, if the ICB is committed to moving towards increased remote interpreting, they should be aware that the evidence points to situations where in-person interpreters are most needed: longer appointments [22], virtual appointments with digitally excluded people [16], mental health appointments, and any appointment where unfavourable news or prognoses are communicated [8].

  The setting of the appointment may also inform triage decisions. National research shows that patients feel that remote interpreting generally works better for virtual compared to in-person appointments. Part of the reason for this is that it can be cumbersome to move screens around to follow the patient and provider where a physical examination is taking place. [8]

  Finally, the practicalities of how providers can make an informed decision about triage need to be considered. As noted elsewhere in this report, d/Deaf and deafblind people do not always have proficiency in written English, and may not be able to communicate their needs effectively to GP staff. One patient, for example, told us that she struggled to articulate her health concerns on the online triage portal to access GP appointments because of her lack of English proficiency, and worried about whether this led to her being deprioritised for faster appointments. In-person versus remote triage decisions would similarly be vulnerable to variability in the patient's English proficiency. A video-relay BSL call with patients before allocating an in-person or remote interpreter – or another preferred type of communication channel that the patient specifies, such as text message or Braille - might help these patients better communicate their reasons for accessing care, which may in turn better-inform interpretation triage decisions.

5. Ensure timely access to qualified interpreters

From our conversations with service users, progress seems to have been made under DAL, with fewer reports of long waits compared with Language Line. Given our small sample size, however, we are unsure if this experience is representative of that of the wider South West London BSL user population. Commissioners should monitor waiting times and ensure BSL users receive care as promptly as hearing patients.

6. Communicate to providers about the value of – and option to offer – continuity in interpreter provision

Patients and carers in South West London and nationally emphasised the value of seeing the same interpreter over time, which helps build trust and confidence

as well as familiarity with each d/Deaf and deafblind person's unique style of communicating. [8] [21] In our survey, GP practice staff also described at least one successful case where DAL accommodated such requests.

NHS England's commissioning guidance Principal 4.3 aligns with this recommendation, stating that "Good practice indicates that where a patient requires continuity of care, systems are in place to enable them to access the same interpreter where this is practicable." The guidance also says that "Such continuity is likely to be particularly important where an individual is undergoing particularly invasive, intensive or sensitive procedures / courses of treatment, including care relating to pregnancy, maternity or sexual health, radio- and chemotherapy, end of life care and when accessing mental health services." [17]

We understand from conversations with the South West London ICB, that DAL cannot be contractually obligated to meet these requests. Nevertheless, we recommend communicating to GP staff that they can submit them.

7. Commission specialist relay interpreters

The carers at Harding House, which routinely work with d/Deaf people with intersecting disabilities, stressed that without specialist relay interpreters, patients are excluded from effective communication.

Relay interpreters play a vital role for d/Deaf people with certain conditions or disabilities that impact BSL communication (e.g., dementia, learning disability, movement disorders). They exist because English-BSL interpreters are hearing people who usually have learned BSL as a second or third language. Because of this, an English-BSL interpreter may struggle to translate for patients who have conditions that make it difficult for them to understand or well-articulate themselves in sign language. A relay interpreter, on the other hand, are often deaf and have native fluency in BSL and Deaf culture. When a relay interpreter is involved during interpretation, there are often four people in the conversation – the patient, who communicates directly to the relay interpreter, who in turn signs to the English-BSL interpreter, who then translates sign language into English for the health provider.

Commissioners should ensure that relay interpretation is available, and that booking routes are clear to GP practices. While we have not vetted any providers ourselves, the carers signposted to Remark! and the Royal Association for Deaf People as providers of these specialist interpreters, and the ICB may wish to consider exploring these options further.

8. Continue to guarantee access to tactile or manual interpreters for deafblind patients and make sure practices are aware how to access these specialist interpreters

The two deafblind people we spoke with, as well as our colleagues at the charity Deafblind UK, stressed the importance of having access to tactile interpreters, specialists who communicate by signing into people's hands. The ICB has confirmed that people have access to this service. If not yet available, commissioners should require providers to maintain a roster of qualified tactile interpreters; we are aware of charities such as Remark! and Action Deafness that provide this service, but have not evaluated these services ourselves.

9. Improve service reliability through enhanced communication with patients and monitoring of interpreter bookings

South West London patients and staff reported cancellations with little or no notice, a concern that is also shared nationally, with 80% of BSL users saying they have experienced their interpreter not turning up despite being booked. [8] Practice managers in Wandsworth and Sutton noted that interpreter reliability was an issue for both BSL and less commonly spoken foreign languages. One practice manager expressed concern that DAL contacts only the specific member of the team who booked the interpreter rather than the general practice email, leading to delays in notifying the patient about the change.

To address this, patients in South West London and nationally **expressed that they want access to an online platform to book interpreters directly**, with 84% in the national sample saying that this would increase their confidence that an interpreter had been successfully booked. [8] A November 2025 report from the government's BSL Advisory Board also listed giving BSL users greater control over booking an interpreter as a top priority for improving NHS and social care accessibility for BSL users. [2]

The UCLPartners model noted above provides this option to patients. In addition, as an interim fix, practices would benefit from instructions to provide a generic practice email, rather than the email address of a specific member of the team, to facilitate faster communication between the interpretation provider and patients when availability changes. Commissioners might also consider exploring whether patients are routinely offered on-demand remote interpreting when an in-person interpreter cancels.

10. Commission written English to BSL translation services (if not already commissioned)

Nationally, only 4% of BSL users have ever been offered written information translated into BSL. [8] While the Accessible Information Standard guidance clarifies that translated materials do not have to be available on-hand,

commissioners should ensure that providers can offer translated materials upon request, particularly for key clinical information for people who are not proficient in written English, and promote awareness of the availability of this service among GP practices.

11. Continue to commission human (rather than AI) interpreters

We were asked by the ICB if AI interpreters were a viable option. As SignHealth's AI Policy (unpublished) advises, technology cannot yet capture the non-manual features of BSL or provide the human interaction essential to safe and person-centred care. Commissioners should avoid substituting human for AI interpreters for clinical interactions or to translate documents until updated national guidance states otherwise.

12. Communicate service changes directly to patients

Patients told us they had not been informed by the NHS about the switch to DAL. This gap created uncertainty and frustration. d/Deaf and deafblind people said they would welcome clear communications about such service changes, ideally using multiple channels (e.g., letters, leaflets, SMS, WhatsApp, braille (for deafblind people)). Commissioners should ensure communication plans are part of any service transition.

13. Require visible interpreter identification

Patients stressed that interpreters should wear ID at in-person appointments. Visible identification reassures patients that interpreters are qualified and regulated. Commissioners should set this as a standard expectation in contracts with interpretation providers.

Case study 2

NHS England commissioned a rapid review published in July 2021 that aimed to improve the quality and consistency of BSL interpreting provision across the country, informed by conversations with d/Deaf BSL users. **Their overarching recommendation was that each ICB establish consistent provision across primary and secondary care through a single BSL service, selected in consultation with BSL users.** The Gloucestershire Deaf Association (GDA) was highlighted as an innovative and effective interpretation provider. We reached out to their team and provide an updated description of their service below:

The GDA is a charitable organisation that offers essential emotional and practical support to d/Deaf, hard of hearing, and deafened individuals across Gloucestershire. A key part of GDA's approach is their comprehensive, person-centred support model. This includes services like hearing aid maintenance, advice on assistive listening devices, employment support, and social activities aimed at reducing isolation.

They also provide BSL interpreter support to primary care providers, local hospitals, mental health services, and the Gloucestershire ICB. GDA ensures interpreter access 24/7, including same-day requests, through in-person interpretation. They can accommodate BSL users' personal preferences such as interpreter gender. Their service complements the remote interpretation option provided in Gloucestershire through the NHS' Attend Anywhere platform.

According to GDA, their strong relationships with BSL users help ensure the success of their programme, providing a holistic approach that meets the communication, practical, and wellbeing needs of their service users.

Best practice key points (as highlighted in review): • Responsive interpreting service offering round-the-clock access to support, including same day requests • BSL interpreting provision that cuts across primary, secondary, and tertiary care • Offer a holistic model of support • Strong, local relationships with BSL users

Conflicts of interest

There are no known conflicts of interest with BSL interpreter providers. We did not use DAL to interpret any of the conversations that informed this report. Evidence for preference for in-person interpretation – which we understand may be preferred by BSL interpretation companies because of better pay compared to online provision – was drawn from organisations and experts by lived experience that do not offer interpretation services in GP practices.

Limitations

Our sample size was relatively small, especially for deafblind people (n=2), and therefore may not reflect the range of experiences of BSL users in South West London. Our findings, however, are corroborated by national research and guidance that lend confidence to our results.

The focus of this project was on the experience of the BSL interpreter service, concentrating our insights on a narrow part of the patient journey. While we have contextualised our findings with broader patient experience data from our previous AIS work and national studies, our recommendations may not fully address all the challenges that d/Deaf and deafblind BSL users encounter when accessing GP care. As noted in the 'Executive Summary' section of this report, BSL interpretation is just one adjustment that d/Deaf, deafblind, and hard of hearing people might require.

Summary

This report captures the continued frustrations and communication barriers that BSL users face when accessing GP practice care in South West London, despite the change in BSL interpreter service provision. By implementing the resulting recommendations arising from patient, carer, and provider insights, South West London ICB commissioners and GP practice staff can create a safer, more equitable experience and better align with the requirements set out in the AIS. Moreover, they can collectively begin to address the health inequalities long experienced by d/Deaf, deafblind, and hard of hearing people, ultimately leading to cost savings for the system.

While the government has announced plans to close Healthwatch around the country, we still do not have a firm timeline for these closures. We hope to

continue to be a partner in implementing these improvements for as long as we operate, linking the ICB and practices with experts by experience for continued consultation and support with co-designing service improvements.

About the authors

South West London Healthwatch is a collaborative of six independent local Healthwatch organisations (Healthwatch Croydon, Merton, Kingston, Richmond, Sutton and Wandsworth). Since 2022, they have collaborated to gather insights across the Integrated Care System's footprint in South West London, to ensure that people have a voice in NHS decision-making. The lead officers of each of these organisations played a consultative role on this project.

Alyssa Chase-Vilchez, South West London Executive Officer, led the research, wrote this report and conducted the engagement with carers and GP practice staff. Questions can be sent to Alyssa at info@healthwatchsutton.org.uk.

Iyinoluwa Oshinowo, South West London Engagement Officer, created the patient and carer survey. Andrew McDonald, Healthwatch Sutton Health Engagement Project Officer and Jeet Sandhu, Healthwatch Croydon Communications Lead, co-facilitated the Croydon focus group.

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Annex

Table 1 – Comparison of our recommendations in section B with NHS England's 2018 guidance for primary care commissioners of language translation and interpreting

Recommendations in Section B	Direct or partial equivalence in 2018 Commissioner Guidance	Assessment and Details
1. Include deaf and deafblind people on BSL interpretation procurement panels and seek their views when conducting equality impact assessments	Principle 8	The 2018 guidance emphasises quality assurance and continuous improvement through user engagement generally (Principle 8), but does not explicitly recommend including deaf and deafblind people on *procurement panels* or specifically seeking their input for *equality impact assessments*.
2. Continue to maintain and strengthen infrastructure for video interpreting	No equivalent.	The 2018 guidance recognises video remote interpreting / video relay services as a type of interpretation that can be made available to patients (Principle 3.3), but does not specify infrastructural needs to provide this.
3. Consider collaborative models of commissioning that provide interpretation service across the ICB footprint	Principle 4.3	The rationale for these models, is, in part to promote continuity of care. Principle 4.3: Personalised Approach of the 2018 guidance states that "Good practice indicates that where a patient requires continuity of care, systems are in place to enable them to access the same interpreter where this is practicable". It further notes that such continuity is particularly important for invasive, sensitive, or intensive procedures, including maternity, sexual health, radio- and chemo-therapy, mental

		health services, and end of life care.
4. Continue to offer patients the option of in-person or remote interpretation	Principles 3.3 and 4.2	The 2018 guidance states that patients requiring language support should be made aware of the different types of interpreting available to them, including face-to-face, telephone, video remote interpreting, and video relay services (Principle 3.3). It also notes that special circumstances may necessitate one form of interpretation over another, such as always having a face-to-face interpreter (Principle 4.2).
5. Ensure timely access to qualified interpreters	Principle 3	Principle 3: Timeliness of Access in the 2018 guidance explicitly states that patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access to primary care services.
6. Communicate to providers about the value of – and option to offer – continuity in interpreter provision	Principle 4.3	Principle 4.3: Personalised Approach of the 2018 guidance states that "Good practice indicates that where a patient requires continuity of care, systems are in place to enable them to access the same interpreter where this is practicable". It further notes that such continuity is particularly important for invasive, sensitive, or intensive procedures, including maternity, sexual health, radio- and chemo-therapy, mental health services, and end of life care.
7. Commission specialist relay interpreters (not in 2018 commissioning guidance)	No equivalent.	As our report describes, relay interpreters are crucial for deaf people with conditions impacting BSL communication (e.g., dementia or learning disability) as they bridge the communication gap between the patient and the English-BSL interpreter.

8. Continue to guarantee access to tactile or manual interpreters for deafblind and make sure practices are aware how to access these interpreters	No specific equivalent.	While the 2018 guidance requires commissioners to consider what support is in place for deafblind people (1.1.3) and signposts to 'The national registers of Communication Professionals working with Deaf and Deafblind people,' it does not specify the need to provide tactile or manual interpreters.
9. Improve service reliability through enhanced monitoring and communication with patients about interpreter bookings	Principle 8 and section 1.1.5	Principle 8: Quality Assurance and Continuous Improvement requires monitoring of service performance, including checks to ensure appointments are being kept (8.2). In the Commissioning and contracting considerations section, the guidance also requires monitoring missed appointments and reasons (1.1.5). The BSL report expands on this by recommending commissioners require providers to report BSL cancellation rates specifically (not pooled with foreign languages), track advance notification procedures, and establish penalties for failures.
10. Commission written English to BSL translation services	Principle 7	Principle 7: Translation of documents covers the need for documents to be available in appropriate formats (e.g., BSL videos or braille for deafblind people) upon request, at no additional charge to patients. Organisations are not required to have 'stocks' of information on hand, but need a process for obtaining materials upon request.
11. Continue to commission human (rather than AI) interpreters	Principle 7	The 2018 guidance advises against using "Automated on-line translating systems or services such as 'Google-translate'" because there is no assurance of translation quality (Principle 7.7).
12. Communicate service changes directly to patients	No explicit equivalent.	The 2018 guidance focuses on making patients aware of

		available services (Principle 3.3), but it does not contain a specific principle or instruction requiring commissioners to ensure communication plans are in place to inform patients directly about major service transitions, such as a switch in interpretation providers.
13. Require visible interpreter identification	No explicit equivalent.	The 2018 guidance covers professionalism and requires interpreters to introduce themselves and explain their role (Principle 5.10), and it mandates that interpreters must be registered and undergo appropriate checks (Principle 5.1, 5.2). However, the guidance does not explicitly require interpreters to wear visible identification.

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