Living with sensory loss in Lincolnshire Engagement and survey report_FINAL

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Introduction

Sensory impairment affects people of all ages across Lincolnshire. National and local evidence shows that sight loss, hearing loss and dual sensory loss can increase the risk of reduced independence, social isolation and poorer wellbeing if services are not accessible.

Previous engagement activity across health, care and community services has highlighted ongoing barriers for people with sensory loss, including difficulties accessing appointments, communicating with services, and navigating health and care environments.

In response, Lincolnshire Integrated Care Board (ICB), Lincolnshire County Council (LCC) and Healthwatch Lincolnshire (HWLincs) worked collaboratively to develop a clearer, shared understanding of these experiences, with the aim of identifying opportunities to improve accessibility, consistency and inclusion across the system

Why We Decided to Collaborate on This Work

- **We were all hearing similar concerns** from people with sensory impairments across multiple engagement activities and recognised the need to bring these insights together into a more coordinated picture.
- **We wanted a deeper understanding of lived experience**, beyond existing reports and complaints data, to understand the day-to-day reality of accessing health and care services with sensory loss.
- **Sensory impairment affects many parts of the system**, so a joined-up approach was essential to identify barriers and solutions that apply across NHS, public health, social care and community services.
- **Inclusive engagement requires a wide range of skills and approaches** – our approach was to offer a range of formats to broaden reach and accessibility.
- **Reaching under-represented communities** needed collaboration with voluntary groups, community champions and organisations already supporting d/Deaf, blind, partially sighted and deafblind residents.
- **Partners share legal duties** under the Accessible Information Standard, making collaboration essential for understanding where improvements are needed and ensuring consistent practice across services.
- **Working together supports system-wide recommendations**, enabling one shared set of insights that can shape service improvement across the ICB, County Council and voluntary sector.

Introduction

This report presents the findings from a **nine-week programme of engagement activity** carried out between **16 January and 24 March 2026**.

The purpose of this engagement was to gather insight from **people living with sensory loss**, as well as from their **families, carers, and the service providers** who support them to access health and care services in Lincolnshire. The report aims to:

1. Provide an overview of the engagement activities undertaken, including survey responses and conversations held within local communities.
2. Reported into the DLN Cluster ICB (ICB) and Quality, Risk & Review Board at Lincolnshire County Council (LCC) for review and consideration.

The engagement activities were designed to explore and better understand people's experiences of accessing health and care services while living with sensory loss, or supporting someone who does. Feedback was gathered from people, carers, family members, and professionals across the system, with the shared aim of improving the quality of care, treatment, and advice available.

All feedback has been analysed across different population groups and equality characteristics. Where notable differences or themes emerged, these have been highlighted throughout the report.

- 322 survey responses
- 4 telephone interviews
- Visited 11 community groups
- Attended one online meeting
- Spoke to 150 people with sensory loss
- Combined social media reach of XXXXXX
- 60 people signed-up to help in other projects
- 28 people willing to share their whole journey

Executive summary

- Between 16th January until 24th March, NHS Lincolnshire ICB, the County Council and HW Lincs carried out extensive engagement work to better understand the challenges people with sensory loss face when accessing health and care services.
- The aim was to gather insights from individuals with lived experience, their carers and families, and the professionals who support them. These insights will guide future service improvements and help remove barriers. A nine-week programme of engagement, combining a public survey and in-depth community conversations, gathered insight from people living with **sight loss, hearing loss, Deafness and Deafblindness**, as well as carers and advocates across Lincolnshire.
- The survey received **182 completed responses – with additional 140 partial completions,** which can be common for these type of surveys that are distributed through broad community channels. While community conversations reached **around 150 people** through local sensory groups, voluntary organisations and community settings across rural, coastal and urban areas.
- Across both strands of engagement, a consistent message emerged: **people value the care they receive once they access it, but the system makes access too difficult**. The most significant barriers occur at the **front door of services**, particularly when booking appointments, navigating primary care, and communicating with services in accessible ways. These barriers are driven by system design and inconsistency rather than individual need.
- The survey showed that **60% of respondents do not find it easy to access the health or care support they need**, with booking appointments more challenging than attending them. Communication difficulties, reliance on phone-based systems, inaccessible digital platforms and lack of choice were recurring issues. Experiences varied by sensory group, with Deaf, Deafblind and partially sighted respondents reporting the greatest barriers.
- Community conversations brought this data to life, highlighting the **cumulative impact of repeated everyday barriers**. People described how missed calls, inaccessible letters, confusing buildings and having to repeatedly explain their needs reduced confidence over time, leading some to delay or avoid care altogether. Reliance on family members or carers was often described as necessary rather than preferred, with impacts on independence and dignity.
- Both the survey and conversations highlighted **uneven awareness and use of sensory and voluntary sector support**, particularly Lincolnshire Sensory Service, despite strong evidence of the positive difference these services make when accessed. Good practice was evident, but often linked to individual staff rather than consistent system design.

What the engagement tells us….

Headlines
• Across services, people with sensory loss are not consistently recognised, recorded or responded to, resulting in avoidable exclusion, delayed care, and loss of independence. These barriers are systemic rather than individual and persist despite the Accessible Information Standard.
• Several examples raised potential safety and safeguarding concerns, including miscommunication about treatment, inability to understand medication instructions, and reliance on family members in confidential clinical discussions.
• Despite awareness of the Accessible Information Standard, community and survey feedback indicates inconsistent implementation across services, with accessibility adjustments often dependent on individual staff rather than embedded systems.
• Digital barriers were driven less by lack of digital capability and more by systems that were not designed or tested with people with sensory loss in mind.
• Barriers described in this report have direct implications for timely diagnosis, treatment adherence, and long-term independence, increasing demand on carers, social care and urgent services.
• Where services worked well, common features included proactive staff support, clear communication choices, consistent recognition of needs, and environments designed with sensory accessibility in mind. These examples demonstrate that improvement is achievable within existing systems.

Previous insight heard by HWLincs

Healthwatch Lincolnshire visited and engaged with approx. 120 people with sensory loss at the following locations and groups

- Lincolnshire Sensory Service Groups in Boston, Horncastle, Lincoln, Sleaford and Grantham
- Macular Degeneration Support Groups in Boston and Spalding

Through these visits Healthwatch Lincolnshire engaged with people with sensory loss and confirmed that people continue to face significant barriers when accessing and using health and care services, despite the Accessible Information Standard and its 2025 update.

Three key themes emerged from the feedback: **access**, **communication**, and **lack of reasonable adjustments**.

- Many individuals reported limited or unsuitable options for contacting services—such as GP practices offering only telephone or only digital routes—making booking and attending appointments difficult.
- Transport challenges and particular problems accessing NHS dental services were also highlighted, with examples of services not accommodating assistance dogs or failing to provide interpreters.
- Communication barriers were common, including failure to book British Sign Language interpreters, assumptions around lip-reading, refusal to provide information in accessible formats, and staff speaking to carers rather than the person.

A lack of practical and procedural adjustments further compounded these issues. People described difficulties when medication was not provided in blister packs, when equipment or home adaptations were unsuitable, and when clinical processes did not account for sight or hearing loss—for example, calling people in by voice or asking individuals with vision loss to check for visible symptoms.

Despite these challenges, positive experiences showed what good practice looks like:

- use of language line and pictorial aids,
- staff adapting communication styles,
- flexible approaches to assistance dogs,
- and the valued support offered by the Lincolnshire Sensory Service.

These examples suggest that with appropriate adjustments, consistent communication support, and increased staff awareness, services can significantly improve the experience and independence of people with sensory loss.

Find the full report here - What is it like using health and care services when you have sensory loss?

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Previous insight heard by ICB (2020-2025)

NHS Lincolnshire Integrated Care Board

Over the past five years, engagement with people with sensory impairments has consistently shown that barriers to care are **system-wide, not personal**.

Accessing appointments remains a major challenge, particularly at GP practices and hospitals

- Telephone-first models, rigid booking times (e.g. 8am calls), long waiting times, cancellations, and inaccessible online systems frequently exclude people with sensory loss
- Systems often exclude people who cannot rely on audio, visual, or digital-only routes
- Many people report having to attend in person to book appointments, or rely on others to do so on their behalf

Communication barriers are persistent and widespread

- Deaf and hard-of-hearing people are disadvantaged by phone-based systems, lack of interpreters, and verbal-only communication
- Staff continue to use inaccessible communication methods despite preferences being recorded
- People with sight loss report inaccessible letters, forms, and digital content, and inconsistent provision of large-print or screen-reader-compatible information
- Many people say they must repeatedly explain their needs, even when these are recorded

Transport and location compound access issues, especially in rural areas

- Long travel distances, poor public transport, clinics not aligned with bus routes, and reliance on expensive taxis
- Barriers increase further where escorts or interpreters are also required

Many people rely heavily on family members or carers

- Support is often needed to navigate the system, including booking appointments, communicating with services, travelling, and advocating for needs
- Without this support, some people feel unable to access care at all

Health settings and service design are often not sensory-aware

- Issues include poor signage and instructions, difficulty locating clinics, lack of working hearing loops, unsuitable lighting or acoustics, and verbal-only calling systems
- Staff do not always read or act on recorded access needs

Key message across all insight

- These challenges reflect how services are designed and delivered, not people's abilities
- Where services are flexible, inclusive, and sensory-aware, barriers are significantly reduced

Examples of what we heard….

Trying to book an appointment feels like hitting a wall. You're told to call at 8am, but if you can't use the phone, you're already excluded. Online systems don't work for you, appointments are gone in minutes, and you're left waiting weeks or months.
Communication is exhausting. You say again and again that you're Deaf or visually impaired, but it doesn't stick. People still phone you, still speak while masked or turned away, still send letters you can't read. It makes you feel invisible.
Getting there can be just as hard. Clinics are far away, buses don't line up, taxis cost too much, and if you need someone to come with you, it's even harder to make it work.
You end up relying on family or carers—not because you want to, but because without them the system is almost impossible to navigate on your own.
Sitting in a waiting room and waiting to be called in; clinicians stand and shout your name – "it is terrifying – what if I miss my turn"
None of this is about what you can or can't do. It's about services that aren't designed with you in mind—until someone listens and makes small changes, and suddenly things feel possible again.

Section 1

Overview of engagement activities and promotion

Overview of engagement activities

This section describes the engagement activities undertaken for the Sensory Loss engagement project. An online survey and community visits were carried out throughout the period of 16th January until 24th March. The survey was open for 8 weeks from 16th January and was available via the ICB website or through a direct link to the survey which was promoted through the leaflet and on social media. HWLincs and the County Council supported the ICB with promotion of the survey.

Distribution and engagement activity

Engagement and distribution activity for this work was led and coordinated by **NHS Lincolnshire Integrated Care Board (ICB)**, with a primary focus on reaching people with lived experience of sensory loss.

The ICB undertook **extensive and targeted engagement activity**, including:

- County-wide promotion via **ICB engagement bulletins, primary care bulletins, staff communications, and provider trust channels**
- Direct distribution through **ICB digital communications**, including websites, email campaigns, and social media platforms
- Sharing content through **ICB social media channels** to widen reach and encourage participation
- Direct distribution to a wide range of community, voluntary, equality, and sensory-specific organisations
- Targeted outreach to groups supporting people who are blind or partially sighted, Deaf, deaf or hard of hearing, and deafblind
- Focused engagement sessions were arranged and attended at established sensory support groups across Lincolnshire
- Direct engagement with specialist organisations such as RNIB, RNID, local blind societies, sensory services, carers' organisations, and community groups

This approach enabled sustained and repeated promotion of the survey over the engagement period, combining **digital, social media, in-person, and network-based routes** to maximise reach, accessibility, and participation.

Lincolnshire County Council (LCC) supported distribution through **existing internal and external communications channels**, including newsletters, stakeholder emails, and **corporate digital and social media channels**. This support focused on communications activity rather than targeted or facilitated engagement with sensory impairment communities.

HWLincs promoted the survey through their digital communication channels, contributing to awareness-raising and enabling seven respondents to complete the survey.

Overall, the **ICB-led engagement approach**, which included face-to-face conversations alongside digital and social media promotion, **supported meaningful engagement** with sensory impairment communities and participation in this work.

Our combined reach

The survey was regularly promoted by the ICB through various channels including:

- Featured in four editions of the NHS Lincolnshire ICB engagement bulletins which was distributed to nearly 11,000 contacts (on each occasion) on the ICB engagement team's stakeholder database
- Published in 5 Primary care bulletins and promoted on the Primary Care intranet
- Promoted 8 times on Nextdoor - the total reach of the NHS Lincolnshire ICB Nextdoor account is 110,269 members spanning across 471 ‘neighbourhoods’. Total number of impressions was – 67973 - highest post reach – 12 March 26 with 3744.
- Shared across NHS Providers’ member databases and staff networks
- Targeted social media promotion.

The staff survey was also circulated directly to Primary Care, stakeholders associated with sensory services and other partners such as the Lincolnshire Resilience Forum.

Audience	Distribution
Staff and internal	LCHS (2,630 via staff bulletin) ULHT (10,000 via staff intranet) LPFT (shared via staff intranet) NHS Lincolnshire ICB (420 via Team Talk News and staff Facebook) GPs and Primary Care via the Primary care bulletin (approx. 650) Patient participation groups
Provider memberships	ULHT Newsletter —12,000

Audience	Distribution	
Voluntary Organisations / charities	Age UK Lincoln and S Lincs Age UK Lindsey Alzheimer's UK Active Lincolnshire YMCA Healthwatch LIVES Lincolnshire CVS RNIB RNID	Every-one Walnut Care LACE Housing Butterfly Hospice Action for Children South Kesteven Blind Society Framework Housing St Barnabas

Promotion of engagement contd.

The below stakeholders received the distribution via LCC and NHS communications cascade or the engagement bulletin:

Audience	Distribution
Health Partners	NHS England EMAS Public Health England Lincolnshire Resilience Forum Health Innovation East Midlands
Community stakeholders including volunteer groups, support groups etc. via the engagement bulletin	Organisations supporting sensory loss LPFT involvement database— 430 (service users, carers, staff, voluntary sector reps & public supporters) Community, voluntary and support groups BAME communities LGBT Communities Carers Older people groups Young people groups Eastern European communities Disability groups (mental and physical) SEND – Lincolnshire Young Voices

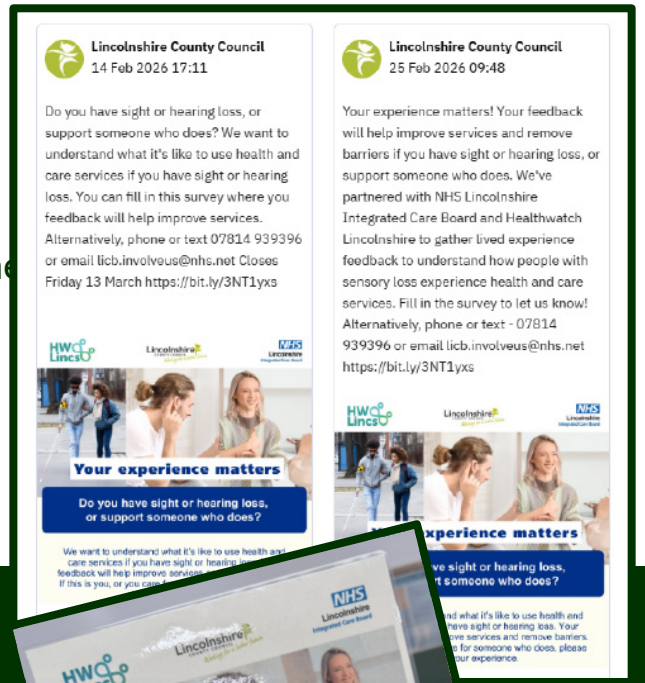
Audience	Distribution
District Councils inc. elected members and staff	City of Lincoln Council Boston Borough Council East Lindsey Council West Lindsey Council North Kesteven Council South Kesteven Council South Holland Council (Plus Parish Councils)
Local Employers	University of Lincoln Anglian Water The Environment Agency
Public sector providers	Lincolnshire Police and Crime Commissioners Lincolnshire Police Lincolnshire Fire and Rescue Libraries Schools LCC internal comms – education, police, commercial services, TPC newsletter

Digital reach and marketing materials

Marketing materials

The NHS Lincolnshire ICB Marketing team created leaflets and social media assets in collaboration with the communications team at LCC. The aim of the materials were to:

- Build awareness of the survey
- Signpost/link people to the survey
- Share with stakeholders to encourage participation
- Promote across a wide range of social media channels
- Encourage people to take part in our conversations



Poster displayed by Moorland Children's Centre

Social Media

- ICB posted 6 on social media
- 9284 views with a reach of 6060
- We received 51 reactions with 14 clicking through to the survey
- Shared by Disabled in Lincolnshire; Lincolnshire Community Foundation; Lincolnshire Deaf Alliance and Brant Road Surgery PPG

- LCC posted 5 times on social media
- 11948 views with a reach of 8325
- LinkedIn - 330 impressions, 194 members reached, 6 engagement clicks

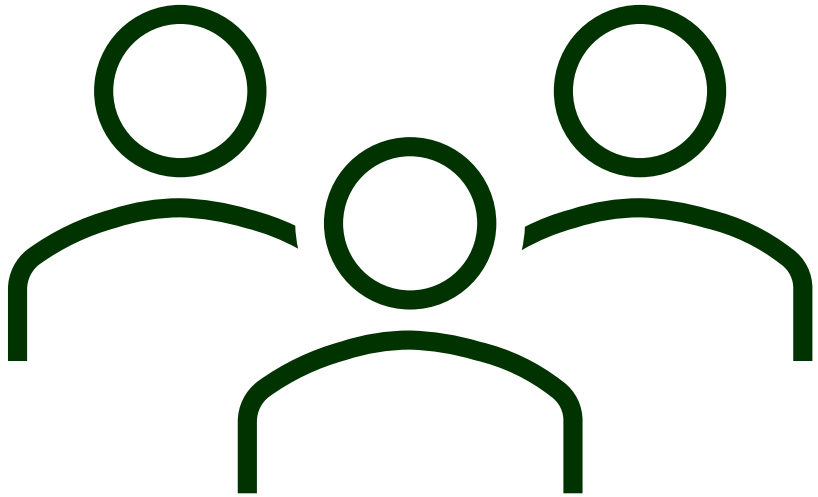
Website

- ICB website traffic was primarily driven social media posts providing additional background traffic.
- The page recorded 344 page views – with 129 active users.
- Without direct access to survey completion data, true conversion performance cannot be fully measured, limiting full analysis.

Section 3

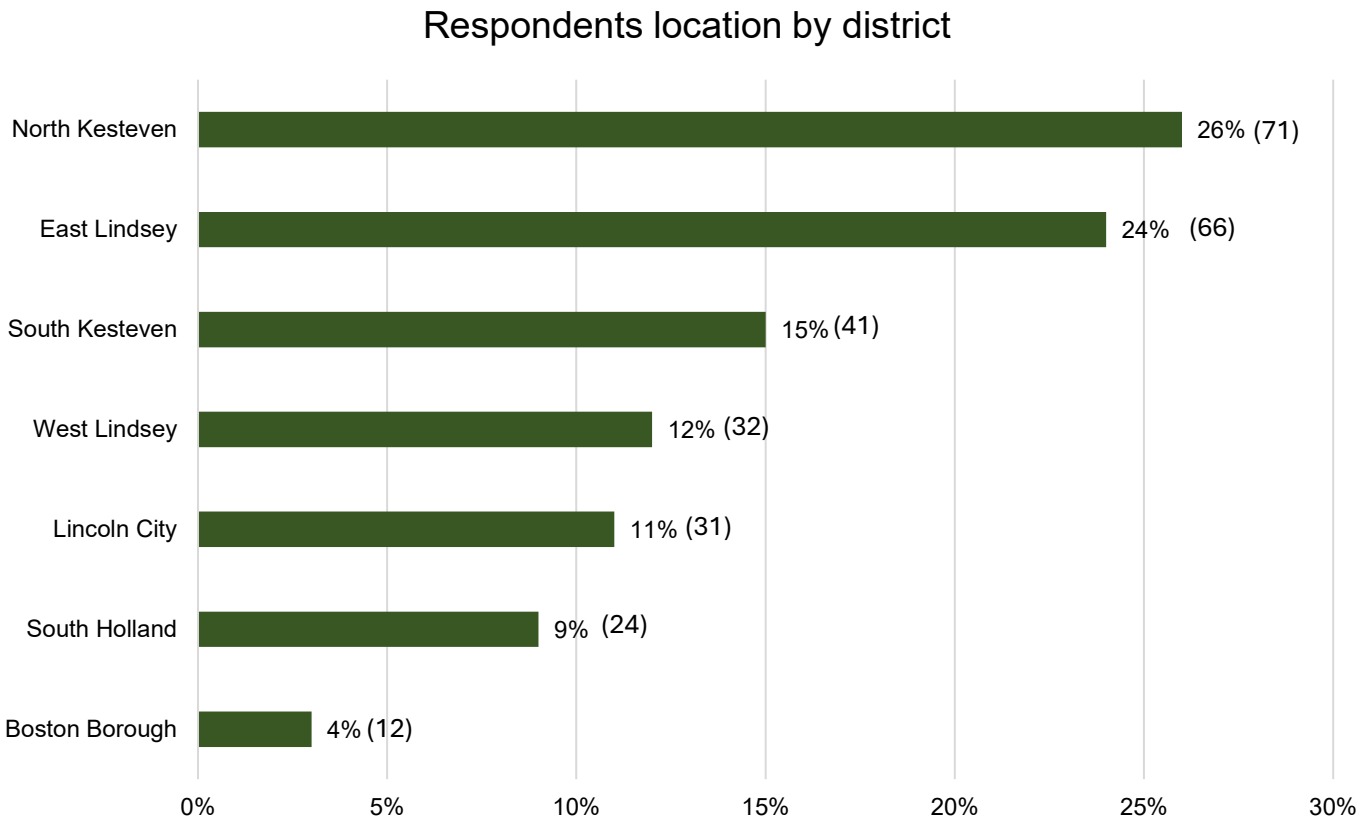
PUBLIC SURVEY

Respondent demographics

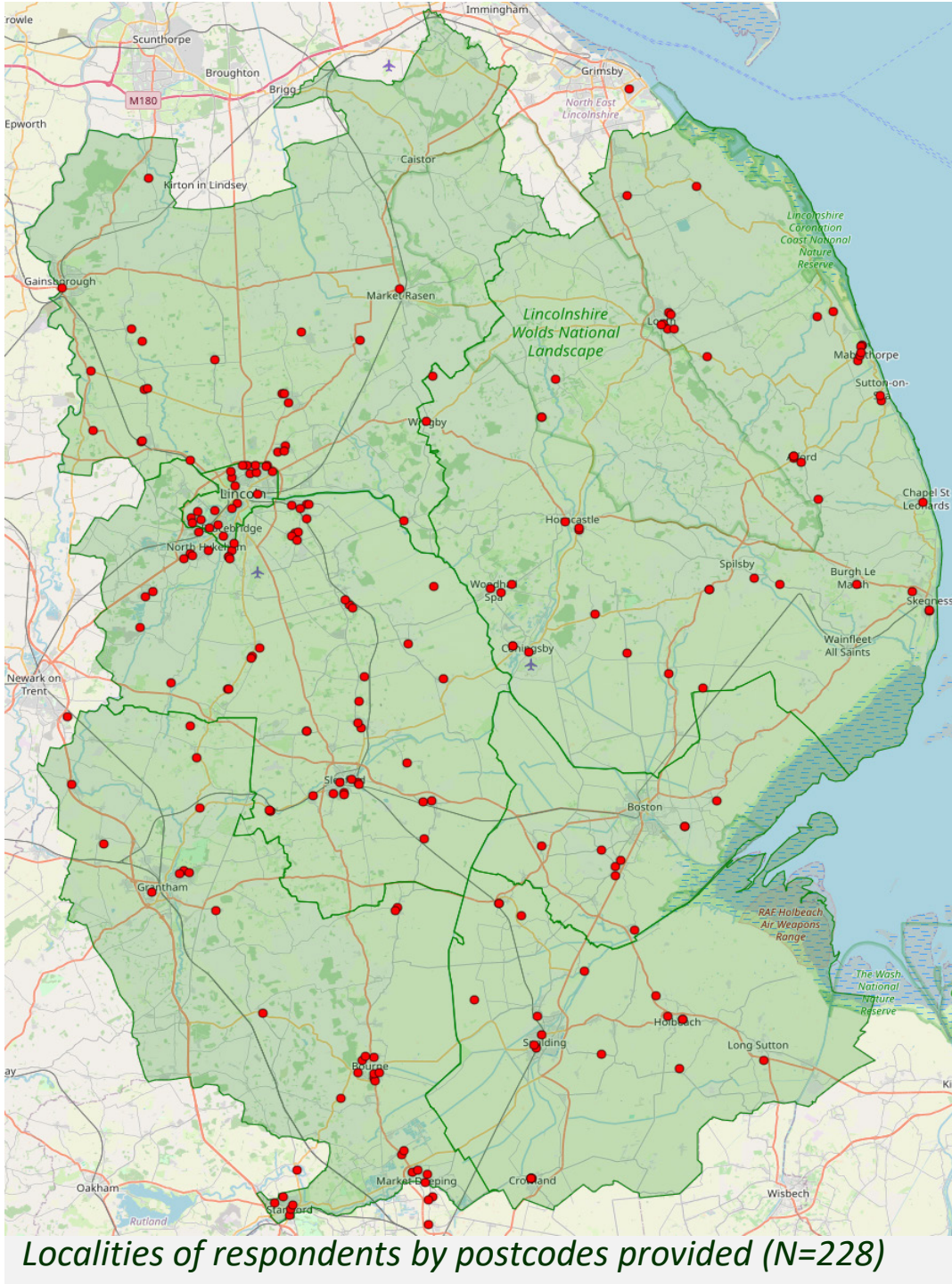


To help identify trends and areas of concern in care and treatment provision, we included a series of questions in the public survey. These covered equality monitoring, health inequalities, and locality data.

For the sensory loss survey, respondents were asked to provide both their postcodes and nearest town. Any anomalies or notable patterns in the data are highlighted throughout the report. This page presents the geographical distribution of respondents.



Localities of respondents displayed by districts (N=277)



Localities of respondents by postcodes provided (N=228)

Responses are highly dispersed across the county within 87 practices.
Most practices 70% (61 practice areas) had 1-4 respondents, indicating no single practice area dominated feedback.
9% (8) practices had between 5-7 responses.

Highest responding practice areas.

GP Practice	Count	%
Millview Medical Centre	7	4%
Marisco Medical Practice	6	3%
Sleaford Medical Group	6	3%
The Deepings Practice	6	3%
Caythorpe & Ancaster Medical Practice	5	3%
Richmond Medical Centre	5	3%
Washingborough Surgery	5	3%
Welton Family Health Centre	5	3%

Response rate by practice.

Response Level	Count	%
0 responses	18	21%
1–4 responses	61	70%
More than 4 responses	8	9%
Total	87	100%

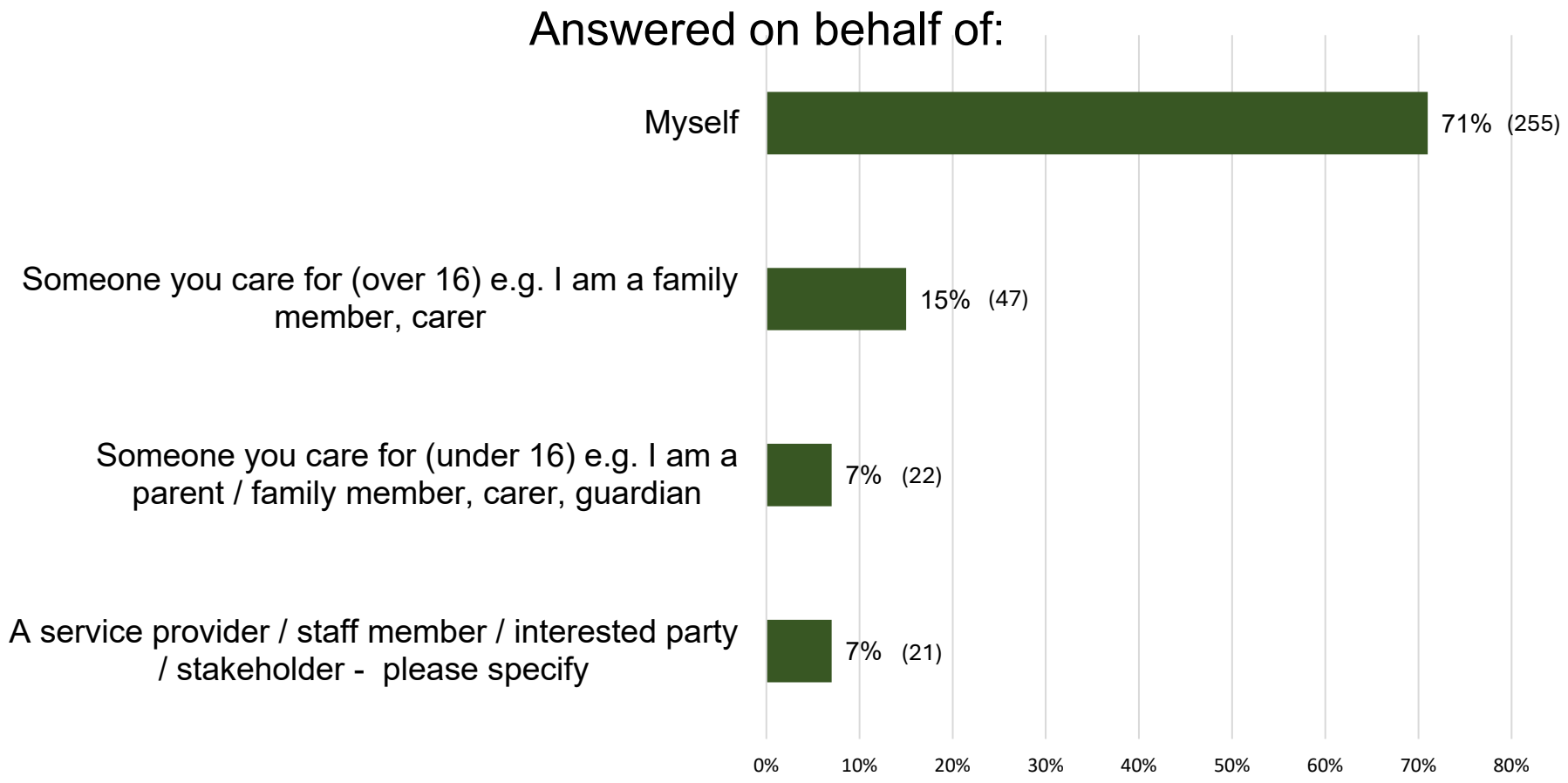
(Base N = 185)

Section 3.1

PUBLIC SURVEY

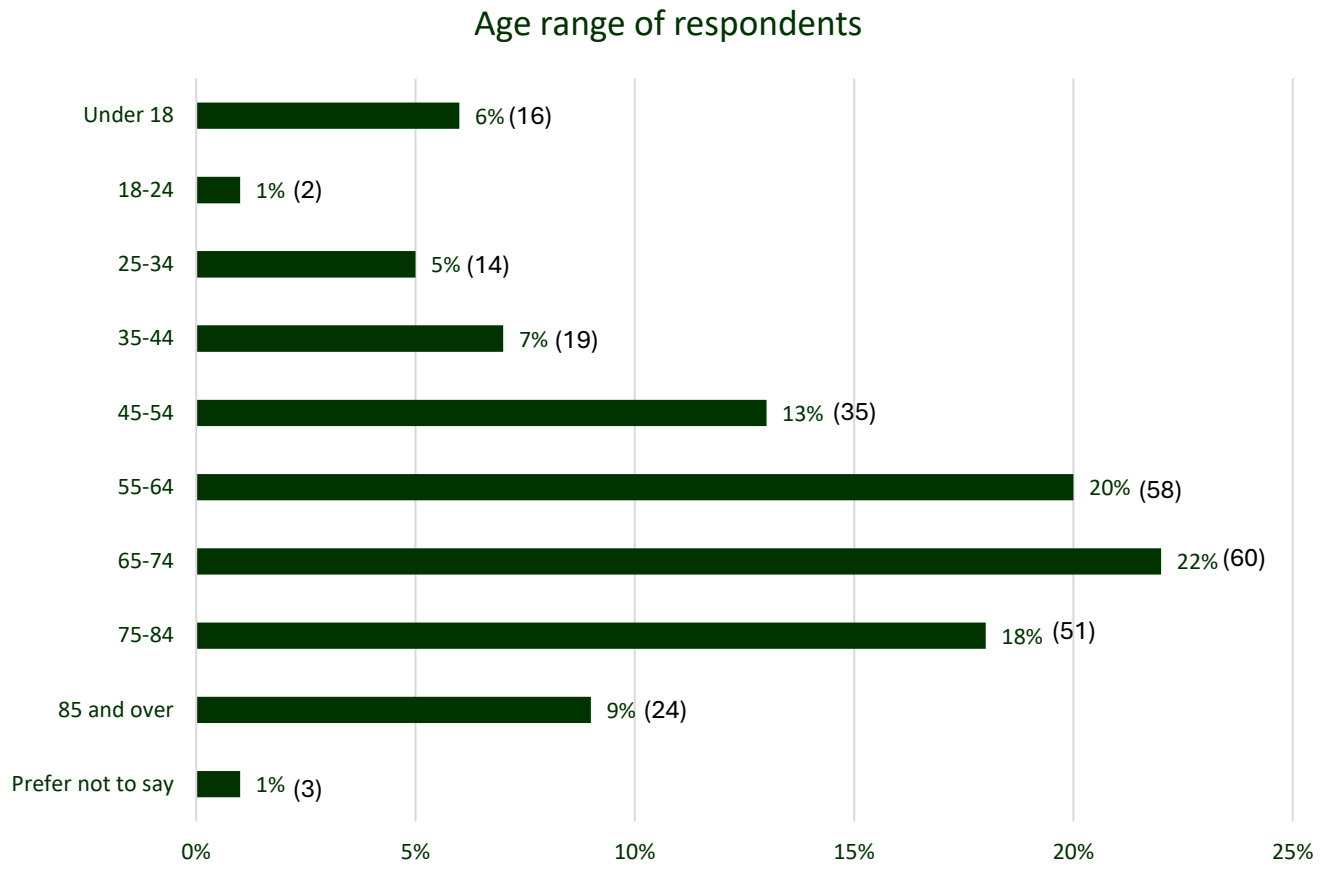
Responses on current services

71% (225) of respondents answered the survey for themselves, and **22% (69) completed it on behalf of someone they care for or as a family member.**
Responding stakeholders included a Community Fire Safety Advocate, colleague from LCC and BSL Interpreter.
More women completed the survey **on behalf of someone else** particularly older relatives, children and young people or those with multiple impairments.



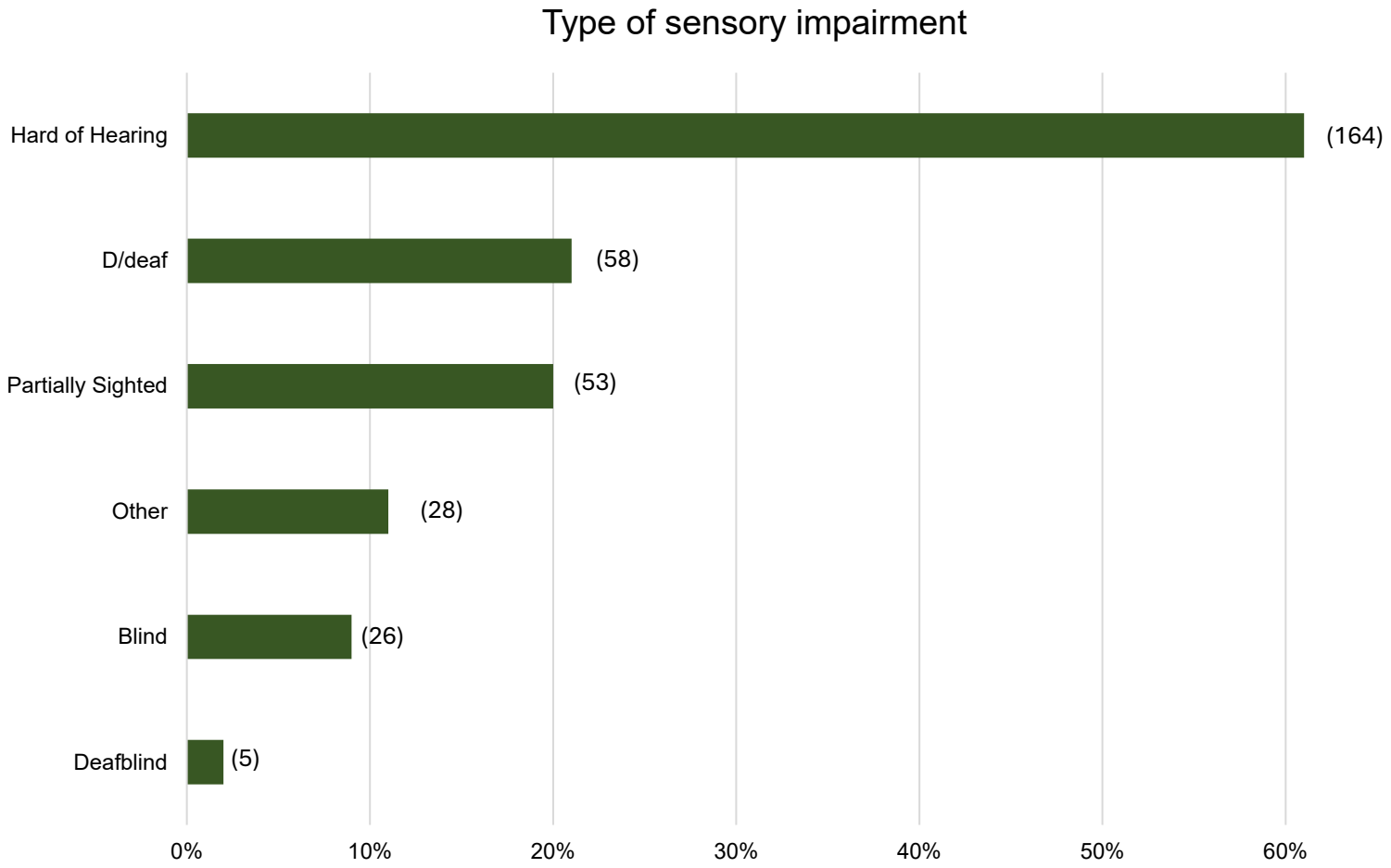
(Base N = 315)

42% (118) of respondents were aged 55-74. Most responses for individuals **under 18 were completed by a family member or carer**.



(Base N = 289)

222 of respondents reported **hearing loss or being D/deaf**.
79 people said they were **partially sighted or blind** and **5** identified as **deafblind**.
Respondents with sight loss were more likely to have had support to complete the survey (or answered on their behalf), typically from family members, carers or service providers.



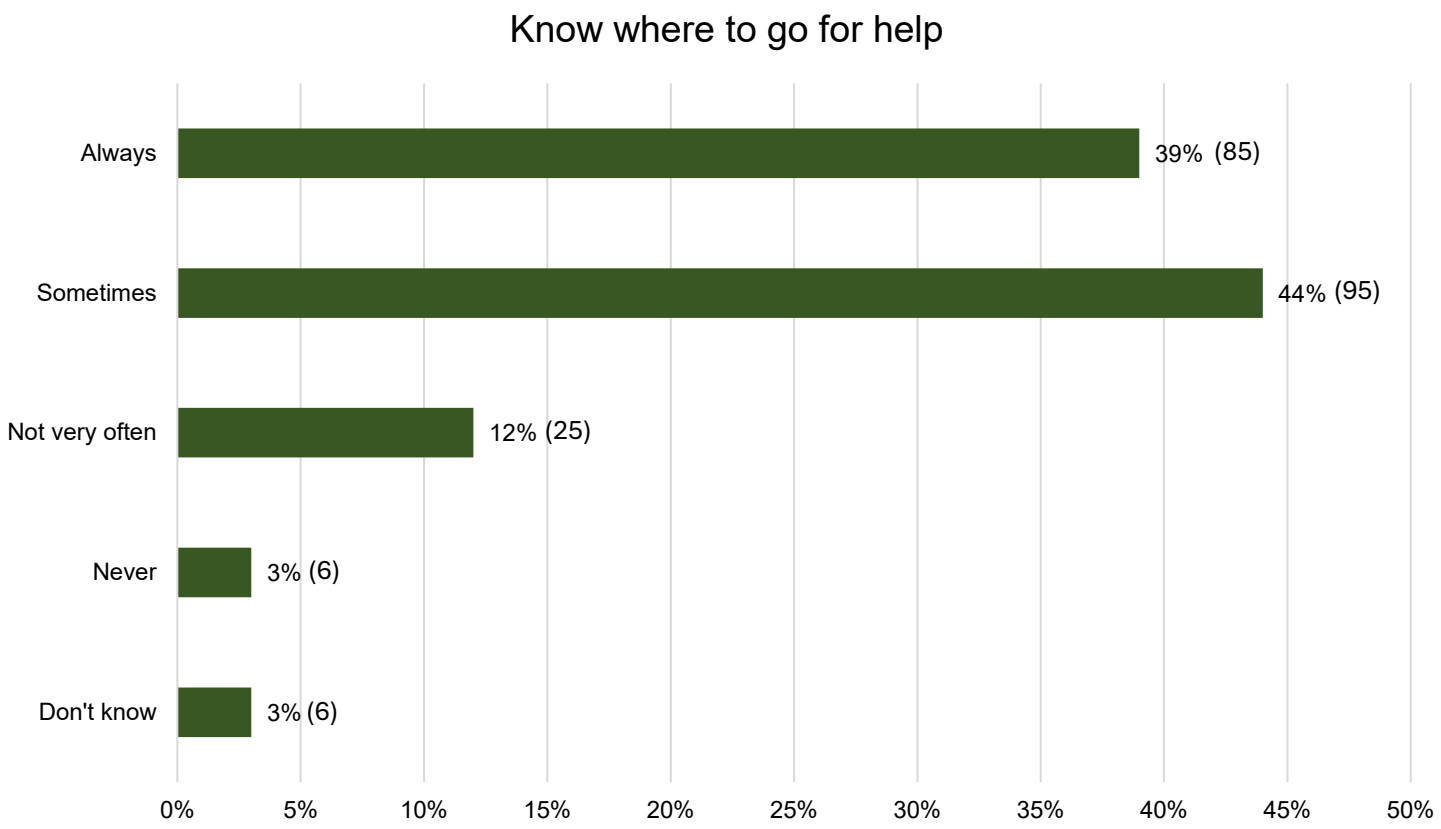
Respondents reported **a wide spectrum of hearing and sight difficulties**, ranging from mild to profound.

These include hearing loss, tinnitus, use of hearing devices, Deaf identity, and balance-related disorders; and a variety of visual impairments such as macular degeneration, keratoconus, glaucoma, optic neuritis, and sight loss requiring specialist clinical support.

Several respondents also highlighted additional neurological or physical conditions that impact their communication needs.

(No definitive base number as multiple selections were allowed for this question)

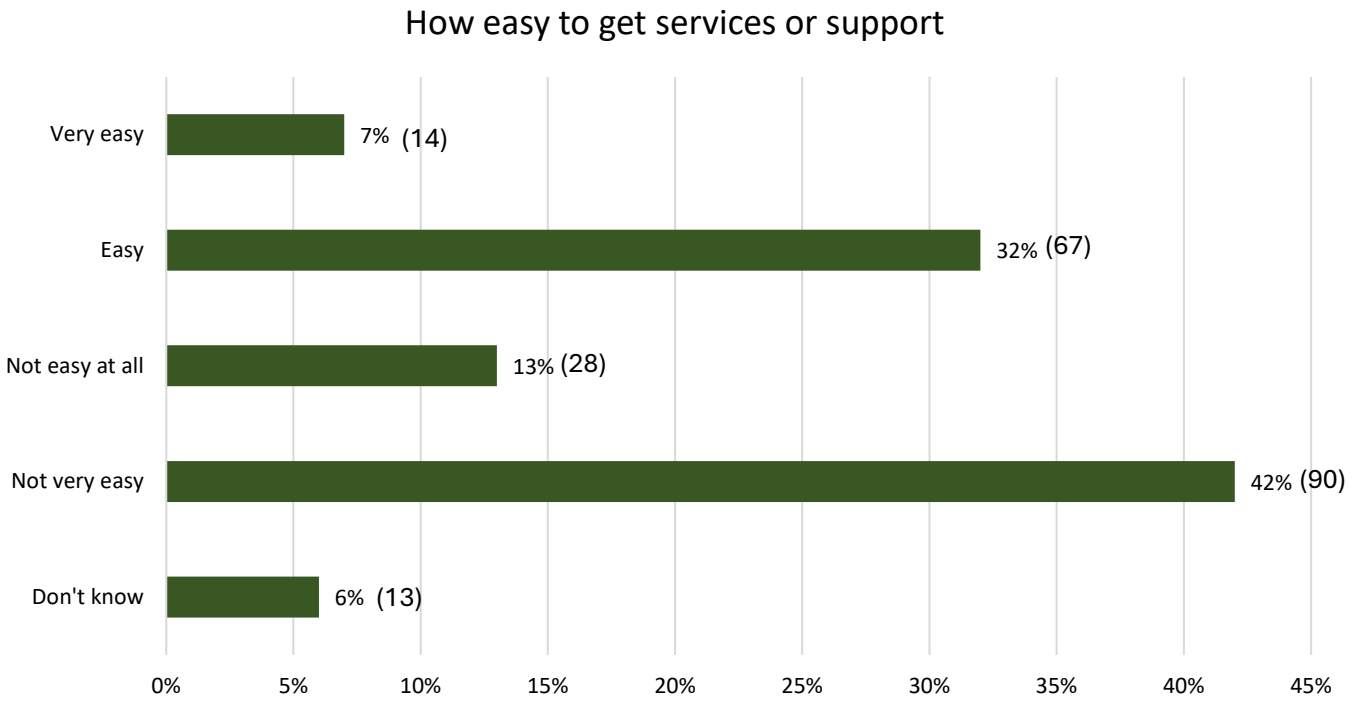
83% (180) of respondents stated that they **sometimes or always** know where to go when they needed help or support for their health and care.
When the responses were broken down by sensory impairment groups, there was **no clear difference** between **people with sight loss and those with hearing loss** in terms of knowing where to seek health or care support. Respondents under 55 were confident in knowing where to seek help. Men reported that they were more likely to know where to go for help than women.



(Base N = 217)

55% (118) of respondents stated that they **do not find it easy or not easy at all** to get the services or support they need. **39% (81) found it easy or very easy** to get the services or support they needed.

By sensory group, difficulties were most pronounced among **Deaf** and **partially sighted** respondents (around three-quarters reporting it was not easy) and 100% (5) **Deafblind** respondents reported it was not easy. **Hard of Hearing** and **Blind** respondents were closer to the overall average, with around 41–44% finding it easy; however, a majority in these groups still experienced difficulty.



Regardless of the group, this indicates that **system navigation can be difficult** for most people with sensory impairment.
This suggests that there are **barriers in entry routes for people trying to access health and care services.**
Although only a small number of responses (5 in total) the **Deafblind appear to face the steepest access barriers.**

(Base N = 212)

We received a range of comments from respondents describing what they liked about health and care services.

- **Negative or neutral sentiment was dominant**: Many respondents reported no positive experiences at all.
- **Positive feedback was generally service-specific**, focusing on certain staff or specialist services rather than general healthcare provision.
- **Accessibility and communication challenges** appear to influence perceptions—people who struggle to access services find little to like.
- **Awareness issues** were also visible, with some unsure of what services exist.

	Positive feedback / comments by group	Negative feedback / comments
D/deaf	Access improving (e.g., local Specsavers opening improved audiology access). Value in routine/device support; care often good once aware of services. "The recent opening of Specsavers in Horncastle has improved my access to audiology…" "Good once we're made aware that such services exist."	Delays and capacity issues (needing to go out of county; long waits following GP referral). Appointment systems not working (e.g., glaucoma clinic). "Had to go out of Lincolnshire for support after 3 years of waiting…" "Glaucoma clinic… appointments system… does not appear to work at all."
Hard of Hearing	Helpful, knowledgeable staff and multiple contact routes (email/online GP) are appreciated. Specsavers and some hospital teams mentioned positively; care can run smoothly once seen. "Knowledgeable, understanding staff." "The recent opening of Specsavers… improved my access…"	Long waits for ENT/hearing tests; phone-based communication felt inappropriate for hearing loss. Several comments of "nothing"/"useless"; difficulty getting help from GP. "Told it's a year waiting list for a hearing test." "Nothing – it's been useless thus far… told by telephone…" "Not easy to get help at all from GP."
Blind	Support services (e.g., education/sensory teams, county services) called helpful. "SEST excellent service for school…" "County's support services are very helpful."	Not impressed with hospital/GP support for disability; lack of home support despite need. "LC hospital has not been good… GP surgery not helpful with my disability." "No acknowledgement for this level of need."
Partially sighted	Some GP staff helpful; services good once known. "Some of the GP staff can be helpful." "Good once we're made aware that such services exist."	"None of it/ nothing" reported by multiple respondents. Access barriers to GP; complexity for carers to coordinate care. "NOTHING." "Not easy to get help at all from GP."
Deaf blind	Positive staff interactions noted. "Some of the staff are nice."	No explicit negative statements
Other	High-quality specialist eye care (e.g., Royle Eye Dept; cataract surgery at Louth). Professional, caring practitioners; email access appreciated. "The Royle Eye Dept at Pilgrim offers a great service… an excellent experience." "Professional, caring practitioners."	Appointment systems described as confusing/not working; some "none of it" responses. "Glaucoma clinic… appointments system… does not appear to work at all." "None of it."

(Base N = 50)

When asked what would make health and care services better - **three dominant themes surfaced – access, communication and co-ordination.**
People value the care they receive once they access it, but the system makes it too hard.
Improvements must therefore focus on **removing access barriers**, **strengthening communication**, and **coordinating services better** for individuals with sensory impairments.

Suggested service improvements

- **Improved accessibility** (video calls, email, non-digital options, visual waiting-room screens).
- **Better staff training** in sensory-impairment communication.
- **Local clinics and reduced waiting times**.
- **More proactive monitoring and recall systems**, especially for hearing loss.
- **Clearer information and navigation support**, so people know what is available and how to access it.
- **Respect for accessibility flags** and personalised communication preferences.

(Base N = 73)

This page sets out the issues and improvements identified by each group. When asked what would make health and care services better, respondents highlighted several clear themes and practical suggestions.

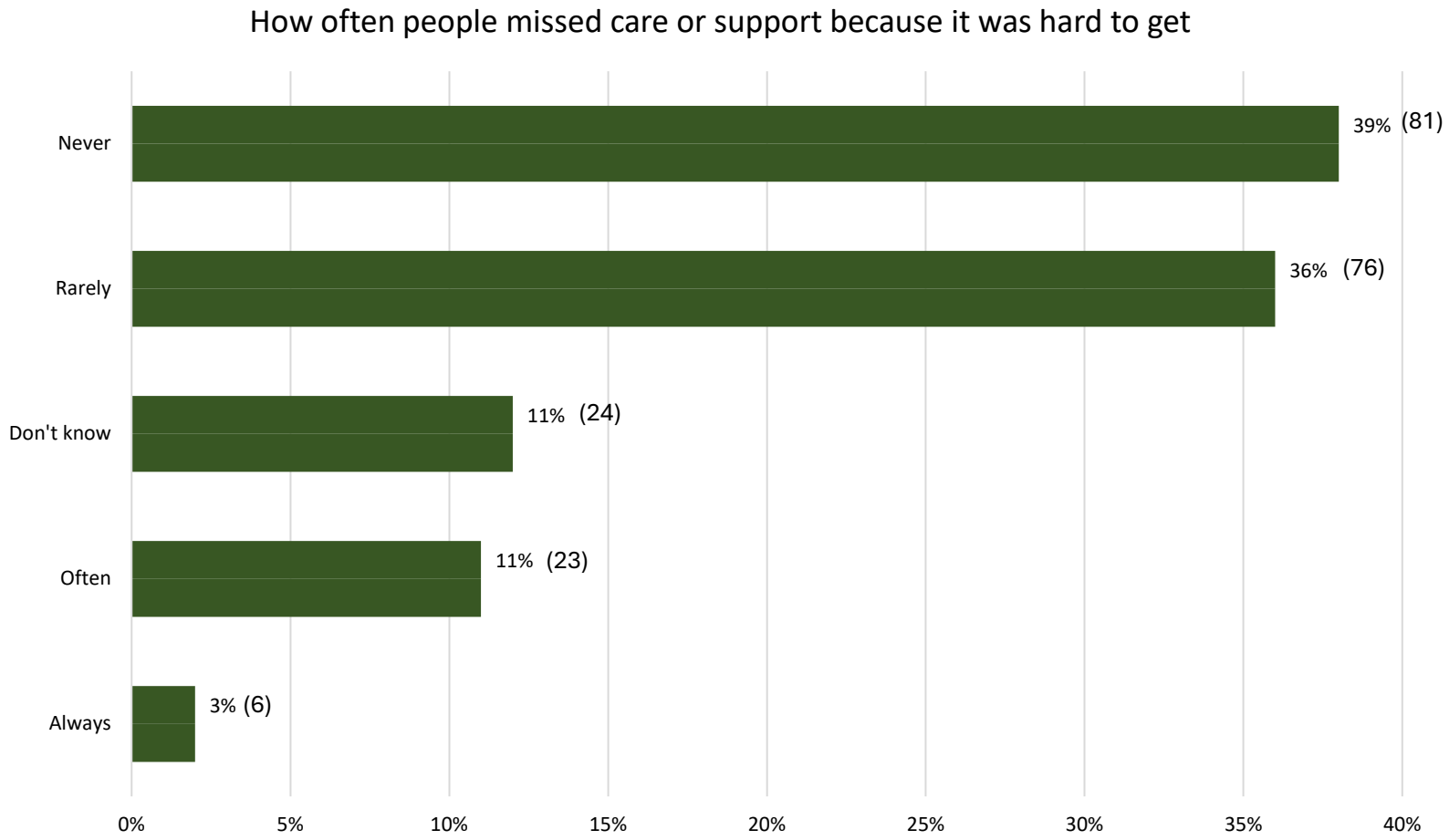
Their comments also show the distinct challenges experienced by people with different types of sensory impairment.

	Improvements suggested	Issue identified
D/deaf	• **Better communication skills training** for staff (lip-facing, understanding bilateral deafness, adjusting speech). • **Video appointments** instead of phone calls. • **Online/email communication routes** with all hospital departments. • **Regular hearing-loss monitoring** (recalls every 2 years like eye exams). • **Improved interpreter booking processes** (automatic, not person-led). • **Clearer appointment-system explanations** and better admin coordination.	• **Difficulty accessing appointments** (long waits, booking systems). • **Contracting services to Specsavers not suitable** for people with more complex or severe hearing loss. • **Poor communication from staff** (staff speaking quietly, not facing the person, defaulting to BSL even when not appropriate). • **Lack of interpreter booking awareness -** "GP said it was my responsibility to book a BSL interpreter". • **Fragmented services across counties** (reliance on Nottingham causing strain).
Hard of Hearing	• **Shorter waiting times** for ENT and hearing assessments. • **Loop systems** that integrate directly with hearing aids. • **Better face-to-face communication practices** (slower, clearer speech; facing the person; minimal accent barriers). • **Clear written follow-ups** after appointments. • **Better signage and waiting-room processes** (visual screens instead of shouting names). • **Local appointments closer to home**. • **Better coordination between audiology, GP, pharmacy, Specsavers**. • **Navigator roles** to help people understand and access support.	• **Long ENT / hearing-test waits** (some over a year; children waiting 11 months). • **Inaccessible waiting rooms** (names shouted, cannot hear). • **Poor communication styles** (staff speaking quickly, accents hard to understand, staff not facing people). • **Fragmented care between Specsavers, GP, hospital** (poor communication, lost prescriptions). • **Inconsistent mask use affecting lip-reading**. • **Navigation barriers** (services difficult to locate/understand; reliance on online systems). • **Transportation and distance issues**, especially when asked to attend distant hospitals

Issues and improvements by each group – continued …..

	Improvements suggested	Issue identified
Blind	• **Automatic acceptance of appointment letters** (no need to confirm online/phone). • **More local clinics**, or improved transport options. • **Better staff disability awareness/understanding**. • **Accessible communication routes** (landline calls, clear instructions, non-digital formats). • **Better coordination for children with visual impairment** (risk awareness, joint working).	• **Appointment systems inaccessible** (letters requiring confirmation, unsuitable for people without digital access). • **Transport challenges** (30 minutes to nearest clinic; EMAS unreliability). • **Getting through to GP difficult**; requires sighted assistance. • **Lack of understanding of needs** (e.g., guide-dog access challenges or lack of risk awareness). • **Insufficient recognition of children's needs** by services.
Partially sighted	• **Clearer information on available services** (especially early intervention for children). • **Local appointment options**. • **Improved pharmacy–GP communication**. • **Someone to help navigate services** (advocacy or liaison roles). • **Accessible communication** (clearer telephone support, larger print on medication labels). • **Better support for visually impaired families** (peer groups, parental meet-ups).	• **Poor signposting** (families "missed early support" due to lack of information). • **Transport and distance issues** (travelling to Lincoln when care exists locally). • **Administrative errors** (prescriptions sent to wrong places; carers having to intervene). • **Lack of continuity and communication** outside appointments. • **Heavy burden on carers**, with little support or guidance. • **Long waits and limited understanding of available help**.
Deafblind	• **Longer appointment times** with adapted communication. • **Better physical access** (parking, layout). • **Staff trained in dual-sensory communication strategies**. • **Reducing reliance on family members for all interaction**.	• **Poor accessibility of GP practices** (parking, building access, reliance on family). • **Inadequate communication methods**, leaving the person excluded from decision-making. • **Short appointment times**, insufficient for people with dual-sensory loss.
Other	• **Consistent use of accessibility flags** across the system. • **Clear written summaries** after appointments. • **Ability to choose communication format** (email, text, letter). • **Local clinics and shorter waits**. • **Better multi-disciplinary coordination** between sensory, hospital, and GP teams.	• **Communication problems between providers** (Specsavers ↔ GP ↔ hospital). • **Hospital appointments still arriving as phone calls** despite accessibility flags. • **Long waits**, rushed clinics, poor follow-up. • **Inaccessible communication (accents, masks, unclear speech)**. • **Lack of advocacy support** for complex health needs. • **What would make it better**

75% (157) of respondents reported that they have **rarely or never** missed care because it was hard to access.
Respondent 75+ were likely to miss care. Women report to missing or delaying care more often than men.



Deafblind respondents had the highest unmet need that often missed care.

The **D/deaf had a consistent pattern of often missing care.**

While the **hard of hearing and blind respondents** were more mixed with around **half saying they never missed care** and the other **half reporting they did**.

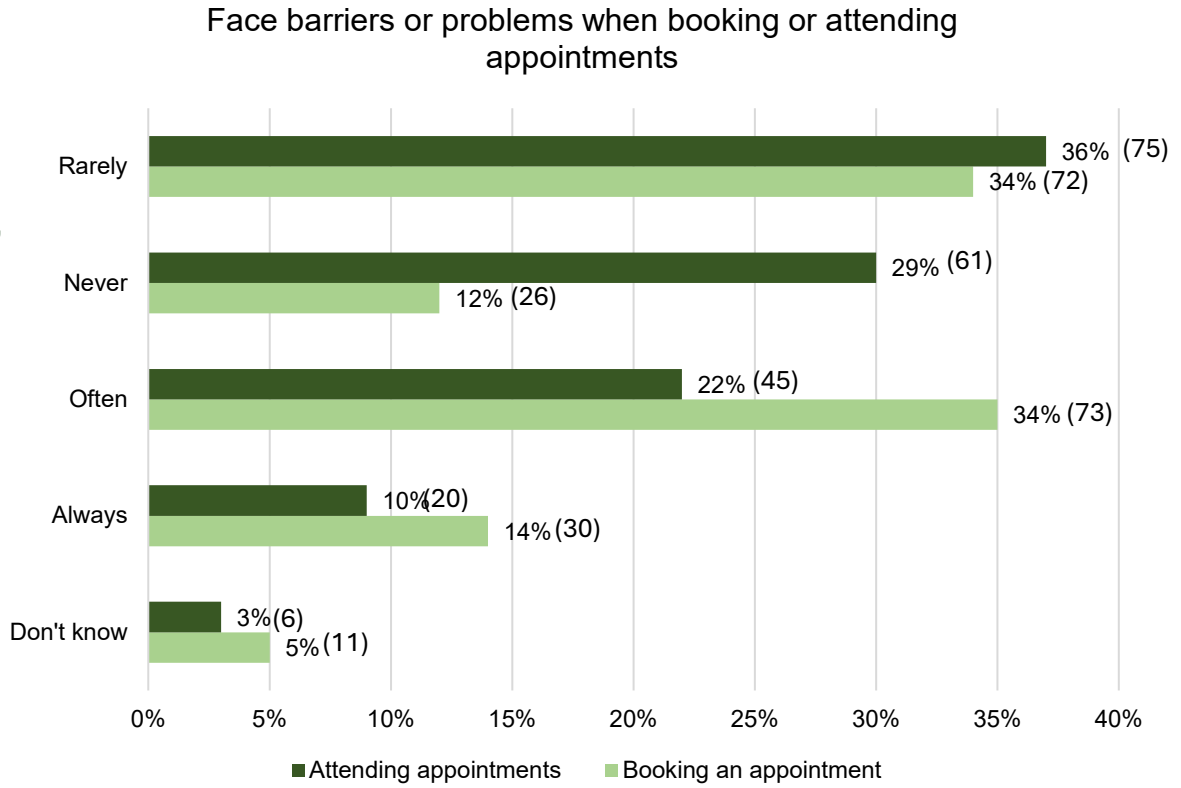
(Base N = 210)

48% (103) of respondents reported that they **always or often face barriers** when booking appointments.
In comparison, **32% (65) face barriers when attending** appointments, while **65% (136)** said that they **never or rarely have face barriers when attending**.
This indicates that **booking appointments is the biggest barrier**, suggesting that **system-related issues such as online booking processes and communication methods** are more problematic than physically getting to an appointment.
Booking appointments was more challenging for those aged 65+ whilst respondents over 75 reported more barriers to attending appointments.

Headline differences by sensory group

- **Deafblind:** report the highest barriers at **both booking and attending appointments.**
- **D/deaf: Booking** is the main difficulty with more people reporting barriers when trying to book than when attending.
- **Blind:** Barriers are **much higher for booking** compared with attending, suggesting communication/booking processes are more challenging than the appointment itself.
- **Partially sighted:** The opposite pattern appears – **attending is harder** than booking**,** indicating challenges with travel or in-clinic accessibility.
- **Hard of Hearing:** report fewer barriers than other groups at both booking and attending.

Compared with the overall results, **hearing loss groups (especially D/deaf)** struggle most at the **booking/communication** stage, while **sight-loss groups (especially partially sighted)** report greater barriers with **attending**, e.g. getting to and navigating appointments.
Deafblind respondents face the steepest barriers end-to-end (with very small numbers).



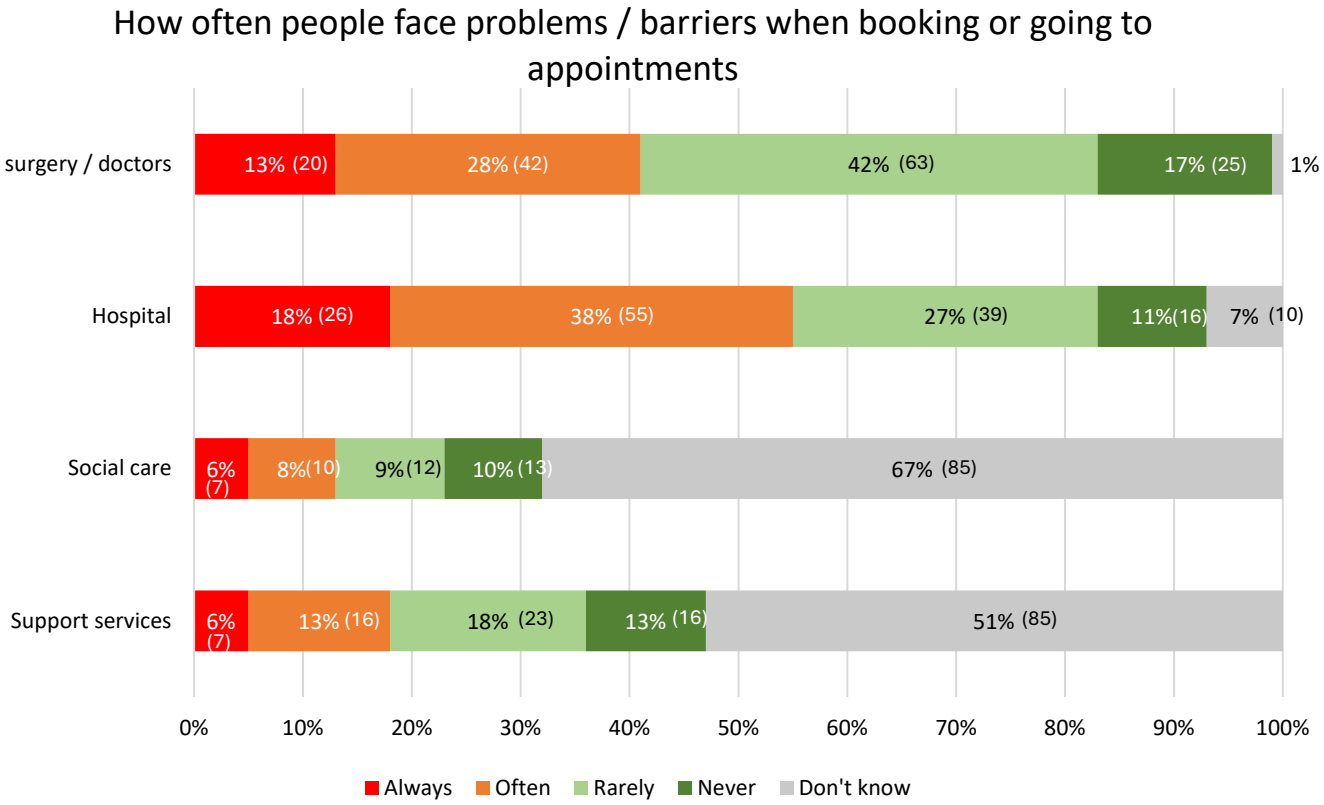
(Base N - Booking = 212; Attending = 207)

59% (88) of respondents reported that they **rarely or never face barriers** when booking or attending appointments at GP practices .
In comparison, **56% (81) face barriers when attending or booking** appointments at the hospitals.
This indicates that **booking appointments is the biggest barrier**, suggesting that **system-related issues such as online booking processes and communication methods** are more problematic than physically getting to an appointment.

Headline differences by service

- **GP: D/deaf and Hard of hearing** faced the highest and most consistent barriers; blind and partially sighted faced further barriers but fewer than hearing loss.
- **Hospitals**: **D/deaf** and **hard of hearing** mostly impacted with fewer barriers for those with **sight loss**
- **Social care: blind, partially sighted** and **D/deaf** faced the highest barriers (always) and **hard of hearing faced significant barriers too** but were less likely.
- **Support services**: people who are **D/deaf faced extremely high barriers**; those **partially sighted were another high barrier group**; **blind people had some barriers but less frequent** and **hard of hearing had a balance spread of access.**

Deafblind respondents face end-to-end exclusion indicating always in a health setting. Social care still indicated as often. However, number of responses are small.

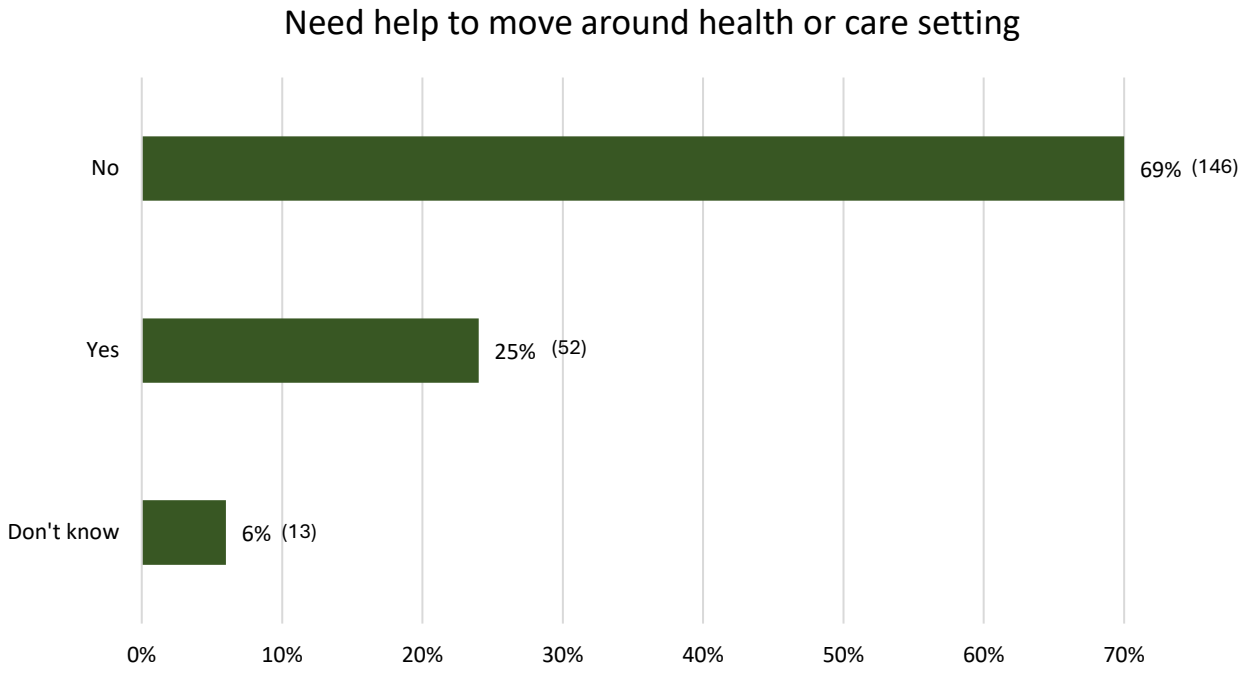


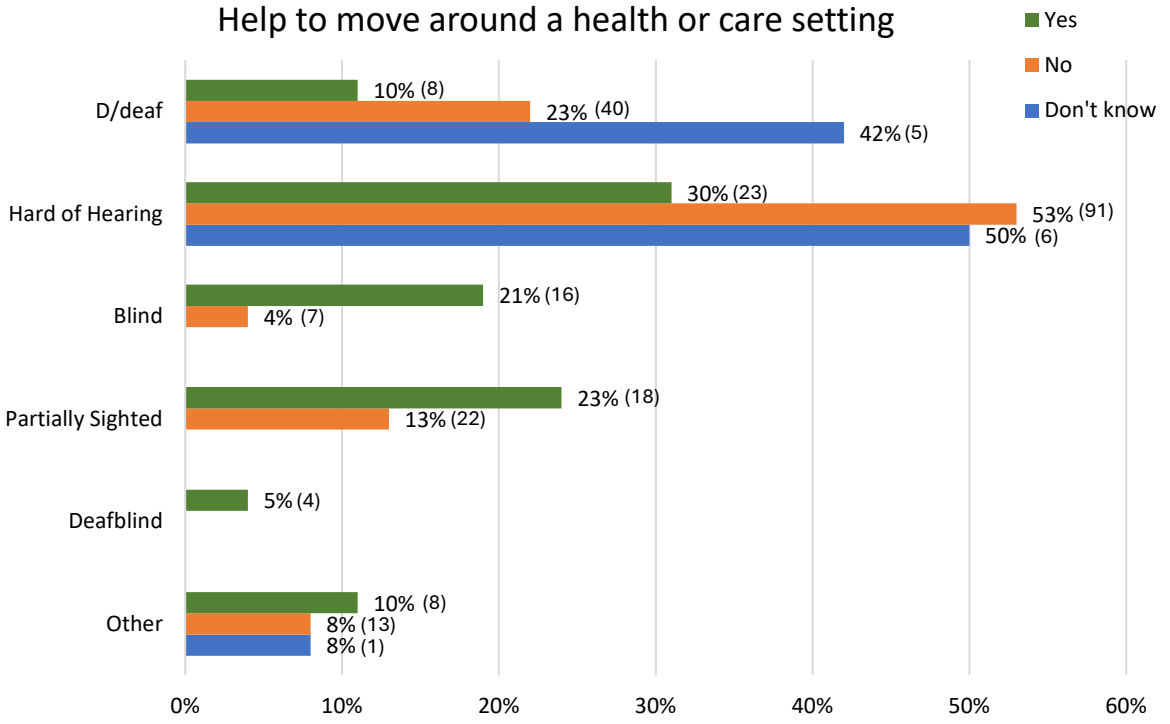
When asked to **expand on the barriers and challenges** they face, respondents described difficulties that were largely **system-related rather than personal**. Many people reported significant problems **accessing appointments**, particularly at GP practices and hospital clinics. Common frustrations included telephone-first systems, limited appointment availability, long waiting times, cancellations, and online booking systems that were not accessible.

Respondents were clear that many of these **barriers could be reduced or removed** through more flexible appointment systems, accessible communication options, clearer information, and services that actively recognise and respond to individual sensory needs.

(Base N - GP = 151; Hospital = 146; Social care = 127; Support services - 126)

69% (146) of respondents reported that they don't need help to move around a health or care setting.
However, those with sight loss (blind, partially sighted or deafblind) were more likely to need help to move around.
Needing assistance was common for respondents 75+ - especially those 85+.





(Base N = 211)

People need help moving around health settings mostly because of **mobility limitations, sight loss,** and **hearing-related communication barriers**, all interacting with **environmental challenges** (poor signage, long distances, unsafe layouts); and many rely heavily on **family or carers.** These issues reflect **system design and environmental accessibility**, not individual capability.

Mobility and physical support needs	
Summary	Key issues mentioned
• Many respondents require physical help due to mobility limitations, disability, or recovery from medical procedures. • Physical navigation within healthcare buildings is difficult for many; long distances and unsuitable rooms increase dependency on others.	• Use of walking aids, sticks, mobility scooters • Wheelchair use or needing wheelchair support on arrival • Balance issues • Pain or reduced movement after hip/knee surgery, stroke or long-term conditions • Difficulty transferring safely (e.g. onto stools, in small rooms)
Environmental / building layout challenges	
Summary	Key issues mentioned
• Respondents with visual impairment frequently needed sighted guides and struggled with navigating spaces independently. • Navigation systems and signage are not designed with sight-loss in mind, creating reliance on carers or staff escorts. • Respondents described needing help because the layout itself prevents independent movement. • Healthcare spaces often lack accessible routes, causing people to depend on others to avoid hazards and find the right areas.	• Can’t read signs, directions or letters • Small, unclear or poorly placed signage • Difficulty seeing steps, hazards or obstacles • Anxiety in unfamiliar spaces • Need for a guide to find rooms or follow routes through departments • Long distances between departments • Cluttered walkways or moved furniture • Unsafe equipment (e.g., wheeled stools for people with balance issues)

Continued …..

Communication barriers

Summary	Key issues mentioned
• Movement support was needed not because of mobility limitations but due to communication barriers that obstructed navigation. • Navigation systems that rely on hearing verbal instructions (e.g., shouted names, spoken directions) are not inclusive.	• Need for BSL interpreters to follow directions • Missing appointment calls (verbal name-calling only) • Difficulty lip-reading due to masks or poor lighting • Hearing aids or implants not always in use

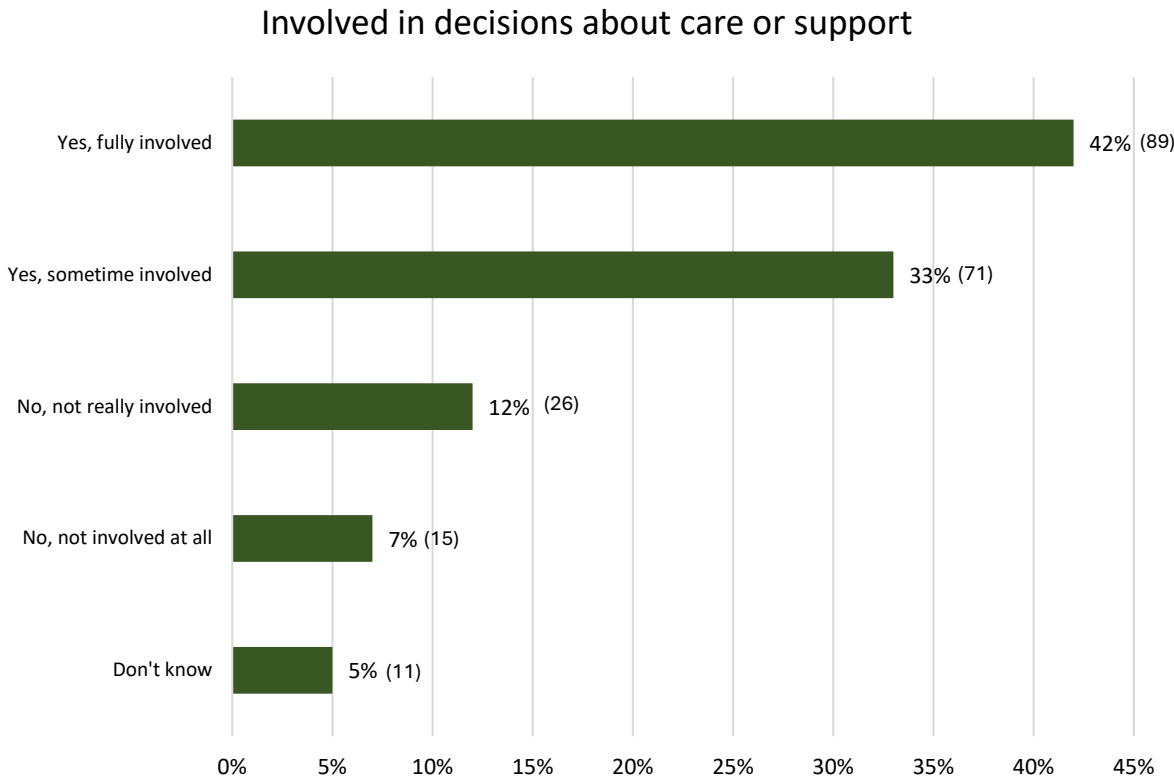
Reliance on carers, family members and staff

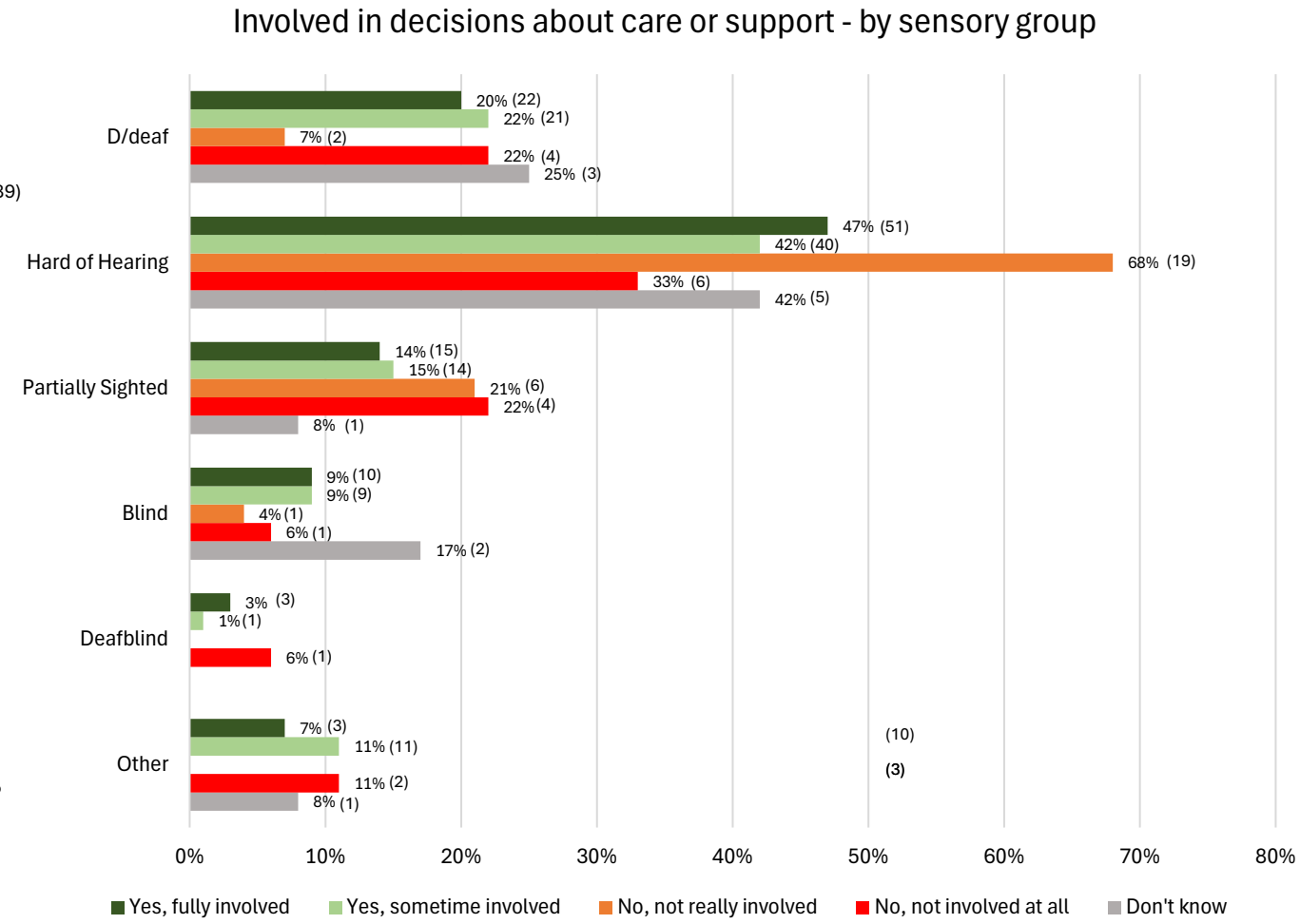
Summary	Key issues mentioned
• A major theme was dependency on others for safe movement within settings. • Many people would **not be able to move safely alone** in current healthcare environments • Some respondents *only* needed help on arrival because transport arrangements were unsuitable. • Transport issues outside the building directly affect people's independence inside the building	• Family members guiding, reading letters, or navigating buildings • Carers providing physical support • Staff stepping in when family not present • Volunteer drivers unable to accommodate mobility scooters • Lack of accessible community transport • Buses unreliable or diverted • Difficulty reaching hospital entrances

Positive experiences

Summary	Key issues mentioned
• A small number of comments highlighted when systems worked well. • These pockets of good practice provide a model for further improvement.	• Helpful staff • Accessible, single-level building e.g. GP practices • Building familiarity with the environment • Making the distances between clinics short and accessible.

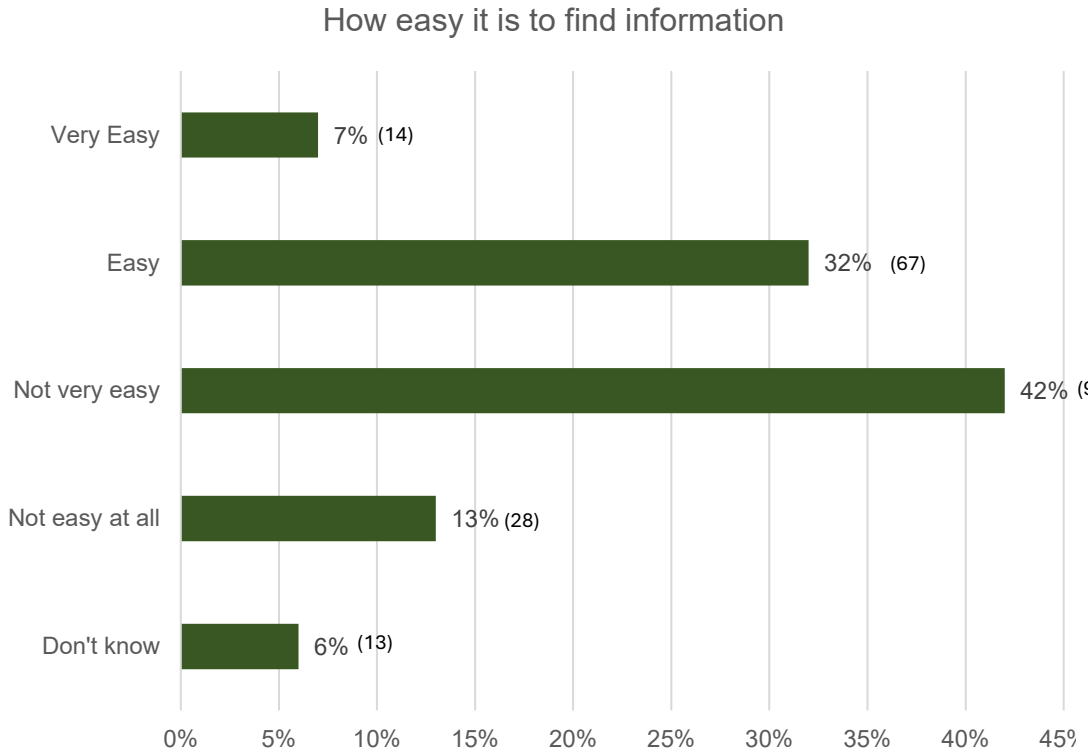
75% (160) of respondents stated that they **feel fully or sometimes** involved in decisions about their care or support.
Those who are hard of hearing, D/deaf or partially sighted often feel uninvolved or unsure about their decisions.
Women and people from the LGBT+ communities felt more excluded in the decision-making about their care.

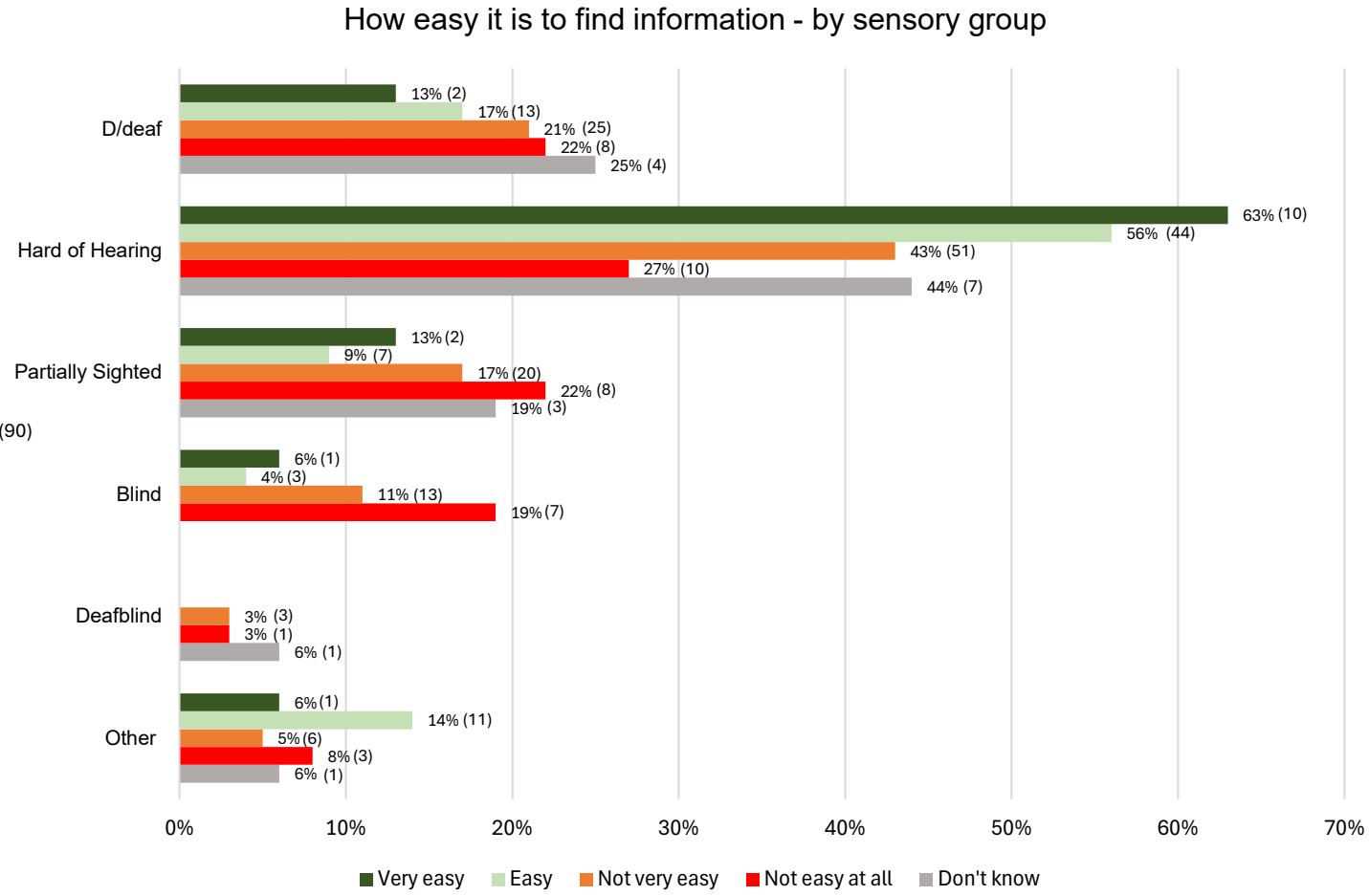




(Base N = 212)

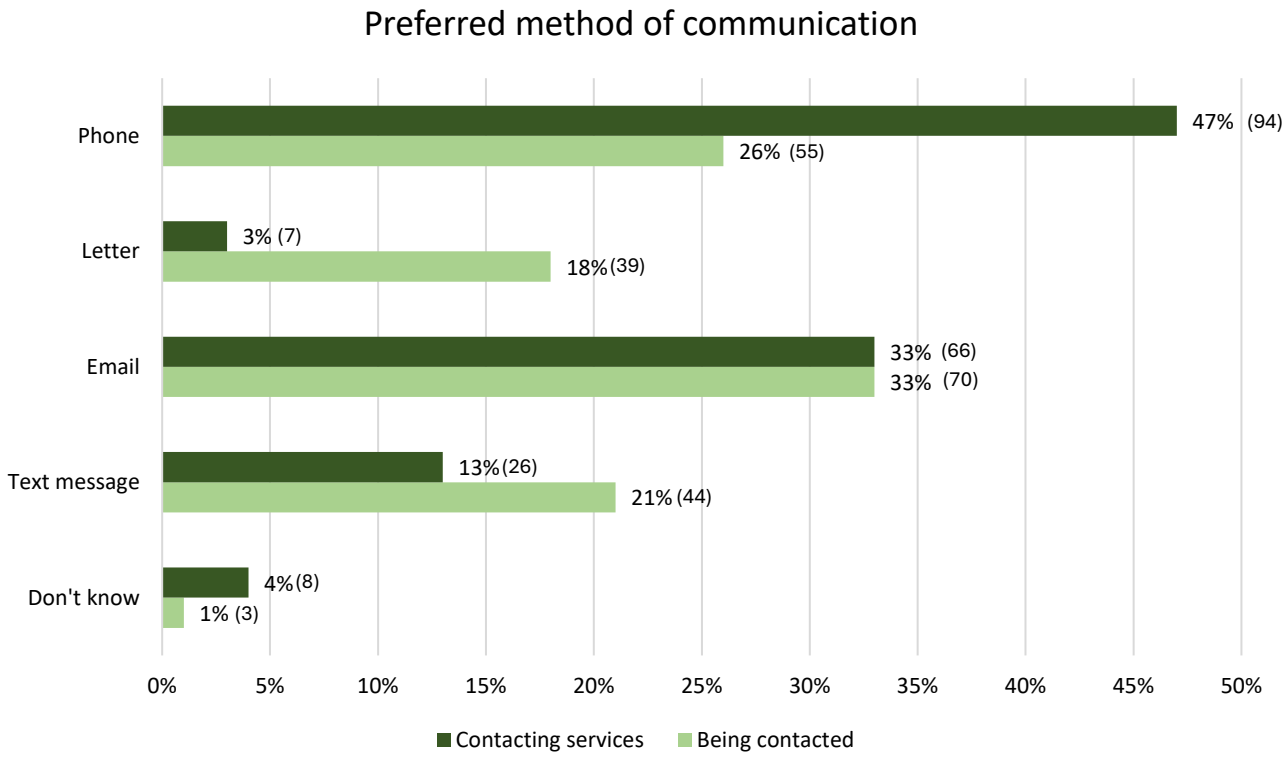
55% (118) of respondents said they **do not find it easy** or **not easy at all** to get the information they need about services or support.
Those who are **blind, partially sighted or D/deaf** generally find it harder to access information while people who are **hard of hearing** report finding information easier to locate.





(Base N = 212)

33% (70) of respondents prefer to be **contacted by services** via email with telephone being the second choice.
When contacting services themselves, **47% (94)** prefer to use the **phone**, with **email** as the next most preferred option.



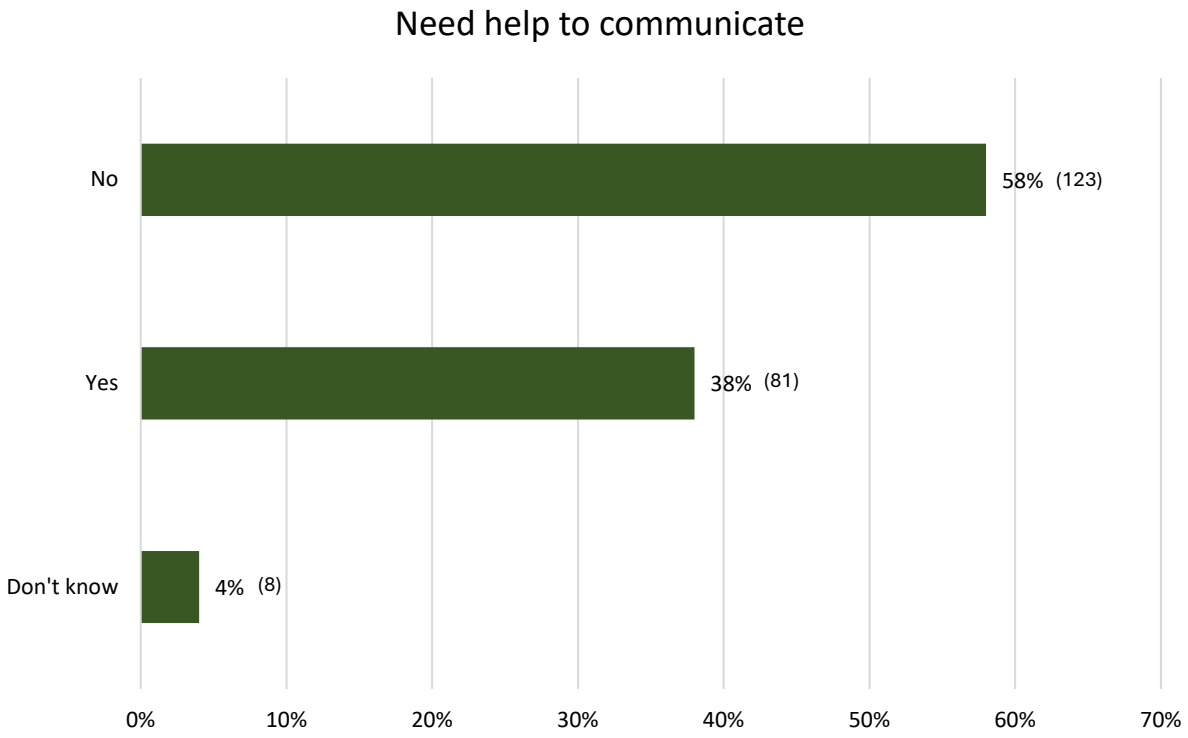
Headline differences by sensory group

- **Deafblind:** most preferred letters as their main communication method - numbers were very small.
- **D/deaf: strong preference for text and email** with very low use of phone.
- **Blind:** rely more on **phone and letters** rather than digital channels.
- **Partially sighted:** showed a mixed pattern but mostly lean toward **phone and email**.
- **Hard of Hearing:** overwhelmingly prefer phone above all other methods but also use email and text messaging.

People with sensory impairments have different communication needs: D/deaf respondents require text-based methods such as email or SMS, Blind respondents rely on phone/letters, Hard of Hearing use a mix of everything but still default to phone, and Partially Sighted respondents sit in the middle — using both phone and email. Demonstrating that services must offer multiple contact routes rather than a single default channel

(Base - Contacting services = N 201; Services contacting me = N 211)

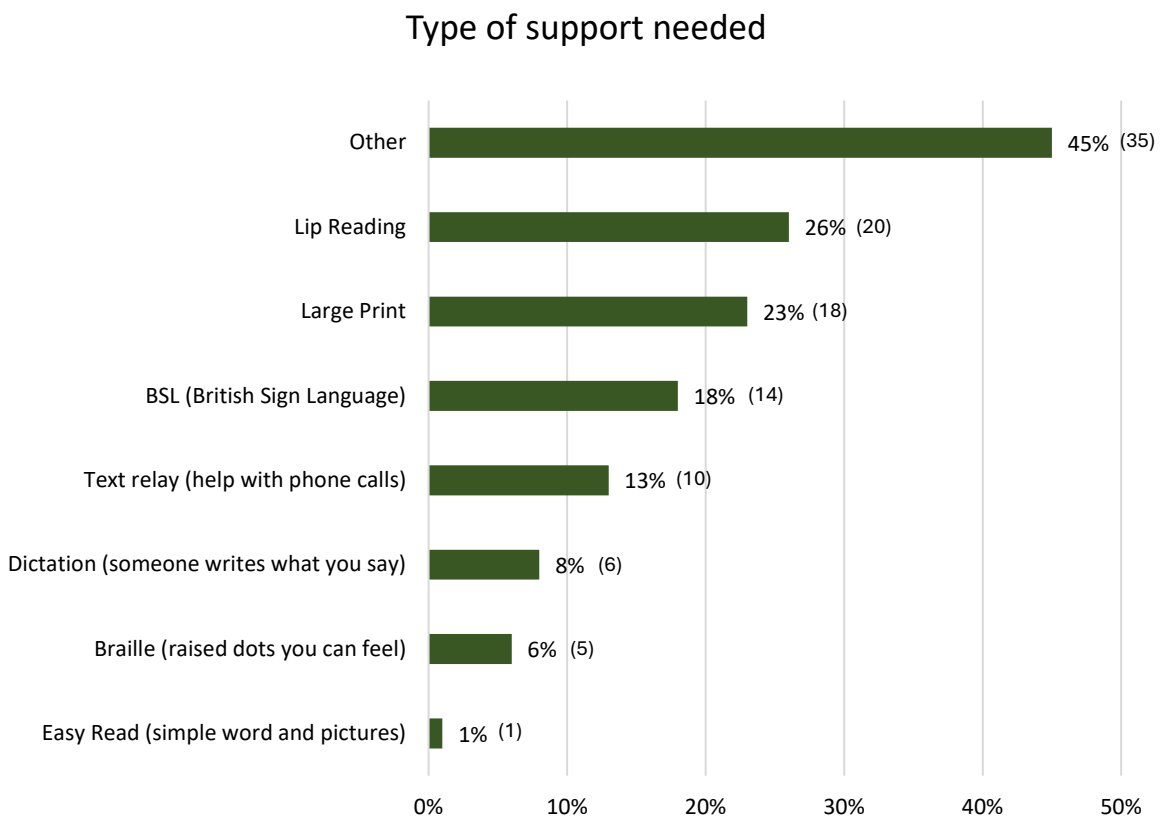
58% (123) of respondents stated that they **did not need help** to communicate whereas **38% (81) said they did**.



- **D/deaf** and **hard of hearing** were most likely to need communication support (29% in both groups.
- **Hard of hearing** respondents (75%) have the **highest level of uncertainty** about communication needs. Many selected “don’t know” when asked about their communication needs.
- **Blind, partially sighted** and **deafblind** reported lower levels of communication support need.

(Base N= 212)

We asked respondents who said they needed communication support what type of support they preferred. **26% (20) preferred to lip read** and **23% (20) preferred large print.**

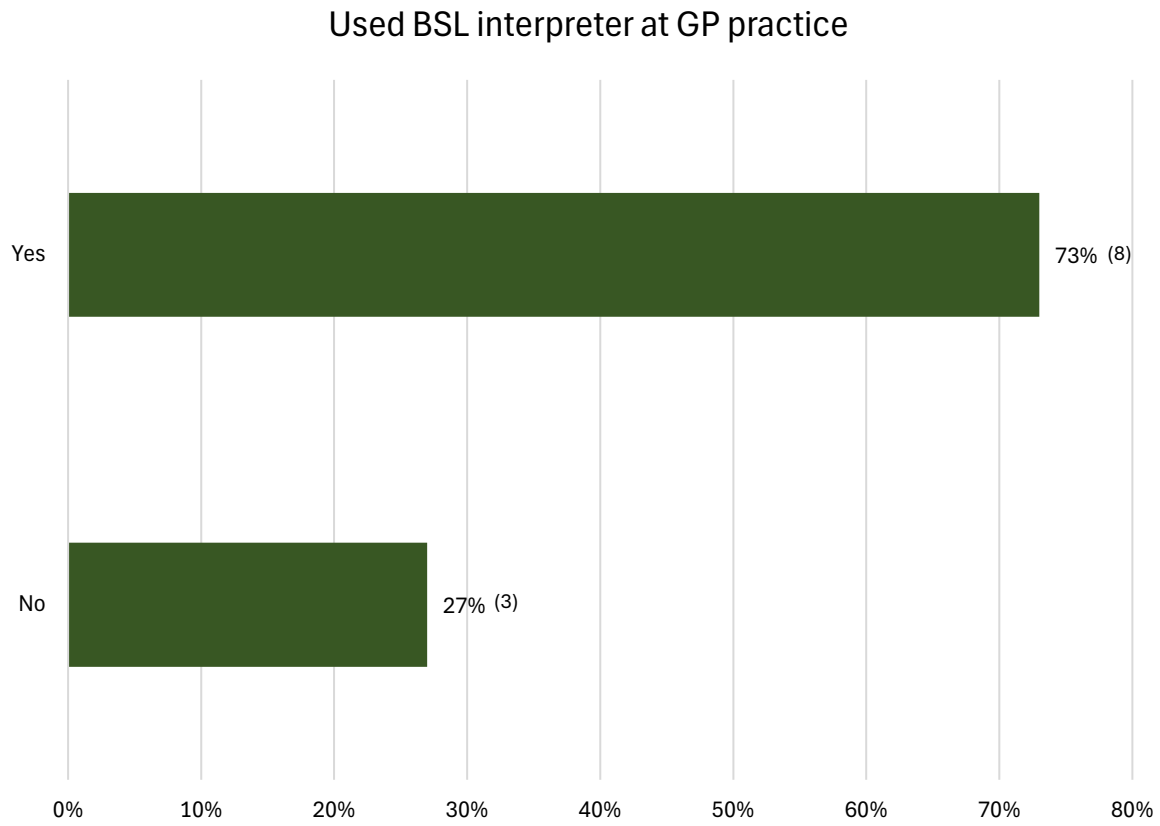


(Base N = 78)

When people selected 'Other' we asked them to explain their selection. This is what people stated they need to communicate effectively:

- **A person to assist (family/carers)**
  Because many cannot navigate communication independently.
- **Accessible written formats**
  Large print, clear writing, email, Braille, digital readers.
- **Lip-reading support**
  Face visibility, no masks, clear speech, good lighting.
- **Alternatives to phone calls**
  Email, text, written info, digital apps.
- **Interpreting & communication-skilled staff**
  BSL, clear English, patience, Deaf awareness.
- **In-person explanations**
  For reassurance, comprehension, and clarity.
- **Assistive tech**
  Hearing aids, voice-control systems, accessibility apps.

We asked those who indicated they use BSL whether they had used an interpreter at their GP practice. **Most said they had (73% - 8),** and **all of those who had used one reported that their interpreter was booked in advance for a face-to-face appointment** – and also confirmed this is their **preferred method**.



Comments received:

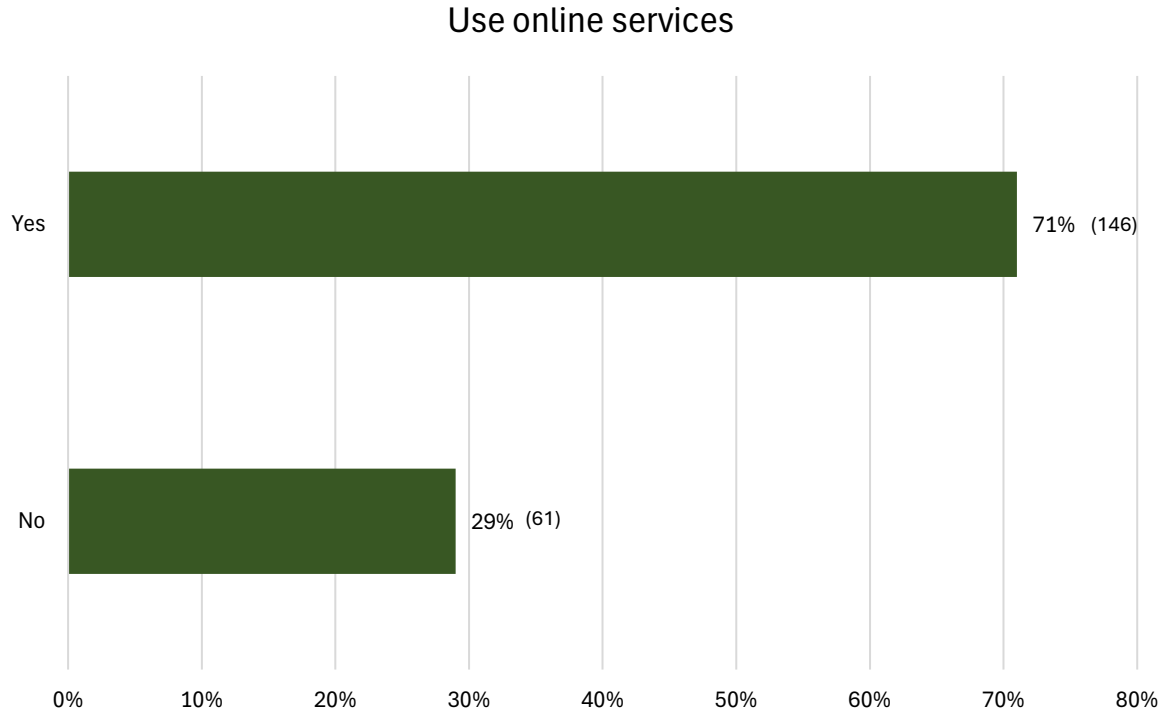
- "They need to book interpreter for me"
- "Can't attend appointment without one"
- "Prefer in person than video. Quality from video can be poor which is frustrating and sometimes I don't know that interpreter - maybe from other region with different sign language"
- "BSL interpreter is absolutely necessary. BSL interpreter in advance is hard due to lack of interpreters."

(Base – Used a BSL interpreter N = 11; How interpreter booked N = 6)

This page sets out **what works well** and **the challenges identified** by respondents who said **they receive what they need from services to communicate**.
Their comments also show the distinct challenges experienced by different sensory groups.

	What works well	Challenges identified
D/deaf	• Face-to-face BSL interpreters when booked in advance • GP arranging interpreters reliably • Receptionists coming to the window to speak clearly • Speakerphone use helps with bookings • Hearing aids + lip-reading when faces are visible	• Masks & screens block lip-reading • Staff not facing the person or speaking clearly • Interpreter rarely available for same-day/urgent appointments • 10-minute appointments too short when using BSL • Virtual interpreting poor quality • Reliance on family for communication when interpreter unavailable • Communication needs not flagged in GP record
Hard of Hearing	• Hearing aids effective in quiet/calm settings • Speakerphone improves clarity • Eye clinic sometimes provides large-print letters • Audiology (e.g., Specsavers) accessible and efficient • External support (e.g., BID hearing support team) helpful	• Masks continue to make speech unreadable • Staff may not speak clearly or face the person • Accents can reduce understanding • Online booking difficult, especially when unwell • Emails sometimes hard to read (formatting issues) • Mixed experiences across services: inconsistency is the norm
Blind	• Large-print letters appreciated when provided • Clear verbal explanations help • Some services (eye clinic) offer accessible communication • Able to use emails/texts if screen-reader friendly • Partner reading letters if needed	• NHS letters not consistently large print • Emails sometimes not screen-reader compatible • Phone calls replacing letters creates gaps • Variation between services—no standard approach
Partially sighted	• Direct verbal communication helpful • Can request interpreters when needed (mixed sensory needs) • Receptionists sometimes come to the window to help • Support available when planned in advance	• Online pathways difficult when vision fluctuates or when unwell • Reliance on family in some cases • On-screen interpreters unusable for people with combined mild hearing and sight difficulties
Deafblind	• Large print provided by support services • Some support from friends	• Still rely heavily on friends for communication • Large print alone is not enough for dual sensory loss • No indication of systematic communication adjustments

71% (146) said that they **use online services** – such as the NHS app, online booking systems, Connect2Support - to manage their health, care and support.
Respondents over 75 mostly reported that they did not use online services.

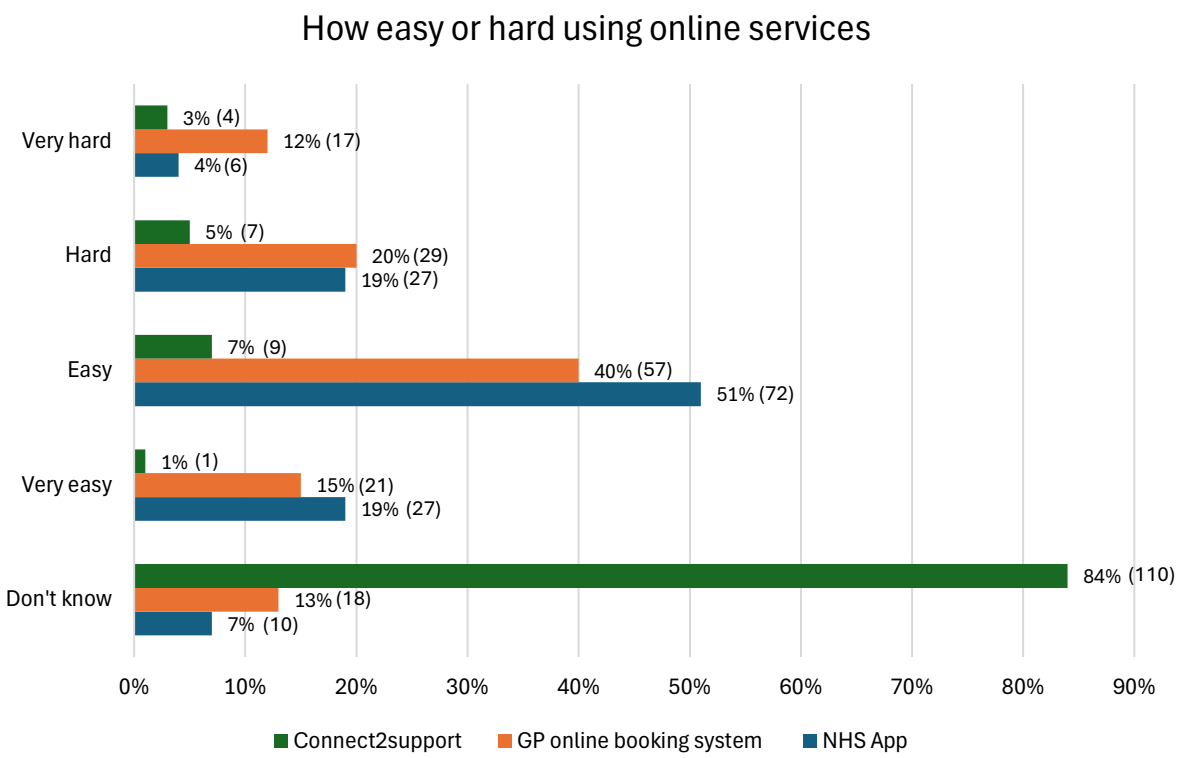


When looking at the results by sensory group, the information suggests:

- Those respondents who are hard of hearing generally have better access.
- Blind and deafblind respondents are more likely to be excluded.
- D/deaf users also faced barriers.
- Partially sighted users show signs of difficulty, though to a lesser extent.

(Base N = 207)

70% (99) respondents found the NHS App easy / very easy to use while a smaller proportion (55% - 78) said the same about the GP online booking system suggesting this was slightly harder to use .
Awareness and use of Connect2Support were low with the majority of respondents (84% - 110) saying they did not know about it.



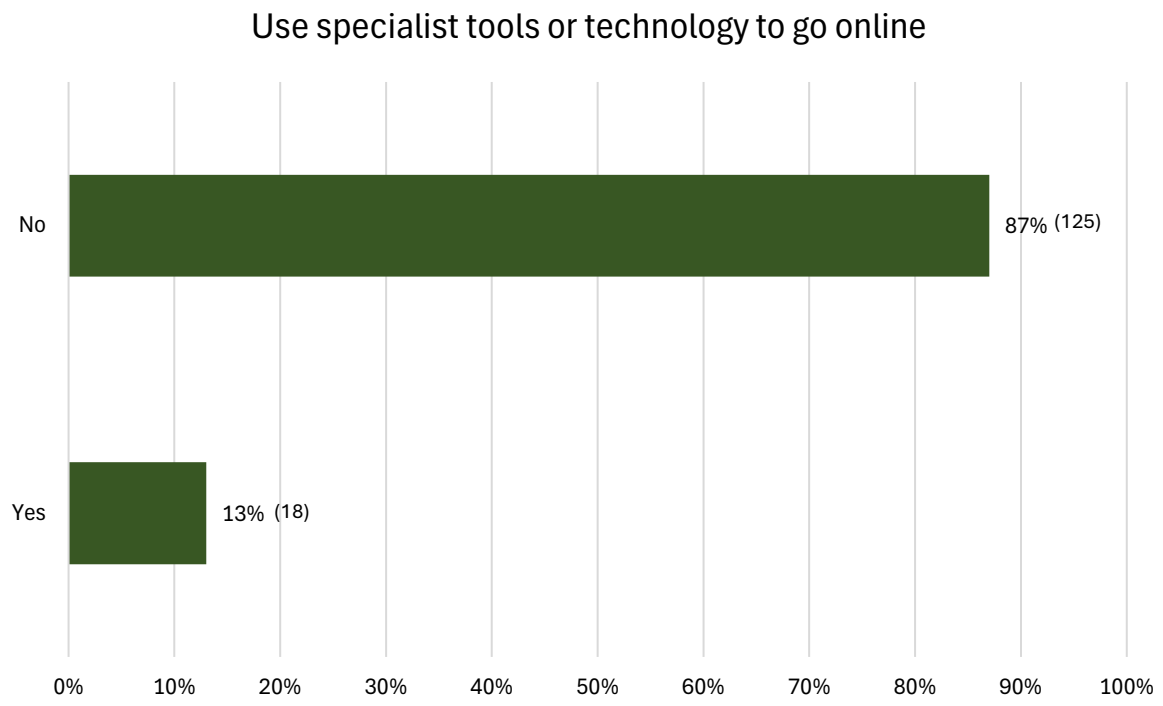
When broken down into sensory groups, the information suggests:

- Hard of Hearing respondents are the only group using digital services comfortably
- While Blind, Partially Sighted, D/deaf, and especially Deafblind people experience greater barriers to accessing them.
- Connect2Support has the lowest awareness and usability across all groups.

(Base NHS App & GP booking system N = 142 each; Connect2Support N = 131)

87% (125) said that they **do not use any special tools or technology to go online**.

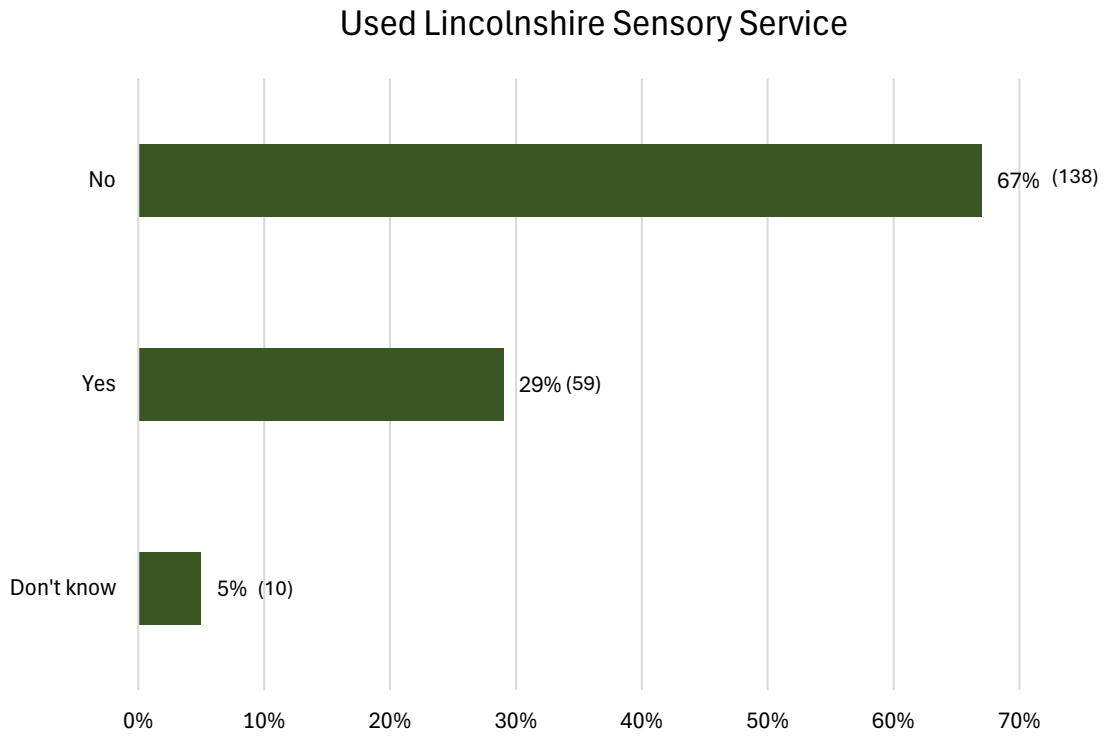
Among those who do, the largest groups were people who were blind or partially blind / partially sighted, although those who are D/deaf or hard of hearing reported using specialist tools or technology to support their online access.



- People use a wide range of technology to get online but **built-in accessibility settings and someone to support them** are the most common aids.
- People with sight-loss rely heavily on **magnifiers, screen readers and large-print.**
- Those with hearing-loss depend on **hearing-aid apps, clear audio settings and subtitles**.
- A significant number still need **carers or family members** to navigate online systems, showing that digital healthcare is **not yet fully accessible** to people with sensory impairments.

(Base N = 143)

67% (138) said that they **had not used Lincolnshire Sensory Service (LSS).** Use of Lincolnshire Sensory Services was highest among Blind and Partially Sighted respondents, but significantly lower among D/deaf and Hard of Hearing groups—while Deafblind individuals showed very little use of the service.



(Base N = 207)

When asked why people don't use Lincolnshire Sensory Service

- **Lack of awareness** – dominant theme with most comments alluding to this. Most respondents **have never heard of the services or don't know what it does**.
    - "Don't know what it is or what it does."
    - "Wasn't aware it existed."
    - "You keep it hidden."
- **Awareness low** across all sensory groups
- Several respondents said they were **never signposted** or were **missed by the referral pathway**.
- A number of people believe they **"don't need it"** – often because of independence or use alternative support / charities
- Service is **not visible** or **easy to access** – felt it was not visible, not promoted or available outside working hours.
- **Clearer eligibility messaging** is needed – people with moderate impairments assume it is not for them.
- A smaller number face **geographical or system navigation** issues, and only a tiny number mentioned any prior negative experiences.

When asked what people liked about LSS, it was valued for their **friendly and supportive staff**, **practical equipment**, **effective mobility and orientation training**, and **personalised home visits**. LSS is seen as responsive, reassuring and helpful, offering both emotional support and tailored practical solutions. Social connection, strong individual staff relationships, and good signposting to wider services further enhance satisfaction.

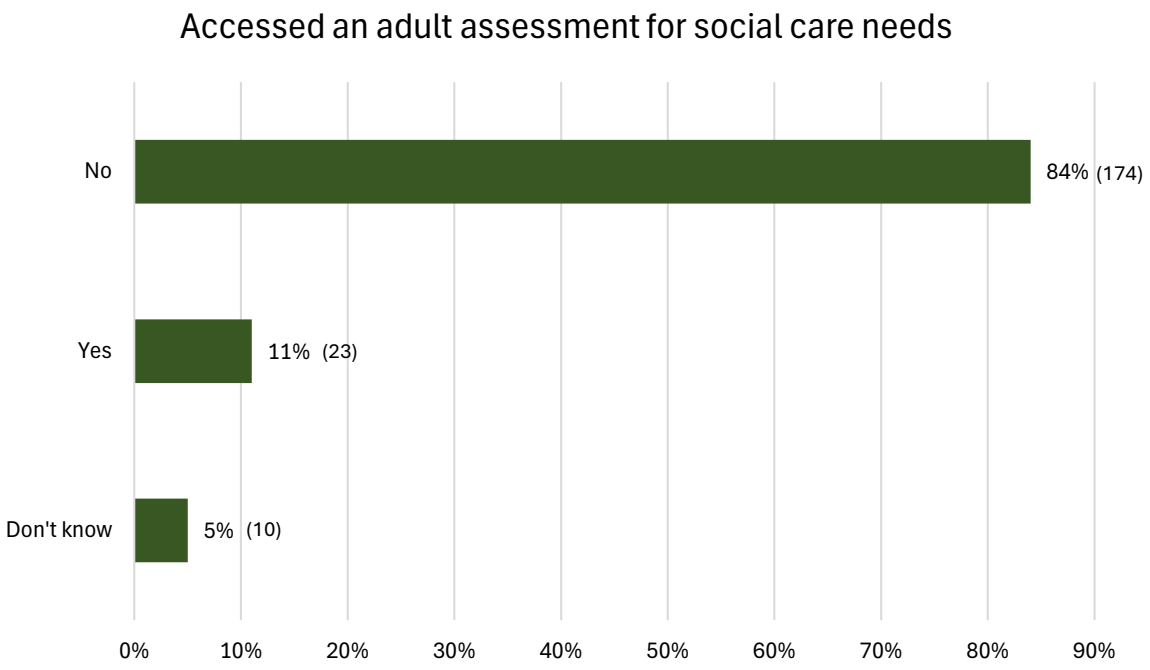
Helpful, supportive and approachable staff:	**Practical, useful equipment and home assessments**
This is the strongest theme and LSS staff are seen as one of the service's biggest strengths. People consistently praised staff for being: • Friendly, kind, and approachable • Patient and willing to work at the person's pace • Honest and supportive • Building strong relationships with families • Good at explaining what will happen next	Many people appreciated the practical tools and safety equipment provided. LSS provides **practical, tailored solutions** that make everyday life safer and easier. Items mentioned include: • Hearing-aid batteries and tubing • Hard-of-hearing fire alarms • Magnifiers, bright stickers, railings and safety devices • Digital or adaptive equipment • Cane training and mobility support
Mobility & orientation support	**Personalised home visits**
Especially valued among people with sight loss. Supported people to maintain independence. Support included: • Cane training • Mobility practice • Helping people learn new locations when moving into the area • Orientation support at home	Home visits feel **timely, personal and relevant**, enhancing safety and independence. People valued: • Home assessments • Tailored advice based on their environment • Staff visiting quickly after referral • Guidance with daily tasks (e.g. cooking safely)
Signposting and referral to other services.	**Social connection & inclusion**
People value LSS acting as a bridge to wider support. LSS is appreciated for connecting people to: • Wellbeing services • RNIB • Local support groups & other sensory charities	LSS helps reduce isolation, especially for those newly diagnosed or new to the area. Some highlighted the **social benefits**: • Interventions that help people meet others • Befriender visits • Ongoing contact and check-ins

When asked what could be improved people generally view LSS positively but would like improvements in **visibility**, **timeliness**, **Deaf awareness**, and **accessibility**. Many want **clearer information, easier self-referral, more proactive contact (including annual check-ins), and better coordination with other services.** Home-based support and travel-free assessments are also key gaps. A smaller set of comments highlight inconsistent responses or unmet needs for people with more profound sensory loss.

Awareness, visibility & accessibility of information:	**Timeliness & follow-up**
People want LSS to be easier to find, easier to contact, and easier to understand. Many respondents said LSS needs to be **more visible**, with clearer information on: • How to contact the service • What support is available • Where and when services take place • How to self-refer	People value the service but feel it needs to be **more proactive**, **regular**, and **timely**. Several people reported delays, missed follow-ups or lack of ongoing contact: • "Often long delays for services." • "They have not done anything else for me since the first visit." • "Recontact every year or so." • "A check-in (wellbeing) by phone would be appreciated." • "Have not yet had the assessment needed after Covid."
Service performance, co-ordination & joined up support	**Training and staff awareness**
People value LSS but want it to be better integrated with NHS, social care, and voluntary sector support. Some suggest LSS could work more closely with other services – both Sight and hearing. • "Plan ahead with other services coming together for sight and hearing." • "Do not refer to other services in the community for long-term support." A small number reported: • service not being suitable for their level of sensory loss • receiving no response • dissatisfaction with some external providers	People want **better Deaf awareness**, consistent recording of communication needs, and reliable access to interpreters. This was a strong theme, especially for D/deaf respondents. • "Train staff to be Deaf aware." • "Staff need to understand what a D/deaf person is entitled to re: interpreter." • "My deafness/communication needs must not be clearly displayed."
More home-based support	**Group activities & social connection**
Home visits and local delivery are especially important for those with mobility, sight loss, or transport barriers. A recurring request was for **support to come to** them, rather than requiring travel: • "Better if they came to us." • "I was not able to travel for the Low Vision Assessment.	People appreciate social contact and would like more opportunities for learning and connection. A minority requested broader community and educational opportunities. • "More guest speakers." • "Social interventions—meeting people."

84% (174) said that they **had not accessed an adult assessment for social care needs.**

The results show that awareness and uptake of adult social-care assessments differ considerably across sensory groups.



- **Hard of Hearing respondents are the least informed**, with half unsure whether they have been assessed,
- **D/deaf respondents also show high uncertainty**, likely reflecting communication and signposting gaps.
- Blind and Partially Sighted respondents are **much more likely to have been assessed**, suggesting stronger pathways from eye-care services.
- Very low numbers for **Deafblind** respondents.

(Base N = 207)

HW Lincs

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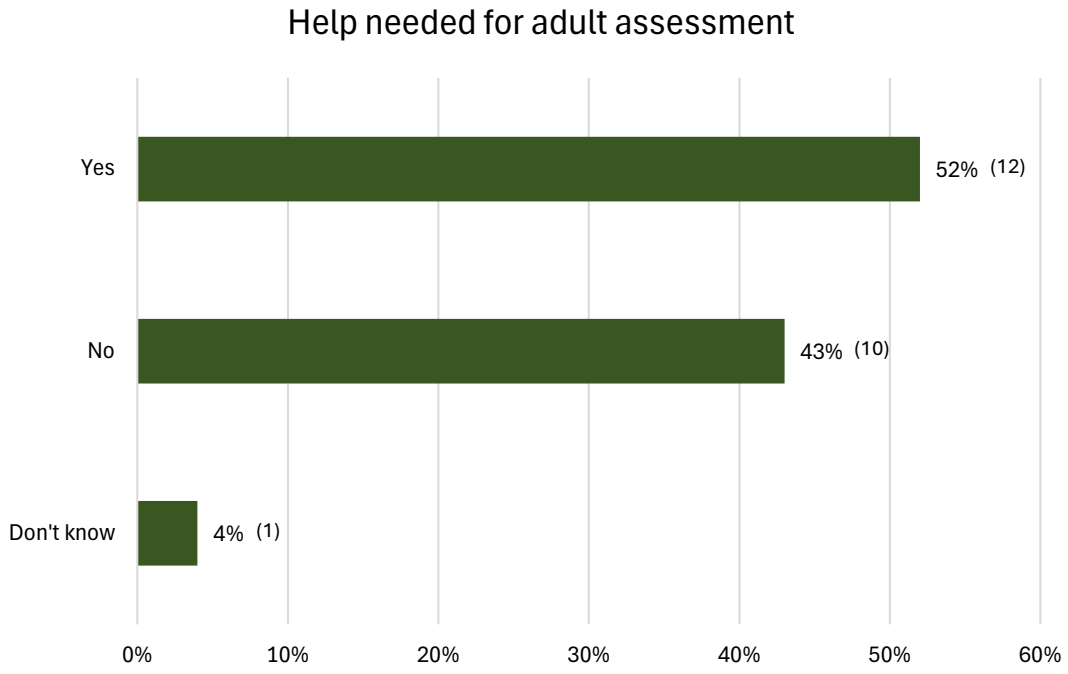
52% (12) of respondents said that they needed help to complete the adult assessment **for social care needs.**

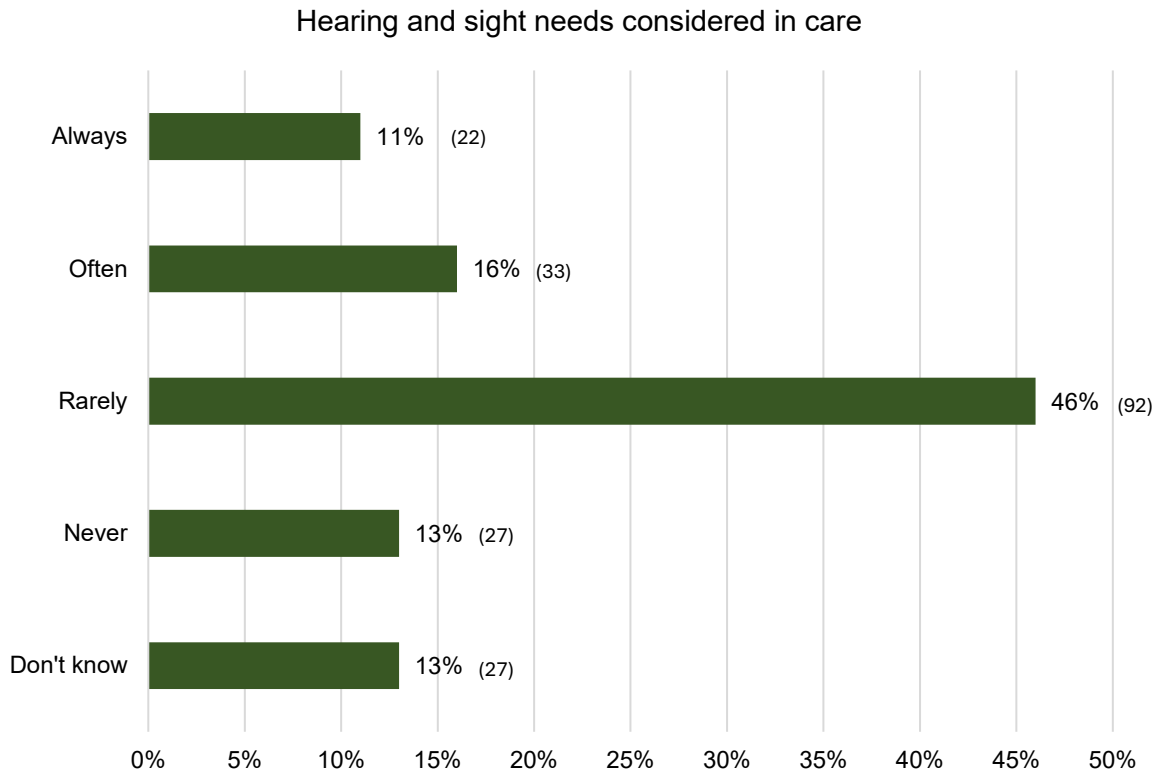
The findings show that a**wareness and uptake of adult social-care assessments vary across sensory groups**.



- **Partially sighted** respondents were the **most likely** to report needing help to complete an adult assessment
- **Blind and D/deaf** respondents showed **similar levels of support need**.
- **Hard of Hearing** respondents reported the highest proportion of **“don’t know”** responses, indicating uncertainty about whether they needed help or whether support was available.
- Reported figures for **Deafblind respondents were low**, reflecting the small number of responses in this group.

(Base N = 23)

59% (119) of respondents said that they **rarely or never** felt their sight and hearing needs were considered in their care.
Across all sensory groups, experiences vary, with respondents reporting a mixed picture of how well their sensory needs were taken into account.

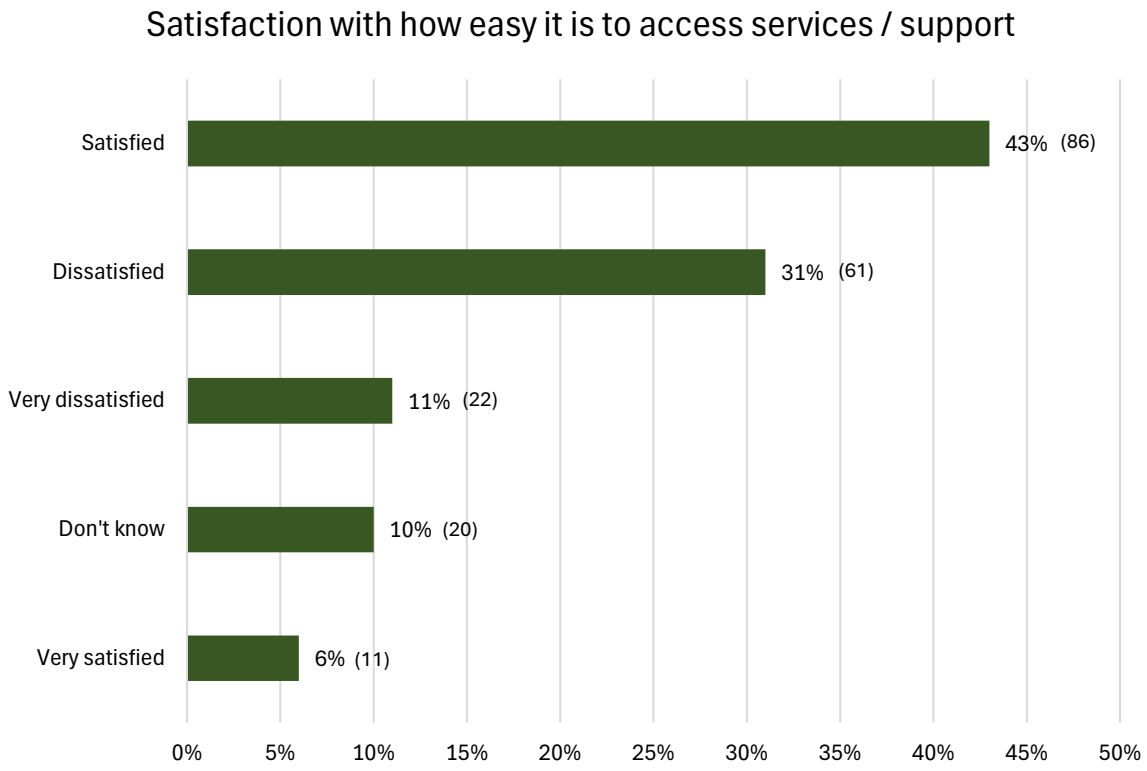


- **Hard of Hearing respondents show the greatest inconsistency,** with many reporting that their needs were **rarely or never considered** and over half saying they "don't know,"
- **Partially sighted** respondents had the **highest proportion** reporting that their needs were "Always / Often" considered.
- **D/deaf and Blind** showed similar mixed patterns with some saying their needs were regularly considered and others reporting "Rarely / Never" taken into account.
- The **small Deafblind sample** shows a mix of outcomes – due to small numbers.

(Base N = 201)

49% (97) of respondents said that they were **satisfied or very satisfied** with how easy it is accessing services (both health or care)– however **42% (83) stated they were dissatisfied or very dissatisfied**.

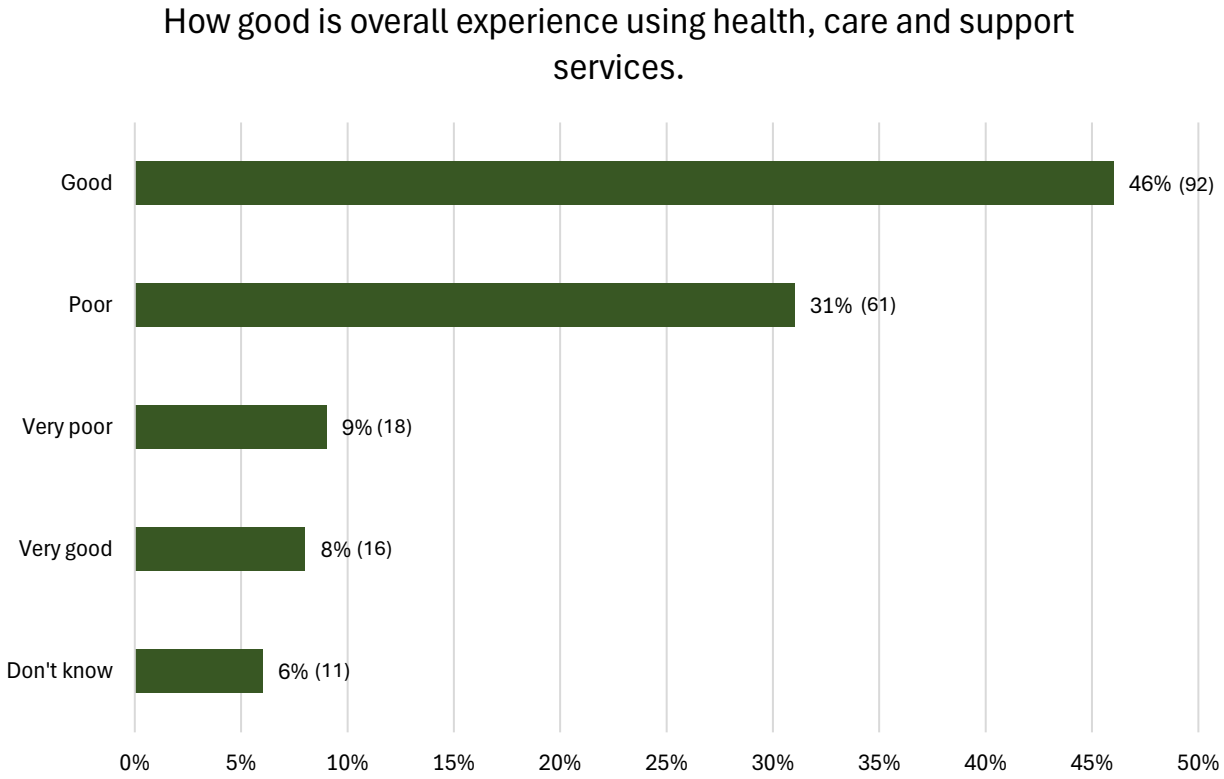
Overall, the results show a mixed picture of satisfaction across all sensory groups with no single pattern emerging.



- **Hard of Hearing respondents show the highest reported satisfaction.**
- **D/deaf, Blind and Partially Sighted groups show more mixed or negative patterns**, with a notable proportion reporting dissatisfaction.

(Base N = 200)

54% (108) of respondents said that their overall experience of using health, care or support services was **good or very good**.
Across sensory groups, experiences vary, with respondents reporting a wide range of satisfaction levels with health, care and support services – with no consistent pattern emerging.



(Base N = 198)

- **Hard of Hearing** respondents show the greatest variation across all categories, including a high proportion selecting “don’t know.”
- **D/deaf** and **Partially Sighted** respondents have more **negative** than positive ratings
- **Partially Sighted** group showing a notably high **“very poor”** score.
- **Blind** respondents appear more balanced with no single rating dominating.
- Figures for **Deafblind** respondents are low due to small sample size.

In response to the question about what health and care services could do differently, respondents consistently highlighted the **need for more support to navigate health settings and access care**. The feedback points to system issues rather than isolated incidents, with people describing difficulties related to **long waiting times**, **appointment access**, and **poor communication**. Many respondents – particularly those who are D/deaf or Hard of Hearing – also emphasised the importance of **better deaf awareness and accessible communication**, including staff training, clearer recording of communication needs, and alternatives to telephone-based systems. The themes below reflect the most frequently raised areas for improvement and illustrate how these challenges affect people's ability to access safe, timely and appropriate care.

Reduce waiting time and improve appointment access

Suggestions / topic	Comments
This was the most frequently topic raised • Respondents repeatedly mentioned long waits for GP, ENT, audiology, eye-care, and hospital appointments, • Reduce last-minute cancellations • Improve appointment choice.	• "Shorter waiting times for appointments." • "Hearing test appointment quicker than 12 months." • "I've been waiting months for hospital appointments." • "Don't cancel appointments at the last minute." • "Hip consultation has been cancelled four times."

Improve deaf awareness and accessible communication

Suggestions / topic	Comments
Particularly strong theme among D/deaf and hard of hearing respondents. • Respondents repeatedly mentioned long waits for GP, ENT, audiology, eye-care, and hospital appointments, • Reduce last-minute cancellations • Improve appointment choice. • Face-to-face communication rather than phone • Staff speaking clearly, facing the person • Not wearing masks when possible • Ensuring communication needs are flagged on records • Reliable access to BSL interpreters • Clearer name-calling systems in clinics	• "Train staff to speak loudly and clearly, facing the person." • "Recognise that I am deaf… if my notes say I'm deaf then I am." • "Make communication needs clear to all staff accessing my records." • "Not having to use the telephone… easier if I could email.

Continued ...

Make digital access easier – or provide alternative	
Suggestions / topic	Comments
Digital access is difficult for many due to sensory loss, age or lack of confidence • Create more options other than phone calls • More use of email, SMS and online chat • Accessible online booking • Avoiding systems that repeatedly change • Support for older people using digital services	• “Make more services available online.” • “Online access is confusing for older generation” • “Easier to book appointments …. Less duplication.”
Improve sight loss awareness and physical accessibility	
Suggestions / topic	Comments
A major cross-cutting theme • Large-print letters – as standard not on request • Clear signage and walkways • Removal of obstacles in clinics • Being guided appropriately – help navigating large settings like hospitals • Better explanations during eye-care • Consideration of where beds are placed for ward patients • Clearer, louder name calling in waiting rooms • Support in wards for blind / hearing impaired patients	• “People forget I am blind.” • “Don’t put obstacles in my way.” • “Phones calls or large print.” • “Pay attention to my requirements …..” • “Don’t leave medication out of reach”

Continued ...

Improve communication, follow-up and information sharing	
Suggestions / topic	Comments
A major cross-cutting theme • Clearer updates between referral and appointments • Better explanations during procedures • Services to read and act on individual's notes / records • Faster responses to queries • Avoidance of contradictory or incorrect letters • Easier ways to contact hospitals and GP practices	• "More communication in between referrals and appointments." • "Keep careful records and read them." • "Better communication from hospital… no explanation as to what was happening." • "Response to requests and replying to questions, not ignoring questions." • "Not easy to book, everything is online.

More compassion, personalisation and time with clinicians	
Suggestions / topic	Comments
People described rushed appointments and lack of empathy.	• "Listen to me." • "Treat me as a whole person" • "More time with clinicians to explain things"

Consistency across departments and joined-up working	
Suggestions / topic	Comments
Respondents reported variation in quality between services. Fragmentation leads to repeated assessments, miscommunications and gaps in support.	• "Support varies from department to department." • "Join up services" • "Should always be an ECLO onsite."

Equalities summary

Some respondents also shared experiences shaped by wider life circumstances, showing how sensory loss can be made harder by social circumstances, protected characteristics and health inequalities. It should be noted that some of the findings within these sections are based on relatively small numbers of responses and should therefore be interpreted with appropriate caution.

Location

District-level analysis shows consistent geographic variation in experiences. Respondents living in **East Lindsey and South Holland** reported greater difficulty across multiple questions, including knowing where to go for help, booking and attending appointments, accessing information, and having sensory needs recognised. These challenges were frequently linked to rurality, transport, service location and limited local provision. Experiences in **Lincoln City and North Kesteven** were more mixed but generally reported better access and awareness, although pressures on availability and communication were evident across all districts, indicating that many issues remain county-wide.

Age

Analysis by age shows a clear and consistent pattern: **respondents aged 75 and over, particularly those aged 85+, report greater difficulty** across almost all aspects of access, communication, involvement and awareness of services. Challenges increase progressively with age and are often compounded by digital exclusion, mobility issues and reliance on carers. Younger respondents generally report fewer barriers and greater confidence navigating systems. These findings suggest that age significantly intensifies the impact of sensory loss on access to health, care and support services.

Sexual Orientation

Analysis by **sexual orientation shows no statistically strong or systemic differences in access to services**. However, respondents identifying as lesbian, gay or bisexual were marginally more likely to report uncertainty about where to seek help, reduced confidence navigating services, and lower involvement in decisions about their care. While these differences were small and numbers limited, they suggest that trust, confidence and cumulative barriers may disproportionately affect some LGBT+ people with sensory loss, alongside the broader accessibility challenges experienced across all groups.

Equalities summary

Gender

Analysis by **gender shows no strong systematic differences** in access or experience for people managing their own care. However, women were more likely to be responding on behalf of others and to report additional barriers linked to caring and coordination responsibilities, including missed care, involvement in decisions, and navigating information across services.

Ethnicity

Analysis **by ethnicity shows no evidence of widespread differential treatment**; however, respondents from ethnic minority backgrounds were slightly more likely to report **uncertainty about where to seek help, difficulties understanding available support, and lower involvement in decisions about care**. These challenges were most apparent where respondents also faced communication barriers or relied on family members for interpretation and advocacy. While numbers were small, the findings suggest that clarity of information, accessible communication and confidence navigating services can compound the impact of sensory loss for some ethnic minority respondents.

Nationality

Analysis by nationality indicates that respondents who were non-UK nationals were more likely to experience **uncertainty about navigating health and care services and understanding entitlement, particularly where English was not their first language**. Some reported additional barriers related to communication, confidence interacting with services, and awareness of support options. Differences were modest and often intersected with sensory impairment and language needs rather than nationality alone, suggesting that system complexity and accessibility play a greater role than nationality itself in shaping experiences

Religion and belief

Analysis by religion and belief shows no strong or systematic differences in access, communication, or experience of health and care services. **Minor differences were observed in confidence navigating services and involvement in decision-making** among some respondents identifying with minority religions or no religion, but these were relatively small and closely linked to communication and accessibility factors rather than belief. Overall, age, impairment severity and service design were far more influential in shaping experiences than religion or belief.

Equalities summary

Caring responsibilities

Analysis by caring responsibilities shows that respondents who provide care for others experience greater difficulty across multiple aspects of access, communication, and coordination. Carers were more likely to report challenges booking and attending appointments, missed or delayed care, lower involvement in decisions, and increased reliance on themselves to interpret and relay information. These findings indicate that caring responsibilities compound existing barriers and place additional burden on individuals who play a critical role in supporting people with sensory loss to access health and care services

Employment status

Analysis by employment status shows that while people in employment benefit from greater access to information and digital systems, they face additional barriers related to appointment timing, flexibility and missed care. Respondents not in employment, particularly those who are retired or not working due to health, more often experience barriers linked to health complexity, transport and digital exclusion. These findings indicate that employment status shapes the type of access barrier experienced, rather than overall need, and that flexible, inclusive service design is required to reduce inequalities across working and non-working populations.

Inclusion health groups (farming, armed forces, homelessness, asylum seekers)

Responses from people identifying with inclusion health groups—including those working in or with experience of **farming and agricultural communities**, **armed forces veterans**, people with current or past experience of **homelessness**, and **refugees or asylum seekers**—indicate heightened vulnerability to access barriers. These respondents were more likely to report difficulties navigating services, delayed or missed care, lower awareness of available support, and challenges linked to communication, transport, and system complexity. In rural and farming communities, barriers were often compounded by isolation and service distance, while veterans highlighted gaps in continuity and entitlement. Respondents with experience of homelessness or migration described additional uncertainty and reduced confidence engaging with services. Although numbers were small, the findings suggest that intersecting factors—such as instability, rurality, and reduced access to information—can intensify the impact of sensory loss, reinforcing existing health inequalities for these groups

Section 4

Community conversations

Summary

This section brings together insight from our community conversations across Lincolnshire. We spoke with people living with sight or hearing loss, including those who had been blind or Deaf from birth as well as those experiencing sight or hearing loss later in life.

Conversations were held across multiple community settings, including local blind societies, sensory service drop-ins, Deaf community groups, and friendship groups in coastal, rural and urban areas. Participants included people with sight loss, hearing loss, Deaf and Deafblind people, carers, and community advocates. These discussions provided rich lived-experience insight, often expanding on or contextualising issues raised through the survey.

Participants consistently described how repeated, everyday barriers—such as inaccessible communication, missed calls, or difficulty navigating buildings—can have a cumulative effect over time. Small failures built into systems were reported to reduce confidence, increase anxiety, and, in some cases, lead people to delay care or disengage from services altogether. Reliance on family members or carers was often described as a last resort rather than a preference, driven by the effort required to navigate systems not designed with sensory loss in mind.

People also described reluctance to be seen as “difficult” or to ask for adjustments, particularly when staff appeared busy or under pressure. While many positive experiences were shared, these were often linked to individual staff rather than consistent system design. Participants emphasised that small, practical actions can make a significant difference, but that these need to be embedded routinely so that accessibility, dignity and independence do not depend on chance or individual goodwill.

- The community visits from **4th February – 24th March**
- Spoke to **150 people** about their experiences of living with sight or hearing loss
- **We visited 11 locations across the county** - Spalding, Grantham, Fishtoft, Louth (x2), Lincoln, Gainsborough, Mablethorpe, Skegness, Sleaford, Boston; and **attended one online zoom meeting**
- **Group visits were organised through Lincolnshire Sensory Service, Lincoln and Lindsey Blind Society and South Lincs Blind Society**
- A variety of **ages and a mix of genders**.
- Received **2 emails from individuals** with comments and held **4 telephone conversations**.
- Attended **one meeting about interpretation services in GP practices** and had feedback from **one service provider**.

Key themes emerging from conversations

These extracts highlight some of the key points raised throughout our community conversations together with specific examples.

Key themes	Specific examples	Personal examples
Accessing appointments: • **Difficulty securing GP appointments**, particularly through 8am phone-based systems and long call queues • **Inconsistent experiences between practices**, with some systems working well for certain people but excluding others –suggesting inequality in the county • People frequently **resorting to workarounds**, such as attending practices in person, relying on family to book, or delaying care • **Appointment flexibility** (e.g. weekend or ring-back options) viewed positively where available	• Long **8am phone queues**, with people reporting being *number 140+* in the queue • Appointment offers sent as **text links or emails**, even where people had explicitly asked not to receive digital communication • People **walking to the GP surgery** to book appointments because phone and online routes were inaccessible • Appointments cancelled or delayed because people could not **access online check-in screens** in time • People waiting **12–18 months for ENT appointments**, leading to unmanaged symptoms and reliance on pharmacies for interim advice	• A person with sight loss described ringing their GP practice every morning at 8am, often waiting 30–45 minutes only to be told all appointments had gone. Eventually, they began **walking to the surgery** to book appointments in person, even though this was physically difficult, because it was the only reliable way to access care. • Another participant received an appointment notification via a **text link**, despite having requested not to receive digital communications. They did not know what the appointment was for and only discovered it was a heart scan by phoning the hospital. Had they not chased it, they would have missed a next-day appointment.
Navigating health and care environments • **Finding and moving around buildings** often reported as more stressful than the appointment itself • **Poor signage, low-contrast colour schemes, unclear directions** (e.g. “go over there”), and inaccessible self-check-in systems • **Verbal-only calling systems in waiting rooms** causing confusion and missed appointments • **Heavy reliance on volunteers, staff goodwill, or family to navigate settings**	• **Black mats, rugs and dark flooring** appearing like holes or drop-offs to people with sight loss • Signs placed **too high**, in **grey or low-contrast colours**, making them impossible to read • Directions such as *“go over there”* or staff pointing, with no verbal description • People being called verbally from busy waiting rooms and staff **walking off immediately** • Inaccessible **self check-in screens** with no audio output, tactile controls, or staff support • No one offering help even when people were using a **white cane or guide dog**	• Several people described **black mats and dark flooring** in hospitals appearing like holes in the ground, causing them to stop abruptly or avoid walking forward altogether. Some said they had almost fallen because they thought there was a drop. • A blind person described **being called into an appointment from a busy waiting room,** hearing their name shouted, and then being left behind as the clinician walked away. They could not see where to go and no one checked that they were following

Key themes continued ….

Key themes	Specific examples	Personal examples
Communication barriers • Repeated need for individuals to restate their sight or hearing loss, despite this being recorded on person's record / notes • Ongoing use of inaccessible formats, including unreadable letters, emails, PDFs, texts, and digital portals • Deaf participants reporting significant distress and loss of independence following changes to BSL interpreter provision, with poor communication and lack of notice • Reliance on family members to interpret sensitive or confidential information, which was widely viewed as inappropriate	• Appointment letters and hospital correspondence sent as **PDFs that screen readers cannot read** • Information sent in **small print**, with no large-print alternatives offered • People repeatedly **having to explain they are blind or Deaf** at every contact, despite this being on their record • Deaf patients being told to **email interpreter services**, despite English not being their first language • Family members being asked to **interpret sensitive medical information**, rather than providing a BSL interpreter • Medication instructions misunderstood due to **lack of visual or signed explanations**, leading to hospital admission	• A Deaf participant described being asked repeatedly to **email an interpreter service**, despite explaining that English is not their first language. When no interpreter attended, they were expected to rely on family members during confidential appointments, which they found distressing and inappropriate. • A person with sight loss received hospital letters only as **PDF documents**, which could not be read by their screen reader. They relied on neighbours or carers to read them aloud, sometimes days later, meaning they missed deadlines or follow-up actions.

Transport and rural isolation
• Difficulty aligning appointment times with bus services, especially in **coastal and rural areas**
• Limited or no access to community transport in some locations
• Inconsistent eligibility for patient transport, even where driving was not possible
• Transport challenges leading to missed appointments, increased anxiety, or avoidance of care
	• Appointment times scheduled with **no consideration of bus timetables**, resulting in:
	  • Long waits (e.g. until 7pm) to return home
	  • Inability to attend early-morning appointments
	• Lack of **community or voluntary transport** in some areas (e.g. Skegness)
	• Being told people do not qualify for patient transport because they are Deaf, despite inability to drive
	• Taxi drivers **refusing to take guide dogs**
	• Having to decline appointments because **no one could bring them home afterwards**
		• A participant from a coastal town explained that a hospital appointment finished at 4pm, but the **next bus home was not until 7pm**. They sat alone in the hospital for hours because they could not afford a taxi and were not eligible for patient transport.
		• Another person was offered a cataract appointment but had no way to get home safely afterwards because they had been told not to drive. When they explained this, the service did not understand why attending the appointment was still not possible.

Key themes continued ….

Key themes	Specific examples	Personal examples
Staff awareness, attitudes and assumptions • **Experiences varied widely** depending on individual staff awareness and confidence • Concerns about **staff speaking to carers** rather than directly to the person • Assumptions that **sight or hearing loss equates to incapacity or dependency** • **Misunderstanding or fear relating to assistance dogs,** sometimes resulting in refusal of care • **Strong view that small changes in staff behaviour could significantly improve experiences**	• Staff speaking to **carers or partners** instead of the person with sensory loss • Doctors expressing fear that guide dogs might attack them • Clinicians surprised that blind people: live independently; work; have families • People **not being offered blindness registration certificates** unless they explicitly asked • **Staff not reading person's notes before appointments, leading to inappropriate questions** (e.g. finger-counting tests for people with no sight)	• A blind participant described attending an appointment with their partner but felt invisible as staff spoke only to the partner throughout the consultation, despite the person answering questions directly. • One person reported that a doctor refused to examine their arm because they were frightened of the person's guide dog, instead sending them for an X-ray without an examination. The same individual had experienced similar reactions from another clinician days later.
Digital access and exclusion • Increased reliance on digital systems viewed as **isolating rather than enabling** for many people • Self-check-in screens, apps and online forms often inaccessible to screen readers or low-vision users • Older participants and those with severe sight loss particularly affected • Some positive experiences where technology had been adapted or supported through training	• Online forms timing out before people could complete them using accessibility tools • GP websites with "accessibility readers" that actually blocked screen reader software • Touch screens being too sensitive, causing screens to move unexpectedly • NHS App and portals requiring multiple codes and screens, which were not compatible with screen readers • People choosing to ignore forms or emails entirely because they could not access them	• A partially sighted person explained that online forms regularly timed out before they could complete them using magnification software. They eventually stopped trying and simply ignored forms they could not access. • At one GP surgery, patients were required to check in via a touchscreen kiosk. A blind participant arrived on time but was marked late for their appointment because they could not use the screen and had to queue at reception for help.

Value of sensory and voluntary sector support
• **Lincolnshire Sensory Service, local blind societies, and Deaf community groups consistently praised**
• **Support described as life-changing in areas such as registration, confidence, navigation, and emotional wellbeing**
• **Awareness of these services uneven, often dependent on chance or community connections rather than systematic referral**
	• Blind societies providing:
	  • Audio newspapers on USB sticks
	  • Badges and lanyards for public understanding
	  • Rapid help finding information
	• Lincolnshire Sensory Service:
	  • Visiting people at home
	  • Supporting confidence and independence
	  • Helping people see a future after diagnosis
	• Guide Dogs and volunteers assisting with:
	  • Navigation
	  • Confidence outdoors
	  • Education of the public
		• Members of a blind society described receiving audio newspapers on USB sticks, which allowed them to keep up with news and feel less isolated when they could no longer read print.
		• People repeatedly described Lincolnshire Sensory Service staff visiting them at home and helping them regain confidence after sight loss, often describing this support as helping them "see a future again".

Quotes to illustrate challenges and barriers

"It says on my record that I can't read text messages, but they still keep sending them instead of ringing me."

"Black mats on the floor look like holes. I stop because I think I'm about to fall."

"They tell you to go *'over there'* and point, but I'm blind. Over there could be anywhere."

"I was told to use a family member to interpret. That's private medical information – it shouldn't be their job."

"When someone just asks, *'How can I help you?'* everything changes. It's the small things."

"If my family didn't come with me, I wouldn't know where to go or what was happening."

What needs to change or improve

These extracts highlight key areas for improvement and suggestions identified through our community conversations.

NHS Lincolnshire Integrated Care Board

Key themes	What needs to change	Suggestions for Improvements
Accessing appointments:	• Reduce reliance on **8am call queues** as the primary access route • Ensure appointment systems are designed around **accessibility, not speed alone** • Recognise that people with sensory loss may require **more time and fewer barriers** to access care	• Provide **multiple accessible routes** to book appointments (not phone-only or digital-only) • Expand and standardise **ring-back systems** and online forms where they work well • Increase availability of **face-to-face booking at GP practices**, particularly for people with sensory loss • Offer greater **flexibility in appointment times**, including later morning slots and weekends
Navigating health and care environments	• Move away from environments designed primarily for **wheelchair access only** • Ensure navigation support is **proactive, not dependent on the person asking** • Remove or adapt **self-check-in screens** that are inaccessible without staff support	• Clinicians and staff to **collect people from waiting areas** and guide them to rooms • Use **clear, descriptive verbal directions** (“turn left”, “door on your right”) instead of pointing • Improve **signage** using high-contrast colours and consistent placement • Explore **assistive navigation technology** (e.g. audio or sat-nav style guidance within buildings)
Communication barriers	• Full and consistent compliance with the **Accessible Information Standard** • End reliance on family members to interpret **confidential or complex information** • Improve communication around **service or contract changes**, particularly where they affect accessibility	• Ensure **communication preferences are clearly recorded, visible, and consistently followed** • Provide information by **letter, phone, email or accessible format**, based on person’s need • Guarantee **timely booking and confirmation of BSL interpreters**, with clear communication to the person • Use **plain English**, visual aids, and explanations checked for understanding
Transport and rural isolation	• Recognise that transport barriers are a **core access issue**, not a personal inconvenience • Reduce centralisation where it disproportionately affects people with sensory loss • Improve coordination between **service providers and transport planning** • Provide more assistance on public and patient transport	• Schedule appointments that better **align with public transport timetables** • Expand **community and voluntary transport schemes**, particularly in rural areas • Provide clearer information about **patient transport eligibility** and alternatives • Consider location of services to **reduce unnecessary travel**

Key themes emerging from conversations

These extracts highlight some of the key points raised throughout our community conversations

NHS Lincolnshire Integrated Care Board

Key themes	What needs to change	Suggestions for Improvements
Staff awareness, attitudes and assumptions	• Address assumptions that sensory loss equates to incapacity or dependency • Embed awareness into mandatory training, not optional sessions • Shift culture from avoiding offence to confident, informed engagement • Shift from isolated examples of good practice to system-wide consistency • Build accountability for accessibility into everyday processes • Treat sensory accessibility as fundamental to safe, dignified care	• Deliver sensory awareness training for clinical, reception, and hospital staff • Encourage staff to ask simple, respectful questions: *"How can I best support you?"* • Reinforce the importance of speaking directly to the person, not carers • Improve understanding of assistance dogs and legal access rights • Implement regular, practical awareness training using lived experience • Use easy wins (waiting with people, reading information aloud, clear direction) • Explore proven assistive technologies for navigation and communication • Share good practice across GP practices and hospitals
Digital access and exclusion	• Stop treating digital access as a default solution for everyone • Design systems around real-world accessibility, not assumptions about ability • Recognise that digital exclusion can be permanent or situational, not transitional	• Maintain non-digital alternatives as equal access routes • Ensure digital systems are compatible with screen readers, magnification and voice tools • Provide support and training where technology is introduced • Avoid time-limited online forms that disadvantage slower input methods
Social care, support and wellbeing	• Reduce reliance on informal networks to compensate for system gaps • Improve coordination between health, social care and voluntary sectors • Recognise wellbeing and independence as core outcomes, not add-ons	• Improve early signposting to social care and sensory support services • Address gaps in respite and support for carers • Provide clearer information about entitlements and assessments • Support opportunities for social connection and peer support
Value of sensory and voluntary sector support	• Move away from chance-based access to support • Treat sensory and voluntary services as integral to the care pathway • Ensure sustainability and continuity of these services	• Strengthen formal referral pathways into sensory and voluntary sector services • Involve these organisations in training, service design and engagement • Increase visibility of services at the point of diagnosis or registration

Patterns emerging from community conversations

Although demographic data was not formally collected, the community conversations revealed clear and consistent differences in experience linked to the nature of sensory loss, independence, and context.

Lifelong vs newly acquired sensory loss - distinct differences emerged between people who had been blind or Deaf from birth and those experiencing **recent or progressive sensory loss**. People with lifelong sensory loss often described greater confidence and self-advocacy, while those newly affected reported anxiety, reduced independence, and difficulty adjusting to systems that did not respond to changing needs.

Differences by type of sensory loss - experiences varied notably by sensory loss:

- People with **sight loss** highlighted challenges with navigation, environmental design, and inaccessible information.
- People with **hearing loss** described difficulties with telephone-based access, background noise, and face-to-face communication.
- **Deaf and BSL-using participants** reported the most significant barriers, particularly around interpreter provision, communication consistency, and loss of autonomy.

Independence and reliance on others - clear differences were evident between those attending appointments independently and those relying on **family members or carers**. Reliance on others was often described as unavoidable rather than preferred, with impacts on privacy, dignity, and independence.

Rural and coastal experience - participants living in **rural and coastal areas** consistently described compounded barriers, particularly relating to transport, service location, and appointment timing. These factors intensified the impact of sensory loss and increased effort required to access care.

Cumulative impact - across all groups, participants described the **cumulative effect of repeated small barriers**, which over time reduced confidence, increased stress, and in some cases led to delayed or avoided care. Differences in experience were driven as much by **system design and consistency** as by individual circumstances.

Useful technology and adaptive tools during the community conversations

Participants described a range of technology and adaptive tools that help them manage day-to-day tasks, navigate environments, and access information, alongside examples where technology created additional barriers.

Where technology helped — and where it didn't

Participants consistently said that:

- Technology **can support independence**, when it is accessible and people are supported to use it
- Technology **became a barrier** when:
  - Systems were poorly designed
  - Accessibility overlays blocked assistive tools
  - Digital routes were the only option offered
  - Time-limited forms or verification steps excluded slower input methods

Screen readers – used to read letters, emails and some online content
NVDA – free screen-reader software used by people with severe sight loss
VoiceOver / accessibility readers – built into some websites and devices, though often inconsistent
Apple Watch and Siri – used for reminders, time, and voice-controlled tasks
Smartphones with voice assistants – used to access information without sight
Desktop computers with a mouse – preferred by some over touchscreens or laptops
Bluetooth hearing aids – streaming audio directly from phones and devices
Guide dogs – supporting navigation and independence
Navilens – QR-style navigation markers discussed for use in hospitals
GoodMaps – indoor navigation tool referenced as a potential solution
AI / smart glasses – used to read text aloud and identify surroundings
NHS App and digital portals – used by some but often described as inaccessible
Directory enquiries (195 service) – used by blind people to obtain contact information
Be My Eyes and **Aira** – live visual assistance services connecting blind users to support
Audio newspapers (USB) – produced by voluntary groups for accessible news access

Section 5

Equalities Monitoring

Survey respondent demographics (public)

Sexual orientation	%	Count
Heterosexual	**82%**	**129**
Gay	1%	1
Lesbian	1%	1
Bisexual	3%	4
Prefer not to say	13%	20
Prefer to self-identify	1%	2
Answered		**157**

Pregnancy	%	Count
Yes	0%	0
No	**99%**	**104**
Prefer not to say	1%	1
Answered		**105**

Gender	%	Count
Male	43%	76
Female	**53%**	**93**
Intersex	0%	0
Non-binary	1%	1
Prefer not to say	2%	4
Prefer to self-identify	1%	1
Answered		**175**

Physical disability or mental illness expected to last more than 12 months	%	Count
Yes, the health problem/disability limits me a little	35%	57
Yes, the health problem/disability limits me a lot	**43%**	**70**
No	21%	34
Prefer not to say	2%	3
Answered		**164**

Gender reassignment	%	Count
Yes	0%	0
No	**99%**	**100**
Prefer not to say	1%	1
Answered		**101**

Religion	%	Count
Christianity	**53%**	**86**
No Religion	23%	37
Atheist	12%	19
Buddhist	1%	1
Jewish	0%	0
Any other religion	5%	8
Prefer not to say	7%	12
Answered		**163**

Survey respondent demographics (public)

Age	%	Count
Under 18	6%	16
18-24	1%	2
25-34	5%	14
35-44	7%	19
45-54	12%	35
55-64	**21%**	**58**
65-74	**21%**	**60**
75-84	18%	51
85 and over	9%	24
Prefer not to say	1%	3
Answered		*282*

Ethnicity	%	Count
Bangladeshi	0%	0
Indian	0%	0
Chinese	0%	0
Pakistani	0%	0
Any Other Asian Background	1%	1
African	0%	0
Caribbean	0%	0
Any Other Black Background	0%	0
White and Asian	0%	0
White and Black African	0%	0
White and Black Caribbean	0%	0
Any Other Mixed Background	1%	1
White British	**92%**	**166**
White Irish	0%	0
Any Other White Background	1%	2
Gypsies/Travellers/Roma	1%	2
Any Other Ethnic Group		
Rather not say	4%	8
Answered		*180*

Main Language	%	Count
Bulgarian	0%	0
English	**95%**	**156**
Hungarian	0%	0
Latvian	0%	0
Lithuanian	0%	0
Polish	0%	0
Portuguese	0%	0
Romanian	0%	0
Russian	0%	0
Spanish	0%	0
Other (specified as BSL)	5%	8
Answered		*164*

If English not first language, to what extent can you:	Speak English		Read English	
	%	Count	%	Count
A lot	**63%**	**12**	**54%**	**7**
A little	25%	5	23%	3
Not very much	5%	1	0%	0
Not much at all	5%	1	23%	3
Answered		*19*		*13*

Survey respondent demographics (public)

Health inequality information	%	Count
Have served in the UK's regular or reserved armed force	**43%**	**10**
Currently working in the Farming/ agricultural industry	9%	2
Have worked in the Farming/ agricultural industry	35%	8
Currently homeless	0%	0
Have experience of being homeless	9%	2
Currently serving in UK's armed forces	0%	0
Refugee, immigrant or asylum seeker	9%	2
Previous experience of being a refugee, immigrant or asylum seeker	0%	0
Answered		**23**

Employment status	%	Count
Employed full time	23%	37
Employed part time	11%	17
Homemaker	0%	0
Not employed and looking for work	2%	4
Not employed and not looking for work	4%	6
Retired	**48%**	**78**
Self employed	6%	9
Student	2%	3
Prefer not to say	1%	2
Other	3%	5
Answered		161

Section 6

What this means for the ICB and Lincolnshire County Council

This engagement shows that people with sensory loss in Lincolnshire **continue to face systemic and avoidable barriers** when accessing health and care services.

These barriers **do not sit within a single service**, but arise from **how services are designed, accessed and coordinated across organisations.**

While examples of good practice exist, **accessibility remains inconsistent** and too often **depends on individual staff awareness rather than embedded, reliable systems**.

What this means for the ICB and Lincolnshire County Council

For **Lincolnshire Integrated Care Board (ICB),** the findings highlight the need to improve access to primary care and first points of contact. Difficulties booking GP appointments—particularly reliance on 8am call queues, phone-first models, and inaccessible digital systems—are a major driver of delayed or missed care for people with sensory loss. Inconsistent recognition of communication needs at the primary care level creates knock-on effects across hospital, community and specialist pathways. Embedding accessibility requirements into primary care commissioning, pathways and contracts, and ensuring consistent use of communication flags across services, would improve early access, reduce non-attendance and support more equitable outcomes.

For **Lincolnshire County Council**, the evidence reinforces the importance of early, proactive and visible support, particularly through sensory services and adult social care. Many people are unaware of available help, are missed by referral routes, or access support only once independence has significantly declined. Strengthening signposting, self-referral and proactive follow-up—alongside closer integration between social care, NHS services and voluntary organisations—would help prevent escalation of need and reduce reliance on crisis responses. The findings also highlight how ageing, caring responsibilities, rurality and transport issues further compound sensory loss and must be addressed through place-based solutions. Feedback will inform the procurement for Lincolnshire Sensory Services.

For **both organisations**, the engagement demonstrates that accessibility is not solely an experience or equality issue, but a matter of safety, effectiveness and system efficiency. Communication failures, difficulties navigating environments, and reliance on family members for interpretation increase risk, undermine independence and contribute to disengagement from care. The report also shows what good practice looks like: where services proactively recognise sensory needs, offer communication choices, involve specialist support and help people navigate settings confidently, experiences improve significantly. The opportunity for the ICB and County Council is to move from reliance on individual goodwill to consistent, system-wide practice, ensuring people with sensory loss can access care safely, independently and with dignity.

Furthermore, the engagement highlights the opportunity to further strengthen how accessibility and sensory awareness are embedded across health and care services. People described how clearer communication, supportive environments and timely recognition of sensory needs can make a meaningful difference to confidence, independence and overall experience. The report also demonstrates that where services take proactive, inclusive approaches—such as offering communication choices, involving specialist support and helping people navigate settings—outcomes are noticeably more positive. Building on these examples provides an opportunity for the ICB and the County Council to continue developing consistent, system-wide approaches that enable people with sensory loss to access care with greater confidence, independence and dignity.