



The Accessible Information Standard

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The title is "The Accessible Information Standard".

Findings from our evidence review
February 2022

Contents

Background.....	2
Why we are reviewing our evidence again	3
Before the pandemic	4
Issues during the pandemic.....	8
Good quality support.....	10
Does the Standard go far enough?	11
Conclusion	16

Executive summary

NHS England implemented the [Accessible Information Standard](#) (AIS) in August 2016. The standard makes it a legal requirement for all health and social care providers to ensure that people with a disability, impairment or sensory loss can access information and communicate effectively with them.

In this evidence review, we have looked at what people said about their experience of accessing information in a way that they can understand. We also highlight the impact of the pandemic on the Standard and accessibility of information.

Our analysis suggests that some service providers implemented the AIS in their practice before and even during the pandemic. However, many did not, and people still struggle to understand important information about their health and wellbeing as they do not get adequate support for their communication needs.

The pandemic further added to people's struggles as information related to COVID-19 wasn't accessible for all. This impacted their ability to follow the constantly changing guidelines to prevent the spread of the virus.

Using our evidence, we have also explored whether the Standard goes far enough to support all groups of people who have different communication requirements. We highlight the struggles of people with language barriers and those who find it difficult to access online information when providers do not consider its accessibility on digital platforms.

Background

Six months after the Standard had started, we published an [insight report](#) which drew on the work of 41 local Healthwatch, incorporating the views of more than 700 people and included evidence from visits to 50 healthcare providers. It was clear from our evidence that the new standards were yet to have a significant impact on people's experiences. We identified four key areas where people wanted to see improvements:

1. Access to services and information should be in an appropriate form that meets people's specific needs.
2. Staff should be made more aware and get better training to communicate with people who have different needs.
3. Patient records should flag individual communication needs, so the onus doesn't fall on people to continuously highlight their needs to services.
4. Ensure people are supported early from the point of diagnosis.

Why we are reviewing our evidence again

Over the past five years, we have continued to hear about communication barriers that people face. As the pandemic struck in March 2020, these problems became particularly acute as more services adopted remote methods of care. Therefore, it is timely for us to analyse our evidence again to understand how people's experiences changed due to the AIS and how it was impacted by the pandemic.

In addition, the NHS is planning to undertake a review of the AIS and present draft recommendations by the end of March 2022. To feed into their review and further improve the Standard, we are running a national campaign at the start of 2022. As part of this campaign, we have decided to review our internal evidence, both before and during the pandemic, and grant fund local Healthwatch to undertake primary research on the needs of people who speak little or no English. We plan to collate all the evidence we gather during our campaign and work with key partners to highlight further improvements to the Standard.

How we have analysed our evidence

To understand the impact of the AIS on people's experiences, we undertook a thematic analysis of our evidence – this includes data shared with us by local Healthwatch and the public via our online "[Have your say](#)" form.

Our evidence is divided into the following periods:

1. Data from before the pandemic

We heard from at least 1,200 people between 1 April 2019 and March 2020 and consists of:

- 106 pieces of feedback from 26 local Healthwatch and some directly from the public.
- 31 research and engagement reports from local Healthwatch which includes 1,792 people's experiences of healthcare services, including accessible information – 14 reports are specifically about accessible information and are based on the experiences of 1,099 people.

2. Data from during the pandemic

From March 2020 – September 2021, we heard from at least 5,000 people, specifically about their experiences of accessing information in a way that they can understand. In reality, the figures below could be much higher, as reports about people's general healthcare experience include people who have also spoken about accessible information. The evidence comes from:

- 248 pieces of feedback shared with us by 43 local Healthwatch and the public.

- 80 research and engagement reports, which include 27,420 people's experiences of healthcare services, including accessible information – 23 reports are specifically about accessible information and are based on the experiences of 4,820 people.

Before the pandemic

Compared with our findings from 2017, we came across several examples of good practice. This clearly indicates that before the pandemic struck, some services were implementing the AIS, which in turn was making it easier for people with communication needs to access information and support.

Some examples of good practice:

- GPs provided longer appointments where there was a need for a BSL interpreter to be present.
- GPs used pictures and symbols to communicate with people with learning/communication difficulties.
- Optometrists put people with a learning disability at ease and helping them complete forms.
- Hospitals used video relay systems for BSL interpreters during appointments, while others were training staff about AIS or appointing staff champions.
- Services undertook an audit of hearing loops.
- People with sight loss received letters with additional information to make it easier for them to read and understand.
- Larger font size on posters, leaflets and appointment cards made it easier for some patients with visual impairments.
- Providers cut down bushes which obscured external signage.

However, most of our evidence suggests that while some improvements had taken place, people were still facing similar barriers reported in 2017. As a result, they were less likely to get the care and treatment they needed. Broadly, there are two main issues:

People with communication needs are still struggling to access services

Although the provision of accessible information is explicitly mentioned in the Equality Act 2010 as a 'reasonable step' to ensure that disabled people are not at a substantial disadvantage when compared to a person who is not disabled, some providers have overlooked the needs of people who struggle to understand information due to their disabilities.¹ As a result, they struggled to access services. For example, we have heard that:

¹ NHS England: [Accessible Information Specification v1.1](#)

- Blind people couldn't access white canes because the request forms were in an inaccessible format.
- D/deaf people struggled to book urgent GP appointments when their only choice was to call the practice. Some GP practices did not make provisions for D/deaf people to book urgent appointments online.
- When services didn't provide people with learning disabilities with accessible information, they could not understand or retain information that was necessary to access other services. They often missed health appointments because they didn't understand the letter or what the appointments were for.

Worryingly, some providers fail to appreciate how not complying with the Standard would impact the people who need it the most

For example, we heard some:

- Dental practices did not have a hearing induction loop installed or even offer a signing service for patients who are hearing impaired.
- GP practices refused people access to a sign-language interpreter.
- Hospitals did not provide accessible maps, either on their website or on the premises, making it difficult for people with communication needs to plan their visit or know where to go for appointments.
- Audiology departments did not have electronic self-check in, a call system for appointments, or designated areas for audiology patients to sit.

People who genuinely need support don't know how to access any information about the Standard

If people are unclear about what the AIS means for them, they will likely fail to seek the support they are entitled to. For example, people have told us they were not aware if the AIS applies to all NHS services, such as NHS dentistry. They were also unsure whether the onus was on them to highlight their communication needs every time they booked an appointment or whether the system would automatically flag it on their medical records. They didn't know how they could find this information either.

Lack of access to sign-language interpreters has caused issues

The British Sign Language (BSL) is the preferred language for many D/deaf and some Deafblind people. It has its own grammar and differs from the English language,Error! Bookmark not defined. which is why a BSL interpreter is often required to provide communication support.Error! Bookmark not defined.

Our evidence shows that people often struggled to communicate with providers due to a lack of access to BSL interpreters. In some cases, this has happened despite repeatedly asking for or reminding providers about their communication needs. Lack of consistent access was especially difficult for people who needed frequent and multiple appointments. Patient records were either not updated with the details, or their needs weren't taken into account, even though the scope of the AIS clearly outlines the five distinct stages of identifying, recording, flagging, sharing and meeting people's needs.Error! Bookmark not defined.

"I need BSL interpreters for all health appointments. I have multiple health problems and...hospitals know I need interpreters. Many times, I arrive for appointments and no interpreters are booked. I had PET-CT scan ... and no interpreter had been booked. I contacted a friend by text to ask for help. I always suffer more stress and anxiety because my basic communication needs are not met." - Healthwatch Kent, 28/08/2019

Lack of BSL interpreters has meant people rely on their family or friends to accompany them to appointments – this has been particularly difficult while sharing sensitive health information in their presence. A report published by Sense further backs up our evidence. It suggests that communication barriers can pose a big challenge to privacy. Of the Deafblind people they asked, 85% reported that they don't get information about their healthcare appointments or other important issues in a format that they could access. Most said that they need to rely on someone else to read their letters to find out what was in them. Relying on somebody else to read your letters can lead to a loss of independence and control over your care, as well as infringing on people's privacy.²

There are implications for family members as well. We have come across evidence that suggests that when family members need to accompany patients to their appointments, they lost income as they had to take time off work. However, it seems services do not consider their issues. Liverpool Clinical Commissioning Group (CCG) have reported widespread experiences where families have been asked to interpret in lieu of an interpreter. This was sometimes because the service had not booked the interpreter, and in some instances, because the health professionals had allowed this to be standard practice for patients. They noted that if a family member started to interpret, then no effort was made to book an interpreter by the hospital or GP.³

Communication barriers have stopped people accessing services

People have felt stressed, frustrated and disappointed when they couldn't communicate with medical professionals about their health issues. Healthwatch York reported that a Deaf person in labour went to the hospital to be induced. She was told that an interpreter would be provided. However, upon arrival, she realised that there wasn't an interpreter to support her, and she was asked to go home. This made her feel very anxious about the wellbeing of her unborn child and whether the delay would harm the baby.

Lack of accessible information has led people with learning disabilities to experience isolation, poor mental health and inability to manage their health needs.

² Sense: [Equal access to healthcare: the importance of accessible healthcare services for people who are deafblind](#)

"I find it impossible to get an appointment and my health is struggling because of this and I also feel like the doctors in the surgery don't even listen to me and they don't even give me the time I need to explain my issues ... I struggle with understanding and need more time because I have a learning disability." - Healthwatch Rochdale, 16/10/2019

Services don't always provide information in a way people can easily understand

This issue seems come from the lack of understanding and awareness about people's different communication needs. For example, we heard that BSL users received information that wasn't written simply enough to be understood. It seems providers are not aware that BSL is not the same as spoken or written English.

Interestingly, in 2018, Liverpool CCG reported that written information, such as letters about appointments, or information about a condition, diagnosis or treatment, was not accessible for those whose first or only language is BSL. Written communication was either not readily understood, or the language was often too complex, and terminology not explained for those who could read English. This lack of cultural understanding left D/deaf people embarrassed and ashamed.³

Similarly, we have heard that people with learning disabilities have struggled to understand invitations related to preventative cancer screenings as they weren't in an easy read format. Even where people had received letters in easy read, some said the quality was poor. As a result, they did not attend the appointments.

People with poor vision have said that they struggled to read publications or information screens, operate check-in machines or find entrances due to inaccessible font and poor lighting. In some cases, providers have even ignored the concerns that people have raised with them.

"I have a client who is blind and reads his medication in Braille. However, when he picks his medication up the Braille is squashed and unreadable. He has reported this to his GP for 10 years and they have ignored him. He therefore has to ask neighbours to read the medication to him. I do not believe this is acceptable in light of the 2016 communication standard." - Healthwatch Essex, 05/02/2020

³ NHS Liverpool Clinical Commissioning Group: [Understanding experiences of D/deaf people and people with hearing loss in getting information and communication support from the NHS in Liverpool](#)

Lack of awareness amongst providers

Lack of awareness may be due to inadequate training, which is a clear requirement under the AIS. Organisations are required to review the ability of their workforce and, if necessary, provide training and awareness programmes to ensure that they achieve the Standard.^{Error! Bookmark not defined.} However, our evidence suggests that staff are either not adequately trained or need greater monitoring and accountability. For example, we have heard that:

- In busy clinics, staff have asked people to come in for their appointments by calling out their names softly, or by making a beep sound – as a result, people with hearing difficulties have missed their turn.
- Staff have called out the name of a blind person and walked away, expecting them to follow without any problems.
- We have even heard that staff have shouted while communicating, which was very distressing for D/deaf patients.
- People have been referred to as ‘deaf and dumb’ in discharge letters, which they have found very offensive.

“Service user has ‘offer interpreter’ on [their] medical records. However, the receptionist is saying something along the lines of “if you can talk to me, you can talk to the GP.” – Healthwatch Bedford Borough, 30/07/2019

In July 2021, the Royal College of Physicians reported that clinicians often feel less comfortable with D/deaf patients, which may be rooted in a lack of education and understanding of communication tools. Anecdotally, BSL and communicating with D/deaf patients are significantly under-represented topics in medical school, which creates anxiety and poor performance when doctors are faced with this in practice.⁴

Issues during the pandemic

Although we heard the same issues during the pandemic, changes to health and social care as a result of coronavirus led to additional difficulties for people with communication needs. We reviewed the experiences of over 5,000 people during the coronavirus pandemic. We found that many service providers did not meet the requirements of the AIS when making changes to how people accessed care or providing information about the pandemic. As a result, people found it challenging to get the care they needed and understand the constantly changing rules and restrictions on how to reduce the spread of coronavirus.

Information related to COVID-19 wasn’t accessible for all

We heard reports from D/deaf people who struggled to understand daily government briefings due to a lack of BSL interpreters at the televised meetings. Our evidence is further supported by an article

⁴ The Royal College of Physicians: [Exploring communication difficulties with Deaf patients](#)

published by Sign Solutions in January 2021. This states that the initial press conferences and TV adverts delivering vital health information as the crisis took hold had no interpreters present, leading to some D/deaf people misunderstanding information.⁵ It is worth noting that there was a judicial review case to this effect, which the Government lost, as the court found that absence of BSL interpreters during the briefings constituted discrimination and failure to comply with their reasonable adjustment duty.⁶

We also heard that, for those who rely on lip-reading, 119 was not accessible because it was not SMS enabled.

"D/deaf people have faced isolation difficulties during Covid-19 such as difficulties with lip-reading. They say this is an issue with face-coverings and using online technology where people have camera turned off. They also highlighted the lack of signing on daily briefings. They say there have been a lot of different video conferencing platforms to get used to." – Healthwatch North Yorkshire, 29/05/2020

People with learning disabilities and autism also reported that they found it difficult to understand news and regulations about national lockdowns and governmental policies designed to limit the spread of the coronavirus. Some of those who cared for people with learning disabilities also told us that they struggled to explain to them information about the coronavirus vaccine.

Public Health England found that the mortality rate due to COVID-19 for people with learning disabilities was between four and six times higher than in the general population, during the first wave of the pandemic.⁷ It suggests that this could partly be due to a lack of clear and accessible information about how to control infection.

It seems like people didn't know where they could access the information either. The Royal Association for Deaf People found in their research that reduced awareness about key information could be the result of poor signposting, i.e., there may be perfectly good, accessible information available, but unless this is clearly signposted to people, it is of little use.⁸

"Person with a learning impairment telephoned to seek reassurance in the current coronavirus situation, asking if it was safe to go shopping and if the shops were still open." – Healthwatch Darlington, 18/03/2020

⁵ Sign Solutions: [Importance of On Demand Interpreters in Healthcare](#)

⁶ Royal Courts of Justice: [Rowley v Minister for the Cabinet Office \[2021\] EWHC 2108 \(Admin\)](#)

⁷ Public Health England: [People with learning disabilities had higher death rate from COVID-19](#)

⁸ Royal Association for Deaf People: [Do Deaf Londoners have enough access to advice in BSL?](#)

Impact of infection control measures

Measures introduced to reduce the spread of infection also made it difficult for people with additional communication needs to access information and care. For example, people who rely on lip-reading told us that it was impossible to understand what was being said when all healthcare providers wore masks. This led to them missing calls for them to attend appointments and missing vital information about their health. Screens that were placed in GP practices negatively impacted D/deaf and hard of hearing people, as they blocked sound.

"Male, 70s with long term hearing loss is concerned that his GP practice has not thought through the access issues for people with hearing loss with the physical changes that have been made to the waiting room due to COVID. He says the screens have had a negative effect on the way sound travels in particular. He also noted that the personal hearing loops which are available for patients to use are put to one side and do not seem to be charged and ready for use. Healthwatch has contacted the surgery for comment." – Healthwatch Northumberland, 10/11/2020

Many times, restrictions on the number of people who could attend appointments – such as those in dentists and hospitals – meant that those with additional communication needs were not allowed to be accompanied by loved ones or carers. As a result, they often struggled to communicate during appointments.

"I was booked in to have a small procedure done at the GP surgery. No interpreter had been booked. I had to contact my daughter to come along and sign for me – only to be told she then couldn't come in with me as she was a family member!" – Healthwatch Medway, 06/04/2020

Good quality support

However, while most of our feedback highlights how people struggled due to unmet communication needs, we have come across examples where providers have supported people, even during the pandemic. This includes people who struggled due to a disability and those with language barriers.

- [Healthwatch Sheffield](#) heard about frontline staff ensuring people could lipread by changing masks to visors, and pre-booking interpreters for the duration of inpatients' hospital stays.
- Joint work between [Healthwatch Harrow](#), Ridgeway Surgery, Harrow CCG and the Romanian community produced some key information in Romanian to enable better understanding and access to primary care during the pandemic.

- We heard examples of staff trying to ensure that people with learning disabilities understood exactly what would happen during their appointments, such as during procedures for female sexual health, or dentistry.
- [Healthwatch Bristol](#) reported that some GP websites gave options for translating content to other languages – people could select the right one by selecting the appropriate national flag.

Does the Standard go far enough?

While analysing our data, we heard that many people experienced issues but the AIS did not cover these. People who speak English as a second language struggled to access information and care in languages they could understand, including interpretation services. The AIS does not cover the importance of ensuring that services are culturally competent, and we heard that a lack of understanding of other cultures led to difficulties for communities. Finally, the digitalisation of services created difficulties for people with additional communication needs, but this is not covered in the AIS.

Unmet communication needs for people with limited English

Both our pre-pandemic evidence and data gathered during COVID-19 clearly indicate that lack of language needs support negatively impacts people with language barriers, most commonly those from minority ethnic communities. A recent report on migrants' access to healthcare during the pandemic found that one of their primary concerns was both the lack of guidance from the government in languages other than English, and the delay in it being made available. This included guidance on social distancing measures, COVID-19 symptoms, or the status of health services during coronavirus and how to access them.⁹

Unmet communication needs lead to difficulties in accessing services for members of these communities. For instance, we heard about people who could not order repeat prescriptions over the phone as they couldn't explain which medications they needed or read out spellings. People told us that they struggled to understand and navigate automated call systems when calling their GPs, and some people were unable to complete essential paperwork in order to access services or to file a complaint.

"I always apprehend the actual consultation with my GP. I'm not saying she's a bad physician, but she always makes me feel like I'm wasting her time, talks to me like I'm an idiot and doesn't let me finish my sentences. English isn't my first language and I sometimes need her to repeat or clarify something, but I don't feel comfortable asking her anything. It can be quite humiliating." – Healthwatch Waltham Forest, 20/10/2020

⁹ Patients not passports: [Migrants' access to healthcare during the coronavirus crisis](#)

Lack of interpretation services

Our evidence suggests that people who speak little or no English struggle to access language-based interpreters. This includes in-person appointments and appointments over the phone, such as when using NHS 111. We have heard throughout the pandemic that people struggled to access care, notably their GPs and dentists, and often resorted to calling NHS 111 as a result. However, Language Line was not offered when calling NHS 111, closing this avenue to care for people with language barriers.

Lack of interpretation support for such people can directly impact their ability to access care when they need it and has a wider impact on their families. For example, Healthwatch York heard from a person with language barriers who had no choice but to bring their 15-year-old to their hospital appointments because the hospital didn't provide them an interpreter. As a result, the child had to miss school, which made the patient anxious.

Similar findings have been reported in an article published by the British Journal of General Practice in 2019. The authors found that refugees and asylum seekers struggle to navigate and negotiate primary care services, often because of language barriers and inadequate interpretation services. The wider implications of ineffective communication with healthcare providers includes burden on family members and impact on the patients' self-esteem.¹⁰

People reported to several local Healthwatch that they found it challenging to access information and support by calling NHS 111 as there were either no interpreters available or when available, they were difficult to use. For instance, some people told us that they were asked to download an app and create an account to access an interpreter. This was a confusing process, especially for those with additional care needs or those in crisis and presented an additional barrier to getting help.

"Asylum Welcome contacted us because a client who is currently seeking asylum is suffering severe dental pain and cannot access treatment. The person does not speak English and was not offered language line when calling 111 for help." - Healthwatch Oxfordshire, 22/10/2020

A lack of interpreters generally has also meant that people experienced postponed treatments until interpreters could be arranged. [Healthwatch Oldham](#) reported a lack of translation services as a reason why a disproportionate number of Eastern European families were presenting at A&E and waiting until the evening when family members could support them with translation.

Lack of information provided in languages other than English

People with limited or no English told us that they struggled to understand COVID-19 restrictions or how to access healthcare, because of a lack of information in community languages. Polish, Romanian and Latvian people have struggled to understand the government guidelines during the pandemic. As a result, they have often relied on turning to friends and families and receiving misinformation. The Turkish

¹⁰ British Journal of General Practice: [Access to primary health care for asylum seekers and refugees: a qualitative study of service user experiences in the UK](#)

and Kurdish community also experienced this difficulty. Because of the lack of information in languages other than English about the pandemic, people didn't know what to do when they had COVID-19 symptoms.

[Healthwatch Haringey](#) also found that healthcare services were fourth on the list when asked where members of this community sought information about the pandemic, after friends, family, and the media. We also heard that people relied on media that was in their native language. Often, these channels were not based in the UK. Therefore, they shared information about the regulations and infection control measures in these countries, creating confusion for people relying on them for information.

We also heard from organisations that work with asylum seekers and refugees that it was difficult for them to access support online, as often they lacked contact details such as an email address. This posed specific difficulties when booking coronavirus tests which required an email address.

"We have a very vulnerable family who speak a dialect of Arabic, do not read or write Arabic and do not speak, read or write English. They are very poor and have a phone with not much data. The mum phoned the volunteer who has been supporting them saying she and two of her children were exhibiting Covid symptoms and she didn't know what to do. Volunteer contacted me and I rang their GP practice who told me they need to go online to the Govt website and book the appointments - impossible for them to do.

Volunteer tried to help her to do it remotely but needed a lot of to-ing and fro-ing with mum and ended up having to ring NHS. She went through the whole rigmarole only to be told that the mum has to have an email address to receive the code to book the appointment- she would not send the code to the volunteer's email address. The volunteer was very frustrated having spent over an hour and a half on this voluntarily and mum was no better off. All we can do is advise mum now on isolating, using Calpol etc and if any of them, particularly mum deteriorates badly what to do next. The lack of literacy and email addresses is causing many problems with our asylum seekers and is a big inequality." – Healthwatch Halton, 08/01/2021

Feeling culturally “othered” by health care staff

Many people shared experiences where they felt that staff were rude or dismissive about their health concerns due to their lack of fluency in English. For example, [Healthwatch Birmingham](#) interviewed members of the Somali community about their experiences accessing health and social care. They reported experiences of being dismissed by GPs, resulting in members of this community choosing to avoid GPs and opting instead to go to A&E or to access healthcare abroad.

“The current situation of Somali community in accessing healthcare is so bad that they travel abroad to Germany, Sweden, Denmark, and Belgium for treatment and care. There is a lot of mistrust between the NHS and the Somali community because the doctors here are not listening. People travel a long distance when we have one of the best hospitals here in Birmingham – people say it’s because the doctors here are not listening, they are not communicating with me, they don’t have time for me.”

Healthwatch Birmingham, 19/11/2020

We also heard about cultural issues which impacted many minority ethnic communities’ experiences of care. Often, mental health services do not acknowledge cultural differences between communities. For instance, standard questionnaires to assess people’s mental health with GPs are not culturally appropriate for asylum seekers. Often, questionnaires do not consider refugees and asylum seekers’ specific trauma, and that they often have very different cultures, beliefs, and experiences.

Service digitalisation and the AIS

The pandemic meant that service delivery had to change in order to reduce the spread of infection, relying heavily on digital services to reduce face-to-face interaction. However, our evidence suggests that while the pandemic has accelerated the digitalisation of services, providers haven’t always considered people’s communication needs.

GP websites were not up to date or accessible

Changes to services were not always communicated clearly, leaving people confused about how to access services. This was exacerbated by service providers not offering information in accessible formats and/or languages other than English. A key area where this presented difficulty was information on GP websites.

Several local Healthwatch reviewed information on GP surgery websites in their area during the pandemic. Many found that information on how to book appointments, what appointments were available, and infection control measures, were not clear, up to date, or accessible. For instance, [Healthwatch Islington](#) found that very few websites had altered or updated their standard information (on opening hours, available services, and appointments, for example) to take account of the new circumstances arising from the pandemic. Information on the home page stating not to attend in

person, was often presented alongside sections providing information on opening hours, clinics, and services as though they could still be accessed face-to-face.

This was especially confusing for patients who were not confident accessing information online, or those for whom English is a second language. [Healthwatch Greenwich](#) found that less than half of GP surgery websites in this area included information on how to access interpreters and/or Language Line. We further heard that many GP websites and social media information could not be read using a screen reader, making it difficult for people with visual impairments to access information in this way. During the pandemic, often, the only way to register for a GP practice was online, but there was no way to ask for a translation of websites, so asylum seekers and non-English speakers found this difficult.

Digital and telephone appointments presented difficulties for people with additional communication needs

The pandemic caused GP surgeries to reduce face-to-face appointments, and the majority of care was delivered digitally. In many cases, surgeries did not put appropriate protocols in place to make digital services accessible to people with additional communication needs.

Booking appointments was difficult for many D/deaf people, because many GPs only allowed appointments to be booked over the telephone. Frequently, there was no facility to communicate via text messages either. This meant that D/deaf people had to ask friends and family to help book an appointment or go without.

"I am very hard of hearing, I am unable to understand telephone consultations at all due to hearing impairment, even in person the quality of the consultation is poor due to the lack of health care professionals knowledge regarding communication to a hard of hearing persons ... The GP Practice and the Hospital, various health care professionals have been ringing insisting that over the phone appointment is the only available appointment ... but I cannot hear them on the phone I am profoundly deaf, the video calls are useless for deaf people, I cannot read lips. ... Now with face coverings, masks, visors, plastic screens, it makes it even worse for people whom are deaf or hard of hearing to understand conversation, any conversation is muffled." Healthwatch York, 31/07/2021

Some GP surgeries updated their phone systems to ones that didn't allow callers to speak to a receptionist unless they pressed a specific number, which we heard was impractical for people with sight loss.

Some surgeries allowed people to book appointments using online triage systems such as e-consult system. However, there was a lack of information about how to use this system in easy read formats, which made it difficult for people with learning disabilities to book appointments. We have reported similar findings in our report on digital exclusion in primary care earlier this year – through our research,

we found that people with language barriers, including those who use BSL, found it hard to understand information on English-based websites. This prevented them from downloading and using online GP applications, such as AskmyGP.¹¹ We also heard that some people with sight loss experienced difficulties logging into and using systems such as e-Consult.

A lack of interactive technology on NHS websites/apps made it difficult for people with learning disabilities to understand it.

Video appointments also posed difficulties for D/deaf people. They told us that they struggled to understand what doctors and interpreters were saying over video, especially when they only had access to small screen devices. Sometimes, providers turned their cameras off, which compounded the difficulties.

Conclusion

Based on our evidence, we feel that although some providers have made sincere efforts to support people with communication needs, many are still falling short, despite the AIS falling under the Equality Act 2010. This highlights the need for better accountability, staff training and clear lines of complaint when people feel providers haven't met their requirements.

Our report also provides some preliminary indication that the AIS might not cover all groups of people who struggle to access services due to communication barriers. Groups that stand out the most are people who speak very little or no English, for example, refugees and asylum seekers. These people are often some of the most vulnerable in our society, as they lack English language skills and understanding of how a complex healthcare system, such as the NHS, works.

¹¹ Healthwatch England: [Locked out: Digitally excluded people's experiences of remote GP appointments](#)

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