Public Service Ombudsman

# Spotlight on accessible communication:

## your stories, your rights

**We believe complaints have the power to change things for the better. We share findings from our casework to help improve public services and complaint handling for everyone.**

**This report shares complaints we have received about accessible communication to help anyone who has had a similar experience.**

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# Who we are and how we help

We are the Public Service Ombudsman. We investigate complaints about UK government services and the NHS in England.

**Our service is free, fair and independent.**

We look into complaints where a person thinks something went wrong with the service they received. This might be because an organisation did something they should not have done or treated a person unfairly. Or it might have provided a poor service and has not put things right.

**Our website has more information about how we deal with complaints.**

When we find that things have gone wrong, we can make recommendations on what the organisation needs to do to put it right. This can involve explaining why things went wrong, apologising and taking steps to learn and improve its service.

# Introduction

**To use public services, people need information that they can understand. Whether it is understanding health information, navigating the benefits system or making informed decisions about care, everyone has the right to get clear, accessible communication.**

When communication falls short, it creates significant barriers, undermines trust between organisations and the public, and can even result in serious harm. This is why, over the next five years in **our strategy**, effective communication between services and people will be an important theme running through our work.

Accessible communication is an issue affecting a large number of people. In the UK, **at least 1 in 5 people have a long-term illness, impairment or disability**, while many more have a temporary disability. This means that accessible communication must be a priority and part of standard practice across all public services.

> **"Public services must be accessible to everyone for the system to be fair and equitable."**
>
> **Rebecca Hilsenrath KC (Hon), Chief Executive**

## Examples of accessible communication needs

People need accessible communication for many different reasons and these needs can change over time. Some need information in different formats, such as large print, or support like British Sign Language (BSL) interpreting. Others will have temporary communication needs after illness or injury, find it difficult to read and understand information, or do not speak English as their first language.

# What organisations should do

By law, public services need to provide for people with accessible communication needs. They should not make assumptions about who needs accessible communication and should be prepared to provide it when needed. They should identify those needs early, record them clearly and act on them consistently.

The **Equality Act 2010** requires public services to make reasonable adjustments to make sure disabled people have the same access as everyone else to information and services. Under this Act, public services must also meet the **Public Sector Equality Duty (PSED)** and think about how they are promoting equality in their decision-making, policies and the services they provide.

**Regulations introduced in 2018** also set out the requirements for public sector websites and mobile applications to make sure information is accessible.

The **British Sign Language Act 2022** says BSL is an official language in Great Britain. While government departments are not required to translate all communications into BSL, they are now expected to actively consider when BSL should be used and to report on how they use and promote it in their public communications.

This is also recognised in the guidance organisations have in place. For example, the NHS **accessible information standard** sets out the specific requirements for organisations providing care. It says they must take steps to make sure disabled people and people with impairments or sensory loss receive information they can access and understand and get communication support if they need it. NHS England published a refreshed version of the standard in 2025.

Unfortunately, organisations do not always provide accessible communication or do not provide it as well as they should. There is growing evidence that systems are not always in place, guidance is not always followed and failings happen as a result.

In April 2025, RNID and SignHealth published **'Still ignored: the fight for accessible healthcare'**. The report said, 'the NHS does not have the systems in place to fulfil the right to accessible healthcare for people who are deaf or have hearing loss'. Similarly, in November 2025, the Disability Unit at the Cabinet Office published **'Locked Out'**, a comprehensive report that highlighted the continuing exclusion of deaf and deafblind BSL users across health and social care in the UK.

# Evidence from our casework

We are not a regulator and cannot enforce the law, but our unique perspective comes from hearing directly from people who experience problems with public services. We can spot when mistakes happen and see how the organisation could learn from them and put things right.

Effective communication is at the heart of good public service. When public services communicate openly, empathetically and effectively with the people who use them, it leads to a better experience and better outcomes. But evidence from our casework shows that organisations are not always meeting people's accessible communication needs.

In our report on **'End-of-life care: improving DNACPR conversations for everyone'**, we found there was a lack of accessible information given to patients. People with learning disabilities told us the NHS should be 'offering DNACPR information in easy read formats, providing audio versions for people with reading difficulties, proactively offering accessible materials without needing requests, [and] providing consistent, accessible information in doctor's surgeries'. This was also reflected by healthcare professionals we spoke to who did not feel they had clear information, support and experience, especially when working with people with additional needs.

Failings happen when systems do not consistently identify, record or act on communication needs. This can have a significant impact on people's lives. It can exclude people, make services less fair, less safe and less effective, and affect trust and confidence in public services.

**The case summaries we share in this report provide examples of what happens when:**

- accessible communication needs are not consistently identified, recorded or acted on
- legal duties and national standards are not followed in practice.

For the people affected, these failures in communication can cause significant pressure and worry in difficult situations, and can have serious, sometimes harmful, consequences.

# What good practice looks like

When organisations respond to feedback and make improvements to their accessible communications, it makes a big difference to people's lives.

For example, North Cheshire and Mersey NHS Foundation Trust (formerly Warrington and Halton Teaching Hospitals NHS Foundation Trust) worked with local advocacy groups and deaf people to improve its service after patients reported exclusion and barriers.

The Trust made several changes, including:

- digital alerts on patient records to raise communication needs
- staff alerts to inform teams when a deaf patient is admitted
- deaf awareness training for staff
- guides for patients on how to access interpreting and translation services
- a dashboard to track whether patients get the interpreters they need.

The Trust worked directly with deaf people by going to the local Deaf Club for quarterly reviews, testing ideas, and including people's feedback in its action plans.

As a result, interpreter use increased by 50% in one year. Now 87% of deaf patients report being supported, as appropriate, with a BSL interpreter during their hospital appointment or stay, compared to just 5% before the changes. One patient said, 'For the first time, I feel understood when I come to hospital.'

> **"By working alongside our patients, in partnership with advocacy services, and using data and feedback to inform the way we do things, we have been able to embed meaningful, practical and person-centred practices. By involving patients in each step of their journey and removing communication barriers, we have enhanced our patient experience, reduced health inequalities and improved health outcomes."**
>
> **Susan Dean, Deputy Head of Patient Experience and Inclusion at NCM**

Communication needs for deaf people are now part of the Trust-wide equality and health impact assessment process, meaning accessibility is built into everyday practice rather than treated as an extra.

This approach shows what all public services should aim to do:

- identify communication needs early
- put the right support in place as standard
- work in partnership with disabled people to develop solutions that meet their needs.

# Case summaries: sharing people's stories

**These case summaries highlight some of the issues we have seen in complaints about accessible communication across different public services.**

**Where we found failings, we looked at how this affected the person and their families, and what the organisation needed to do to put things right.**

**When we make recommendations to put things right, we follow up on them until the organisation acts. This helps to make sure the same mistake does not happen again and improves public services for everyone.**

**In the cases featured here, the organisations carried out all the actions we recommended.**

**We have not used people's real names in these summaries, apart from in Jen's and Samantha's complaints.**

# Trust did not provide BSL interpreters


## Summary

**The Trust did not meet national standards to arrange BSL interpreters during a Deaf patient's hospital stay. This caused distress for the patient and his extended family.**

## The complaint

Jen complained about the care her Deaf father received at University Hospitals Birmingham NHS Foundation Trust between June and September 2021. She said the Trust did not arrange regular British Sign Language (BSL) interpreters during his hospital admissions, despite BSL being his first language and his written English being limited.

Jen also complained the Trust inappropriately used her children to interpret sensitive medical information, including discussions about her father's prognosis and end-of-life decisions. She said this caused her family additional stress and distress at an already difficult time and affected their ability to grieve after her father died in September 2021.

## What we found

We found the Trust did not provide regular interpreters for Jen's father despite knowing he was Deaf and had limited written English. During his two-month stay in hospital, the Trust only arranged interpreters on three occasions. This meant he was not always able to say if he was in pain or needed anything.

The Trust regularly used family members to interpret, including Jen's children, and relied on written communication. This was not appropriate and did not follow NHS guidance. Guidance says patients should be offered an interpreter if they have difficulties speaking or understanding English. It also strongly discourages relying on family members as interpreters. Using children as translators can cause them harm by exposing them to complex and distressing medical scenarios.

**"The details of this case are entirely unjust and unacceptable, yet sadly unsurprising. We know from our research and campaigning work in this area that the levels of communication support and access to healthcare information for deaf communities and those with hearing loss are often woefully lacking."** **Victoria Boelman, Director of Insight and Policy at RNID**

## Putting things right

We recommended the Trust should write to Jen to accept what it got wrong and apologise for how this affected her and her family.

We also recommended it should pay Jen £750 to recognise the distress, frustration and worry it caused her, as well as £900 each to Jen's two children.

We said the Trust should make an action plan explaining what it will do to stop this from happening to another family. We said it should share the plan with Jen, the Care Quality Commission and NHS England.

> **"Too often there is a lack of interpreters in healthcare settings all over the UK, I have experienced it myself when being referred by GPs. There needs to be more awareness about the barriers faced by Deaf people and things need to change."** Jen

Following our investigation, the Trust took action to make sure there was organisation-wide learning. This included providing guidance to all ward staff and presentations on Jen's experience to several forums. It also improved its process for booking BSL interpreters on its website and added a section on communication needs to its admission form.

# Reasonable adjustments not put in place for dyslexia

## Summary

**NHS England did not meet its legal duty to put in place reasonable adjustments that were requested for an important review meeting. This caused anxiety and distress for the person involved.**

## The complaint

In May 2019, Derek asked NHS England to hold an independent review panel (IRP) meeting to look at his mother's eligibility for continuing healthcare funding.

Derek is neurodivergent and has dyslexia. Dyslexia is a learning difficulty that can affect how someone processes information, and planning and organising. Between May and September, Derek contacted NHS England to discuss reasonable adjustments for his dyslexia and a hearing loop for his brother to support him during the meeting.

Derek said NHS England did not properly manage these requests, so he did not have enough time to prepare and present in the meeting and then found it hard to read the report afterwards. This caused Derek stress, anxiety and distress.

**"The NHS failed to provide the simple reasonable adjustments they had agreed to ensure my brother and me were not disadvantaged at an important healthcare meeting, concerning our mother's end-of-life care. We are grateful to the Parliamentary and Health Service Ombudsman for ensuring the NHS understood the impact of their failings on our family."** Derek

## What we found

We found that NHS England did not provide all the reasonable adjustments Derek asked for, so it did not follow the relevant standards. It knew what Derek needed but did not properly think about whether his requests were possible or about offering alternatives. We could not find evidence that it had told the people involved in the IRP meeting about the adjustments.

Before the meeting, Derek asked for the IRP Chair to discuss his adjustments with him because dyslexia makes it difficult for him to respond to unexpected changes. NHS England agreed but did not arrange this conversation.

During the meeting, the Chair did follow Derek's request to discuss each area in the same order as previous meetings. NHS England had also arranged for the meeting to be longer than usual, which was a positive response. But Derek still ran out of time to present his evidence. There was no evidence the Chair made any adjustments on the day, such as offering to continue the meeting on another date.

Derek requested a hearing loop for his brother. NHS England arranged a hearing loop, but the room that was booked could not use the equipment. This meant Derek could not get the support he needed.

Derek also asked for changes to make the decision report more accessible to him. This including not sending it by secure email, setting out the details in the order they discussed them, numbered pages and using a specific font and size. The Chair agreed to the reasonable adjustments but did not do any of these things.

This caused Derek a lot of frustration and distress for over six months. After he complained, we could see that NHS England tried to resolve some of the issues, but it had not done enough to put things right.

## Putting things right

**We recommended NHS England should accept what it got wrong, apologise to Derek for how this affected him and pay him £500. We said it should explain what it is going to do to learn from what went wrong and improve its service.**

**Following our investigation, NHS England spoke with Derek to hear his reflections and experience of its service. This led to NHS England making several policy and procedure changes to how it records and fulfils reasonable adjustments.**

> **"I hope the follow up work I have undertaken with the NHS will remove barriers for others with a recognised disability, to ensure the NHS can be inclusive and fulfil their legal duty."** **Derek**

# HMRC did not consider reasonable adjustments

## Summary

**HMRC did not make reasonable adjustments for a claimant which left him without financial support during the COVID-19 pandemic.**


## The complaint

Elliott has ADHD (attention deficit hyperactivity disorder) and dyslexia. ADHD is a condition that affects the way someone thinks, feels and behaves. He needs support to use the services provided by HMRC (HM Revenue and Customs). HMRC is the government service that collects taxes and gives financial support to people in this country. HMRC had been sending Elliott audio documents for years, so it knew about his reasonable adjustments.

During the COVID-19 pandemic, Elliott needed to claim Self-Employment Income Support Scheme (SEISS) grants. His tax return was submitted late because of his disabilities, which meant HMRC said he was not eligible for SEISS.

In May 2021, Elliott asked HMRC to review his case and explained his return was late because of his disabilities. He said he could provide evidence over the phone, not in writing. HMRC promised to contact him within three weeks to hear the evidence but then decided to reject his case without speaking to him first.

Over the following year, Elliott contacted HMRC many times. It kept promising to call him back but never did, repeating the same decision without considering his circumstances. Elliott was not told about the discretionary board at HMRC, which could have reviewed his case. He was left without financial support for over a year, causing him significant worry and distress.

> **"It is taking up a lot of time and effort and as someone with a disability it makes raising a complaint very difficult. [HMRC] have been putting me through this for over a year."** **Elliott**

When HMRC finally reviewed his case in July 2022, it agreed he should receive the grants and paid him £5,600. It offered him £150 to recognise the impact, but Elliott said this was not enough.

## What we found

We found that HMRC knew about Elliott's reasonable adjustments in May 2021. It should have spoken to him to understand the reasons why the tax return was late. Over 14 months, HMRC kept promising to phone him to discuss this but it never happened.

HMRC did not refer Elliott's case to its discretionary board until June 2022, over a year later than it should have done. When the board reviewed the case, it immediately agreed he should receive the grants.

HMRC provided no records to show how it decided on the amount of £150 to recognise the impact on Elliott at a time when he was experiencing financial worries during the pandemic.

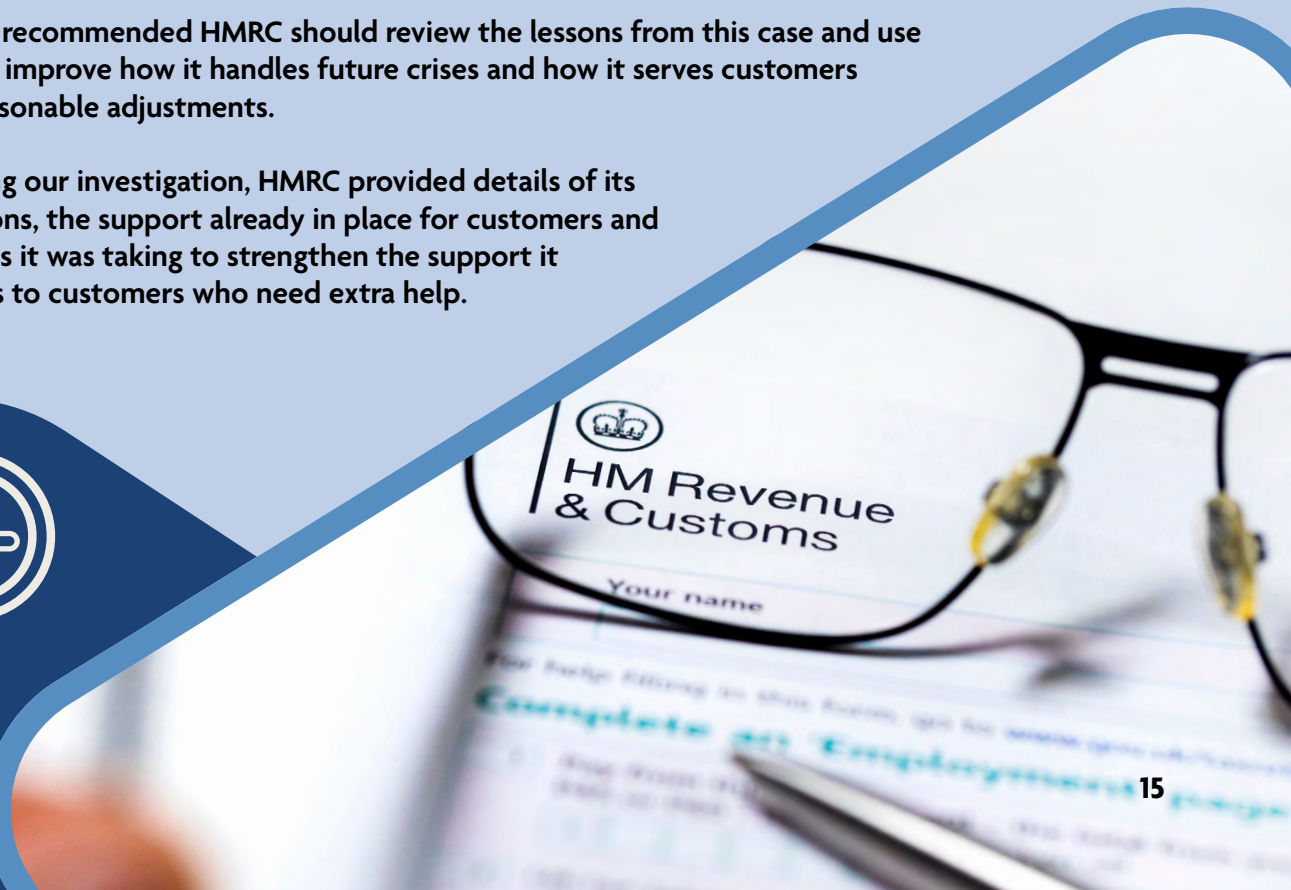
## Putting things right

**We recommended HMRC should write to Elliott to accept what it got wrong and apologise. We said it should pay him £1,500 to recognise the distress he experienced.**

> **"An apology without addressing the incident is meaningless. I want their procedures changed so that it doesn't happen again."** Elliott

**We also recommended HMRC should review the lessons from this case and use them to improve how it handles future crises and how it serves customers with reasonable adjustments.**

**Following our investigation, HMRC provided details of its reflections, the support already in place for customers and the steps it was taking to strengthen the support it provides to customers who need extra help.**



# Deaf patient not aware of what they were consenting to

## Summary

**The GP practice did not identify or act on a patient's communication needs in line with national standards. This led to the patient being given a vaccine she had not consented to leading to side effects that were not clearly explained.**

## The complaint

In October 2022, Samantha went to a pre-booked appointment at a doctor's surgery in Northamptonshire for her flu vaccination. Samantha's first language is British Sign Language (BSL). There were no BSL interpreters at the appointment. Samantha had travelled to the appointment with her grandmother.

Samantha said she typed 'flu jab only' into her phone and showed it to the Practice when they tried to communicate with her. Samantha had a different appointment booked for her COVID-19 vaccine a few weeks later. She said she was not asked any clinical screening questions or warned about the side effects of the vaccine. She said she did not know that it was the COVID-19 vaccine that was then given to her.

Samantha said she had side effects from the vaccine and was shocked to find out she had been given the COVID-19 vaccine without consenting to it. She said the incident also affected her sleep.

**"Sadly this experience has had a profound impact on my emotional wellbeing, and I have completely lost trust and confidence in having any type of injection. In the past, I would confidently attend blood tests or any procedures involving injections, but now I feel very nervous and anxious."** **Samantha**

## What we found

We found that the Practice did not know what vaccine Samantha had booked the appointment for, so the nurse asked her which injection she wanted. It said Samantha had not requested an interpreter and that it used other ways to communicate with her. This included the nurse removing their mask so Samantha could lip read if required.

The Practice believed it correctly established Samantha wanted the COVID-19 vaccine and got her consent through her grandmother. Samantha said her grandmother has early-stage dementia and did not come with her into the treatment room.

Our adviser said it was not appropriate for the nurse to communicate to a patient's relative instead of using a qualified BSL interpreter. There was no way to know if Samantha's grandmother was a qualified translator.

NHS England advises that a BSL COVID-19 vaccination consent video is available if an interpreter cannot be present in these situations. There is no record that Samantha was given the opportunity to watch this video.

## Putting things right

**We recommended the Practice should apologise and pay £450 to Samantha to recognise the distress she experienced. We also recommended it should introduce service improvements in line with the NHS England accessibility guidance.**

**Following our investigation, the Practice now has a contract with a sign language interpreting company and displays posters in the surgery with information on services available for patients with impairments.**

# Lack of accessible information for patient with visual impairment

## Summary

**The Trust did not identify, record or act on a patient's accessible information needs, meaning he was discharged from hospital with information he could not understand.**

## The complaint

Carol complained about the care and treatment Manchester University NHS Foundation Trust gave her boyfriend, Neil. Part of her complaint was that the Trust did not provide accessible information.

Neil was in his 60s and had a visual impairment. He went to hospital in May 2020 for a leg amputation and went home the following month. Carol told us Neil was bombarded with so much information when he was sent home and he was finding it difficult to take everything in.

She said the hospital should have provided large print information about his medication and telephone numbers to ring, so he knew who to contact if he needed help. She told us an advocate had rung the hospital to request this.

## What we found

We found that the Trust did not follow the NHS accessible information standard, which includes asking people if they have any information or communication needs, finding out how to meet them and recording them clearly. We found that this went wrong at several stages during Neil's hospital stay.

**The Trust's complaint response said:**

- there was no record of Neil's visual impairment in the emergency department notes and the admission notes were incomplete
- the pharmacist who confirmed the medication history with Neil did not pick up that he had a visual impairment, so they did not record this on the inpatient prescription chart or discharge prescription
- there was no information about Neil's visual impairment on the previous conditions box.

It was clear that the failure by the Trust to provide information in an accessible format caused anxiety and upset to Neil and Carol. The Trust had apologised for this, but it had not recognised why this went wrong nor improved its service.

## Putting things right

Carol hoped to make sure things are better for patients in future. We asked the Trust to write to her to accept what it got wrong and apologise. We also said it should learn from the complaint. We recommended that it should look into why the mistakes happened and make an action plan to stop them from happening again.

Following our investigation, the Trust reviewed Neil's care to identify where learning was needed. This led to actions for pharmacy staff, nursing and clinical staff to make sure patients' disabilities are identified and documented.

It also took action to improve the accessibility of written material for patients with a visual impairment. It updated its guidance and electronic system so that adjustments for patients with a disability are built in from the start.

# Making a complaint

**If you are not happy with the service you have received from the NHS in England or a UK government department, you have the right to make a complaint.**

**Hearing from people when things go wrong is really important. Sharing your experience can improve services for everyone and help stop mistakes happening again.**

**This guide tells you more about how to complain and what to expect. You can also read our top tips on how to make a complaint.**

# How to make a complaint

## Step 1

### Speak to a member of staff at the organisation you are not happy with first

Before you make a complaint, you could share your views and experiences with a member of staff. Feel confident in raising your concerns. Staff should welcome your feedback because it can help to improve services.

## Step 2

### Get advice if you need it

If you want help and advice about making a complaint, there are lots of organisations that can support you.

For example, if you have a complaint about your healthcare you can speak to your local Patient Advice and Liaison Service (PALS). If you are complaining about a government department or service, your local Citizens Advice will be able to give you more information.

**If you need help making a complaint, our website has more information about getting advice and support.**

## Step 3

### Make a formal complaint

If you want to make a formal complaint, you should do this within 12 months of when the problem happened or from when you first became aware of it.

Each organisation will have its own complaints process. You can usually find this on its website or by asking staff. After you have sent your complaint, the organisation should explain what will happen next, how it will deal with your complaint and how long it will take.

The organisation must deal with your complaint properly and investigate it as quickly as it can. It should respond to your complaint in writing. This should tell you how it carried out the investigation and what it found. If it made mistakes, it should apologise to you. The organisation should explain any lessons learned or changes it will make to put things right.

## Step 4

### Complain to the Public Service Ombudsman

If you are not happy with how the organisation handled your complaint, you can ask us to look into it.

You can complain to us if you have reached the end of the organisation's complaints process and you still do not feel the issue has been sorted out. This can include a review process by some government services.

There are time limits for making your complaint to us, and these are set out in law.

If your complaint is about a government service, you will need to ask a Member of Parliament (MP) to bring the complaint to us.

**Find out more about how to complain to us and how we deal with complaints.**

# What to expect when you make a complaint

## The Complaint Standards explain how organisations should approach complaint handling. They say organisations should:

welcome complaints in a positive way

be thorough and fair

give fair and accountable responses

promote a learning culture

## When organisations meet the Complaint Standards you should feel:

confident to speak up

that making your complaint was simple

listened to and understood

that your complaint made a difference

confident to make a complaint in the future

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This report is also available in large print, easy read and a British Sign Language (BSL) video on our website.

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