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Equality Matters – improving inclusion and accessibility in public services in Wales

January 2025

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Mae'r ddogfen hon hefyd ar gael yn y Gymraeg.

This document is also available in Welsh.

Foreword

Over recent years, my office has shared information about cases in which equality and human rights implications have been considered in an annual Equality and Human Rights Casebook. This year, I felt it appropriate to issue a thematic report, given that some equality and human rights themes continue to appear in casework, despite them having been previously highlighted in the Equality and Human Rights Casebooks. Lessons must be learned from the casework dealt with by my office and the aim of this report is to share that learning. I make several recommendations to all public bodies in Wales, to improve inclusion and accessibility across public services.

Firstly, I must emphasise that it is not my role to conclude that someone's human rights have been breached, or that they have been discriminated against. That is a matter for the Courts. However, human rights and equality issues are often intrinsically interlinked within some of the complaints about public services received by my office. In such cases, although not always expressly referred to by the complainant, if we see that someone's human rights or equality rights may have been engaged, we will clearly state that in our decisions and make appropriate recommendations.

The case examples included in this report relate to ensuring the needs of service users are met to make sure that they are not disadvantaged or discriminated against when using public services. The examples used in this report highlight the need for public services to proactively take positive action to ensure that they meet their equality duties and that there are no barriers to accessing public services.

I hope that this report will be helpful to all public service providers and encourage them to reflect upon the learning highlighted in this report and to use the recommendations to drive improvements in meeting the equality needs of service users across Wales.

Michelle Morris

Public Services Ombudsman for Wales

January 2025

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Our role

As the Public Services Ombudsman for Wales, we have legal powers to look at complaints about public services. We can look at complaints about local authorities and all health care providers and independent care providers in Wales, including Health Boards, Trusts, GPs and dentists.

We have a team of people who consider and investigate complaints. We are independent of all government bodies and our service is impartial and free of charge.

Equality and human rights frameworks

We are committed to the statutory principles and duties under the equality and human rights UK legislation and international frameworks.

In looking at our complaints, we consider:

- The equality duties under the Equality Act 2010 ("the Equality Act") – this requires public bodies to make reasonable adjustments for people with protected characteristics, such as disability, race or religion, to ensure that they are not disadvantaged when accessing services. A failure to make a reasonable adjustment for a person with a protected characteristic is a form of discrimination.
- The Articles of the European Convention on Human Rights and enshrined in law by the Human Rights Act 1998 ("the Human Rights Act").
- The FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy) – core values which underpin human rights.

Further information about relevant legislation is provided in Appendix 1.

It is not our role to conclude that someone's human rights have been breached, or that they have been discriminated against. That is a matter for the Courts. However, we see in our casework that human rights and equality issues are often inseparable from people being treated unfairly or suffering injustice. Therefore, when we see that someone's human rights or equality rights may have been engaged, we will state that clearly in our conclusions and make appropriate recommendations.

Themes and learning points

A review of our cases closed between April 2023 and September 2024 identified themes in the difficulties people have experienced in accessing public services. The case examples referred to are included in Appendix 2.

Lack of reasonable adjustments

We have seen numerous complaints about public bodies failing to make reasonable adjustments for individuals with disabilities. Duties under the Equality Act apply to all public bodies and ensuring these duties are met, including ensuring reasonable adjustments are in place, when necessary, should be fundamental to the work that is undertaken.

In the case of Ms A's complaint (case example 1), we were concerned that Betsi Cadwaladr University Health Board failed to anticipate and support Ms B's needs as a person with learning disabilities and make reasonable adjustments to ensure she was not disadvantaged. Our findings demonstrated a lack of understanding of the approach needed to provide care to address Ms B's needs as an individual. The shortcomings identified represented a serious service failure, which resulted in a poor standard of care and unnecessary suffering for Ms B. This also caused her family distress. As a result of our investigation, the Health Board agreed to undertake a number of actions, which included reviewing its care planning practices, reviewing a sample of care plans to ensure they included any adjustments to meet a patient's individual needs and reviewing its approach to pain assessment for people with learning disabilities.

In the case of Miss C (case example 2), we identified that there were missed opportunities for Hafod Housing Association to consider reasonable adjustments at an early stage and in its response to Miss C's complaint. Had timely enquiries been made, this may have given the Housing Association a better understanding of the impact of Miss C's concerns upon her, taking into consideration her disability.

In a case against Cardiff and Vale University Health Board (case example 3), we identified concerns in how a tetraplegic patient, Mrs D, was supported. Information about her needs and preferences was not always included within care plans so there were occasions whereby care was not tailored to her specific needs. This

had a significant impact upon Mrs D's dignity and autonomy as she relied upon others and her fundamental needs were not met. We were concerned this meant that due regard may not have been paid to the need to take steps to remove the barriers Mrs D faced because of her disability. As a result of our investigation, the Health Board agreed to complete its evaluation of how to improve its provision of individualised care to patients with complex needs and provide an action plan to take forward the findings from the evaluation.

In another case against Betsi Cadwaladr University Health Board (case example 4), we found that the Health Board had not considered reasonable adjustments for Mr E, despite being informed that he had autism and dyslexia. It had therefore failed to ensure he was not disadvantaged due to his disabilities and this caused Mr E unnecessary stress. The Health Board agreed to consider lessons that could be learned from this case, including ensuring enquiries and consideration of reasonable adjustments are made in a timely manner and documented.

Principle 1 of the Ombudsman's Principles of Good Administration is 'getting it right'. This includes acting in accordance with the law and with due regard for the rights of those concerned. The consideration of reasonable adjustments is essential to ensure that the rights of disabled people are upheld and to ensure equal opportunity and access to services for disabled people. Without this, disabled people may not receive the service they are entitled to and may be adversely affected by the failure to make reasonable adjustments. We will continue to work with public bodies to raise these issues where it is clear that there has been a failure in its duty to do so.

Good communication – an obligation to adapt approach

Good communication is essential in ensuring the effective delivery of public services. There will be occasions when the method of communication may need to be adjusted in order to meet the needs of the service user. We have seen examples of cases where public bodies have failed to take appropriate consideration of people's communication needs or failed to make the necessary adjustments to support their method of communication. This has directly impacted the quality of the service people have received.

In Ms F's complaint (case example 5), Cardiff and Vale University Health Board did not consider the use of a translation service, despite Mr F not speaking English as his first language. An Interpretation and Translation Service policy was in place, but this was out of date. The failure to ensure that Mr F was able to communicate effectively may have contributed to the shortcomings in his care and treatment. We were concerned that this meant that due regard may not have been paid to the need to protect Mr F from discrimination on the grounds of his race. It is essential that individuals accessing health services are able to share information with clinicians and understand the information and advice provided to them.

In Miss G's case (case example 6), she faced barriers in communicating with Hywel Dda University Health Board. Miss G is deaf and was the primary carer for her mother who had a cognitive impairment and had experienced a number of inpatient admissions to hospital. At the start of our investigation, the Health Board provided information on the actions it was taking to address the barriers faced by individuals with sensory loss when communicating, which are ongoing. It then undertook a further investigation of the concerns Miss G had raised which identified failings in the care provided to her mother. It took actions to address these failings, which included ensuring the in-patient visitor policy was implemented by staff to ensure the involvement of carers to support patients, where appropriate. This demonstrated that it is not only important that policies are in place and up to date, but to also ensure staff understand and implement them.

We have also identified communication difficulties in settings other than health services. In Ms I's case (case example 7), she had complained to Cardiff Council about its handling of her complaint, including a lack of reasonable adjustments made for communication. We found that it was unclear if reasonable adjustments for communication had been formally agreed. Difficulties communicating caused Ms I unnecessary stress. We were concerned that the Council had failed to pay due regard to the need to take positive steps to remove the barriers faced by Ms I and to ensure she was not disadvantaged. The complaint was resolved without investigation, following agreement by the Council to undertake a number of actions, which included writing to Ms I to confirm that appropriate reasonable adjustments were in place for her.

Principle 2 of the Ombudsman's Principles of Good Administration is 'being customer focused'. This includes ensuring people can access services easily and responding to people's needs flexibly. Public service providers must ensure that they are proactive in meeting the communication needs of their service users. A failure to ensure that service users can communicate effectively could lead to them being disadvantaged. As demonstrated through these examples, as a result of the work that has been undertaken, we are continuing to raise awareness with public bodies of the need to ensure individuals' communication needs are taken into consideration and appropriately responded to.

Policy and guidance

The case examples included in this report have highlighted issues in relation to public bodies failing to ensure that policies relevant to the delivery of services are compliant with their obligations in relation to equality and human rights. They have also highlighted failings in relation to ensuring policies are reviewed and kept up to date.

Ms F's complaint (case example 5) highlighted a failure by Cardiff and Vale University Health Board in ensuring that its Interpretation and Translation Service Policy was up to date and regularly reviewed. As a result of the investigation into Ms F's complaint, the Health Board agreed to conclude a review of its Interpretation and Translation Service Policy, including ensuring that all relevant staff were aware of it.

In Ms J's complaint (case example 8), it was apparent that, although Bron Afon Housing Ltd appeared to have considered its duty to provide reasonable adjustments, its criteria and guidance was dated 2009. Bron Afon Housing Ltd agreed to update its criteria and guidance to incorporate and reflect newer and relevant legislation, including the Equality Act.

Principle 3 of the Ombudsman's Principles of Good Administration includes being open and clear about policies and procedures and ensuring that information is clear, accurate and complete. This is reliant upon public bodies ensuring that they regularly review policies, procedures and guidance relevant to the delivery of services, to ensure they are compliant with their obligations relating to equality and human rights matters. Public bodies also need to ensure that staff who deliver front line services are aware of their organisation's duty

to ensure that adjustments should be made to allow individuals to access services. Public bodies need to ensure that staff receive appropriate training and feel empowered and supported to take decisions when individual circumstances indicate a need to deviate from usual practice.

Good practice

We also see examples of good practice in our case work. In Mrs K's complaint (case example 9), she said that a GP Practice in the area of Cardiff and Vale University Health Board would not make reasonable adjustments to meet her needs. Mrs K had requested all communication with her was via email. However, we found that the Practice had considered Mrs K's needs and preferences. It had made appropriate adjustments, taking into consideration those needs, and it was reasonable for it to require that urgent, same day appointments were requested by telephone, due to the nature of these requests.

Future considerations

We hope the themes outlined in this report will provide a helpful guide to public bodies of the need to consider their duties under the Equality Act and Human Rights Act when they are delivering front line services to members of the public.

We **recommend** that this report is shared with the Equality, Diversity and Inclusion Lead and the relevant Board/Committee with oversight of their organisation's compliance with Equality duties at all public service providers in Wales and that they ensure that their organisations:

- Encourage staff to be person centred in their consideration of the needs of the people they provide a service to, including being proactive and anticipating their needs.
- Ensure staff document the considerations and decisions they have made discharging their duties to make reasonable adjustments under the Equality Act.
- Ensure policies are reviewed and kept up to date.
- Ensure staff receive appropriate training, are aware of the policies in place and how to implement them, and that they feel empowered and supported when taking decisions to make reasonable adjustments to meet the needs of service users.
- Ensure staff are aware of who to contact if they need advice or support when addressing equality and human rights issues.

Appendix 1 - Relevant legislation

Equality duties

Under the general duty, we must have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act.
- Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.
- Foster good relations between people who share protected characteristics and those who do not.

The general duty covers the following protected characteristics:

- Age
- Disability
- Sex
- Sexual orientation
- Gender reassignment
- Race (including ethnic or national origin, colour or nationality)
- Religion or belief (including lack of belief)
- Pregnancy and maternity; and
- Marriage and civil partnership (but only in respect of the requirement to have due regard to the need to eliminate discrimination).

Public bodies in Wales also have specific duties to help them in their performance of the general duty.

Human rights

The Human Rights Act incorporates into domestic law the rights and freedoms as set out in the European Commission on Human Rights. Some are absolute rights, meaning that the citizen should be free to enjoy them and the state can never interfere. There are some limited rights, meaning they might be interfered with in certain circumstances (such as during times of war or emergency). Finally, others are qualified rights, meaning that the state can legally interfere with them in certain situations – for example, to protect the rights of other citizens. The most common human rights featured in the complaints considered by our office are the following:

Article 2 - The right to life

Article 3 - The right to be free from torture or cruel, inhuman or degrading treatment or punishment

Article 5 - The right to liberty and security

Article 6 - The right to a fair hearing

Article 8 - The right to respect for private and family life, home and correspondence

Article 9 - The right to freedom of thought, conscience and religion

Article 10 - The right to freedom of expression

Article 14 - The prohibition of discrimination

Appendix 2 - Case examples

The following relevant cases were closed between April 2023 and September 2024. We have simplified and adjusted case summaries to make them more accessible and to better explain the equality or human rights implications of the complaint. However, formal summaries of these cases can be found **here**. Please note that parties to the complaints referenced in this report may be referred to differently in the formal summaries of the cases.

Case example 1

Ms A's complaint – 202300527 – Betsi Cadwaladr University Health Board

The complaint

Ms A complained about the care and treatment her sister, Ms B, received from Wrexham Maelor Hospital ("the Hospital") in July 2022. Ms B had several medical conditions, including epilepsy (a condition which causes seizures), cerebral palsy (a condition that affects movement and co ordination) and learning disabilities. She lived in a nursing home, had limited communication, and required 24 hour care and support.

What we found

We found that the Health Board's management of Ms B's personal care needs, her nutrition, hydration and communication with her, fell below an adequate standard. On the occasions that the Learning Disability ("LD") team and Ms B's family were not present to assist, the nursing care on the ward fell short of acceptable standards, especially at weekends and overnight. No additional staff were brought in to support care delivery. There was no person-centred nursing care plan, setting out the care objectives and adjustments that were needed to provide Ms B with effective care. This meant that staff did not fully understand her needs. We also found that there were multiple occasions when Ms B's pain was identified by her family and the LD team, but it was unclear whether nursing staff were consistently able to identify pain, as the assessment tool used was not adapted for Ms B's particular needs. This failure meant that Ms B suffered unnecessarily. We found that there was a poor standard of record keeping in relation to Ms B's seizures. This was dangerous and represented a poor

level of care. It was unclear whether nursing staff recognised Ms B's seizures themselves and, had her family not been present, it is likely that many of her seizures would have gone unnoticed. Administration of medication was also found to be inadequate. Poor compliance with anti-seizure medication may have contributed to the increase in Ms B's seizure activity.

What we said

We were concerned that the Health Board had failed to anticipate and support Ms B's needs as a disabled person and failed to make reasonable adjustments to make sure that she was not disadvantaged. We were also concerned that the findings demonstrated a lack of understanding of the approach needed to provide care to meet Ms B's needs as an individual.
We made a number of recommendations, which the Health Board accepted. These included:

- An apology to Ms A, on behalf of Ms B, for the failings identified and for Ms A having to pursue her complaint.

- A review of care planning practices on the ward to ensure care plans are embedded into basic care.

- A review of a sample of person-centred care plans, to ensure they include any adjustments to meet a patient's individual needs.

- Implementation of a regular ward audit of nursing documentation, to include care plans and seizure charts.

- A review of the approach to pain assessment for people with learning disabilities, to ensure adjustments and appropriate tools are used.

- Providing training to ward staff in respect of mental capacity and 'best interest' decision making.
- Engagement with the social services departments of all local authorities within the Health Board area to implement a joint care pathway to ensure safe staffing levels when vulnerable people with additional needs are admitted from care/nursing homes.

- Providing confirmation that its Patient Safety and Experience Committee will monitor compliance with ongoing actions to satisfy our recommendations.

Case example 2

Miss C's complaint – 202304536 – Hafod Housing Association

The complaint

Miss C complained that, between February 2021 and January 2023, Hafod Housing Association had not acted in accordance with its policy and procedure regarding her anti-social behaviour ("ASB") complaints about parking and noise nuisance. In addition, concerning the ASB, the Housing Association had failed to take her disability into account and consider whether it was appropriate to make reasonable adjustments under the Equality Act. Finally, Miss C said that the Housing Association did not handle her complaint in line with its complaint handling process and did not sufficiently address the ASB matters that she raised in its complaint response.

What we found

We found that the Housing Association had not always acted in accordance with its ASB policy and procedure, or indeed best practice, as set out by the Welsh Government. We also identified that communication with Miss C could have been more effective than it was. In respect of record-keeping, we found that it was not always clear when contact was made or what the ASB management plan was, in Miss C's case. Inaccuracies in some of the responses provided by the Housing Association were also not helpful. There were also instances when the Housing Association did take action. Despite this, shortcomings in the way the Housing Association carried out its ASB policy and procedure added to Miss C's distress and caused an injustice. In light of these shortcomings, to that extent only, this part of Miss C's complaint was upheld.

We identified that there was a lack of meaningful engagement shown by the Housing Association in relation to Miss C's health issues. This led to missed opportunities for it to consider reasonable adjustments, in line with the Equality Act, at an early stage. We found the Housing Association failed to identify and acknowledge this as an issue in its responses to the complaint, including to the Ombudsman's office. Had timely enquiries been made about reasonable adjustments, this might have given the Housing Association a better

understanding, at an earlier stage, about the effect of the noise and parking on Miss C, given her brain tumour diagnosis. This part of Miss C's complaint was also upheld.

Case example 3

Mrs D's complaint – 202207136 – Cardiff and Vale University Health Board

The complaint

The complaint related to care provided to Mrs D, a tetraplegic patient, during an admission to the University Hospital of Wales ("the Hospital") in April/May 2022.

What we found

We found no concerns in relation to the medical care provided to Mrs D nor about the decision to discharge her. However, we found that clearer information about her ongoing care could have been provided, on discharge, to carers and family.

We also identified inconsistences in the manner that Mrs D's fundamental care needs were assessed and documented in the care plans. Detailed information provided on admission about Mrs D's needs and preferences was not always properly translated into the care plans. This meant that there were occasions when care was not tailored to Mrs D's specific needs. We were concerned this meant that due regard may not have been paid to the need to take positive steps to remove barriers Mrs D faced because of her disability.

What we said

We recommended that the Health Board should provide an apology to Mrs D's family and arrange an opportunity for them to share their experiences with Health Board staff. The Health Board confirmed it was evaluating how to improve its provision of individualised care to patients with complex physical needs. It agreed to complete the evaluation within 4 months and share a copy of it, and any associated action plan, with our office. A copy of our report was also to be provided to the Health Board's Equalities Lead.

Case example 4

Mr E's complaint – 202402918 – Betsi Cadwaladr University Health Board

The complaint

Mr E complained that the Health Board had not responded to all the questions that he had raised about his GP Practice. He was also unhappy with the Health Board's handling of his complaint, including the time taken to provide a response. He referred to the effect this had on him.

What we found

We were critical of the Health Board's complaint handling and its complaint response. We noted that the Health Board had not properly taken into account its freedom of information ("FOI") duties. It had also not considered the need for reasonable adjustments under the Equality Act, given that Mr E had informed the Health Board that he had autism and dyslexia and what this meant in terms of his needs. We were concerned that the Health Board had failed to ensure Mr E was not disadvantaged due to his disabilities. Given the stress that the Health Board's poor complaint handling had caused Mr E, we were satisfied that this had caused Mr E an injustice.

The Health Board agreed to apologise to Mr E for the failings identified and to pay him a financial redress payment of £250 for the inconvenience and time and trouble caused to him by its complaint handling failings. It also agreed to look at lessons to be learned from Mr E's case around FOI and reasonable adjustments and to take other measures, including arranging appropriate FOI training and improving documentation around reasonable adjustments.

Case example 5

Ms F's complaint – 202302461 – Cardiff and Vale University Health Board

The complaint

Ms F complained on behalf of her husband, Mr F, about the assessment and treatment provided by Cardiff and Vale Health Board for a laceration to his left wrist, when he attended the University Hospital of Wales ("the Hospital") Emergency Department, on 24 August 2022.

What we found

We found that Mr F did not receive appropriate treatment and assessment when he attended the Hospital. Accurate records were not kept of the treatment he received and opportunities were missed for Mr F to be referred for more timely treatment of his injury. The use of a translation service was also not considered, despite Mr F not speaking English as his first language. We were concerned this meant that due regard may not have been paid to the need to protect Mr F from discrimination on the grounds of his race.

The Health Board agreed to apologise to Mr and Ms F. It also agreed to remind the clinician who treated Mr F of the importance of keeping accurate records and to ensure that she is familiar with the Health Board's guidelines on treating hand injuries and its Interpretation and Translation Service Policy. In addition, it agreed to develop a policy on referrals for treatment for patients that live outside the Health Board's area and to conclude a review of its Interpretation and Translation Service Policy, which was dated 2014 and last reviewed in 2017, including ensuring that all relevant staff are aware of it.

Case example 6

Miss G's complaint – 202308108 – Hywel Dda University Health Board

The complaint

Miss G complained about the care and treatment provided to her mother, Mrs H, by Hywel Dda University Health Board. Miss G also complained about communication with herself, as a deaf carer, by the Health Board.

What we found

At the start of the investigation, the Health Board agreed to issue a further letter to Miss G, apologising and recognising the barriers she had faced as a deaf carer. It also agreed to provide an update to the Ombudsman on the actions it was taking to address these communication issues, including detail on how it was working towards compliance with the Wales Standards for Accessible Communication and Information for People with Sensory Loss. Our investigation therefore focused on the care and treatment provided to Mrs H during 2 hospital admissions. This specifically considered if there was a lack of reasonable adjustments, taking into consideration Mrs H's cognitive impairment, including support with fluid intake and the involvement of Miss G, as a carer.

In response to our investigation, the Health Board undertook a further investigation into the care provided to Mrs H during the 2 hospital admissions. This identified failings in the care provided. The Health Board agreed to issue another complaint response to Miss G, detailing its further investigation and apology for the failings. It also agreed to include in the response details of the actions it was undertaking to address these failings, which included ensuring staff were aware of, and implemented, the in-patient visitor policy and ensured involvement of carers, where appropriate. We considered the actions the Health Board agreed to take were reasonable and discontinued the investigation on this basis.

Case example 7

Ms I's complaint – 202301907 – Cardiff Council

The complaint

Ms I complained that she was unhappy with Cardiff Council's response to her complaint about flies in her property from exterior bins, issues relating to housing officers and reasonable adjustments for communication.

What we found

We found that the Council had not provided a solution to the flies problem. Ms I's relationship with housing officers was no longer positive and it was unclear if reasonable adjustments for communication had been formally agreed. We were concerned that the Council had failed to pay due regard to the need to take positive steps to remove barriers Ms I faced in communicating with the Council and to ensure she was not disadvantaged due to her disabilities.

We sought and gained the Council's agreement to write to Ms I to confirm the reasonable adjustments, allocation of a new housing officer and arrangements for the installation of fly screens.

Case example 8

Ms J's complaint – 202300591 – Bron Afon Housing Ltd

The complaint

Ms J complained to us, through an advocate, that the Housing Association's Adaptations Panel ("the Panel") declined to fund works to adapt her home, to enable her disabled daughter to remain living at her property.

She was concerned that the family was not given a reasonable opportunity to directly make its case to the Panel and that their views were disregarded. She was also concerned that, by declining to fund and undertake some of the requested work, the Panel disregarded the family's rights under the Equality Act.

What we found

We saw evidence that the family's wishes had been fully considered as part of the Panel's decision-making process and were not "disregarded". There is no procedural right to directly speak in person to the Panel. In our view, the Housing Association appeared to have evaluated what options would be cost-effective and appropriate, in relation to their wider housing stock, and did so in line with its policy and guidance.

Overall, we found that the decision of the Housing Association appeared to be compatible with the principles of the Equality Act, as requests for adaptation may be refused, if deemed unreasonable. However, we noted that, although the Housing Association appeared to have considered its duty to provide reasonable adjustments, its criteria and guidance was dated 2009. Therefore, it needed to be updated to incorporate and reflect newer and relevant legislation, including the Equality Act.

Case example 9

Mrs K's complaint – 202401145 – A GP Practice in the area of Cardiff and Vale University Health Board

The complaint

Mrs K complained about the care and treatment she and her partner received from the Practice, including that it would not make reasonable adjustments to suit her needs. Mrs K said that she had complex post-traumatic stress disorder and she had made repeated requests to communicate with the Practice via her preferred contact method of email. She said she had been informed she should not contact them via email to book appointments.

What we found

The Practice had apologised that it had not responded to 2 emails Mrs K had sent. This had been raised with the relevant staff. It had also outlined the ways Mrs K could contact it (including online, via telephone and via email) and when each of these methods was appropriate.

We were satisfied that the Practice had considered Mrs K's requests for reasonable adjustments and attempted to address them. It had explained that routine appointments could be booked using its online booking system up to 4 weeks in advance. A request to change an appointment to 'face to face' could be made via email. The Practice agreed that Mrs K could contact it via email for general enquiries, including those relating to prescriptions. However, requests for urgent appointments would need to be made via the telephone, due to the nature of these appointments and way they are booked. We considered the Practice had made all the reasonable adjustments it was able to make, in the circumstances.

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