HealthHarmonie
Quality and safety first.

Accessible Information Standard

Version	V1.2
Name of responsible (ratifying) committee	Senior Management Team
Date ratified	Nov 2020
Document Manager (job title)	Head Of Quality
Date issued	May 2018
Review date	Nov 2021
Electronic location	Shared Data/ Governance.Policies and Procedures

Contents

Purpose

The Accessible Information Standard aims to ensure that disabled people have access to information they can understand and the communication support they may need. The Standard applies to service providers across the NHS and adult social care system. As organisations that provide NHS services, GP practices are required by law to follow the Standard under Section 250 of the Health and Social Care Act.

SCCI1605 Accessible Information – the 'Accessible Information Standard' – directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents, where those needs relate to a disability, impairment or sensory loss. (Accessible Care Standard)

Responsibilities

Managing Director

To ensure the oversight of this policy.

Medical Director

To work with the clinical and operational staff to ensure patient care and consent is provided at all times.

Clinical Governance Manager

To support the Medical Director and Clinicians to ensure consent can be evidence on file and to investigate, monitor and conduct analysis of non-compliance.

Scope

This policy relates to all care provided by HealthHarmonie.

Patients or service users of publicly-funded health or adult social care, or their parents or carers.

- Patients or service users of all publicly-funded health or adult social care, or their parents or carers, including (but not limited to) that received as an inpatient or outpatient, as part of urgent or emergency care, routine or elective care, acute care, day-care, and long-term and residential care.
- Information or communication support needs or requirements which are caused by or related to a disability, impairment or sensory loss.
- An individual’s need or requirement for information or correspondence in an alternative (non-standard print) format including print alternatives such as braille, and electronic and audio formats.
- An individual’s need or requirement for communication support.
- An individual’s need or requirement for a longer appointment to enable effective communication / the accessible provision of information.
- An individual’s use of communication tools or aids.
- An individual’s need or requirement for support from an advocate to support them in communicating effectively.
- An individual’s use of alternative or augmentative communication tools or techniques.
- The detail or specific type of alternative format or communication support which is needed or required by the patient, service user, carer or parent.
- All information provided to individuals with particular information or communication support needs including ‘personal’ or ‘direct’ communication (for example appointment letters or prescriptions) and ‘generic’/ ‘indirect’ communication (for example leaflets or manuals).

Policy Specific Content

To meet these standards there are five key areas:

1. Identification of the Needs
2. Recording of Needs
3. Flagging of Needs
4. Sharing of Needs
5. Meeting the Needs

Identification of Needs

Patients and their carers to tell us if they have any communication or information needs relating to a disability, impairment or sensory loss, and if so, what they are

New patients will be asked at the point of registration if they have any communication or information needs relating to a disability, impairment or sensory loss, and if so, what they are (there is a section on the New Patient Questionnaire that covers this question)

Existing patients can be asked opportunistically (e.g. when making an appointment, with repeat prescriptions, newsletters, posters, email, text message, information screens, website)

Patients should be asked to self-define their communication/information needs and it is these needs (and not the disability) which should be recorded.

Recording of Needs

For each patient we need to review and record the needs of the patient. This needs to include

- That they have communication or information needs relating to a disability, impairment or sensory loss,
- The information will be added to the patient's medical record using the approved template to create a protocol to provide information to all users that access the record.

Flagging of Needs

In order to inform all users and provide the opportunity to keep information up to date the protocol will launch each time the patient's record is entered informing the user of the patients access needs and giving the opportunity for these to be updated if required.

Sharing of Needs

As the information is being recorded in a standardised way via Read Code and users are being informed of any needs every time they enter the record the information recorded will be shared subject to patient's choice regarding the sharing of information. To achieve this protocol we need to work with GP practices and other key services (e.g. Social Services) to ensure that this requirement is met in a consistent manner (in line with Data Protection legislation).

Meeting of Needs

The organisation provides one or more contact methods which are accessible to the patients. Methods include email, text message, telephone and text.

Where information/communication needs are identified, information (e.g. correspondence) will be provided in one or more accessible formats (e.g. non-standard print). Alternative formats can be provided if available either through auto-generated systems, or through prompting staff to make alternative arrangements. For example in brail or in different languages.

The adjustments made should be reasonable – but this does not mean that the patient must always receive information in their preferred format. What is important is that they can access and understand the information.

Where needed, appropriate professional communication support is arranged by the organisation to enable patients and carers to effectively receive NHS care i.e. Text Talk, Interpreters.

A patient’s family member, friend or carer may also provide necessary support in certain circumstances and where this is the patent’s consents (which should be recorded);

Patients or carers themselves must not be asked to meet the costs of any information or communication needs.

Related Policies

- Clinical Governance Policy
- Mental Capacity Act Policy
- Clinical Audit Policy

Related Legislation or Best Practice Guidance

The following information standards should also be referred to by organisations to ensure safe and effective implementation of the Standard:

- Clinical Risk Management: its Application in the Deployment and Use of Health IT Systems (ISB 0160 Amd 38/2012 Version 2)
- Clinical Risk Management: its Application in the Manufacture of Health IT Systems (ISB 0129 Amd 39/2012 Version 2)
- Information Governance Standards Framework (ISB 1512)
- ISB Information Governance baselines
- Read Codes (ISB 1552 and 1553)
- SNOMED CT (ISB 0034)

Version Control

Version	Date	Author	Amendment(s)	Approved By
V1.0	May 2017	Samantha Patterson	This is the first version of the document. Drafted By Samantha Paterson	Andrew Jackman
V1.2	May 2018	Samantha Paterson	Reviewed By Samantha Paterson	Andrew Jackman
V1.2	Nov 2020	Natalie Shield	Reviewed – no changes	Andrew Jackman