ELLISON VIEW SURGERY, HEBBURN

Piloting the draft accessible information standard

Reporting

Organisations participating in the pilot of the draft accessible information standard are expected to report to NHS England on actions taken, impact, benefits and costs, experiences and opinions, challenges and suggestions for improvements. Specifically, following the conclusion of the pilot, organisations are to provide a report to NHS England which includes the following information.

NB This document may be used as a template for submission of reports – please add information below each section and delete prompts as appropriate.

1. Scope and scale of the pilot

Noting the information provided as part of the application to pilot and MOU, please provide details in order to inform an overview of the scope and scale of the pilot. With reference to the pilot phase, please provide details of:

- Approximate number of patients / service users making contact with and / or seen by the pilot site(s);
- Patients / service users making contact with and / or seen by the pilot service known to have information and / or communication needs;
- Number of records adjusted to include details of individuals' information and / or communication needs in line with the standard;
- Numbers and types of information produced in alternative formats (including which formats), whether such information was produced proactively or on request, approximate turnaround times and any issues;
- Support arranged from communication professionals including type of support / professional, timescales and any issues;
- Any other comments in this regard.

- *We have been in actual contact with two patients. One patient visually impaired and the other deaf.*

- *We have 67 patients identified so far who have either hearing or visual problems who may need different accessible information.*

- *All 67 patients' notes have been marked, either with the way they wish to be communicated with, or a note on to ask them opportunistically when they next come to surgery.*

- *Practice leaflet reproduced in large print which will be given out as necessary at opportunistic appointments, or for new patients. We have also added a sentence to our ordinary leaflet letting patients know they can have the brochure in larger print. Our LD health check invitation letter has been changed to make easier reading, with pictures. We have spoken to our LD patients who have recently attended for a health check with permission to inform the Bowel and Breast Screening Service that they have learning difficulties so their screening invitation letter is easier to understand. It is also our intention when a person with communication needs attends surgery and is required to go to hospital for investigation, to ask their permission to inform the hospital they have special communication requirements and what that is.*

2. <u>Actions taken to effectively implement the standard into existing systems</u>

Please provide details of:

- System(s) used to implement the standard, including details of any IT software package(s) and electronic record systems (and / or paper-based systems);
- How the standard was implemented into relevant systems including specific actions taken and any associated processes which were followed, challenges or issues identified / overcome;
- Any adjustments which were made to systems during the pilot phase (i.e. if further changes were made following initial commencement of the pilot);
- Changes to policies and / or procedure which were made in order to implement the standard (where possible please supply copies of 'original' and 'revised' policies / procedures, where it is not possible to supply copies please provide details of changes made);
- Who was involved in making changes to systems in order to implement / pilot the standard, include job titles of relevant staff and any external support required (consider both those involved in the 'approvals' process and in implementing operational changes).

- *GP and members of staff (Practice Manager and Deputy Manager) met to discuss potential read codes for the computer to be used to search and identify patients coded with a visual/hearing problem. We were already aware of the patients we had with learning disabilities. Deputy Manager then set up a search on computer to identify possible patients..*

- *GP and member of staff (Practice Manager) looked through the list to agree who should be classed as having a visual/hearing problem and the correct diagnosis. Practice Manager then went through each patient record, ensuring the problem was coded in the correct section of our EMIS system.*

- *Practice altered new patient registration form to include a question about whether that new patient had any specific communication needs, and to get patient consent to share this information in communications from the Practice to other healthcare professionals. This consent is recorded on patient record.*

- *Practice Manager had discussions with Sight Solutions in South Shields, regarding what aids might be useful from a Practice point of view, for visually impaired patients.*

- *Practice arranged to have a supply of the practice leaflet put into large print.*

- *Member of staff went through each of these patient records and put an alert on asking staff to ask the patient if they had any particular communication needs as and when they attended surgery. This would then be noted on their record and consent to share this information sought from patient. This special information could include bold, large print letters, communication by e-mail (visually impaired people can use a type-talk system to have their computer 'voice' read out an e-mail. Some patients may prefer double appointments to give them time to communicate more easily.*

- *Staff meeting held with Manager to explain Project to staff and what staff need to do if they identify a patient with a possible communication need. Staff also advised to be aware of these patients and assist them where they may not be able to use the self-check in system or the patient call board, which is visual.*

- *Staff attended training in Visual Awareness and will be attending Dementia Friends training.*

- *Discussion with medical secretaries and GPs about including special communication needs information in referrals to other healthcare professionals and recording the patient consent to share information.*

3. <u>Impact and cost of implementing and following the standard</u>

Please provide data on and comments about the impact (positive and negative) and cost of initial implementation of the standard AND the impact and cost of following the standard on an ongoing basis as part of 'business as usual'. Please provide data

which demonstrates actual impact where possible, accompanied by any relevant comments and views on anticipated likely current / future impact (especially where hard data is lacking). Specifically, information and comments should be shared with regards to the impact on:

- Documentation / paper-based systems (for example registration forms and patient / service user correspondence);
- Electronic record / management systems (for example data held about patients / service users and automatic generation of correspondence);
- How and how often professional communication support is provided / arranged (for example British Sign Language interpretation);
- Process, policy and procedure (for example how patients / service users are registered and / or 'called through' for appointments);
- Provision of information in alternative formats (for example types of information made proactively available in particular formats / response to requests);
- Staff morale / experience (especially with regards to patients with disabilities);
- Staff time;
- Staff training and support;
- Types of communication methods used and materials produced / displayed (for example how the service is 'advertised' / information displayed in waiting areas);
- Use of alternative communication methods (for example email).

We had to re-do our patient registration form to include a question regarding communication needs and discuss with Healthcare assistant what kind of communication need information would be required.

A search had to be set up electronically on the computer; this search took staff time to build up using the codes identified by the GP. It is being added to all the time as we come across different diagnosis codes. Once the search was completed and had the list agreed by the GP, the patients' electronic record had to be noted, both to ensure correct diagnosis code was being used, was in the right place in the patient record, and adding an alert onto each record. This was a time consuming piece of work by the P/Manager to check the diagnosis codes and an admin member to add the alert to the record.

Consent must also be sought from the patient, as overleaf, before their special communication needs can be shared with other healthcare professionals. Unless the practice writes, telephones or otherwise contacts the patients, this can only be an ongoing job.

We have created a poster for the waiting room to ask patients with special communication needs to let us know. We are re-designing this poster at the moment.

Communication needs of patients will be done opportunistically as the patient attends. This means we can discuss with the patient what is best for them. Sight Service say 'one size does not fit all' and there are lots of reasons why people have visual impairment. The communication need for visually impaired patients should be 'person' based and not generalised; some patients have partial sight, in which case bold, large lettering would be helpful; others have very little sight, or peripheral sight, so it would make no difference to them the size of the font. Some patients without sight or very low vision have family to read their correspondence and do not require anything different from the Practice. Braille is apparently dying out according to Sight Service, with more patients accessing voice type-talk on their computers for e-mail. It would therefore not be practical for the practice to invest time and money into putting our patient leaflet into braille, unless there was a proven need from our patients.

Patients with a hearing impairment tend to bring their own sign interpreter with them. Although we have an interpreting service for language barrier, it would be impractical, we feel, to invest in staff training to learning to 'sign'.

Patients hard of hearing but who are able to talk, can access 'Speak and Read' via an 'app' on their mobile. This way they can speak directly to the other person whilst using Next Generation Text lite app running on their smartphone whilst in the surgery. NGT works by connecting to a relay assistant who types the words spoken, say by the receptionist, so the deaf person can read them on their mobile. The relay assistant stays on the line during the call to relay the conversation by text, the relay assistant speaking to the receptionist. Although this is not strictly our responsibility to advertise this service, we discussed with our healthcare assistant that she could mention it and we have copies of the information to hand.

4. <u>Feedback on the practicality of implementing the standard using existing documents / in its current form</u>

Please provide comments on the practicality of implementing the standard, including feedback on any aspects of the draft standard which you feel should be amended or clarified, with reasons as appropriate.

As above, the main time/cost implication to the practice was setting up the guidance, eg identifying read codes, computer search, agreeing the list, ensuring diagnosis code is correct and in the right place, adding alert to patient record, staff meeting time to discuss Project, changing Registration Form and meeting with Healthcare assistant to explain; PM discussions with LD team and Sight Service and investigation of Type Talk, Speak and Read, etc. Apart from extra staff time costs and GP time costs, practical cost of having leaflet put into large print.
There will also be additional staff time involved as patients are identified and attend surgery, in explaining to them the Project, getting their agreement as to what

communication needs they may have and obtaining consent. This cannot be done 'over the reception desk' and a member of staff will have to be identified to take charge of this aspect of the project.

This Project, we feel, can only be done opportunistically. Our patient numbers are 5800 and we have identified 67 potential patients with communication difficulties. The numbers are obviously going to be greater for bigger practices, which would make it impractical to do 'everyone at once'.

5. Feedback on the usefulness of the Implementation Guidance in supporting implementation of the standard

Please provide feedback on how useful the Implementation Guidance was in supporting the pilot, and any suggestions for amendments or additions.

We have struggled with how to make our Website more accessible to patients who are visually impaired. We could 'print off each page' and make this in bigger print but this is a rather bulky way of doing it. The standard says we give them the information in a different way if they cannot read it but we would appreciate guidance on how we can do this.

It will be essential under Information Governance, that the practice gains the consent of the patient to share their disability and communication need with other healthcare providers.

It could prove difficult to record the communication needs of a person's carer, if that carer is not registered with the Practice. Consent would then be difficult to be got.

As above, it is very impractical to expect a practice to arrange a Sign Language Interpreter, deafblind manual interpreter or advocate. Every patient we have come across who attends brings their own interpreter with them. This can often be a family member or friend and the standard discourages this but in real life, this is what happens. It would be difficult for a practice to turn away a family member or friend who has come to interpret? If we arranged this as a Practice, there would be a cost implication as language interpreters are commissioned by ? NHS England, and we do not pay for them. Would NHS England pay for the cost of a sign interpreter too? Would that deaf person be happy with a stranger interpreting sign for them in a consultation? This has never been required in the past.

Practices would need specific support if they were to offer communication by audio cassette, compact disc etc as practices would then need perhaps special equipment to do this? Some of the specific information formats listed would not be easily available to an average practice.

6. Assessment of the effectiveness and clarity of the Specification, Implementation Plan and Clinical Safety Case

Please provide feedback on the Specification, Implementation Plan and Clinical Safety Case, including comments on clarity and any suggestions for amendments or additions.

See above 5.

7. Benefits / efficiency savings associated with implementing / following the standard

Please provide data and comments on the impact of implementing / following the standard on:

- 'Did Not Attends' (DNAs): specifically whether there was any measurable increase or decrease in DNAs during the pilot period which could be associated with relevant changes in practice;
- Clinic scheduling: specifically whether implementation of the standard had any impact on clinics / sessions running to time (potentially due to the ability to proactively schedule additional time for patients / service users known to have communication needs);
- Complaints and the patient / service user experience: including any relevant comments received from patients / service users;
- Any other comments about the benefits associated with the standard.

The Pilot has not been running long enough to see any changes in DNAs. We only have 67 patients and only two have been contacted for advice. None of the other patients have yet attended.

It is unlikely that extra appointment time for such a small cohort of patients will impact on the practice.

We have only had one comment from a deaf patient about the type-talk service, which we have now investigated.

8. Any other comments

Please provide any other comments on:

- Your experience of participating in the pilot / implementing the standard;
- Changes which you feel should be made to the standard and / or supporting documentation;
- How best to support organisations in implementing the full standard.

In addition, anonymised comments from different members of staff involved in the pilot as to their thoughts and experiences and / or comments from patients / service users would be welcomed.

General reception staff feel a bit daunted about having to have such a communication conversation with patients, which is why we thought we would appoint a 'patient champion' to discuss with patients rather than ask each member of staff to have the conversation at a busy reception desk, or telephone switchboard.

Further support should be given to Practices through guidance as to where to obtain other forms of communication such as audio, CDs etc and the availability of computer applications, rather than leaving each Practice to investigate themselves.

We feel that the standard, whilst very laudible, could be pared down a little to make it more practical to implement, particularly in smaller General Practices, who are not part of large organisations with the resources to investigate and implement some of the suggestions put forward in the guidance.

9. Submission

In line with the MOU, following conclusion of the pilot phase, a report including the information above should be shared with NHS England on or before 24.04.15. Completed reports should be sent to sarah.marsay@nhs.net