**Piloting the draft accessible information standard**

**Report from Dorset HealthCare University NHS Foundation Trust**

Dorset HealthCare University NHS Foundation Trust (DHC) provides integrated community health and mental health, specialist learning disability services, community brain injury, community dental services including community hospitals and prison healthcare.

Whilst our Trust HQ is in Poole, the Trust provides local services across a range of locations throughout Dorset. We serve a population of almost 700,000 people across Dorset, Poole and Bournemouth (Pan Dorset).

Most of our services are provided in the local communities, in people's homes, community hospitals or in local centres through locally based integrated health and social care teams and facilities. We also provide specialist assessment and treatment inpatient centres.

DHC had several teams who were working independently on Accessible Information, for the benefit of their service users and staff. Staff within the Communication teams identified the Accessible Information (AI) Standard Pilot and applied to join the pilot at the end of 2014. Our successful engagement onto the project pilot gave further strength and impetus to the teams to progress their individual projects. The development of the AI Standard and the Trust's involvement in the pilot became a focus to bring teams with a common interest together with a specific aim.

DHC formed a small project group to take this pilot forward; the group consisted of staff who were already doing work in this area to help streamline their efforts. They were:
- Kirsty Mayhew; Speech & Language Therapy Team Leader, Learning Disability Services
- Ginny Boniface; Senior Community Nurse, Bournemouth Community team for People with Learning Disabilities
- Jenni Kingman; Speech & Language Therapist, Adults with Learning Disabilities
- Charlotte Watkins; Community Nurse, LD Intensive Support Team
- Deb Slate, Team Leader for Adult Community Speech and Language Therapy
- Daniel Austin; Clinical Lead, LD - Transition Team
- Kate Hardy; Business & Project Manager (Innovation)
- Georgie Braitch; Project Support Officer, Innovation Team
- Louise McCulloch; Project Facilitator, Accessible Information Pilot

- In addition the following people were integral to the implementation of the project:
    - David Corbin, Equality and Diversity Advisor
    - Damian Quinn, SystmOne Product Specialist
    - Jo Elliot, Clinical Lead for SystmOne, Informatics
    - Nikki Holland, System Configuration Administrator Lead, EPR Helpdesk
    - Andrew Curry, Clinical Lead for RiO
    - People First Bournemouth

The Accessible Information group met fortnightly from December to April to ensure momentum was maintained (example of meeting minutes attached). The main actions achieved by the Accessible Information pilot group were:

- The **Electronic Patient Record (EPR) systems** used within the Trust were investigated with regard to how they could support the recording, alerting and sharing of information collated from service users on their communication support needs.  The two main systems had differing contracts and support, resulting in different ways forwards with each of the systems.

- Development of a **Communication Support Form**, in order that teams could capture data from engagement with service users. The AI Standard's Technical document formed the basis of this form. Rigorous review and adjustment was made to the form over the course of the pilot, to ensure it met each team's perceived service user's needs.  The form was made accessible as a paper form, an electronic form and an online template, for completion as required by each team member.

- Implementation of **staff training** & awareness sessions to inform professional groups about the AI standard and engage them on the pilot. The Trust is a large, multi-professional community Trust, covering a vast geographical area. The participants in the project were recruited purposefully, using a snowball technique to recruit interested clinicians to both the working group and the pilot.

- Multiple **Easy Read documents** were developed as an outcome of the pilot. It was identified that many groups created easy read documents and that there was some duplication of information. Whilst the majority of leaflets were processed correctly via the Trust's Communication & Quality channels, some were not being correctly reviewed, checked and stored. A QA process has been identified specifically for easy read documents, to ensure they are reviewed by the service users they are aimed towards and also updated regularly. Existing easy read documents have been reviewed and a process to review, update & archive inactive paperwork has been initiated.

- The **Trust policy** entitled 'Policy for Interpreting and Translation (including Sign Language)' was reviewed in light of the new AI standard and changes were made to ensure that it reflects and meets the AI standard.
- An **Accessible Information poster** was also produced, on implementation of the AI Standard, to join other AHP (Allied Health Professionals) posters which rotate around different venues within the Trust (attached as an appendix). The posters are created to promote, for example, new practices, services or research being used within the Trust, and are seen by all stakeholders – clinicians, service users, carers, commissioners & managers. This will be increasing awareness of the imminent implementation of the standard.

1. <u>Scope and scale of the pilot</u>

We commenced initial preparatory work in December 2014, with the AI Project Facilitator role starting in early January 2015. This role was funded by NHS England and was for on average 15 hours per week for a period of 16 weeks, until submission of the evaluation report.

The teams that were involved in the pilot project invariably felt that all of their service users may have a communication support need, although naturally there was some variance.

The table below describes each of the teams who piloted the AI standard at Dorset HealthCare. Much of the preparatory work was completed by the project team and the specific services piloted the use of the communication support form (i.e. the technical document in practice) with a number of patients, as recorded below.

| Profession | Speciality | System | Named link | Form version | Trained | Approx no of patients |
|---|---|---|---|---|---|---|
| Audiology | Adults with Learning Disabilities / Elderly | Practice Navigator | Emma Sprake/Amanda Lillywhite | Paper, 2nd version | Yes | 15 |
| Multi Prof (Nurse/ SaLT) | Bournemouth Community team for People with LD | RiO | Kirsty Mayhew / Ginny Boniface / Jenni Kingman | Paper, 2nd version | Yes | 30 |
| Acute Admissions Unit | Mental Health | RiO | Cathy Franks / Kelsey Pickin | Paper, 2nd version | Yes | 2 |
| Intensive Support Team | LD | RiO | Charlie Watkins / Dan Austin | Paper, 2nd version | | 1 |

| Eating Disorders | | RiO | Stuart Lynch | Paper, 2nd version | Yes | 1 |
|---|---|---|---|---|---|---|
| SaLT | Bournemouth & Christchurch team | SystmOne | Sharon Owens, Deb Slate | Paper, 2nd version | Yes | 4 |
| SaLT | Central Team | SystmOne | Lindsey Howat, Deb Slate | SystmOne, Orig | Yes | 4 |
| SaLT | Poole & East Dorset Team | SystmOne | Marie-Claire Lawson, Deb Slate | Paper, 2nd version | Yes | 6 |
| SaLT | Jurassic Team | SystmOne | Janne Schack, Deb Slate | SystmOne, Orig | Yes | 5 |

The number of service users who completed forms is reflective of several factors:
- The short time frame of the pilot project
- The number of appropriate service users who attended relevant clinics within a specific time frame
- Availability of staff to engage in AI meeting, training and feedback sessions
- Administrative support provided to different teams

One of the initial teams involved in the pilot since its inception, the Stroke Pathway, unfortunately had to withdraw in the early stages of the pilot. Multiple teams were invited to join the pilot through a snowballing technique, in order that their profession/services views were considered. Some services did not have capacity to join the pilot, despite their best intentions.  Other teams were able and keen to join in so their views were incorporated in the pilot.

Collaboration between specific DHC teams within the AI project and a local 'People First' advocacy group, for people with learning difficulties, has resulted in a number of outcomes. Easy Read leaflets and packs of Flash cards have been created within the duration of the pilot, for use within the DHC teams.

Whilst there is no quantifiable data on the number or costs of AI communication support translators or interpreters, awareness has certainly been raised on the access, processes and staff responsibilities with regard to using translators or interpreters, as a direct consequence of the AI pilot.

Much of th pilot project involved development of systems and processes and the engagement of the pilot teams with AI to ascertain the similarities and differences that services have, to establish how a generic versus individualised process could work. Individual, tailored communication support was perceived to be the preference.

## 2. Actions taken to effectively implement the standard into existing systems

**Electronic Patient Record systems**

DHC currently has two main electronic patient records in general use, plus smaller accessory systems for specific groups (eg: Practice Navigator for audiology). The systems used within the Trust are **RiO**, primarily for Mental Health Services and **SystmOne**, for community health services, which has been introduced over the last 2 years. SystmOne is being introduced to many community services (eg: SaLT, DNs, Podiatry, PT, OT) – those not yet converted are still using records in paper format. Acute and health & social care providers in the county currently use different systems to DHC.

Members of the project pilot teams met fortnightly throughout the pilot. Early discussions identified that different EPR systems were used by teams participating in the pilot. Both RiO & SystmOne were investigated to ascertain how best to record & alert AI requirements of service users onto them.

**SystmOne**: Due to the technical specifications and the in-house support of SystmOne, changes could be made to SystmOne via the in-house EPR support team. The project team were able to request specific tailoring to meet the needs of the pilot. It was agreed that a template could be created on SystmOne, which would be accessible via the navigation tree.  Alternatively, a paper form could be completed and scanned onto an individual's EPR. This choice was determined by the administrative support available to individual clinicians and teams.

**RiO**: Due to the contract between DHC & RiO, at the time of the implementation of this pilot, it was ascertained that DHC was unable to make changes to RiO templates, without affecting all RiO systems nationally, however it was possible to upload individual forms onto an individual EPR profile. Therefore a paper form was used, rather than system changes being pursued. Subsequently, the pilot team have learnt that, due to a renewal of the RiO contract, system changes may be able to be made in the future.

**Communication Support Form**

The AI Standard's Technical document was used as the basis to create a form to collate communication needs data for service users. This form – the Communication Support Form (Appendix 1) – was scrutinised, peer reviewed and adjusted by the AI pilot team at the fortnightly meetings, over a period of 4 weeks, after which it was piloted in practice.

The Communication Support Form was continually evaluated throughout the course of the pilot and adjustments were made through a Delphi style group consensus.

Examples of the adjustments made and the reasoning include:

How should we contact you? - 'By contacting your carer' was added as it is a commonly required method of contact for people with learning disabilities and other communication support needs.

Who might you need with you when you see us? – 'Requires learning disability communication support worker' was replaced with 'Carer / support worker who knows me well'.

What do we need to do when we see you? - The pilot group interpreted this as communication strategies required for face to face communication and information giving. The following were added / amended as being particularly relevant for people with learning disabilities:

- Requires easier words and short sentences
- Requires time to understand and respond
- Requires verbal communication to be supported by: objects, pictures, writing
- Uses Key Word Signing (e.g. Signalong, Makaton)
- Uses personal communication tool, book or aid (e.g. Voice Output Communication Aid)
- Uses a learning disability Yellow Health Book or passport (e.g. My Care Passport, Communication Passport)

The above changes were made due to the pilot teams feeding back their preferences to ensure the most practical and useful application of the AI standard through the Communication Support Form. However, following a discussionwith a participant involved with coding at the AI Workshop meeting in London on 14<sup>th</sup> April 2015, it is now understood that these additions / amendments may not fit with the current modelling for the coding system, as the final section relates to capabilities rather than requirements. However, they are included in Appendix 2 as they are the results of our pilot experiences.

The Communication Support Form was then converted into multiple formats:

- o a paper form, which could be completed, then either added to paper records or scanned onto EPRs;
- o an electronic form (word document) with simple check-boxes, that staff could complete electronically then upload onto service users EPRs ; and,
- o an online template (within SystmOne) which can be completed directly and saved on the EPR.

One professional team use an independent system, separate to the rest of the Trust (Practice Navigator). There was discussion during the period of the pilot regarding whether the team would move to SystmOne, however it has been subsequently decided that this will not occur. Practice Navigator does not share information with either of the other systems.

As the pilot progressed, feedback received from piloting teams was continually considered by the Project Team and, when appropriate, amendments were made to the original template. As new teams were recruited into the project, they were allocated either the original or the newer form (Communication Support Form 1 or 2) according to their preference.

At the final AI project meeting (21st April), some discussion centred on the 'generic' versus 'individual' requirements of the form. The challenges of how different professions and experiences of staff, might influence their utilisation and interpretation of the form was discussed. Further adaptations were made to guide staff in the use of the form (Appendix 3).

**Alerting other staff of communication needs**

Once the Communication Support Form was completed, an alert needed to be made to bring attention to the form and its contents to other staff.   This alert mechanism varied between the electronic systems:
- The **SystmOne** template was set up to automatically create an alert when the form was added, which presents an alert on the 'home' page of the service user's EPR.
- If a paper form is scanned in to either of the systems (**SystmOne** or **RiO**) a manual alert must be created by the practitioner to alert future EPR users to review this form.

**Sharing communication needs across services**

The sharing of data across the Trust is one major area that, despite lengthy discussions with IT providers and in-house system support, is not currently possible.

The system a professional uses, determines which other teams can access this information. For example, currently if a Speech & Language Therapist within DHC completes a Communication Support Form on SystmOne – it can be accessed by (for example) podiatrists, community nurses, specific groups of physiotherapists and vice versa, but not by the Mental Health teams (on RiO), audiologists (on Practice Navigator), GPs or A&E (different Trusts on different EPR systems again).However, it should be noted that:

- The Bournemouth Community Team for Learning Disabilities is a multi-agency team which crosses Dorset HealthCare and Bournemouth Local Authority and therefore sharing of communication support needs across these teams and agencies was part of standard practice.
- The Stroke Pathway, although weren't able to pilot the AI standard due to the infancy of the pathway development, is a multi-agency care pathway spanning acute hospitals, community care, third sector and local authorities, and the elements of the AI standard were being discussed and addressed as part of that pathway development.

**Acting upon individual communication needs**

Dorset HealthCare already had a Policy in place for Interpretation & Translation guidance. DHC's 'Policy for Interpreting and Translation Services Including Sign Languages' (IN-154) was due for review in January 2016 however this has been brought forward and carried out as part of the AI pilot. David Corbin (Equality and Diversity Advisor) and Louise McCulloch (Project Facilitator, Accessible Information Pilot) have been updating Policy IN-154 to ensure the Accessible Information Standard is reflected and implemented. The policy is currently in draft format, awaiting review for approval by the Trust's Equality & Diversity Steering Group. One of the actions in amending and updating the policy was to update the list of Trust staff who have non-verbal communication skills. This has, in itself, created interest and heightened awareness of communication support needs of service users. Both the original (Appendix 4) and updated version (Appendix 5) are included at the end of this report.

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

Services within the Trust are very individual, diverse and local. Implementing a 'one size fits all' approach could be challenging to achieve. Each team involved in the pilot reviewed, trialled and inputted to the design of the form to ensure it met their service's needs as much as possible. Multiple teams were invited to join the pilot, in order that their profession/services views were considered.

Pilot site users feedback indicate that a few (5-10) extra minutes were needed to complete the form, however staff anticipated that this would reduce as they became more familiar with the paperwork and standard. It was felt important to allow additional time, as this emphasised the importance of the process & standard. When paperwork is just 'added on' to staff workloads without a time allowance it may be perceived that it is an extra task, but of little value or significance to the service user. Future implementation will require Trust-wide promotion and support of the

amendment to EPRs, which will be reflected in the support given to clinicians and administrators to meet the Standard.

The use of personalised appointment letters or bespoke contact (text or email), where a need is indicated, is not currently available. It has been advised that if a service user has a need (for example a Braille appointment letter) yet the Trust cannot currently provide it, then an incident report / Ulysses form ought to be completed. This would ensure that the frequency and type of such occurrences could be established and steps can be taken to make changes or acquire new services or equipment as required. The refreshed Trust policy will include details of all services who can provide alternative formats of documentation for patients, so these will be available in future, but it was necessary to establish the elements that are required before we could source a supplier.

Current data is not available on the use of BSL or translation services within DHC. The most recent data available, from one of the Trusts, pre-merger in 2010, indicates that BSL is the joint second most used translation service. The Equality & Diversity Manager has, as a result of this AI pilot, identified the need to access and monitor this data.
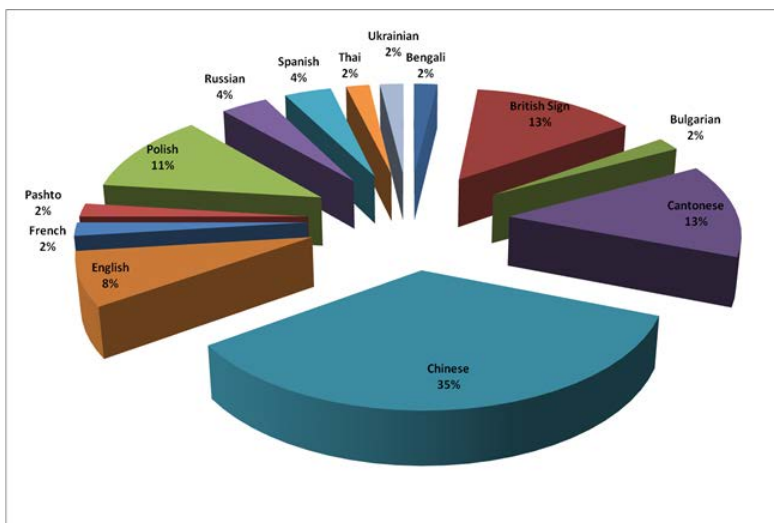


Dorset PCT Translation Service Usage Sept 08 - Mar 10

Clinical staff involved in the pilot, generally felt that they were already meeting the service users need, when they were engaging with them, however identified that there could be more administrative support and engagement. Often there was a perceived 'inability' to meet needs as it 'wasn't available' (such as texting appointments to service users) however staff acknowledged that raising such incidents would be a way to address them and change practice or policy.

Some discussion occurred regarding the quality of the completion of the Communication Support forms – specifically that some staff (in a pertinent profession; more experienced or in a specialist profession, eg: SaLT) may provide more meaningful information when completing the form.

All clinical staff felt that completing the form was already integral to the professional interaction they had with service users, however that by making a clear form/section/alert, it raised awareness to all EPR users of the service user's needs.Staff were overall enthusiastic & supportive about use of the communication support form.

It was identified by several pilot teams that the alerts would be useful to clinicians prior to meeting a service user for the first time, and for administrators when scheduling appointments.

Some teams/practitioners had administrative support to upload forms onto records whereas others had to incorporate this into their appointment time and again, staff felt that if 'communication support' was perceived to be heavily endorsed and supported by the Trust and managers, there would be more emphasis from frontline staff.

> *"They seemed to be more useful for the patients on the …. clinics in that much more useful information could be captured, however how that then becomes useful - moving forwards, is still up for debate."*

Training /Support sessions to raise staff awareness of the AI standard were well received. Staff members were fully supportive, interested and engaged with the AI Standard and the pilot requirements. Staff who were more involved in the AI working group or met with the project facilitator for their training, had a higher level of understanding and engagement in completing forms

Feedback from clinicians and managers on the pilot suggested that as staff became more familiar with the Communication Support Form & AI Standard, it would be quicker & easier to elicit information from service users and record it.

During this pilot, the majority of clinicians used the form as designed, as a prompt to elicit service users' needs from them. In a few cases (primarily when training was disseminated, rather than directly from the AI pilot facilitation team) staff either 'read the form out' or 'gave it' to service users. This did not return effective results (service users became confused; staff requested AI friendly version of the form). Discussions regarding whether to remove the options and just ask the four key questions,

culminated in the decision to amend the communication support form to include the 'Ask & Consider' format (see Communication Support Form 3, Appendix 3)

We have had interest from service users through the pilot, interested in the AI standard and how it will affect them. One service user saw a Twitter comment and contacted the DHC Communication Team for further information on the project. They were signposted to the AI website.

There have been discussions on ascertaining service users' needs versus their preferences. Whilst it was acknowledged that the AI Standard places an obligation on the Trust to meet service users' needs, in some cases, meeting their preferences also ensures that we are engaging with them and their perceived 'needs'.

There were misinterpretations about the level of support the Trust could offer, for example there were a small number of service users who requested that they 'require contact by email' but on further questioning, had no facility for this (such as internet access or email address). This is easily avoidable by the way we train staff and communicate with service users.

> *"Some clients have requested information via email despite not having internet on further discussion."*

Several clinicians on the pilot commented that service users had indicated that they would like communication via a certain means (eg: email or text) but were not able to provide this as 'it was against Trust policy' or 'contravened data protection / IG guidance' or 'our team can't offer that service'. The identification of a service or the Trust not being able to meet a service user's needs (rather than preference) was identified by the pilot team as necessitating an Incident Report / Ulysses form submission. This was felt to be the most effective way to identify occurrences and consider review of policy/practice to enable teams to meet individual's communication support needs and the AI standard.

> *"{Service name} particularly have fed back that they have not been able to offer all of the listed modes of communication e.g. email or texting, due to concerns and difficulties opening up some channels of communication with clients, (often pertaining to a mental health disorder)."*

No incidents were recorded or fed back of service users requesting support that we could not currently provide (eg: audio recording). Nor were any incidents reported of requests for support that we can provide but have not previously been asked for (eg: Braille).

We have had no reports of specific actions that have resulted from the pilot, throughout the course of the pilot, however this could be for multiple reasons:

- Staff already offer accessible information specific to service users communication support needs
- Participating service users may be well known to staff and already have their needs identified and met
- The short time frame of the project meant only a limited number of service users were engaged; however the pilot has highlighted accessible Information to staff and services, anticipating greater participation in the future
- Service users not requesting further communication support mechanisms
- Service users not understanding the offer of further communication support, due to cognitive awareness
- Service users having carers who supported them independent of the mechanisms that the Trust may be able to offer

**Costs**

The financial costs of piloting the AI standard across the teams described were as follows:

| Description | Actual Cost |
|---|---|
| A project facilitator to support and coordinate the project, develop the Communication Support Form and policy, support translation of key documents to alternative formats, provide training in the form of awareness raising to those staff involved in the pilot. | Until 31st March 15 = 211 hours = £4555.07 |
| IT system development costs for introduction of flags/alerts | £700 |
| Allocated time has been agreed for Bournemouth People First to produce high quality easy read information. | £3,465 In progress – total spend allocated. |
| Conversion of key documents to braille and development of templates by the RNIB. | £1,000 Under development, awaiting conversion of most appropriate / common documents. |
| Conversion of documents to audio format on CD or MP3 by the RNIB. | £1,000 Under development, awaiting conversion of most appropriate / common documents. |

| TOTAL | £10,720.07 |
|---|---|

Additional costs include:

- An overall project manager, funded from existing budget to initiate and oversee the project. Whilst the project facilitator was employed on a bank contract to complete the bulk of the work, there were a number of hours required by the project manager to attend meetings, write up minutes, follow up action points, and provide overall support, totalling approximately 30 hours over the course of the pilot.
- The project facilitator was employed for a further 8 days after 31st March, which is expected to cost an additional £860 (at £21.52 per hour), totalling £11,580 overall spend.
- Travel expenses for the project facilitator to attend meetings and undertake training/awareness sessions etc across Dorset.
- Time for all those in the project team to attend meetings, review the form and policy, complete the awareness training, and provide feedback.
- Although our in-house EPR team charged £700 for the SystmOne changes to set up the Communication Support Form template and alert mechanisms, the time to meet, amend, review and discuss changes would have more than doubled the costs.

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

Having a tool/form that services can tailor to meet their service users individual needs would enable practitioners/teams to exercise autonomy in delivering personalised communication support. Having corporate facilities accessible to all teams (such as text appointment reminders from EPR systems or an AI appointment letter format or the permission to email appointments) from which services could choose the most appropriate for an individual service user, would enable Trusts to provide a tailored service to meet individuals' needs.

The AI Pilot team found that there was a plethora of documents and information available to support the pilot project. Several comments were received on the need for the AI Standard itself to be in a simpler, easier accessible format, rather than a 36 page technical format, to reflect the message it is delivering.  There is a large amount of rich information available on the NHS England internet site, but this could perhaps be in a more 'Accessible Information friendly' format to encourage access to it.

On using the communication form:

*"if an alert now pops up on my patient's screen saying he will need a longer appointment because of his difficulties with verbal expression and understanding of complex language but his wife will deal with any correspondence, I suppose that will be quite useful."*

*"Many people need more time because their ability to process information is slower or because their own speech is slow.  Those requirements don't seem {sic} to be catered for at all, and – as shown by the feedback you already have from learning disabilities – they would require dedicated tick- or text- boxes, not just to be lumped into a general feedback text box."*

*"I didn't find any of the tick boxes useful as they only concern themselves with how to contact the person and provide them with information.  I found I was only able to describe his needs in the free text boxes, which I did."*

*"from a speech and language therapy perspective it [the communication support form] is not terribly well suited to our purposes"*

*"initial feedback is that it is very much aimed at people with sensory impairments, e.g. deaf/blind, or cognitive impairments, e.g. learning disability. Our client group is people with acquired communication difficulties, e.g. after a stroke or as a result of Parkinson's Disease, who may require literature or appointment letters to be in an easy-to-read, aphasia friendly, format or they may require verbal information to be relayed using short, simple sentences to make up for reduced understanding of complex language"*

*"My initial thoughts regarding the form would be as follows:*
*• How should we contact you?*
    *I don't feel this box would be used in our service as we are not required to contact individuals in this manner due to the nature of the in-patient ward environment.*
*• How should we give you information?*
    *Emailing patients information is not a method that we would use on the ward to pass information on. Most of our information is passed to patients verbally in face to face conversations. Written information is used also, therefore, the use of Braille and additional font sizes would be appropriate here.*
*• Who might you need with you when you see us?*
    *We would make use of this box to ensure patients have the choice of having individuals with them to support their communication. Face-to-*

*face communication is a large part of our service here due to the need
to complete ongoing assessment of mental state.*
- *What do we need to do when we see you?*
  *Similar to above, this box would be useful in ensuring we are
  appropriately adapting our communication for patients."*

On using the communication form, in paper version:

*"We have used with a few folk but still waiting for info {sic} how to transfer the
paper version into an alert"*

*"It has been easy to use as a ticklist and some pts {sic} are happy we
complete on their behalf."*

On using the communication form, online version:

*"The form looks simple enough.  The only downside I could see was that at
the moment it only appears in the tabbed journal, which obviously isn't that
great.  It would have been nice to see how it would actually 'alert' on the
patients home screen as noted in the email below."*

*"currently if the Communication Support Form is printed out from SystmOne,
the print is minuscule, virtually unreadable and, therefore, inaccessible!  Is
there any way that the form can be printed in a larger font – there appears to
be space on the page, or could the form be printed in landscape?  Although
the form can be completed on-screen, it may sometimes be useful to print out
a form to go through with a patient."*

During this pilot, the majority of clinicians used the form as designed, as a prompt to
elicit service users' needs from them. In a few cases (primarily when training was
disseminated, rather than directly from the AI pilot facilitation team) staff either 'read
the form out' or 'gave it' to service users. This did not return effective results (service
users became confused; staff requested AI friendly version of the form). Discussions
regarding whether to remove the options and just ask the questions culminated in
the decision to amend the communication support form to include the 'Ask &
Consider' format (see Communication Support Form 2)

**Points for clarity:**
There was a continual line of questioning within the pilot team, about whether we rely
on carers, if it is either essential or requested by the service user.  For example, an
elderly gentleman attends an outpatient clinic with his wife and advises that he has
lost his hearing. He indicates for his wife to answer on his behalf. He advises that

she opens all the mail, answers the telephone and deals with all his appointments. The Communication Support Form asks how he wished to be communicated with. Do we proceed further with the form on his behalf, or hers?

*"The need for some clarification around who it is that we are asking how they want their information provided (i.e. carer or client), which we problem solved today could acknowledge both with two separate ticking boxes."*

5. <u>Feedback on the usefulness of the Implementation Guidance in supporting implementation of the standard</u>

Overall, the AI Pilot team found that there was a plethora of documents and information available to support the pilot project. As previously highlighted, the AI Standard itself needs to be in a simpler, easier accessible format. Some points relevant to implementation that team members felt should be covered in the final guidance follow:

*"Promote the principle of making everything as accessible as possible as the norm - this would help to remove the stigma that some service users feel is attached to being offered an easy read version."*

*"Review the coding system to ensure that when used it is capable of providing a description that truly reflects and can meet people's support needs"*

*"Tool for collecting information - It would be helpful for the guidance to include a tool for gathering information about the person's communication needs."*

*"Service user held information – alert card - for people who are comfortable with acknowledging their communication needs to other people and would prefer to share pre prepared information about themselves or where supporters are sharing information in the person's best interest."*

*"People with cognitive impairments are likely to need support to provide an accurate description of their communication needs. Where relevant, the information would ideally be produced as a result of a collaborative process, involving the person and their circle of support, in the same way that a Communication Passport is made. This would help to improve the consistency of reporting and recording, the quality of the information shared, and most importantly, it would increase the likelihood of the person getting the right communication support."*

*"A directory of useful services and organisations - Services can add local contacts"*

*"National standards for easy read information and quality assurance"*

*"Staff training – different types and levels including:*
- *Awareness training – communication needs and support*
- *Implementation of local policy and process*
- *Knowledge & skills – producing information in different formats"*

*"National network for sharing good practice – it would be/have been very useful if pilot sites could communicate with each other to share experiences and avoid duplication of work"*

6. <u>Benefits / efficiency savings associated with implementing / following the standard</u>

It has been very difficult to judge the impact of piloting the AI standard at Dorset HealthCare in terms of benefits and / or efficiency savings.Initially it was identified that there were no efficiency savings from the time it took to complete the Communication Support Form as most patients were already catered for in their appointments and so little changed from completing the communication needs assessment. However, it was thought that the time would reduce as staff became more conversant with the AI standard and the Trust's policy.

There was no measurable increase or decrease in Did Not Attends (DNAs) during the pilot period which could be associated with relevant changes in practice.

There were no complaints but the patient / service user experience seemed more positive as patients appreciated being asked what their communication needs / preferences were.

Access to a specific budget to produce easy read documents and resources has enabled staff to work in partnership with Bournemouth People First, a local self-advocacy group for people with learning disabilities. Staff would welcome the opportunity to continue this.

A review of easy read information within the Trust has been initiated as part of this pilot and has highlighted the need to maintain robust quality assurance processes, incorporating the views of relevant partners & service users, in the easy read or translated paperwork that is produced in teams

It has been identified that further centralised support within the Trust to lead the implementation of the AI Standard and ensure parity and consistency was essential.

7. <u>The Future of the AI Standard at Dorset HealthCare</u>

The standard, if implemented in an effective and meaningful way, presents a tremendous opportunity to shift the culture within services and make a real difference to the experience of people with communication support needs.

We feel less, but simpler implementation guidance would be more effective, and encourage full participation. Healthcare professionals, administrators, service users and carers will all need to be made aware of the AI standard and how organisations will meet their needs. A simple guide (leaflet, poster, newsletter) would be a helpful tool to inform all relevant people of their expectations.

From the ASK-RECORD-ALERT-SHARE-ACT strapline, which DHC have used as a focus for the Trust Policy on Interpreting & Translation, we believe that we either do already achieve, or can achieve ASK RECORD ALERT & ACT.

The greatest obstacle in implementation of the standard has proven to be the **sharing** of data between EPR systems. Trusts within CCGs, using more than one EPR, will require their EPRs to link to allow data sharing. Central support (from NHS England or IT contractors for NHS systems) will be invaluable in ensuring parity of services. This would be a more cost effective alternative to individual teams, Trusts or CCGs negotiating with EPR companies to engage in changes to their systems.

> *"As I explained we use a clinical system called ………….. and would at this stage have to fill out the paper form and scan it on to the patient records. We would be unable to share this information with other services."*

Having a template already accessible on the EPR systems would be a large step forwards in making the data collection easier to implement.

Centrally requested activation of an information sharing facility on each EPR system may give better results than individual organisations approaching IT companies.

**Actions for completion at Dorset HealthCare**:

The **Equality & Diversity** manager will take the amended policy to review groups, including the Equality & Diversity Steering Group, for their feedback and ultimate approval. He also will be in a position to advice the Trust on required changes to processes and policies, as required.

A **Quality Assurance** process has been initiated for Easy Read documents, in collaboration with the Trust's Patient Experience and Customer Services Manager. This will ensure that service users and advocacy groups will have the opportunity to

review and input to documents being produced. It will also ensure that documents are shared Trust-wide and are periodically reviewed and updated as necessary.

**Easy Read** documents are to be more accessible to all. Leaflet access is to be incorporated within a wider project of updating online resources to ensure they are easily accessible for all staff via the intranet or service users via the internet. This also incorporates ensuring leaflets are named in a way suitable for the search method (eg: a leaflet on Dementia, in an alphabetical list should be named 'Dementia' rather than, for example 'Understanding Dementia'). DHC would like to promote the principle of making everything as accessible as possible as the normal standard, to help to remove the stigma that some service users feel maybe attached to being offered an 'easy read version'.

Although the project facilitator role ends imminently, the team all felt that it was essential to continue the **Accessible Information working group** periodically in order to maintain momentum of the project. Engaging a diverse membership, of staff who are actively engaged in AI projects and work, and who will be able to engage at Director and frontline staff levels, was felt to be necessary to ensure a smooth implementation of the AI Standard by March 2016.

In order for the ongoing project group to be able to actively promote the AI Standard Trust-wide, key links are being sought to maintain the focus on Accessible Information. Quarterly meetings have been proposed and calls will be put out via the communications teams for interested staff. Director sponsorship is also key to the success of the AI standard at Dorset HealthCare. With Director endorsement, it is anticipated that the AI Standard will be more easily recognised, acknowledged and implemented at corporate, leadership and frontline levels.

DHC will now await advice from NHS England on the **final AI Standard** (ISB 1605), in preparation to share and implement the standard Trust-wide.

Dorset HealthCare is a partner in the development of a new system called Dorset Care Record which has recently won a bid of £1.35 million from the NHS England Integrated Digital Care Fund to create a **seamless electronic record system** for patients. This aims to create a combined record of information from hospitals, GPs and local councils that can be looked at wherever a patient or client is being treated, giving a comprehensive view of a person's health, social care and communication needs. A similar system is already in place in Hampshire, with plans for Wiltshire to follow suit, giving the potential for shared information and improved care when people move across county borders. There is also the long-term possibility of extending the system to share data with other health and care organisations, such as

hospices. The DCR system would allow health & social care practitioners to record, alert and share communication support needs, to meet the AI Standard.