ACCESSIBLE INFORMATION STANDARD
Piloting and Problem Solving Phase - Report

1.0 Introduction

gtd healthcare first became aware of the Accessible Information Standard in November 2014 having received an email via CQC Communications inviting applications to participate in the pilot of the draft standard. Following initial communications with the Project Lead, it was agreed that there was insufficient lead in time to undertake the project as it was felt that any major changes would require the input of the organisation's clinical system suppliers which would be difficult to achieve in the given timescales.

The principles of the Accessible Information Standard were considered to be important and fit with *gtd healthcare's* drive to innovate care and offer patients the best experience possible. Therefore, when a further call for pilot sites was made in January 2015 with a more refined remit, an application was submitted and accepted.

This report details the actions undertaken to try to implement the Standard, observations on the project and recommendations for progress.

2.0 Scope & Scale of the Project

2.1 Organisational Profile

gtd healthcare is a not for profit organisation. Our main business is the provision of primary healthcare services including both urgent and scheduled services to patients across Greater Manchester and Merseyside. This includes:

- **Urgent and out of hours care**
  gtd healthcare provides urgent and out of hours services to over 3 million patients across the CCG areas of Manchester, Oldham and Tameside & Glossop (Greater Manchester) and Southport, Formby and South Sefton (Merseyside). We also provide out of hours dental services to patients across Greater Manchester.
- **GP Practices**
  gtd healthcare also manages 11 equitable access (APMS) GP practices across Manchester, Oldham, Tameside & Glossop and Rochdale.
- **GP Led Health Centres**
  We run 3 GP Led Health Centres in City Centre Manchester, Ashton-under-Lyne and Oldham Town Centre which provide primary health care services for both registered and unscheduled patients.

Due to the large area covered by *gtd healthcare*, we serve a very mixed population. This includes patients in highly urbanised areas to more rural areas (particularly for the out of hours service). We also serve patients from a wide range of ethnic backgrounds. There are no specific key patient or service user groups as all individuals requiring primary care services are accepted.

It was agreed that the pilot would be carried out across a sample of GP Practices, GP-Led Health Centres & Out of Hours Primary Care Service across *gtd healthcare's* Greater Manchester sites with a view to extending any learning to all *gtd's* sites.

2.2 Scope of Pilot

It was agreed to focus on three aspects of the Accessible Information Standard: identifying needs, recording and flagging. The proposal put forward was as follows:

i) Identifying needs

- To determine how many patients we currently have across our pilot practice sites that have information and/or communication needs.
- To review how this information has been gathered to date.
- To try to establish whether there are other patients known to the sites that have information/communication needs that have not been formally recorded and ascertain why.
- To explore the potential of gathering and using this information during our brief/ and usually single episode contacts with patients in the out of hours and unscheduled care settings.
- To develop other means of identifying information/communication needs where gaps are identified.
- To review and revise the questions in our patient satisfaction surveys to reflect the Accessible Information Standard to support the identification of general needs and service feedback.

ii) Recording

- To review the current codes used across our pilot sites.
- To agree the READ codes for recording this information across our practices for both registered and unscheduled care populations.

iii) Flagging

- To explore the use of patient alerts on the clinical systems within our pilot practices.
- To explore the requirements for practices to alert our out of hours services of patients' information/communication needs and how this information would be utilised.

3.0 Implementation

3.1 GP Practices/GP-Led Health Centres

The project has been led by the Quality Assurance Manager (QAM). She attended the practice managers' meeting on 22nd January 2015 to discuss the proposal for the pilot project. Once notification had been received that the application was successful, an email was sent to the practice managers to inform them of this, to request volunteer sites and to request copies of their latest new patient registration forms. This resulted in the identification of 2 practices and 2 GP-led health centres as previously described (2.1). The pilot was further communicated to staff by inclusion in the organisation's monthly e-bulletin.

3.1.1 Identification of Need

Arrangements were made to visit the first GP-led health centre and work with one of the administrators responsible for note summarising and running reports on the clinical information system, EMIS Web. Together, the administrator and QAM identified any READ codes that might indicate that a patient had some sensory loss that might affect communication (see Appendix 1), based upon the patient groups highlighted within the "Information for staff involved in piloting the standard". Searches were then run for each area and a sample of patient records scrutinised to ensure that the report results were relevant. A slight adjustment to the search criteria was required to the "Registration Type" to differentiate between the registered patients and unscheduled care attendances.

A meeting was then held with a GP at another pilot practice to discuss the search criteria and the results produced. His input was particularly helpful as he has a number of roles across the organisation, i.e. a GP in a practice, a GP Advisor with the governance team so has experience of developing good practice across our sites and also a GP with a specialist interest in Ear, Nose & Throat (ENT) conditions so has experience in areas such as hearing loss. The search criteria was refined slightly and used to generate reports at each of the pilot sites.

Search Results

	Pilot Site 1 (GP-Led Health Centre; List Size - 7,541)		**Pilot Site 2** (GP-Led Health Centre; List Size - 2,674)		**Pilot Site 3** (GP Practice; List Size - 3,478)	**Pilot Site 4** (GP Practice; List Size - 4,829)
	Scheduled	**Unscheduled (Walk-in)**	**Scheduled**	**Unscheduled (Walk-in)**		
Blind/visual loss	37	2	60	43	58	21
Deaf/hearing loss	141	3	57	113	209	111
Deafblind	0	0	0	0	0	0
Learning disability	0	0	6	0	4	14
Aphasia	25	0	17	4	66	27
Dysphasia/dysarthria	0	0	2	0	4	0
Autism	2	0	2	4	13	14
Mental health problem affecting communication	2	0	4	0	5	5
Communication Needs	0	0	0	0		0

Once the search criteria had been agreed, the searches were easy to transfer and run at the other pilot sites as they all use the same clinical system. Patients coded as having a learning disability were already identified through the register required to be maintained by each practice as part of the Quality Outcomes Framework. The mental health register could have been used to identify those patients with a mental health problem affecting

communication, however, after discussion with the GP Advisor, it was agreed to limit the conditions to mutism and psychosis.

The highest numbers of conditions were those affecting hearing, sight and speech. On closer inspection of a random sample of these records, it would appear that in many cases these related to a temporary sensory loss, especially for those patients attending on a walk-in/unscheduled care basis. This potentially means that a suitable/appropriate member of staff would need to review the records of all the patients from the reports to identify those that may have ongoing communication needs. These patients could either then be contacted to go through those needs or an alert could be added to the clinical system to review those needs when the patient next attends the practice.

There were no patients identified using any of the current communication needs READ codes. However, anecdotally, it was pleasing to note that the members of staff who assisted at each practice, from the administrator to the GP, were able to quite readily identify a number of patients for whom communication was an issue and how these needs were currently being met.

One of the simplest methods of identifying patient needs at practices is to try to capture that information at registration. Each of the *gtd healthcare* practices uses a paper registration form for general information usually accompanied by a health questionnaire covering areas such as past medical history, medication, allergies and alcohol consumption, etc. The clinical information supplied is reviewed with the patient at a new patient health check once they have registered at the practice. Although a standard form was developed when the organisation commenced management of the practices, the majority have since made their own amendments. It was therefore agreed at the practice managers' meeting on 19th February 2015 to review the existing forms with a view to producing a standard form which includes the identification of communication needs, which is currently limited to language requirements.

At the start of the project, the QAM had made an assumption that gathering communication needs information would simply be a matter of adding a prompt, possibly a small table detailing the different requirements, into the registration/health check form. However, through the project, it has become apparent that this is not the case due to the wide variety of communication methods available. Following discussion with the GP Advisor, a general question regarding communication needs has been added to the registration form:

> *Do you/the patient require any assistance with communication due to hearing, sight or speech difficulties? Yes / No*

It is envisaged that this will prompt the completion of a more detailed form either at this stage or as part of a discussion at the new patient check. The proposed documents are to be presented for discussion and agreement at the next practice managers' meeting at the end of April 2015.

3.1.2 Recording

There are READ codes available on the EMIS Web clinical system relating to communication needs. From the results of the searches run, these are not currently being used. The detailed communication needs form which has been developed is based upon a list of SNOMED CT codes supplied by a member of staff from the Health & Social Care Information Centre (HSCIC) following a recent Accessible Information Standard event (see Appendix 2). Until the use of READ codes is phased out in favour of the SNOMED CT codes, the ability for the practices to record any patient communication needs within the clinical system is limited to the far smaller list of READ codes available, with the addition of free text as appropriate. The list supplied will be discussed at a forthcoming meeting to agree which of the current code descriptors to adopt outside of those already available as READ codes.

3.1.3 Flagging

Within the EMIS Web system, there is a facility to add alerts which flash up on the screen once a patient record is accessed. This is a relatively simple process to set up manually once any communication needs are identified. Whilst attending the pilot sites, the QAM was made aware of the potential for automating this process upon application of specific READ codes through the use of a computerised protocol. Unfortunately, the expertise was not available within the practices at the time to test this.

In terms of sharing information, it was noted that there was a prompt within the alert set up do allow information to be viewed by other organisations (see Fig 1). However, it was not clear how this could be utilised, who the information could be shared with and whether this could be done with other systems; further advice will be sought from EMIS.

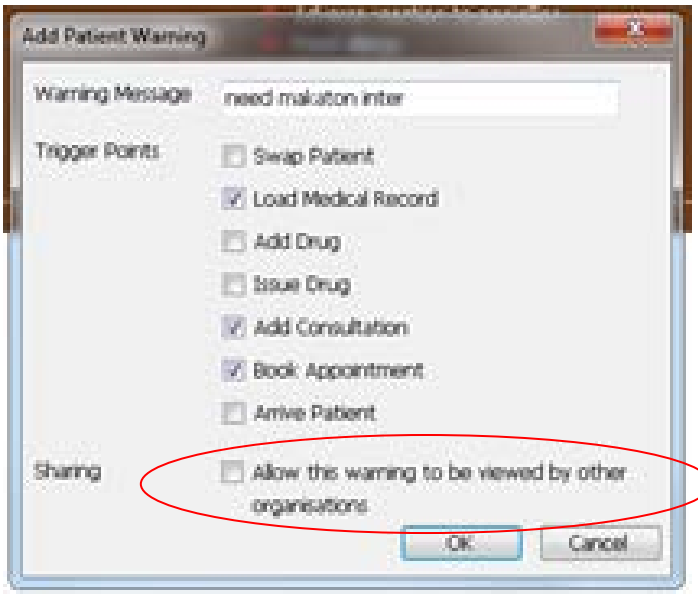

Figure 1

3.1.4 Conclusions

- The only way to identify patients with communication needs who are currently registered at one of the pilot sites is to run searches based upon clinical conditions or to rely upon staff awareness. The searches will produce a report but this may include patients with a temporary sensory loss and not longer term communication need, e.g. a temporary hearing difficulty due to an ear infection.

  This potentially means that a suitable member of staff would need to review the records of all the patients from the reports to identify those that may have ongoing communication needs. A way of reviewing these needs with the patient would then be required, e.g. contacting the patients directly or adding an alert to the clinical system to review those needs when the patient next attends the practice.

- The easiest way to collect information relating to patient's communication needs within a practice would appear to do so prospectively using a prompt within the patient registration forms to indicate that a more in-depth review needs to be carried out either through completion of a detailed document or during a telephone or face-to-face appointment.

- Once information has been gathered relating to a communication need, there are some limited READ codes available to record this information which may need to be further clarified through the use of accompanying free text.

- Communication needs can be flagged to team members within a practice through the use of the alerts. Currently, these would need to be set up manually but there is the potential for this to be automated through the use of specific READ codes.

3.1.5 Recommendations (Internal)

- To present the findings from this report and the associated documentation at the next practice managers' meeting.

- To agree with the pilot sites how to proceed with identifying the communication needs of their current registered population using the information already obtained.

- To commence prospective information gathering relating to the communication needs of patients as part of the registration process.

- To update the organisation's Note Summarising Policy to include information on the gathering and READ coding of patients' communication needs.

- To extend the learning from this pilot to all *gtd healthcare* practices/health centres.

- To explore what resources are available to meet the communication needs of patients.

3.2 Out of Hours

The identification, recording and flagging of patients encountered in the out of hours setting was explored by members of *gtd healthcare's* Information Management & Technology group. The computer system used is Adastra. Patients will typically access the service by telephone and depending upon the outcome of an initial clinical assessment, patients may be provided with self care advice, referral to A&E/secondary care or are seen face-to-face at a treatment centre or at home. Communication needs are usually identified upon contact with the service by the call handler taking the initial patient demographics and presenting condition and would be recorded within the main body of text. Whilst there are codes available on the clinical system, there do not appear to be any related to communication needs. This means that it is currently not possible to run any searches to identify such patients. The out of hours service is therefore reliant upon any information that may have been recorded in a previous encounter or information provided from other sources such as the patient's GP practice.

The out of hour's service currently receives information from practices in the form of 'Special Patient Notes' (SPN's). These may be initiated by the practice themselves or additional information may be requested from the practice where any cause for concern has been raised with regards to supporting clinical care during the out of hour's period. Practices supply this information through faxed documents or they can record this information electronically via a web portal directly into the clinical system. Adastra Web Access has three standard templates for palliative care, high risk adults or safeguarding children, but again there is the opportunity to add free form text which could be utilised to inform the out of hours service of any communication needs. Unfortunately, the use of Web Adastra by GP practices has been limited across the areas we serve..

gtd healthcare is currently exploring the use of the Medical Interoperability Gateway (MIG) to enable the secure sharing of data from practices via EMIS Web. It is envisaged that where communication needs are READ coded within a practice, that the out of hour's service will be able to view this information via Adastra. However, the project is in the early stages and it is therefore difficult to assess the practicalities and impact of this option.

3.2.1 Conclusions

- Currently, communication needs for patients in out of hours service are identified at the time of contact or from information gathered either from a previous encounter or from a patient's practice either manually or via Adastra Web Access.
- If this information is recorded at practices, then there are IT solutions already available, such as the MIG, to ensure that this can be accessed.

3.2.2 Recommendations (Internal)

- To ensure that as a minimum, *gtd healthcare* GP practices record patient communication needs and that these are visible to the OOHs service as part of the evaluation of the MIG project.

4.0 Impact & Cost

For the practices, in terms of the identifying patients with communication needs, there would appear to be little impact or cost implications if done on a prospective basis as part of the initial registration process. However, this would be dependent upon the patient and/or their representative being able to provide this information easily on the documents provided. Should additional involvement be required from either the administrative staff or clinical staff at the time of the new patient health check or other consultations as needs arise, this may have some impact on the time required to gather this information. Although the same is true of any other assessment carried out and should therefore not be considered out of the ordinary or therefore a barrier. The same is true of recording and setting up alerts for this information. As the standard becomes more embedded in practice, with GP2GP transfers it should become easier to identify new patients with communication needs as if the information has been accurately recorded in one practice it will be transferred each time the patient registers elsewhere. However, it is important to remember that the information will need to be reviewed on a regular basis to keep up to date with any changes in a patient's requirements or communication methods available.

There is likely to be a bigger impact for practices trying to review the needs of their current registered patients, and this may need to be managed on an ongoing basis as and when patients present.

Within primary care there is a heavy reliance upon IT systems. From the pilot, there are already a number of IT solutions available to support the identification, recording and flagging of communication needs. However, the expertise may not always be available to use these to their full effect and additional training and/or system supplier input may be required.

It is assumed that once SNOMED codes are introduced, any communication need READ codes recorded within a patient's clinical records will be mapped across to the corresponding SNOMED code. However, these will need to reviewed with patients to take into account any further information detailed within the free text, any additional needs that can be coded using the longer SNOMED list and/or any advances in communication methods/technologies.

Outside the scope of the pilot carried out by *gtd healthcare,* consideration will need to be given to the costs of producing materials in different formats and whether current systems could be adapted to facilitate this process. There may be resource needs to even review what is already in place that could be used and also in maintaining a database list of available resources.

5.0 Feedback on Documentation

No feedback to provide other than it is important to keep it simple. The information provided to the project leads and staff involved was clear and straightforward and would help staff working in the primary care environment to know what communication needs they need to identify and record and also provides some helpful hints on how to support individuals with those needs on a day-to-day basis.

6.0 Benefits of Implementation

It is recognised that communicating with patients using methods appropriate to meet their individual needs will improve the experience for the patient, support the delivery of high quality care by staff, ease the pressure on both staff and patients and ensure a much more meaningful and productive relationship. This will hopefully avoid complaints due to an improved patient experience and minimise the risk of untoward incidents caused through any misunderstanding and miscommunication.

Through accurate recording of this information, it is envisaged that communication needs can be met more promptly and appropriately which may help to avoid missed, cancelled or repeat appointments (where the necessary support has not been available) for scheduled care. However, for unscheduled care such as in the out of hours service or walk-in centres it is far more difficult to anticipate when and how to meet communication needs on an individual basis and the choices of what can be accessed within a short space of time appear to be quite limited.

7.0 Any Other Comments

Being part of the pilot project has been very useful in raising awareness that communication needs are not restricted to language and is something that needs to be addressed in terms of the benefits outlined above. The recent participant event attended by the project lead was particularly interesting and informative providing the opportunity to discuss some of the challenges encountered with people working in different areas.

It is considered that the time allocated to carry out the pilot has been a major challenge. In reality, the majority of the pilot has been used to review the current situation and to develop tools to support the implementation of the standard. The actual implementation of the standard can only take place once the staff involved have agreed to the tools and processes to do so. To this end, the project will continue beyond the end date of the pilot following agreement of the adapted registration form and detailed communication need form at the next practice managers' meeting and a discussion on how to manage further identification of communication needs for those patients already registered at the practices. For the out of hours service, work will continue on improving access to information recorded on practice systems.

One of the original proposals for this pilot was to review and revise the questions in our patient satisfaction surveys to reflect the Accessible Information Standard to support the identification of general needs and service feedback. Our survey forms had recently be updated and re-issued and it has not been possible to incorporate these questions at the present time. However, this will be addressed in the next version release to be able to explore some of the issues for patients to ensure we are addressing those that have the most impact for them.

Although not within the scope of the pilot carried out by *gtd healthcare,* what to do once communication needs have been identified and highlighted has caused some further questions, such as: what resources are available to meet those needs; how can these be accessed; how much will these cost? Ultimately the standard raises the dilemmas of the

legal and moral responsibilities of highlighting these needs and not having the awareness, capability or resources available to meet them. It is hoped that the pilot will provide some of the answers to this.