Accessible Information Standard

Meeting communication and information needs

The final step for the successful implementation of the Accessible Information Standard is based on taking steps to ensure that the individual receives information in an accessible format and any communication support which they need.

Overview of requirements – meeting of needs

Services MUST provide one or more communication or contact methods which are accessible to and useable by the patient, service user, carer or parent. The method(s) MUST enable the individual to contact the service, and staff MUST use this method to contact the individual. Examples of accessible communication / contact methods include email, text message, telephone and text relay.

Information, including correspondence and advice, MUST be provided in one or more accessible formats appropriate for the individual – in line with records made in this regard. Where systems are used to auto-generate correspondence, systems MUST identify a recorded need for an alternative format and either automatically generate correspondence in an appropriate format (preferred) or prompt staff to make alternative arrangements. Systems MUST prevent correspondence from being sent to a patient in a standard format where this is not suitable / not in line with their recorded needs.

Where needed, appropriate, professional communication support MUST be arranged or provided to enable individuals to effectively access / receive health or adult social care, to facilitate effective / accurate dialogue, and to enable participation in decisions about their health, care or treatment.

Appropriate action MUST be taken to enable patients, service users, carers and parents to communicate, including through staff modifying their behaviour and / or supporting the use of aids or tools. This includes provision of communication support for individuals accessing both outpatient and inpatient services, including long-term care, and those in receipt of publicly-funded social and / or NHS care whilst resident in a nursing or care home.

Response times

As stated in the Specification, "Organisations MUST take steps to ensure that communication support, professional communication support and information in alternative formats can be provided promptly and without unreasonable delay. This includes making use of remote, virtual, digital and telecommunications solutions."

Costs of accessible information / communication support

In order to ensure equity and promote equitable access to services by people with a disability, impairment or sensory loss, organisations should be aware that it is their responsibility, and not that of the disabled person, to cover the costs of meeting an individual's information and / or communication support needs. **Guidance from the Equality and Human Rights Commission (EHRC)** states that, "If an adjustment is reasonable, then the person or organisation providing it must pay for it. As a disabled person, even if you have asked for the adjustment, you must not be asked to pay for it."

Meeting of needs under the four categories / subsets

As outlined in the Specification, the Accessible Information Standard has defined four new subsets to which SNOMED CT, Read v2 and CTV3 codes have been associated and which are now available for use (noting that their use is mandated in line with the conformance criteria and timescales set by the Standard):

- Accessible Information - requires specific contact method

- Accessible Information - requires specific information format

- Accessible Information - requires communication professional

- Accessible information - communication support

Specific contact method

This category relates to the need for services to provide accessible methods or mechanisms which individuals with information and / or communication needs are able to use to contact the service, and which the service uses to contact them. This may require adjustment to current systems or processes. For example, many service users, including those who are d/Deaf or have some hearing loss, will not be able to use a telephone to, for example, book an appointment or receive test results.

Alternative communication / contact methods which may be accessible to individuals with information and / or communication needs include email, text message, telephone and text relay.

Organisations MUST ensure that an individual's need to use or be contacted by an alternative communication method is flagged and / or highly visible to staff to enable appropriate action to be taken.

Specific information format

This category relates to a need to send correspondence or provide information to an individual in an alternative (non-standard print or non-print) format, and will be of particular relevance where auto-generation systems are used and / or 'standard' or 'generic' letter formats.

Organisations MUST ensure that an individual's recorded need for information in an alternative format is flagged and either triggers the automatic generation of correspondence / communication in an alternative format (preferred) or prompts staff to make alternative arrangements. A standard print letter MUST NOT be sent to an individual who is unable to read or understand it.

Organisations MUST also ensure that they have effective processes in place to ensure and assure the accuracy and quality of translated or transcribed information.

As well as correspondence in alternative formats, the Standard includes the provision of patient information – such as that often contained with leaflets or booklets – in alternative, accessible formats where this is in support of direct patient / service user care (including self-care). Organisations should consider their most frequently used patient information leaflets / booklets and take steps to ensure that these are readily available in commonly used accessible formats.

It should be noted that, although expected standards of general health and adult social care communication / information (i.e. that provided to individuals without additional information or communication support needs) are excluded from the scope of the Standard, actions taken to maximise the accessibility of 'standard' documents, including those published electronically, will reduce the number of alternative formats which are required by individuals with particular needs (see section 6.4.3 and appendix d).

Organisations should take steps to ensure and assure the quality and accuracy of 'standard' documents / information prior to any translation or transcription into alternative formats. One framework for this is **The Information Standard**, a quality assurance kitemark scheme for organisations producing health and care information

for the public. Note that, despite the similar terminology, 'The Information Standard' is a voluntary scheme and is not an 'information standard' in the sense of the **Health and Social Care Act 2012** (and is therefore entirely separate to SCCI1605 Accessible Information).

Organisations are advised (although not required) to consider the accessibility and usability of their website, where this offers information or advice for patients, service users, carers and parents. Individuals MAY be signposted to online information by way of meeting their needs, however, the service provider MUST ensure that this is accessible to the individual, including where they have a disability, impairment or sensory loss.

Organisations should note that increasing web and digital accessibility will reduce (although never remove) the need to produce information in alternative formats.

Note about 'large print'

Data items associated one or more of the four subsets of the Standard include those to record individuals' requirements for information in 'large print'. Such codes specify font size and type of font needed, and the recording of a need for 'large print' has been deliberately avoided due to ambiguity.

Many individuals will ask for / require printed information in 'large print' – i.e. a larger point size than 'standard' (i.e. above 10 or 12 point). It should be noted that individuals requiring a particular font size, such as point 16, can read a larger font size (such as point 20) – and provision of a larger font size should not cause difficulty, and may often make reading easier for the individual.

'Sans serif' fonts are easier to read for most people with visual loss and for most people with a learning disability. A 'sans serif' font is one is one that does not have the small projecting features called 'serifs' at the end of strokes. A well-known example is Arial.

Printing in a point size above 28 is generally considered to be impractical and unwieldy, and in most instances individuals' needs would be better met through the provision of information in an alternative format, for example audio.

Communication professional

Where a need for support from a communication professional is identified, services MUST ensure that such support is arranged / provided and that interpreters and other communication professionals are suitably skilled, experienced and qualified. This SHOULD include verification of accreditation, qualification and registration with

a relevant professional body.

Organisations MUST ensure that communication professionals (including British Sign Language interpreters and deafblind manual interpreters) used in health and adult social care settings have:

- appropriate qualifications;

- Disclosure and Barring Service (DBS) clearance;

- signed up to a relevant professional code of conduct.

Assurance of the above SHOULD be obtained by applicable organisations including through reviewing relevant professional identification / registration.

Organisations SHOULD ensure that communication professionals working with d/Deaf and deafblind people (including British Sign Language interpreters and deafblind manual interpreters) are registered with the **National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD)**. Registration confirms they hold suitable qualification(s), are subject to a Code of Conduct and complaints process, have appropriate insurance, hold an enhanced disclosure from the Disclosure and Barring Service, and engage in continuing professional development. The NRCPD includes the following professional categories:

Registered Interpreter for Deafblind People Registered Lipspeaker

Registered Notetaker

Registered Sign Language Interpreter Registered Sign Language Translator Registered Speech to Text Reporter

If it is impossible to engage an NRCPD Registrant, organisations MUST ensure that the communication and language professional holds relevant interpreting qualifications and, in the case of British Sign Language (BSL), has achieved BSL level 6 or an honours degree in their second language, in line with NRCPD registration requirements. They must also have appropriate insurance and an enhanced disclosure from the Disclosure and Barring Service.

Use of health and social care staff as communicators / interpreters

Where health and social care staff are themselves appropriately qualified, experienced and registered as communication professionals (including with reference to the NRCPD registration requirements listed above) they MAY take on

the role of communicator or interpreter. This MUST only occur with the patient, service user, carer or parent's explicit consent – which MUST be clearly recorded – and the provision of an independent communication professional SHOULD always be offered.

Where staff members within a team, organisation or service are able to communicate using British Sign Language (BSL) or deafblind manual (or using Makaton or another key word signing system), and with the agreement of the patient, service user, carer or parent, it MAY be appropriate for them to communicate with the individual directly (for example in BSL). Where the individual consents to this approach, steps SHOULD be taken in order that the individual can be seen by the individual with the relevant skills. For example, if a particular Practice Nurse is able to communicate in BSL, if the patient, service user, carer or parent agrees, it would usually be appropriate to arrange for the individual to be seen by this Practice Nurse whenever they require access to this service. The level of skill and knowledge held by the health or social care professional in BSL or deafblind manual MUST be assessed and assured to be sufficient so as to enable effective, accurate dialogue and care of the individual.

Members of health or social care staff MUST only be used in an interpretative role (i.e. to enable dialogue between a service user and other professionals) where they are appropriately qualified and registered (including complying with guidance above). In addition, where it is proposed that a member of health or social care staff acts as an interpreter or communicator, consideration MUST always be given – including with the involvement of the patient, service user, carer or parent – as to the appropriateness of the health or social care professional acting in this role.

Use of family members, friends or carers as interpreters

As the Accessible Information Standard aims to support individuals' rights to autonomy and, specifically, their ability to access health and social care services independently, in general, British Sign Language (BSL) interpretation and other communication support SHOULD be provided by an appropriately qualified and registered professional (see section 11.4.4.1) and not by an individual's family members, friends or carers.

In all instances, the individual patient, service user, carer or parent MUST be offered professional communication support where they have an identified need for communication using British Sign Language, deafblind manual or other alternative communication system.

Where an individual has sensory loss (hearing loss and / or visual loss) and no other impairment, a professional interpreter / communication professional MUST be used (see section11.4.4.1) unless there is documented, supported evidence of the individual's explicit preference for the use of a family member / friend / carer. The parameters in which the individual's family member / friend / carer is to be used MUST be agreed with the individual and recorded as part of their record or notes.

This preference MUST also be regularly reviewed and MUST be reviewed whenever a new course of treatment / episode of care is started or proposed or significant decision or choice is to be made.

Where an individual has sensory loss (hearing loss and / or visual loss) AND one or more other impairments which impact upon their ability to communicate, for example a learning disability, and especially where individuals have multiple or complex needs, it MAY be appropriate for one or more family members, friends or carers to support communication and / or act as an interpreter or communicator instead of or alongside one or more communication professionals.

Discussion about how an individual communicates and the support needed to enable effective communication with a health or social care professional MUST take place with the individual and / or with their parent or carer as appropriate. Whatever decision is taken MUST be clearly documented and, where the individual may lack capacity, MUST be demonstrably in their 'best interests'. Use of family members, friends or carers to support communication / act as interpreters is most likely to be appropriate where an individual has multiple / complex needs (for example a moderate to severe learning disability and sensory loss) and / or a personal method of communication (i.e. not 'standard' BSL or deafblind manual).

Access to appropriate, and suitably skilled / qualified / knowledgeable support, from a communication professional provides assurances that important information is interpreted accurately, which is essential for safe, effective care. However, there is a need for flexibility to respond to individuals' needs and preferences, as outlined above. Such flexibility is most likely to be appropriate where 'bespoke' / highly personalised communication approaches are used by individuals and their families / friends / carers, especially where they have complex needs.

In all instances, consideration MUST be given to the most effective way of enabling effective, accurate dialogue between a health or care professional and the service user to take place. Communication support MUST enable individuals (as much as possible) to provide or withhold consent, and to make informed choices about care or treatment. Services MUST also recognise that communication support and interpretation supports both the health or care professional as well as the service

user – and clinicians reliant upon family members, friends or carers do so 'at risk' with regards to associated lack of assurance about not only their skill and ability to communicate / interpret effectively, but also how their lack of objectivity may affect accuracy and completeness of the messages conveyed.

Services should be mindful of their responsibilities to ensure that individuals' rights are met, including rights to privacy and confidentiality, to accept or refuse treatment, to information to support choice, and to make choices about care and treatment, including as outlined in the **NHS Constitution.** However, this also states that, "NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers. Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment."

Requests for / use of particular professionals

Wherever possible, requests from individuals for a male or female communication professional, for a particular professional and / or for the same professional to provide support to an individual during a course of treatment, SHOULD be met. This will support continuity of care and is likely to improve the experience of the patient, service user, carer or parent.

Good practice would suggest that particular efforts should be made to accommodate requests for individual, consistent and / or male / female communication professionals where an individual is undergoing particularly invasive, intensive or sensitive procedures / courses of treatment, including care relating to pregnancy, maternity or sexual health, radio- and chemo-therapy, end of life care and when accessing mental health services. Such preferences should be clearly and objectively recorded in a free text area of an individual's notes or record, linked to the basic (and mandatory) recording of needs, for example: Special Requirements: 204331000000107 British Sign Language interpreter needed (finding). "Pref. interpreter Jane Smith (NRCPD ID 1234567) or if unav. other female interpreter."

Organisations should also consider the use of interpreters with additional skills, knowledge or experience in relevant terminologies and / or care settings. This is recommended but not required and may be linked to an individual's preferences. For example, a Mental Health Trust may wish to stipulate in relevant contracts / include in their policy that only interpreters with experience in mental health settings should or must be used, either generally or in particular circumstances. All services may wish to consider the stipulation of knowledge / proficiency in medical / care / social care terminology as part of contracts / policies.

Remote access to communication support

In addition to the 'traditional' approach of arranging for a particular communication professional to attend an appointment to support dialogue between an individual and a service provider, it is now possible for services to access such support remotely (or 'virtually') over the internet.

Working in a similar way to a video call, and using telecommunications application software to support a video conversation over the internet, video relay services / video remote interpreting services enable a three-way conversation to take place between a d/Deaf BSL user and an English speaker via a BSL interpreter.

The technology can be accessed via a smartphone, tablet or computer, enabling quick and easy access to communication support for d/Deaf people. The technology has been used as part of a pilot since 2012 for the **NHS24** service (in Scotland) and is now (from May 2015) available to users of the **NHS 111 service** (in England).

Video interpreting services are particularly useful in urgent or emergency care settings, when it may not be possible to arrange for face-to-face support from a communication professional in time. They should not be seen as a total replacement for face-to-face interpretation / communication support, and may not be appropriate in some circumstances, especially for longer appointments. Best practice would be that, where possible, and for routine care, individuals should be given the option of remote or face-to-face interpretation.

Key word signing including Makaton

'Key word signing systems' use signs (given as gestures or described in pictorial format) to enable and support communication. They are most commonly used to support people with a learning disability. Two of the most commonly used, and well known, key word signing systems are Makaton and Signalong:

"**Makaton** uses signs, symbols and speech to help people communicate. Signs are used, with speech, in spoken word order. This helps provide extra clues about what someone is saying. Using signs can help people who have no speech or whose speech is unclear. Using symbols can help people who have limited speech and those who cannot, or prefer not to sign."

"**Signalong** is a sign-supporting system, which requires you to speak as you sign… Signalong is a total communication system, in which you give every clue to meaning which is relevant in the situation. While signing, always remember to use body language, facial expression and voice tone to reinforce the message."

Communication using a key word signing system, such as Makaton, is included within the scope of the Accessible Information Standard. This includes 'translation' of information using Makaton or another key word signing system (as part of the 'specific information format' category), use of Makaton or another key word signing system as a type of 'communication support', and requiring a Makaton or other key word signer as a 'communication professional'.

Communication support

This category relates to the provision of support to enable effective communication / conversation, for example by the provision or use of aids or equipment, or by health or social care staff making adjustments to their behaviour. It is recognised that staff may need training or other awareness-raising in order to effectively provide some of the types of support / adjustments indicated.

Perhaps the most commonly used additional aids to communication are lipreading and hearing aids – often used by individuals in combination – and easily supported by provision of a (working) hearing loop and ensuring that the lipreader has a clear line of sight to the speaker's lips and face.

Requests from individuals with communication needs / requiring support to communicate to be seen by one or more particular members of staff should be accommodated wherever possible. Familiarity with the nuances of a staff member, clinician or professional's dialect, accent and manner of speaking can assist an individual with a disability, impairment or sensory loss to communicate effectively.

Longer appointments

The scope of the Standard includes accommodation of an individual's need or requirement for a longer appointment to enable effective communication / the accessible provision of information. Applicable organisations should ensure that systems and processes for scheduling and managing appointments enable this flexibility. In particular, any appointment requiring support from a communication professional will almost invariably take longer – because of the 'three-way' nature of the conversation – and allowance for this should be made. Commissioners should ensure that they support this requirement including through tariffs, contracts and performance-management frameworks with provider organisations.