

Accessible Information Standard

Sharing Information and Communication Needs

The fourth step for the successful implementation of the Accessible Information Standard is based on the inclusion of recorded data about individuals' information and / or communication support needs as part of existing data-sharing processes, and as a routine part of referral, discharge and handover processes.

Overview of requirements – sharing of needs

Organisations **MUST** ensure that information about individuals' information and / or communication support needs is included as part of existing data-sharing processes, and as a routine part of referral, discharge and handover. Note that this data-sharing is to support direct patient / service user care, and is not for reporting or analysis.

Guidance for sharing of needs

All applicable organisations should include information about individuals' information and communication support needs as a routine part of referral and handover communication, and as part of other data-sharing processes with other professionals and services involved (or soon to be involved) in an individual's care. Information as shared should be formatted in line with relevant Read v2, CTV3 or SNOMED CT codes or using the associated 'human readable' definitions / categories.

All information-sharing as part of this Standard should utilise existing data-sharing processes, including following existing information governance protocols and processes for the obtaining and recording of patient / service user consent.

Information about individuals' information and / or communication needs should be included as part of referrals both within and between organisations, including (but not limited to) referrals from primary into secondary care, transfers and handovers between wards or units, and discharge from an inpatient setting into the community.

Data recorded as part of this standard should be included (with consent) as part of shared and integrated records, and using existing systems for the sharing of patient information with other services such as the [Summary Care Record](#) and [NHS e-Referral Service](#).

The codes associated with the four subsets of the Accessible Information Standard have been included as part of the [inclusion dataset](#) (SCR v2.1) for Summary Care Records (as of April 2016).

Once the system used by the GP practice supports SCR 2.1, this means that if any of the codes are included on an individual's GP patient record – and the patient consents to additional information being included on their SCR – then the code will be added to their SCR. It will then be automatically visible to any health or care professional accessing their SCR in future. Patients with online access can view summary information from their detailed GP record, allowing them to confirm correctness and relevance over time.