Accessible Information Standard – requirements (DAPB1605)

Publication

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Introduction

The Accessible Information Standard ('the standard') aims to ensure that people who have a disability, impairment or sensory loss:

- can access and understand information about Shalom Health Recruitment Ltd and adult social care services
- receive the communication support they need to use those services

This document sets out what organisations need to do to meet the standard.

Read the Implementation guidance, which helps organisations meet their obligations under the standard.

What's new?

We have:

- updated the language and structure of the standard to make it easier for organisations to implement and to comply with their obligations
- made organisations' responsibilities clearer
- incorporated legislative changes since 2016
- incorporated lessons learned from the COVID-19 pandemic

- added a sixth 'review stage' to help improve compliance with the standard
- introduced the Accessible Information Standard self-assessment framework to support with assurance and compliance
- made the standard compatible with the Care Quality Commission's assessment framework and improved our information about it
- updated the implementation guidance to reflect current best practice
- updated the standard's reference number from DCB1605 to DAPB1605

See Annex A for more information on why the standard has been updated.

This updated standard has been approved by the Data Alliance Partnership Board (DAPB).

What does the standard require and who does it apply to?

The standard describes how Shalom Health Recruitment Ltd and adult social care services should identify, record, flag, share, meet and review people's information and communication support needs (referred to as 'needs' throughout the standard). It specifically applies to people who have information or communication support needs related to a disability, impairment or sensory loss. This includes service users, carers and members of families who are involved in people's care and have information or communication support needs related to disability, impairment or sensory loss themselves.

The standard aims to ensure these people get:

- accessible information: information they can access and understand
- communication support: the support they need to have effective and accurate dialogue with health and care professionals. This means that no one who needs support is put "at a substantial disadvantage in comparison with persons who are not disabled" (Equality Act 2010) when accessing NHS or adult social services
- Shalom Health Recruitment Ltd and adult social care services must enable disabled people with communication and Information needs to:
- make decisions about their health and wellbeing, about their care and treatment and about giving or withholding consent
- self-manage their conditions
- access services
- make a complaint in a way that is accessible for them

The standard covers any disability that affects an individual's ability to access, read or understand information or to communicate. That includes people who have sensory loss

(including people who are blind, deaf or deafblind), people who have a learning disability, autistic people, people with aphasia and mental health service users. Read our implementation guidance for more information on how to support mental health service users.

What activities are required to meet the standard?

The standard encompasses activities such as:

- meeting people's needs for information in alternative formats to printed text (including Braille or large print), and other print alternatives such as email and audio formats
- meeting people's needs for longer appointments
- using specific contact methods
- support from a communication professional (for example, a deaf blind interpreter or British Sign Language interpreter)
- supporting the use of communication methods or communication aids and tools (for example, lipreading or a hearing aid)
- meeting people's needs for support from an advocate to help them communicate effectively
- meeting people's needs for communication from a service in specific formats

Activities beyond the scope of the standard

More information about areas of work relevant to improving the accessibility of health and social care services, and which are out of scope of this standard, is provided in the 'Activities beyond the scope of the standard' section.

Which organisations does the standard apply to?

Shalom Health Recruitment Ltd and publicly funded adult health and social care services including:

- NHS foundation trusts and NHS trusts
- integrated care boards
- commissioners, including NHS England, who must also ensure their actions, especially through contracting and performance-management arrangements (including incentives and penalties), enable and support providers to implement the standard

- all providers of publicly funded adult social care, including providers from the voluntary, community, social enterprise or private sectors
- independent providers of NHS-funded services
- general practice, community pharmacy, dental and optometry services
- providers of public health services, including advice and information services
- organisations that contact people who use health and care services, for example, to invite them to attend screening or vaccinations

Where there is a cost to providing a reasonable adjustment, this must be met by the provider of the service, as required by the Equality Act 2010.

The standard

6 essential steps

Organisations should complete these 6 essential steps to implement the standard for people who require communication support. This applies to people with a disability, impairment or sensory loss – as well as their carers and family members who are involved in their care and have a disability, impairment or sensory loss:

1. **identifying needs**: a consistent approach to identifying people's information and communication needs
2. **recording needs**: consistently and routinely recording people's information and communication needs in their records as well as in clinical management and administration systems. This means:
    - recording people's needs in electronic systems.
    - using specific definitions to record needs when systems are not compatible with any of the 3 clinical terminologies or where paper-based systems or records are being used
    - recording people's needs so staff can ensure those needs are met
3. **flagging needs:** using electronic flags or alerts, or paper-based equivalents, to indicate that an individual has a recorded information and / or communication need, and to prompt staff to act. The flags may include other actions (such as triggering information in an accessible format to be automatically generated) to ensure needs are met (see DAPB4019: Reasonable Adjustment Digital Flag)
4. **sharing needs:** including recorded data about people's information and communication support needs as part of existing data-sharing processes, and as a

routine part of treatment, ongoing care, referral, discharge and handover processes (for more information see DAPB4019: Reasonable Adjustment Digital Flag)

5. **meeting needs:** ensuring people receive information that is accessible to them and receive the communication support they need

6. **reviewing needs:** consistent and regular reviews of people's information and communication needs in patient or service user records and on clinical management or administration systems

1. Requirements of Shalom Health Recruitment Ltd and adult social care providers

When implementing the standard, all professionals and organisations must follow relevant existing legal duties, including those set out in data protection law and Mental Capacity Act 2005 on the handling and processing of personal data.

Definitions

- all 'must' requirements must be met
- all 'should' requirements must be met or there must be a credible, legitimate reason documented for why they have not been met
- 'may' requirements are optional

Requirements

Implementing the standard: procedures, systems and governance	
1.1	Organisations must implement the standard. This includes assessing their systems and processes and developing and delivering an improvement plan.
1.2	Organisations **should** use the implementation guidance to steer decisions.
1.3	Organisations **must** review their administration and recording systems, platforms, processes and documentation, and update, change or replace them so they conform to the standard.
1.4	Organisations developing, implementing and / or contracting for new electronic record or administration systems **must** specify the requirement to comply with the standard in IT system and software provider contracts.

1.5	All organisations **should** identify an Accessible Information Standard lead who is responsible for ensuring the standard is met. A senior person at executive level should assume responsibility for the standard within their portfolio.
1.6	Information governance leads **must** review the information governance implications of the standard within their organisation(s) and understand and mitigate any risks.
1.7	Clinical governance, adult social care governance and IT safety leads **must** understand and mitigate the identified hazards outlined in the clinical safety case and any other identified risks or hazards associated with the standard.
1.8	Clinical leads and adult social care team leaders or service managers **should** review the implementation guidance and consider whether changes are required to current professional practice, business practice, training and local policies or pathways.
1.9	Organisations **must** establish a clear, step-by-step approach to complying with the standard and support staff to follow this. This **must** include a clear procedure for anticipating and addressing the barriers to access that people might experience. Organisations **must** accurately and consistently identify, record, flag, share and review the data items or categories defined by the standard. Organisations **must** have clear and well publicised procedures for ensuring that people's needs are met.
1.10	Organisations **must** accurately record people's needs and plan appropriate and effective service capability to meet these needs.
1.11	Organisations **should** improve their performance and assess how they have improved over time using the Self-Assessment Framework or the organisational maturity index in the implementation guidance.
Implementing the standard: workforce, human resources and training	
1.12	Organisations **must** review the ability of their workforce to implement the standard and implement a training and / or awareness programme to ensure staff consistently comply with it.
1.13	Organisations **should** enable all their staff to access NHS England's e-learning and resources to support them to implement the standard.

Ongoing compliance with the standard: identifying and recording needs	
1.14	Health and social care staff **must** identify and record people's needs: this **must** be recorded during the individual's initial interaction with the service, or during their next interactions if they are already in the system in electronic systems that use SNOMED CT, Read v2 or CTV3 codes, this **must** be recorded using the coded data items associated with the subsets defined by this standard In electronic systems that use other coding systems or terminologies, or where paper records are used, this information **must** be recorded in line with the human-readable definitions or categories associated with the data items.
1.15	Staff **should** ask people if they have needs and support them to describe the type of alternative format and support they need at their first or next interaction with the service.
1.16	Organisations **must** ensure people's needs are identified and recorded at every contact including: on registration with the service as part of the initial contact or interaction with the service in an emergency or urgent care scenario, as soon as is practical after initial interaction with the service at first appointment on receipt of a 'certificate of vision impairment' from an ophthalmologist on receipt of notification that a person has a sensory loss or learning disability when a diagnosis or symptoms indicate a new or revised communication or information support need as part of a health check as part of care or support planning This may require changes to existing electronic and paper recording systems and documentation. Electronic recording and administration systems **must** record information and communication needs in line with the data items or categories associated with the subsets defined by the standard. Paper-based systems and documentation **must** record needs in line with the subsets defined by the standard. IT systems and documentation **must** be formatted to make it easy to record people's needs.
Ongoing compliance with the standard: verifying data accuracy	
1.17	Organisations **must** ensure that information recorded about people's needs is accurate. Processes for checking data as it is inputted, to ensure it meets defined conditions, and processes for quality assuring data **should** be put in place. This includes setting up alerts or mechanisms to stop incorrect or incomplete information being entered by users.
1.18	Organisations **must** ensure that data recorded about people's needs is up to date. Processes **must** enable records about people's needs to be revised and **should** include prompts for review at regular points.

1.19	People **should** be aware of the exact information recorded about their needs, so they can verify its accuracy.
1.20	If online systems enable people to access their own records, and subject to data protection law requirements, these systems **must** enable people to review the data recorded about their needs and request changes if necessary. Systems should enable people to record their own needs when appropriate.
1.21	Professionals **should** review and update data recorded about people's needs when they are updating / checking data in other demographic fields.
Ongoing compliance with the standard: supporting documents	
1.22	If an individual has a care plan, the organisation responsible for developing or holding it **must** ensure it includes information about the individual's needs and that these are recorded in line with the standard.
1.23	Documents used to help professionals understand people's needs (for example, health passports, communication passports, 'my health need' cards and 'NHS help cards') **must** include the individual's specific information and communication support needs.
Ongoing compliance with the standard: flagging needs and prompts to action	
1.24	Organisations **must** take appropriate action to ensure that electronic administration and record systems include flags or alerts to indicate an individual has a recorded information or communication need. These **must** where possible prompt staff to take appropriate action and / or trigger information to be automatically generated in an accessible format (or other actions required to meet the individual's needs).
1.25	Organisations **must** ensure paper-based administration and record systems include flags to indicate an individual has a recorded need. These flags **must** be visible to staff and prompt them to act.
1.26	Organisations **must** ensure electronic administration and record systems automatically identify a recorded need for information or correspondence in an alternative format and can: automatically generate correspondence or information in an alternative format (preferred) enable staff to manually generate correspondence in an alternative format

	upon receipt of an alert Organisations **must** ensure that a standard print letter is not sent to an individual if it is not in an appropriate or accessible format for them (due to correspondence being automatically generated in a standard format, or for any other reason).
Ongoing compliance with the standard: sharing needs	
1.27	Organisations **must** where possible ensure information about people's needs is included as part of existing data-sharing processes, and as a routine part of referral, discharge and handover. All information sharing **should** follow existing processes and information governance protocols.
Ongoing compliance with the standard: meeting people's needs	
1.28	Organisations **must** ensure people are provided with information and correspondence in formats (for example, information in a non-standard print format) that meet their needs and that they can understand.
1.29	Organisations **must** ensure people are able to access their services by having accessible contact methods in place.
1.30	Organisations **must** ensure people are provided with appropriate communication support, including using aids or equipment and / or staff adjusting their approach to enable effective communication.
1.31	Organisations **must** ensure that communication support can be provided promptly (for example, arranging interpreter support or providing information in alternative formats without unreasonable delay).
1.32	Organisations **must** ensure communication professionals (including British Sign Language interpreters and deafblind interpreters) meet all these requirements: appropriate qualifications Disclosure and Barring Service (DBS) clearance signed up to a relevant professional code of conduct valid recognised professional registration (for example, NRCPD, RBSLI)
1.33	Organisations **should** ensure that people, their families or carers are given a longer appointment if this is needed to support effective communication or the provision of

	accessible information.
Assessing assurance and compliance with the standard	
1.34	Organisations **must** publish their accessible communication policy which outlines how they will identify, record, flag, share, meet and review people's needs in line with the standard.
1.35	Organisations **must** quality assure the types of communication support or alternative formats provided to people to ensure they meet their needs. This **should** be undertaken in partnership with patient groups.
1.36	Organisations **should** engage and consult with local stakeholders and 'experts by experience' to improve how they implement the standard.
1.37	People **must** be encouraged and enabled to provide feedback about their experience of receiving information in an accessible format or of getting communication support, including being able to access and follow a complaints policy.
1.38	Organisations **should** publish or display their improvement plan to demonstrate they have assessed and assured their compliance with the standard. This can be best evidenced using the Self-Assessment Framework or the organisational maturity index in the implementation guidance.

If any of the above cannot be implemented in existing systems, organisations should develop and deliver an improvement plan to address this.

Conformance criteria

Health and adult social care providers should provide evidence against each criterion to demonstrate compliance with the standard.

Implementing the standard: procedures, systems and governance
Organisations have prepared effectively for implementing the standard, including assessing their current policy, systems and processes, and developing and delivering an implementation plan.
The implementation guidance has been used to inform local decision-making.

Administration and record systems, platforms, processes and documentation adhere to the standard.
Contracts for patient or service user record and administration systems and software include a requirement that they adhere to the standard.
Information governance risks associated with implementing the standard have been identified and mitigating actions delivered.
Clinical and other safety risks associated with implementing the standard have been identified and mitigating actions delivered.
Following assessment, actions required to change current professional practice, business practices, training and / or local policies and pathways to enable implementation of and compliance with the standard have been completed.
A clear, step-by-step approach to ensure compliance with the standard as part of 'business as usual' is in place and is being followed by staff. There is a high level of awareness of the approach among the workforce.
Implementing the standard: workforce, human resources and training
Where identified as necessary following local assessment, a programme of staff training and / or awareness-raising has been delivered.
Staff competency or training records indicate that all relevant staff and professionals in communication and information roles have received any training identified as locally necessary to implement the standard, including accessing training and resources offered by NHS England to support implementation of the standard, where appropriate.
Ongoing compliance with the standard: identifying and recording needs
Organisations identify and record needs when people first interact or register with their service.
Organisations identify and record needs as part of ongoing and routine interaction with the service by existing service users.

Fields in records relating to information and communication support needs are consistently completed.
Staff competency or training records indicate that staff have received any training identified as locally necessary to implement the standard consistently and accurately.
Record systems and relevant documentation enable staff to record needs in line with the standard.
Ongoing compliance with the standard: verifying data accuracy
Quality assurance and edit checking processes are in place to enable the accuracy of data about people's needs to be verified.
Systems enable records about people's needs to be revised and amended and, where possible, include prompts for review at appropriate points.
Feedback from patient surveys, Patient Advice and Liaison Services (PALS), local Healthwatch or other sources demonstrates that individuals are aware of the exact information that has been recorded about their needs.
Data recorded about people's needs is reviewed and refreshed alongside other data in demographic fields in people's records.
Ongoing compliance with the standard: supporting documents
Care plans include information about people's needs.
Local documents used to support staff to understand people's needs include specific information about an individual's needs.
Ongoing compliance with the standard: flagging and prompts to action
Electronic patient or service user administration and record systems automatically identify a recorded need for information or correspondence in an alternative format and / or for communication support, and flag / prompt this to staff whenever the record is accessed.

Electronic patient or service user administration and record systems automatically identify recorded needs and either automatically generate correspondence or information in an alternative format or enable staff to manually generate correspondence in an alternative format on receipt of an alert.
Systems are in place to ensure that a standard print letter is not sent to an individual for whom this is not an appropriate or accessible format.
Ongoing compliance with the standard: sharing needs
Arrangements and protocols are in place to ensure information about people's needs is included as part of existing data-sharing processes and as a routine part of referral, discharge and handover.
Ongoing compliance with the standard: meeting people's needs
Feedback from patient surveys, PALS, local Healthwatch and / or other sources demonstrates that people's needs are routinely and regularly met.
Records show that individuals have been provided with information and correspondence in formats that are appropriate for and accessible to them and that they can understand.
Policies and procedures are in place to enable communication support, professional communication support and information in alternative formats to be provided promptly.
Staff are aware of and understand the organisation's policies and procedures for providing communication support and information in alternative formats and these are embedded as part of 'business as usual'.
Ongoing compliance with the standard: reviewing people's needs
Reviews are consistently and routinely carried out of people's records and of clinical management or patient administration systems.
People's needs are accurately recorded and used to plan the service capability required for these needs.

Assessing assurance and compliance with the standard
An accessible communication policy has been published which staff and people using services can access. This outlines how people's needs will be identified, recorded, flagged, shared, met and reviewed.
Feedback from patient surveys, PALS, local Healthwatch or other sources demonstrates that people have received communication support and / or information in alternative formats that meets their needs.
People can feed back on whether and how their needs have been met and this feedback is used to improve compliance with the standard.
Mechanisms are in place for individuals to make a complaint, raise a concern or pass on feedback in a way which is accessible to them, and using communication support, if required.
Mechanisms are in place to demonstrate to commissioners the organisation's current position and compliance with the standard. The organisation has published an improvement plan demonstrating assessment and assurance of compliance using the Self-Assessment Framework or the organisational maturity index in the information guidance.

2. Requirements of Shalom Health Recruitment Ltd and adult social care commissioners

Definitions

'Commissioners' refers to organisations with responsibility for commissioning NHS or adult social care:

- all '**must'** requirements must be met
- all **'should'** requirements must be met or there must be a credible, legitimate reason documented for why they have not been met
- **'may'** requirements are optional

Requirements

2.1	Commissioners **must** ensure their commissioning and procurement processes, including contracts, tariffs, frameworks and performance management arrangements (including incentives and penalties) with providers of NHS or adult social care reflect, enable and

	support implementation of and compliance with the standard.
2.2	Commissioners **must** ensure their own activity complies with the standard (including ensuring accessible communication needs are met when engagement is undertaken, in complaints processes and in individual meetings with people).
2.3	Commissioners **must** seek assurance from providers that they comply with the standard, including evidence of identifying, recording, flagging, sharing, meeting and reviewing needs. Commissioners **should** review the results of a self-assessment as part of their assurance that services are complying with the standard. If the Self-Assessment Framework is not used to measure delivery, the provider **must** have an alternative process to provide assurance to the commissioner.

Conformance criteria

This section describes the tests that can be applied to indicate that a commissioner is complying with the standard.

Contracts, tariffs, frameworks, and performance management arrangements reflect the standard's requirements and enable and support providers of NHS and adult social care to implement and comply with it.
Commissioners have sought and received assurance from providers (through the Self-Assessment Framework or equivalent) of their compliance with the standard, including receipt of evidence of identifying, recording, flagging, sharing, meeting and reviewing needs. If the provider's overall position is not set out using the Self-Assessment Framework, a clear alternative should be agreed between the provider and commissioner.

3. IT system requirements

Definitions

In the table below, 'systems' refers to patient or service user record and / or administration systems supplied to or used by Shalom Health Recruitment Ltd or adult social care:

- all '**must'** requirements must be met
- all **'should'** requirements must be met or there must be a credible, legitimate reason documented for why they have not been met
- **'may'** requirements are optional

Requirements

3.1	Colleagues responsible for the Shalom Health Recruitment Ltd's patient or service user record or administration IT systems **must** update, change or replace them so they conform to the standard.
Design: safety and accessibility	
3.2	IT systems used to record people's communication needs **should** be designed to take account of the clinical safety risks in the clinical safety case.
3.3	IT systems used to record people's needs **may** allow the person (or their carer or family member) to access their own record electronically, and to have editing rights for specific fields about their information and communication needs.
Functionality: data items	
3.4	IT systems **must** enable recording of all the data categories within the subsets defined by the standard.
3.5	IT systems **should** alert users where none of the data items or categories in any one of the subsets associated with the standard has been selected.
3.6	IT systems **should** support edit checking and quality assuring data recorded about people's needs. This **may** include generating an alert or preventing users from entering incomplete or incorrect information.
3.7	Relevant IT systems **must** allow for changes to the data items associated with the standard over time, including following release of new or amended SNOMED CT, Readv2 or CTV3 codes (where used by relevant systems). It must also allow for locally defined additional information to be captured.
Functionality: notification or flagging	
3.8	IT systems **must** include functionality to notify staff of people's communication and

	information needs.
3.9	IT systems **must** automatically identify a recorded need for information or correspondence in an alternative format or for communication support. It **must** flag, prompt or otherwise make this need highly visible to staff whenever the record is accessed. If this is currently not possible, this functionality **must** be introduced in a timeframe agreed with the commissioner.
Functionality: automatically generating correspondence	
3.10	If IT systems automatically generate correspondence, they **must** automatically identify a recorded need for information or correspondence in an alternative format. The IT system must then do one of the following: automatically generate correspondence or information in an alternative format (preferred) enable staff to manually generate correspondence in an alternative format (upon receipt of an alert) The IT system **must** not produce the standard printed output for sending to people with communication and information needs.
Functionality: review	
3.11	IT systems **must** enable records about people's needs to be revised and amended.
3.12	IT systems **should** prompt users to review data about people's needs when they are reviewing data held in other demographic fields.
3.13	IT systems **must** enable people's needs to be recorded and flagged or shared with other individuals who are involved in their care or in the administration of the service.
Terminology and coding	
3.14	The specified codes **must** be used where electronic systems use or refer to any one of the 3 clinical terminologies, and these codes **must** be up-to-date and in line with scheduled code releases.
3.15	In electronic systems that do not use SNOMED CT, Read v2 or CTV codes, or where paper-based systems are used, information **must** be recorded in line with the human-readable definitions of the data items (also known as categories) or using the 'fully specified name'

	that is listed alongside SNOMED CT codes.

If any of the above cannot be implemented in existing IT systems, organisations should develop and deliver an improvement plan to address this.

Conformance criteria

This section describes the tests that can be applied to indicate the standard is being used correctly in IT systems.

Conformance criteria
Design: safety and accessibility
IT systems used for the recording of people's needs have been designed to adhere to the specific risks set out in the clinical safety case.
Where online systems and local procedures enable people to access their own records, the system should allow them (or their family or carer) to access the data recorded about their information and communication needs.
Where online systems and local procedures enable people to edit their own records, the systems should allow them (or their family or carer) to edit fields relating to information and communication.
Functionality: data items
IT systems enable recording of the 4 categories defined by the standard.
IT systems support quality assurance of data recorded about people's needs.
IT systems allow for changes to the data items associated with the standard over time, including following release of new or amended SNOMED CT, Readv2 or CTV3 codes (where used by relevant systems). IT systems enable any locally defined additional information to be captured.
Functionality: notification or flagging

Conformance criteria
IT systems can notify staff of people's needs. Staff providing care, staff involved in the administration of services and staff who will be involved with the individual in the near future all receive these notifications.
IT systems automatically identify a recorded need for information or correspondence in an alternative format or for communication support, and flag, prompt or otherwise make this need highly visible to staff whenever the record is accessed.
Functionality: automatically generating correspondence
If IT systems automatically generate correspondence, the system automatically identifies a recorded need for information or correspondence in an alternative format. It then either automatically generates correspondence or information in an alternative format or enables staff to manually generate correspondence in an alternative format (on receipt of an alert).
If IT systems automatically generate correspondence, they must automatically identify a recorded need for information or correspondence in an alternative format. They must not produce the standard printed format.
Functionality: review
IT systems allow records about people's needs to be revised or amended.
IT systems should prompt for a review of data held about people's needs when system users are reviewing data held in other demographic fields.
Terminology and coding
IT systems use the specified accessible information codes in the native code system. These codes are up-to-date and in line with scheduled code releases. Where there is no native code system, information is classified and recorded using the human-readable definitions (fully specified name) of the relevant code or the applicable category.
Shalom Health Recruitment Ltd and adult health and social care organisations and suppliers

Conformance criteria
implementing the standard use Information Standards Board for Health and Social Care SCCI0034 (the SNOMED CT fundamental standard) and include this in the specification in any new procurement, irrespective of any other coding systems that are also required.

4. Data management and quality requirements

The standard does not require organisations to submit data as part of a national collection. However, its requirements relate to the use of data to support direct care and access to services and specify how data should be recorded and used:

- all '**must'** requirements must be met
- all **'should'** requirements must be met or there must be a credible, legitimate reason documented for why they have not been met
- **'may'** requirements are optional

Terminology and coding requirements

The standard aims to improve clarity about how information concerning people's needs should be recorded and therefore the consistency of practice across health and care systems.

The standard has defined 4 subsets, listed within the Data Dictionary for Care (dd4c), with associated data items available in SNOMED CT, Read v2 and CTV3.

Current SNOMED CT, Read v2 and CTV3 codes and data items associated with the 4 subsets defined by the standard **must** be used to record people's needs, where electronic systems use or refer to any one of the 3 clinical terminologies.

Organisations responsible for individual record systems or administration systems used by providers of NHS or adult social care **must** ensure the coding used in them is current and up to date.

If IT systems do not use or refer to any of the clinical terminologies, or if paper-based systems are used, information about people's needs **must** be recorded using the 'fully specified names' (which is listed alongside SNOMED CT codes) or the 'human-readable definitions' of the data items or 'categories'.

Further advice about the data requirements of the standard is in the implementation guidance under "Recording of needs."

Mandatory fields requirements and conformance criteria

It is mandatory for IT systems to support the recording of the data items associated with the subsets defined by the standard or their human-readable definitions or categories.

4.1	Organisations and IT systems **must** comply with the standard by recording people's needs, including using defined data items and codes (where relevant terminologies are used in systems or the human-readable definitions). If any of the above cannot be implemented in existing IT systems, organisations **should** develop and deliver an improvement plan to address this.
4.2	If an individual has a need, the data item or its human-readable definition or category **must** be supported and populated.
4.3	Organisations implementing the standard **may** decide on any additional content to be included as part of local data collection and recording practice.

Conformance criteria

People's needs are recorded in IT systems using defined data items and codes (where relevant terminologies are used in systems) or human-readable definitions (where relevant terminologies are not used in systems).
If an individual is identified as having a need, the data item or its human-readable definition cannot be left blank.

Data flow requirements

The standard requires recorded data about people's needs to be included as part of existing data-sharing processes, and as a routine part of referral, discharge and handover processes. Information sharing **should** follow existing processes and information governance protocols.

The codes associated with the standard's 4 subsets are included in the 'inclusion dataset' (SCR v2.1) for Summary Care Records with additional information. The National Care Records Summary (NCRS) is the improved successor to the Summary Care Record application (SCRa) and required all users and organisations to switch from SCRa/1-Click to the NCRS product by 29 September 2023.

Guidance on sharing information recorded under this standard via the NHS e-Referral Service is in the implementation guidance.

In a GP practice setting, correct recording of people's needs using the codes associated with the standard's 4 subsets will support effective transfer of data through the electronic

'GP2GP' system when patients change practices. See the implementation guidance for more information.

Information governance requirements and conformance criteria

It is mandatory for IT systems to support the recording of the data items defined by the standard or their human-readable definitions or categories.

4.4	All IT systems **must** be compliant with legal information governance requirements (including DAPB0086: Data Security and Protection Toolkit) on data security and confidentiality to ensure security and protection of the data when it is viewed, transferred and stored. Organisations should also refer to and comply with all relevant professional or sector-specific information governance protocols.
4.5	Implementation of the standard **must** follow existing information governance standards and frameworks, including complying with ISB 1512 Information Governance Standards Framework.

Conformance criteria

IT systems used to record people's needs comply with legal information governance requirements for data security and confidentiality to ensure the data is secure and protected when it is viewed, transferred and stored.
IT systems adhere to existing information governance standards and frameworks and comply with ISB 1512 Information Governance Standards Framework.

Activities beyond the scope of the standard

The following areas are relevant to improving the accessibility of health and adult social care but are out of scope of the standard:

- meeting the needs or preferences of staff, employees or contractors of the organisation
- organisations' corporate communications that do not relate to people's care or services and do not directly affect individuals' health or wellbeing (for example, board papers)
- aspects of the Equality Act 2010 that do not relate to the provision of information or communication support (for example, ramps)
- meeting spoken language needs or provision of information for people who require information in a language other than English for reasons other than disability.

- signage standards (covered under the Equality Act 2010) and building regulations (see 'Access to and use of buildings: Approved Document M')

Health and social care websites

The Public Sector Bodies (Websites and Mobile Applications) (No. 2) Accessibility Regulations 2018 cover the accessibility of health and social care websites.

However, the standard is relevant in circumstances where a health or social care professional would usually refer people to a website for information. In these instances, it is the duty of the professional – and their employing organisation – to verify that the website is accessible to the individuals being referred and if it isn't, to provide the information in another way.

For example, if a GP would usually direct a patient newly diagnosed with diabetes to information on the practice's website about diabetes, they must check with the patient that they are able to use the website for this purpose. If the website is inaccessible to them as a result of their disability, the GP must provide the information in an alternative format.

Organisations must continue to review and improve the accessibility of their websites so they comply with the legislation and the standard. Increasing web and digital accessibility will reduce, although never remove, the need to produce information in alternative formats.

People should be able to do the following on health and social care websites:

- use web browsers to change colours, contrast levels and fonts
- zoom in up to 300% without the text spilling off the screen
- navigate most of the website using just a keyboard
- navigate most of the website using speech recognition software
- listen to most of the website using a screen reader (including the most recent versions of JAWS, NVDA and VoiceOver)
- access the website using a mobile or tablet device

Website content should be as easy to understand as possible.

Read the NHS digital service manual for advice on building accessible NHS digital services (including websites).

The Government Communication Service explains the relevant standards and provides resources and support. The standard's implementation guidance contains further information.

Meeting spoken language needs

The provision of a language other than English interpretation or translation is out of scope of this standard.

However, organisations **should** record details of individuals' spoken language interpretation or translation needs when they record information and communication support needs in line with the standard.

The NHS website provides advice and resources on health information in other languages.

Meeting the needs of individuals with low literacy or a non-disability related communication barrier

Difficulty in reading or understanding information for reasons other than a disability, impairment or sensory loss (for example, people with low literacy) is not covered by the standard.

The focus of the standard is on accessibility needs where an individual's condition meets the Equality Act 2010 definition of disability. This means that where an individual's condition (for example, dyslexia) meets the definition of a disability it is included in the standard.

Read more about how to improve the quality and accessibility of health information for people with low literacy.

There are clear benefits to expanding organisations' activities as part of the standard to include individuals who would not meet the Equality Act 2010 definition of a disability but experience communication barriers. Local areas are free to develop their own additional criteria.

Corporate communications (including consultations and engagement)

Corporate communications aimed at informing people about the corporate activities or intentions of an organisation – and have no direct interaction with an individual's health, wellbeing or access to services – are excluded from the scope of the standard.

Examples of these types of content that would typically be excluded include annual reports and accounts, strategy and policy documents, meeting papers, consultation documents and reports.

The standard does not cover communications with employees (including prospective and former staff), volunteers, consultants, advisors or other internal audiences

However, organisations are reminded of their existing legal obligations under the Equality Act 2010, , NHS Act 2006 and Health and Social Care Act 2012to respond to requests for information, to reduce inequalities and to avoid discriminating against 'protected characteristic' groups when making decisions about the publication and availability of corporate documents in alternative languages and formats.

In the case of consultation and engagement activities, organisations should read Guidance on working in partnership with people and communities.

Signage

Signage is not within the scope of the standard.

What is the legal and regulatory framework for the standard?

The law and professional standards

The Equality Act became law in October 2010. The Accessible Information Standard is issued under s. 250 of the Health and Social Care Act 2012 and supports public bodies to comply with their duties under the Equality Act 2010.

The Equality Act 2010 covers all the groups that were protected by previous equality legislation and describes them as "protected characteristics". One of the protected characteristics is disability.

The Equality Act 2010 places an anticipatory legal duty on all service providers (which will also include many commissioners) to take steps or make "reasonable adjustments" to avoid putting a disabled person at a substantial disadvantage (that means a disadvantage that is "more than minor or trivial") when compared to a person who is not disabled.

Schedule 2 of the Act says this duty applies to organisations providing a public function and explains how the anticipatory duty "means service providers and people exercising public functions must anticipate the needs of disabled people and make appropriate reasonable adjustments". The Act is explicit that, where the circumstances require it, information should be provided in "an accessible format" (section 20(6)) as part of reasonable adjustments for people who have a disability.

In addition, the Care Act 2014 specifies duties for local authorities around the provision of advice and information. These include the requirement that "information and advice provided under [section 4] must be accessible to, and proportionate to the needs of, those for whom it is being provided."

Many professional bodies and regulators provide support for improving communication as part of their codes of conduct or similar statements of expected behaviour. For example, The Code: Professional standards of practice and behaviour for nurses and midwives (Nursing and Midwifery Council, 2015) says: "you must: […]take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs [and] use a range of verbal and non-verbal communication methods."

Care Quality Commission Assessment Framework

The Care Quality Commission (CQC) has revised its approach to assessment, with a new assessment framework.

The AIS is not assured by the CQC, that is the role of the commissioner. However, the performance of organisations in meeting people's needs is considered in CQC assessment of providers. Where the CQC has learned that an organisation is not meeting accessible communication and information needs, it may act.

More information about the CQC assessment framework is on the CQC website.

The Accessible Information Standard also relates to a number of the CQC's fundamental standards (including: person-centred care; dignity and respect; consent; safety; safeguarding from abuse; food and drink; premises and equipment; complaints; good governance; staffing; fit and proper staff; and the duty of candour).

The Accessible Information Standard Self-Assessment Framework supports organisations to understand how they perform against the standard, and to publish a performance rating and action plans to address gaps in provision. It helps organisations, commissioners and CQC to judge performance and compliance and improve assurance.

This provides an indicator for the CQC to assess when determining further action. Where the CQC has information through the Self-Assessment Framework, or other sources, that an organisation is not meeting people's needs, it may take action.

Organisations can also use their performance against the standard as evidence in their completion of the Equality Delivery System and other equality performance frameworks.

Other relevant standards

Organisations should refer to the following when implementing the standard:

- Mental Health Services Data Set (DAPB0011)
- Clinical risk management: its application in the deployment and use of health IT systems (DCB0160)
- Clinical risk management: its application in the manufacture of health IT systems (DCB0129)
- Information Governance Standards Framework (ISB 1512)
- SNOMED CT (SCCI0034)
- Secure Email (DCB1596)
- Reasonable Adjustment Digital Flag Information Standard (DAPB4019; see below)

In line with established assurance arrangements and governance processes, the standard will be reflected in other information standards as part of their scheduled review processes.

Standards for the clinical structure and content of patient records

The standard provides indicative content for the 'Special requirements' sub-heading set out in Standards for the Clinical Structure and Content of Patients Records from 2013. Subsequently, the Professional Records Standards Body (PRSB), an independent member organisation representing colleges, professionals and patient groups, was established to develop and promote the use of standards for digital health and care records.

The PRSB standards build on the 2013 work and include standards for the structure and content of patient records covering hospital referral letters, inpatient clerking, handover communications, discharge summaries, outpatient letters, care planning and discharge to care homes. These standards are developed using published evidence and consultation with health and care professionals and patient representative groups.

We'll continue to engage with the PRSB with a view to including specific reference to and direction about the inclusion of the data items associated with the 4 subsets of the standard as part of the 'Special requirements' sub-heading.

Reasonable Adjustment Digital Flag Standard

The Reasonable Adjustment Digital Flag Standard (DAPB4019) sets out the requirements for the digital flagging of reasonable adjustments.

Digital flagging of reasonable adjustments enables local and inter-organisational identification and sharing of these adjustments, ensuring they are recognised, highlighted and implemented as required by the Equality Act 2010. NHS England has built the Reasonable Adjustment Digital Flag in Spine to enable professionals to record, share and view details of reasonable adjustments across the NHS, wherever the person is treated.

Annex A: Why has the Accessible Information Standard been revised?

The Accessible Information Standard has been revised to incorporate statutory changes since its initial publication in 2016, and to improve adherence and compliance using the evidence of lessons learned from the Covid-19 pandemic.

The team worked with a wide range of stakeholders including people with lived experience, charities, regulators, commissioners and providers to assess whether the standard was being effectively implemented to meet people's information and communication needs.

That engagement and further reports from Healthwatch and SignHealth demonstrated that people's information and communication needs were not consistently being met.

Annex B: Glossary

- **Accessible Information Standard / AIS / Standard**: Refers to this document, which sets out how to identify, record, flag, share, meet and review the information and communication support needs of people with a disability, impairment or sensory loss, and their families and carers.

- **Advocate**: Advocates include but are not limited to health and healthcare advocates, patient advocates, patient navigators, health or patient advisers, care managers and case managers, as well as those who work on behalf of communities, consumers and family caregivers (including advocacy on legislative and health policy initiatives). Advocates may work independently, in a medical setting, or on behalf of communities or specific populations across organisations and agencies. The code of ethics for patient and health care advocates provides more information.

- **Accessible information**: Providing information for people who fall within scope of the Accessible Information Standard in a range of formats that can be read and understood by the individual or group for which they are intended.

- **Accessible Information Standard lead**: An individual who is responsible for ensuring the Accessible Information Standard is implemented in their organisation.

- **Alternative format**: Information provided in an alternative to standard printed or handwritten English (for example, large print, Braille or email).

- **Blind or Partially Sighted**: See 'Severely Sight Impaired' or 'Sight Impaired' below.

- **Braille**: A tactile reading format used by people who are blind, deafblind or who have low vision. Readers use their fingers to 'read' or identify raised dots representing letters and numbers. Not all blind and partially sighted people use Braille. Although originally intended (and still used) for paper-based communication, Braille can be used as a digital aid to conversation, with some smartphones offering Braille displays. Refreshable Braille displays for computers also enable Braille users to read emails and documents if they are formatted correctly.

- **British Sign Language (BSL)**: The signed language of the Deaf Community in the UK. BSL is a complex visual spatial language. It involves a combination of hand shapes, facial expressions, lip patterns and body language. BSL has its own grammar and sentence structure and is not a signed equivalent of English.

- **BSL interpreter**: A trained and registered professional skilled in interpreting between BSL and English. A type of communication support that may be needed by a person who is deaf or deafblind.

- **Carer**: A carer is defined in the Care Act 2014 as an adult who provides or intends to provide care for another adult. This includes the provision of practical or emotional support. When used in this standard, a 'carer' is anyone, including children and adults, who looks after a family member, partner or friend who, because of an illness, frailty, disability, mental health problem or addiction, cannot cope without their support. When we refer to carers in this standard, we mean adult and young carers.

- **Communication support**: Support that is needed to enable effective, accurate dialogue between a professional and a service user.
- **Communication tool or communication aid**: A tool, device or document used to support effective communication for and with an individual. Tools or aids can be generic or bespoke to an individual. They often use symbols or pictures. They range from a simple paper chart to complex digital and electronic tools.
- **d / Deaf**: A person who identifies as being deaf with a lowercase d is indicating they have a significant hearing impairment. People who have lost their hearing later in life may be able to speak and / or read English to the same extent as a hearing person. A person who identifies as being Deaf with an uppercase D is indicating they are culturally Deaf and belong to the Deaf community. Most Deaf people are sign language users who have been deaf all their lives. It should be noted that for some Deaf people whose first language is BSL, there may be some barriers to them reading, writing or speaking English.
- **Deafblind**: The widely accepted definition of deaf blindness, established by the Department of Health and Social Care and reiterated in its guidance Care and Support for Deafblind Children and Adults (2014) is: "A person is regarded as deafblind if their combined sight and hearing impairment causes difficulties with communication, access to information and mobility. This includes people with a progressive sight and hearing loss".
- **Disability**: As defined in the Equality Act 2010, a physical or mental impairment that has a substantial and long-term adverse effect on a person's ability to carry out normal day-to-day activities.
- **Disabled person**: A person who has a disability, as defined in the Equality Act 2010.
- **Easy read**: A format created to help people with learning disabilities understand information easily, using pictures to support text. Often used by carers to explain communications to someone with learning difficulties.
- **Impairment**: A physical or mental condition that has substantial and long-term negative effects on a person's ability to carry out normal day-to-day activities, as referenced in the Equality Act 2010.
- **Family**: Family members or other individuals (such as friends or members of an individual's support network) without formal caring responsibilities who are supporting a person accessing services.
- **Interpreter**: A trained professional able to transfer meaning from one spoken or signed language into another spoken or signed language when in scope of the standard.

- **Learning disability**: Defined by the Department of Health in Valuing People (2001) as involving life-long development needs and difficulty with certain cognitive skills, varying greatly between individuals.
- **Lipreading**: A way of understanding speech by visually interpreting the lip and facial movements of the speaker, used by some people who are deaf, have hearing loss, or are deafblind.
- **Lipspeaker**: A hearing person professionally trained to be easy to lip-read, who reproduces what a speaker is saying clearly using facial expressions, gestures and fingerspelling. May offer lip speaking with sign support.
- **Low vision**: An impairment of visual function that impacts quality of life, either permanently or temporarily, that is not fully correctable through surgery, pharmaceuticals, spectacles or contact lenses.
- **NHS services**: As defined in the Health and Social Care Act 2012, services arranged by NHS England or an integrated care board, including those arranged through functions of another person under the National Health Service Act 2006.
- **Parent**: Any person who holds parental responsibility for a child, as defined by the Children Act 1989.
- **Patient Administration Systems (PAS)**: IT systems used to record patients' contact or personal details and manage interactions such as referrals and appointments, primarily used in hospital settings.
- **People**: Refers to patients, service users or others communicating with NHS or adult social care services where information and communication needs relate to a disability, impairment or sensory loss.
- **Read codes**: A coded thesaurus of clinical terms representing the clinical terminology system used in general practice, with two versions (v2 and v3/CTV3) used for recording patient findings and procedures.
- **Severely Sight Impaired or Sight Impaired**: People certified by an ophthalmologist using the Certificate of Vision Impairment (CVI) guidance, with vision impairment that is not fully correctable and significantly impacts quality of life.
- **Speech-to-text-reporter (STTR)**: Someone who types a verbatim account of what is being said, with the information appearing on screen in real time. May provide a transcript or present text in alternative formats.
- **SNOMED CT**: Systematised Nomenclature of Medicine Clinical Terms – a classification of medical terms and phrases providing codes, terms, synonyms and

definitions, managed internationally by SNOMED International and in the UK by the UK Terminology Centre.

- **Text Relay**: A service enabling people with hearing loss or speech impairment to access the telephone network through a relay assistant who converts speech to text and vice versa, including British Telecom's 'Next Generation Text' service.
- **Translator**: A person able to translate written content into a different signed, spoken or written language, requiring different skills and qualifications from an interpreter.

Signed: PA

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