THE STATE HOSPITALS BOARD FOR SCOTLAND

SUPPORTING PATIENT AND CARER INVOLVEMENT (incorporating Interpretation, Communication Support and Translation Policy)

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Lead Author	Person Centred Improvement Lead	
Contributing Authors	Director of Nursing, AHPs and Operations	
	Consultant Psychiatrist – Forensic Network Clinical Lead for Intellectual Disabilities (ID)	
	Lead AHP	
	Clinical Nurse Specialist – ID	
	Professional Nurse Advisor	
	Senior Nurse Infection Control	
	Senior Nurse Practice Development	
	Speech and Language Therapist	
	Head of Procurement	
	Information Governance and Data Security Officer	
	Head of Communications	
	Patient Partnership Group	
	Carers' Support Group	
	Patients' Advocacy Service	
	Health Improvement Scotland	
	Carers' Trust (Scotland)	
	Deafscotland	
	Royal National Institute for Blind People	
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This policy update incorporates the national Interpreting, Communication Support and Translation Policy (ref. 33), which supersedes the local Interpretation and Translation Policy.

The date for review detailed on the front of all State Hospital policies/ procedures/ guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy/ procedure/ guidance at any time due to organisational/legal changes. Staff are advised to always check that they are using the correct version of any policy/ procedure/ guidance rather than referring to locally held copies. The most up to date version of all State Hospital policies/ procedures/ guidance can be found on the intranet:
http://intranet.tsh.scot.nhs.uk/Policies/Policy%20Docs/Forms/Category%20View.aspx

This policy has been produced using font size 12, recognised as the minimum font size to support accessibility.

REVIEW SUMMARY SHEET

No changes required to policy (evidence base checked)	☐

Changes required to policy (evidence base checked)	☒

Summary of changes within policy:

The Interpretation and Translation Policy (PCIS01) has been combined with this policy (PCIS05) as the content of both policies relates to supporting stakeholders to communicate effectively.

There are a considerable number of changes, including some fundamental changes to the approval process for use of external service providers.

CONTENTS

1. PURPOSE

The State Hospital (TSH) has a legislative responsibility to ensure that all patients, carers and Named Persons are supported to communicate effectively, in a form, language and manner that enables them to understand the information shared by the Hospital (Equality Act, 2010 (ref 20)) (the Act).

Communication is the two-way process of transferring information and understanding between people during which they reach a mutual understanding. The participants not only exchange (encode-decode) information and feelings but also create and share meaning.

The Act states that the Hospital must ensure that information is accessible to disabled people, including carers.

For the purposes of this policy the word 'carer' is used to describe those who have regular contact with the patient and Clinical Team, may attend Care Programme Approach / Mental Health Tribunal Meetings, and, with the patient's consent, have access to relevant information relating to care and treatment. This descriptor therefore includes named persons, nearest relatives and any other person the patient identifies as a 'carer'.

The policy acknowledges this human right and supports The State Hospitals Board (the Board) to implement a framework which encourages patients and carers to meaningfully engage in all aspects of care and treatment, demonstrating a person centred approach.

Through implementation of this policy, the Board will:

- Ensure that patient and carer language and communication needs are met in order to facilitate equality of access to services.
- Minimise the risk around potential miscommunication with patients and carers.
- Ensure a consistent approach to the provision of language and communication support mechanisms.
- Meet legal, moral and ethical obligations.
- Ensure the most effective and appropriate use of language and communication support tools.
- Foster good relations between all stakeholders.
- Support patients and carers to contribute meaningfully to service improvement.
- Ensure a cost effective approach.
- Demonstrate a commitment to overcome potential discriminatory practice.
- Embed best practice to support Protected Characteristic groups.

The key aim of the policy is to ensure the right messages reach the right people, in the right format, at the right time.

Through effective communication, the Board can manage, motivate, influence, explain and create conditions for change. Effective communication is more than the exchange of information. It involves the management of relationships and the need for involvement based on personal preference in relation to the style of language / communication. Communication is as much about attitude and behaviour as it is about the information being relayed. It is also a dynamic two-way process. As well as informing and sharing, it is essential that we listen and respond to incoming communication. Every member of staff whose role requires the need to communicate with patients, and carers shares the responsibility for effective communication.

From a patient safety and quality perspective, communication barriers between patients and staff reduce the quality of healthcare delivered, Language, cultural and communication barriers increase the risk of misunderstandings and, within TSH can contribute to an increase in violence / aggression as a result of frustration and / or incorrect assumptions.

Support to communicate effectively enables patients to participate and make informed choices about their care. For staff, it enables therapeutic relationship building, assists with diagnosis, identifies behavioural triggers, informs effective assessment and helps in the process of obtaining informed consent. Ensuring that carers understand diagnosis, care and treatment plans, intervention and medication supports a collaborative approach to recovery.

Poor communication can contribute to non-compliance with treatment, cancelled / missed appointments, delayed transfer and exposure to litigation for negligence and errors.

Providing support to communicate for individuals who do not have effective language mitigates risks because the individual is enabled to:

- Give informed consent.
- Ask questions / seek assistance.
- Provide / confirm information.
- Understand available options for treatment.
- Engage effectively in care and treatment planning.
- Understand rights / responsibilities.

The policy provides information which supports staff to communicate effectively with all stakeholders. The guidance specifically prompts staff to ascertain that information shared, whether locally prepared or through external sources, is in plain English and / or easy read, other languages / formats e.g. Braille, without jargon and with minimal use of acronyms (which are always explained). The policy promotes the sharing of written messages which are clear and concise, avoid the use of 'management language' and support the recovery approach explicitly through the use of partnership language e.g. 'we', 'us', 'together'.

The policy encourages a proactive approach to communication, advocating a planned and considered model to ensuring communication activity is appropriate and timely, delivered in a coordinated way, without contradictions. Barriers to communication should be anticipated and planned processes applied to deal with them.

The policy provides information to support staff to communicate information and messages in a variety of ways, to maximise their effectiveness, recognising that patients / carers do not always absorb all information on first hearing, giving them the opportunity to ask questions at the time or at a later date.

The policy also supports the Board to develop local practices which demonstrate a tailored approach to enabling the meaningful involvement of stakeholders within the Care Programme Approach (CPA) process highlighted as a priority as one of the Board's Equality Outcomes, 2017-22.

In recognition of the need to ensure staff are appropriately trained in this area, the policy also supports the ongoing continuing professional development of staff whose role requires communication with patients / carers.

As one of its strategic objectives, the Board is committed to addressing health inequalities, paying due regard to statutory duties and national guidance, including:

- Equality Act, 2010, Scottish Government.
- Mental Health (Care and Treatment) (Scotland) Act, 2015, Scottish Government.
- The Human Rights Act, (Scotland Act), 1998, Scottish Government.
- A Fairer Scotland for Disabled People: delivery plan, 2016, Scottish Government
- Patient Rights (Scotland) Act, 2011, Scottish Government.
- The Charter of Patient Rights and Responsibilities, 2019, Scottish Government.
- Carers (Scotland) Act, 2016, Scottish Government.
- Augmentative and Alternative Communication (AAC) – Communication equipment and support: Part 4 of the Health (Tobacco, Nicotine etc. and, Care (Scotland) Act, 2016, Scottish Government.
- Race Relations Act, 2002, Scottish Government.
- The Healthcare Quality Strategy for NHSScotland, 2010, Scottish Government.
- Clinical Strategy, 2016, Scottish Government.
- Mental Health Strategy, 2017-2027, Scottish Government.
- Health and Social Care Delivery Plan, 2016, Scottish Government.
- British Sign Language (BSL) National Plan, 2017-2023, Scottish Government.
- Realistic Medicine, 2017-2025, Scottish Government.
- 'Keys to Life: Improving quality of life for people with learning disabilities', 2013, Scottish Government.
- 2020 Vision for Health and Social Care, 2011, Scottish Government.
- Active and Independent Living Programme, 2017, Scottish Government.
- 'Five Must Dos', 2012, Scottish Government, Person-Centred Health and Care Collaborative.
- Making it Easier: A Health Literacy Action Plan for Scotland, 2017, Scottish Government.
- 'See, Hear' Strategic Framework, 2014, Scottish Government.
- Scotland's National Dementia Strategy, 2017-2020, Scottish Government.
- 'House of Care', 2016, Scottish Government.
- 'Excellence in Care', 2015, Scottish Government.
- Interpreting, Communication Support and Translational National Policy, 2020, Public Health Scotland.

The policy calls for a robust approach to consideration of the individual language and communication needs and preferences of patients and carers, including those with any barriers to language / communication as a result of physical and/or mental health presentation at the time of the communication.

The policy contributes to addressing feedback relating to enabling and supporting patient involvement, following the 2018 Forensic Network Continuous Quality Improvement Framework Peer Review Visit: High Secure Mental Health & Learning Disability Forensic Services.

The policy reassures the Board that the way in which information is shared is fit for purpose, cost-effective, within budget and delivered within a reasonable time frame. TSH operates within a context of finite and reducing budgets, caring for a small number of patients (117 currently). Supporting communication needs therefore calls for a commitment to direct resources to have the biggest impact on those with the greatest need.

2. SCOPE

Implementation of the policy applies to all staff and volunteers, where appropriate, whose role requires communication of any type with TSH patients / carers at any stage of the recovery journey.

TSH is responsible for ensuring that any information provided to patients / carers by partner organisations external colleagues / contractors etc complies with local standards and that any amendments are made to the content by the person sharing the information prior to being shared with patients / carers. As partners in the delivery of care / support, reasonable costs incurred by service led agreement providers including, however not limited to: Social Work, Pharmacy and the Patients' Advocacy Service (PAS) are included within TSH financial arrangements.

There are processes in place to determine barriers to language and communication as part of the patient admission process, including completion of the Pre-Admission Specific Needs Form. It is more difficult to establish the needs of a carer in relation to communication in the absence of information. However, the organisation has a duty to pay due diligence to supporting this group of stakeholders to be meaningfully involved in the work of the Hospital. Clinical Teams are therefore expected to encourage carers to discuss preferred methods of communication.

It is not feasible to include all barriers to language and communication in terms of informing this policy. The framework has been developed to support the language and communication needs of TSH patients/ carers whose needs are currently known to the organisation. Additional information will be added to the policy in response to changing communication needs as required throughout the duration of the policy.

The Person Centred Improvement Lead remit incorporates that of TSH Equality Lead, specifically responsible for ensuring the needs of Protected Characteristic groups, (including patients / carers with any disability) as defined within the Equality Act, 2010 are considered as a fundamental element of service delivery.

TSH Equality Impact Assessment process requires the organisation to consider the impact of decisions made about service design in relation to patients and carers. One of the components of this assessment process requires detailed consideration of the needs of a range of stakeholders including those with specific needs related to barriers to language and communication within the Protected Characteristic Disability group.

Clinical Teams work closely with the PAS, whose input supports patients to communicate effectively with a wide range of multi-agency stakeholders including, however not limited to, TSH staff, Social Work, Mental Health Officers, Lawyers, Mental Health Tribunal Service, Police Service, Mental Welfare Commission, Scottish Public Services Ombudsman. This independent support ensures that there is an unbiased approach where there is the potential for conflict of interest e.g. supporting patients to communicate concerns relating to care and treatment.

It is important to ensure a consistent approach is adopted across all areas of service delivery in relation to supporting what has been agreed with the patient / carer as the preferred method of communication.

Within TSH patient and carer populations, there is a wide range of barriers to communication. This policy highlights those which are more prevalent, contributing to health inequalities:

3. INTELLECTUAL DISABILITY

Most people with intellectual disabilities (ID) experience a degree of speech, language and communication difficulties, many also experience sensory impairment, including a large number with undiagnosed hearing loss (Royal College of Speech and Language Therapists, 2013 (ref 14)).

Barriers to communication result in people with ID having difficulties expressing themselves through both spoken and written modalities, in addition to understanding others and comprehending mainstream written information. Communication difficulties, including social interactions, of patients with ID can result in challenging behaviour, leading to some being prevented from accessing placements and socialising with peers, who are important to their recovery (Scottish Commission for Learning Disability, 2015 (ref 18)).

All TSH staff and volunteers who interact with patients / carers with ID require to be equipped with the skills to make reasonable adjustments, which support meaningful involvement and inclusion in all aspects of care and treatment. Continuity of care/ support is important to achieve successful transfer, achieved through collaborative working with step-down services. The development of transferable care and treatment planning communication processes, which meaningfully engage patients and carers, should be an integral part of TSH ID care pathway.

Speech and Language Therapy (SLT) input is paramount to delivering a person-centred approach, supporting the Clinical Team to develop skills and knowledge to identify reasonable adjustments and introduce tailored processes which encourage patients with ID to make choices, assume responsibility for recovery and improve personal outcomes.

'Easy Read' documents are used to make information more accessible (refs 4, 13, 14, 16) for patients with ID. This format uses short, simple sentences, often with pictures, which are developed either for general use (e.g. patient related policy, menu) or tailored for use with one patient (e.g. CPA review paperwork, Advance Statement).

A range of additional resources can be used to support language and communication, based on the patient's / carer's preference, including 'Makaton Sign Language' (ref 10), which uses signs and symbols to support spoken language and 'Talking Mats' (ref 29), which help patients to organise their thoughts and express their views. In order to ensure consistency of use and appropriate clinical supervision support is in place, staff should be trained in the use of these language and communication support tools.

Regular conversations with a patient / carer with ID may be the preferred communication style. Audio recordings (e.g. CD, MP3) and / or film (e.g. DVD, supervised internet sites including 'You Tube') are also helpful when considering a range of options to support language and communication.

The Forensic Network Clinical Lead for Intellectual Disabilities is responsible for ensuring that TSH ID patients and their carers are meaningfully involved in all aspects of care and treatment.

TSH patients with an ID who need to engage in legal processes require to have an advocate present, with whom the patient has an established relationship, to support effective engagement.

4. ACCESSIBLE INFORMATION

Providing accessible information (AI) is a key element of promoting health literacy, crucial to empowering patients and carers to engage as partners in the recovery journey and reducing health inequalities.

Any barriers to communication should be established either through the referral / pre-admission process, or as they become apparent on admission. Any issues should be highlighted with everyone who is required to communicate with the patient / carer. This process will ensure that standardised written information, which the patient / carer is unable to understand, is not provided as a matter of routine.

On request, TSH is legally required to produce information in accessible formats, adopting the principles of Plain English (ref 13). It is best practice, when creating a document for TSH patient use, to develop an AI version at that time.

Patients / carers with an ID are experts on AI (Change People, 2016 (ref 4)). TSH Patient Partnership Group (PPG) membership includes patients who experience a wide range of barriers to language and communication. The monthly Communications Meeting provides a useful forum for authors drafting / updating written information to seek the views of patients whose communication needs call for an AI approach.

AI includes printed, electronic, face-to-face and telephone communication and covers all areas of access to information including:

- Alternative formats;
- Support for patients to attend meetings e.g. note-takers.

TSH is responsible for the cost of ensuring patient information is developed and produced using AI principles and must not seek reimbursement for individually tailored communication from patients and / or carers.

The organisation is committed to ensuring that AI skills are developed across the Hospital in order to ensure that Clinical Teams can respond quickly to individual patient/ carer needs. The Person Centred Improvement Lead is responsible for providing AI training. Hub Leadership Teams are responsible for identifying staff within each Clinical Team, who would benefit from completing AI Training, whose role will include responsibility for adapting patient information to AI format.

Access to a range of materials / resources is available via TSH intranet. The Person Centred Improvement Lead has access to a wide range of ID resources through the NHS Equality and Diversity Lead network and wider network groups.

5. SPEECH, LANGUAGE AND COMMUNICATION NEEDS

Speech, language and communication needs (SLCNs) include speech, voice, language and social communication difficulties. Speech disorders (dysarthria, apraxia of speech, dysfluency, phonological and articulation difficulties) result in reduced intelligibility of speech. A voice disorder (dysphonia) is where there are changes to the sound of the voice itself. Language difficulties (often related to ID) and disorders (aphasia) result in reduced understanding of information and difficulties with expression, often including reading and written skills. People can also have difficulties with social communication skills (including turn taking, topic maintenance, body language) impacting on social interactions and relationships. Speech, language and social communication difficulties often co-occur.

Clinical Teams should ensure that the referral form, available via the intranet, is completed requesting Speech and Language Therapy (SLT) input to ensure a consistent approach to enabling the patient to communicate effectively - *note this referral relates to clinical input available locally and therefore differs from the wider referral form (appendix 1) which should be used for different types of support.*

6. DYSLEXIA

Dyslexia is a common learning difficulty that can cause problems with reading, writing and spelling. Intelligence is not affected.

The signs and symptoms of dyslexia differ for individuals who will have a unique pattern of strengths and weaknesses.

Common signs of dyslexia include difficulty / slow labour-intensive reading and writing, reading aloud, problems spelling, avoiding activities that include reading / writing, mispronouncing names / words, problems retrieving words. Because word reading takes more time and focus, the meaning of the word is often lost and reading comprehension is poor.

Patients / carers may transfer to TSH with a formal diagnosis of dyslexia and be able to describe what works best for them in terms of supporting communication. Many patients have had limited exposure to consistent educational support in formative years, and as a result, may not have been formally tested for dyslexia.

7. AUTISTIC SPECTRUM DISORDER

Autism is a lifelong, developmental condition that affects how a person communicates with and relates to other people and how they experience the world around them. Autism is a spectrum condition and affects people in different ways. Some may not speak, or have fairly limited speech and will often understand more of what is said to them than they say.

Autistic people have difficulties with interpreting both verbal and non-verbal language (e.g. gestures, tone of voice). Many have a very literal understanding of language and assume people mean exactly what they say, which can cause issues when a joke / sarcasm is used. Intense and highly-focused interests are common and often reported as fundamental to wellbeing (The National Autistic Society (ref 29)).

Echolalia, where a person is repeating words, often words which others have said, may indicate a lack of understanding of the question and / or how to respond. Visual support may be helpful in terms of supporting the person to work through this.

Some autistic people prefer to use sign language and / or visual symbols (e.g. Makaton (ref 10)), Widgit Symbols (ref 32), which can be accessed through TSH subscription to 'Photosymbols'. TSH Access to 'Boardmaker', an additional resource which can be used to support barriers to communication, is available within Iona 2 or via SLT.

Autistic people may find it difficult to form friendships. Visual supports can help encourage independence, build confidence, improve understanding, avoid frustration and anxiety and provide opportunities to interact with others.

People with Asperger syndrome are of average or above average intelligence and have fewer problems with speech than autistic people experience.

When supporting TSH patients / carers with autism, it is important to acknowledge that, as adults, support processes and resources need to be age appropriate, tailored to individual need and delivered consistently.

Communicating effectively with TSH patients / carers who are autistic is particularly important in relation to risk management processes. Communication issues can present as challenging behaviour, including non-compliance, self-harm, biting, spitting and / or hitting. Changes in routine, sensory stimuli, including minor changes to the environment, can trigger challenging behaviour.

TSH patients who are autistic and need to engage in legal processes require to have an advocate present, with whom the patient has an established relationship, to support effective engagement.

8. SENSORY IMPAIRMENT

"Meeting the communication needs of people with a sensory impairment is fundamental to ensuring that they can engage with the care pathway, and is an essential element in their everyday lives." (See Hear, Scottish Government, 2014 (ref 27)).

The term 'sensory disability' in the context of this policy document is used to describe deficits in the sensory functions of hearing and vision.

"People with a sensory disability experience life with their individual disability in a completely different way to others who may be classed as belonging to the same group – no two people will be exactly the same and services should not be delivered as if they were" (NHS Education for Scotland, 2014 (ref 12)).

The largest cause of sensory disability is the ageing process, which is very relevant with mainstream population demographics which may correlate with an ageing TSH patient population. However, injury, physical trauma and / or prolonged exposure to loud music are also common causes of hearing impairment.

Hearing Impairment: Four Pillars of Deafness

This term describes Deaf, Deafblind, Deafened and Hard of Hearing people and reflects the different barriers people with different levels of deafness have to overcome, which call for different language and communication support needs (Scottish Council on Deafness (ref 19)).

Deaf – born deaf - usually refers to a person born with very little or no functional hearing, who often uses sign language to communicate.

Deafblind - a person who has difficulties seeing and hearing is described as 'deafblind'. This combination of sensory impairment normally means that a deafblind person will not benefit fully from services for deaf people or services for blind people. Meeting the complex needs of deafblind patients therefore calls for a tailored approach, with specialist communication methods and systems required to enable communication (Deafblind Scotland (ref 6)). The terms dual sensory loss and dual sensory impairment are often used interchangeably.

A person who is Deafblind may need written information in an accessible format such as audio, Braille, Moon (both tactile methods) or via e-mail. The guide / communicator uses the index finger as a 'pen' pointing to different finger positions on the Deafblind person's hand or drawing letter shapes on the person's palm. Some Deafblind people use screen readers, which convert text to speech, and other assistive technologies.

Deafened – acquired deafness - refers to a person who becomes deaf, often as an adult, experiencing different challenges to those who have been deaf since birth. Language issues generally depend on when the change happens.

Hard of Hearing – refers to a person who has a mild-to-moderate hearing loss, who may communicate through sign language, spoken language or both.

Amplification of residual hearing may be made possible with a hearing aid/hearing loop/microphone, lip reading, electronic note takers, subtitles and captions also help.

'D/deaf' is often used to abbreviate the words 'deaf' and 'hard of hearing', with people describing themselves using a variety of descriptors including:

- Deaf person with a visual impairment.
- Dual sensory impaired.
- Hard of hearing with a sight loss.
- Blind with a hearing impairment.

Indications that a person may have a hearing impairment include:

- Use of a hearing aid.
- Use of sign language.
- Failing to react to voices behind him/her.
- Difficulty interacting within a group.
- Turning up the TV, radio volume.
- Failing to respond to sound cues e.g. telephone, doorbell, staff PA, fire alarm.
- Leaning forward and looking intently at the speaker's face.
- Giving inappropriate responses.
- Asking for repetition of what was said.

People often adopt coping strategies to unintentionally conceal their impairment and it may be some time before others are aware which may impact on progression through e.g. psychological therapies, outcomes of clinical assessments, engagement in CPA Meetings.

The ability of people who are D/deaf to read and understand written English varies considerably. It should not be assumed that because someone is using one or more hearing aids, they no longer require any support to communicate as they may be supporting their hearing via lip reading.

People with a hearing disability can choose from a number of language and communication access methods, including sign language, textphone, lipreading, fingerspelling, written, speech to text, determined by many factors to do with their experience and the nature and degree of their deafness.

Electronic note takers type a summary of what is being said on a computer and this information appears on the D/deaf person's screen.

It is important to establish the person's preferred way of language way of communicating as soon as possible and to share this information with everyone who requires to interact with the patient / carer before initial contact.

Different factors require to be considered depending on whether interactions are on a 1:1 basis or within a group setting.

Environmental adaptations e.g. acoustic dampeners, hearing loops, microphones, furnishings, use of space should be considered as part of individually tailored support mechanisms.

For those with a hearing loss, who can understand English, subtitling on any video information is essential and should be added as standard to all video relayed information.

British Sign Language

British Sign Language (BSL) is a language in its own right, with its own grammar, syntax, vocabulary and dialects. Many Deaf people define BSL as their first or preferred language, including those who receive the language in a tactile form due to sight loss (Scottish Government, 2017 (ref 22)).

TSH BSL Action Plan (2018-24 (ref 31)) should be used as a reference tool to support understanding of the language and communication needs of BSL users,

Deaf patients / carers should be involved in the choice of interpreter (British Deaf Association, 2012 (ref 3)) who should be experienced in working with inpatients with a mental health disorder. There is a national shortage of BSL interpreters, therefore an anticipatory approach is required in order to ensure the patient / carer is supported to meaningfully engage in key elements of care and treatment (e.g. CPA process, Tribunals, clinical appointments, formal assessments). Staff should be familiar with the guidance (ref 35) in relation to working with BSL interpreters in order to support effective communication.

It should not be assumed that a BSL user can communicate in written English as this may not be their first language.

A BSL video version of information will ensure equitable accessibility to people who are D/deaf who use this language. BSL videos should be commissioned from an organisation which specialise in their production.

Contact Scotland provides a video relay service for D/Deaf and Deafblind people http://contactscotland-bsl.org.

E-learning resources are available including BSL and Tactile BSL Awareness and Making Communication Better via the TURAS platform.

Visual Impairment

The term ‘visual impairment’ in the context of this policy document describes a wide range of sight deficits including:

- People who have no vision, often described as ‘blind’.
- Those who are partially sighted defined as having some ‘useful vision’, sometimes referred to as ‘low vision’.
- People whose sight is impaired however can function with the use of spectacles / contact lenses.

Those with a congenital visual disability were born with the impairment or developed it in early childhood, often as a result of genetic conditions e.g. Retinitis Pigmentosa (Tunnel Vision).

Sight loss can be as a result of an acquired brain injury, resulting in neurological sight difficulties causing issues in respect of e.g. proprioception, hemianopsia, recognising people / objects.

Medical conditions including diabetes e.g. Diabetic Rethinopathy, infection e.g. meningitis, measles and disease e.g. Meniere's, can also cause blindness / sight loss.

The ageing process is the largest cause of sensory loss, with age-related macular degeneration a common cause of sight loss in the over 65s, often presenting as cataracts / Glaucoma. Commonly with these conditions, the person is seen to hold reading material very close to read, moving a seat closer to the TV.

A tailored approach is required to support the very differing needs of those who have no vision / no central vision / no peripheral vision as sight loss is individual to the person and will therefore be experienced in different ways.

It is therefore important to understand the person's preferred way of communicating at the outset, ensuring information shared within the referral process is shared where possible prior to admission.

Adjustments to mainstream practice should be discussed with the patient / carer who should be fully involved in decisions about support mechanisms provided which may include:

- Increasing the font size of written communication to minimum 16 point.
- Use of e-mail which supports use of assistive technology e.g. screen reader.
- Ensuring appropriate use of contrasting background / text colours.
- Use of screen magnification / reader software.
- Use of audio (CD / MPs file) instead of written formats.
- Access to Braille / Moon (both use embossed shapes) embosser and translation software.

People with very limited / no vision may opt to use a white cane, which patients transferring to TSH may have relied on for some time (deafblind people use a red and white cane). Where access to a cane is identified as a risk, and the person may therefore be unable to use this support, it is important to ensure robust rationale is recorded and shared with the person. Alternative coping mechanisms should be identified as part of this process, including consideration to allocating the patient a bedroom closest to the day room, ensuring he has use of the same seat in the day room / dining room / placement area and ensuring that furniture in situ is consistently returned to its original location if moved. 1:1 support may be required to ensure carers are able to access a visiting environment which is appropriate for their needs. An initial pre-visit orientation session is helpful to orientate the carer to the unfamiliar environment.

An extended referral assessment process should be undertaken by Skye Centre staff in conjunction with the patient and key worker to agree on protocols and support systems in place to support access to this environment.

If, prior to admission, a patient has been supported by an 'assistance dog', it would not be considered reasonable and in the best interests of the dog to continue this type of support within TSH. Due consideration would include the specialised nature of this care environment,

in addition to challenges relating to infection control / potential allergies, the safety of the dog and the need for the patient to assume responsibility for the wellbeing of the dog, (specifically around toileting and regular walking). The Clinical Team should consider alternative reasonable adjustments to ensure the patient is able to engage fully in all aspects of care and treatment.

Similar concerns relate to carers who may have an 'assistance dog', however it would be reasonable to expect that, as part of the visitor approval process this situation would be highlighted and consideration given to facilitating visits within the Family Centre with access to outdoor space, or offering appropriate alternative support in order to support carers to maintain contact with the patient.

9. DEMENTIA

The Board is committed to ensuring that TSH patients living with dementia are fully included in all aspects of their care and treatment through individually tailored care. This approach helps to preserve the patient's existing capabilities as far as possible and supports them to cope better with their symptoms and improve their quality of life. As communication remains important throughout a person's journey with dementia, staff require to be appropriately trained to support and enable effective communication to meet the changing needs of individual patients (ref 5).

Dementia is an umbrella term for a range of progressive conditions that affect the brain. There are a number of risk factors associated with dementia including: age, head injury, obesity, alcohol misuse and diabetes *(NHS Health Scotland, 2013 (ref 25)).* The four most common types of dementia are Alzheimer's disease, Vascular Dementia, Frontotemporal Dementia and Dementia with Lewy Bodies. The term alcohol related brain-damage covers several different conditions including Wernicke-Korsakoff syndrome and alcoholic dementia. Neither of these is actually a dementia, but they may share similar symptoms. Unlike Dementia, Korsakoff's syndrome does not progress over time. It can be halted if the person abstains from alcohol and has a healthier diet with vitamin supplements.

Dementia will gradually affect the way a person communicates. Their ability to present rational ideas and to reason clearly will change. Therefore, consideration should be given to the gradual impact of dementia on the person's ability to communicate. Common symptoms include memory loss, difficulty with processing skills and decreased language/judgement skills. Word finding are common, with related words used e.g. 'book' for 'newspaper' and use of substitute words e.g. 'thing to sit on' instead of 'chair'. The person may continue to have fluent speech, however with little meaning e.g. jumbled up words and grammar. As the condition progresses, the person may be unable to use language to communicate.

In addition to verbal communication, use of non-verbal cues e.g. gestures and facial expressions can all convey meaning to help exchange messages. Body language and appropriate physical contact e.g. shaking hands, touching the person's shoulder become significant when speech becomes difficult for a person with dementia.

As part of the visitor approval process, Clinical Teams should discuss how best to support carers with dementia to maintain contact with a patient, where this is deemed appropriate for both parties. Consideration would be given to whether the carer could visit with a Support Worker.

10. AUGMENTATIVE AND ALTERNATIVE COMMUNICATION

The Board has a statutory duty to "provide communication equipment and support in using that equipment to such extent as deemed necessary to meet all reasonable requirements to any person who as lost their voice or has difficulty speaking." (Part 4 Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 (ref 23)).

TSH Allied Health Professional Lead (AHP) has responsibility for ensuring that local practice complies with this legislation and national core pathway (ref 24).

Augmentative and Alternative Communication (AAC) is a term used to describe a wide range of methods which can be adopted to support people to communicate when they find speaking difficult.

AAC can be used to describe support mechanisms including pictures, gestures, symbols, photographs as well as technological aids e.g. tablets, voice output communication aids, 'eyegaze' technology.

An individually tailored assessment process, undertaken collaboratively by the patient's Occupational Therapist, and the SLT, includes consideration of the patient's cognitive and functional ability, his goals, wider care and treatment plan objectives and the environment in order to determine the most appropriate form of AAC. An agreement is in place with NHS Lanarkshire to enable TSH to borrow equipment on a trial basis to support individual communication needs.

11. INTERPRETATION, TRANSLATION AND COMMUNICATION SUPPORT

Interpreting is the facilitation of spoken or signed language communication between users of different languages.

Translation is the process of transferring written text from one language into another; or from English written text to BSL sign captured on video.

Communication support relates to the additional support a person requires to understand English including, note taking, lip speaking, guide communications.

Different types of interpretation / communication support services are available. When determining whether there should be face-to-face provision of interpreting or translation support, each case should be assessed and determined individually, using the information detailing the patient's communication support requirements as identified within the electronic patient record.

Interpretation

Interpreting relates to languages specifically, including:

- Spoken language: telephone / face-to-face.
- BSL: face-to-face, remote video relay, tactile / manual signing.

For spoken community language users, telephone interpreters (available 24 hours a day, 365 days a year) should be used as the initial and principal form of language support.

Telephone interpretation is the preferred option as this route supports:

- Immediate access, responding to emergencies / unexpected needs.

- Rapid resolution.
- A more cost effective approach as it does not incur travelling costs for the interpreter.
- An easy way to establish the patient's language, if this is in doubt.
- Security processes / resourcing required to enable access to the Hospital.

Where telephone interpretation is deemed inappropriate, a video consultation through 'Near Me' or similar video consultation technology should be arranged: www.nearme.scot.

Telephone / video interpreting is not suitable for all patients e.g. BSL users, those with cognitive impairment e.g. Dementia / mental health issues.

Face-to-face interpreters must be used for BSL users and should be used to support meetings which may be lengthy e.g. CPA, Tribunals, Court Hearings or where complex / distressing information is being shared.

Face-to-face interpretation supports:

- Good eye contact.
- Non-verbal cues.
- Development of a trusting relationship, conducive to sharing sensitive information.
- Compassionate sharing of bad news e.g. bereavement.
- Clinical service delivery e.g. psychological therapy, risk assessment.

Should face-to-face support be required, individually tailored risk assessments should be developed to support a safe approach, mitigating any risks identified for the patient, interpreter and staff. Due to the nature of TSH patient group, continuity of input should be a priority, with the same interpreter commissioned to support communication where possible.

Deaf sign language users or D/deaf people who do not have BSL or any recognised sign language should have access to a deaf relay interpreter or International Sign Language interpreter.

For Deafblind tactile BSL users, as the guide/communicator uses touch, which takes much longer than any other form, this method must be accounted for within the process.

A note taker, using specific software, must be provided for those whose first language is not English, but cannot hear well enough to understand speech. Remote note takers can be used to support communication during an emergency.

Lip speakers re-state what is being said and may be the preferred communication support method for some people with a hearing loss.

The national policy clearly allocates responsibility for providing and funding the cost of an interpreter and / or translation to the Board and not the patient / carer (ref 33).

TSH must ensure that the appropriate type of interpreting service (telephone, face-to-face or virtual) is booked and provided to meet the individual's health and language needs, where practically possible. Appropriately trained interpreters must be commissioned (ref 34). It is acknowledged, however, that limitation to the provision of face-to-face interpreting services may occur e.g. in emergency situations, if a patient's mental health is cause for concern.

Interpretation should not be used to support understanding of information which is intended to be reference information to which the patient / carer may wish to refer at a later date.

It is expected that support will also be forthcoming for patients and carers who speak some English however require input to understand detailed / complex information e.g. Care Programme Approach documents.

For Deafblind patients / carers, due to their dual sensory impairment, appointments should take place within the Hospital / carer's home with a guide communicator. If the patient / carer is also a BSL user, a BSL/English interpreter will still be required.

Where possible a cultural match should be made and gender preferences acted upon.

Staff who can speak other languages, however are not registered with an accredited interpretation / translation service must not act as an interpreter / translator in professional discussions for either patients or carers. This practice carries a risk of conflict regarding the ability to undertake different roles and, unlike professional interpreters / translators they are not covered by the required indemnity insurance.

Although they may wish to do so, family, carers, relatives must not be used as interpreters / translators unless there is an emergency and a registered professional cannot be sourced.

Children must never be used as interpreters as this may have harmful effects on the child who should not be held responsible for sharing serious information relating to healthcare.

Accurate and vital information may be omitted or the untrained interpreter / translator may change the information given due to a lack of knowledge or understanding of the situation or terminology. Abusive / incoherent language may be omitted which impacts on the assessment process particularly in relation to mental health presentation. The person may also be unwilling to say that they do not understand something that has been said, leading to a breakdown in communication.

There may also be a conscious decision to protect the patient from bad news through the filtering of information shared.

In suspected adult / child protection investigations, it is imperative that professional interpreters / translators are involved.

The patient may not wish to discuss sensitive / personal issues with those close to him – effective disclosure may be impacted in the presence of family / friends.

There may be a conflict of interest involving e.g. finance, property which could result in vital information being withheld.

Patients who have been subject to gender-based violence can be misrepresented by a person who does not have their protection as a priority.

If a patient declines interpretation / translation support and insists on using family / friends, this decision must be documented in the patient's electronic record. Informed consent must be sought independently of family / friends and recorded in the patient's own language, signed by the patient. This document must be translated into English and retained by TSH.

If a patient's first language is not English, however he states that he is able to communicate in English to a high standard and does not require an interpreter, his wishes should be respected. This decision should be formally reviewed as part of the Care Programme Approach (CPA) review process.

The use of interpreters to engage in any aspect of patient care, including appointments within the local Health Centre, out-patient consultations, Solicitor discussions, Tribunal hearings, court proceedings, CPA Meetings, therapeutic activities, will result in additional time to support meaningful engagement. Planning of any sessions involving patients / carers therefore requires the allocation of additional time for all involved.

TSH has a responsibility to advise interpreters of potentially sensitive / emotive situations that they may encounter. Occupational Health support should be available in case there is a need for debrief / counselling.

NHSScotland is responsible for providing appropriately trained interpreters and translators, with a professional qualification. It is not always possible to secure a qualified interpreter for lesser spoken languages, however unqualified interpreters should undertake relevant training prior to providing support.

All BSL interpreters and translators must have previous experience of working within healthcare settings, fully qualified and registered with an appropriate governing organisation. They must also be Disclosure Scotland checked and have an agreed code of conduct for working within TSH.

Each interpreter should be aware of their own limitations and the type of situations they can manage and should not accept bookings beyond their level of experience. Interpreters providing input to TSH stakeholders should have knowledge of mental health related vocabulary.

All interpreters and translators are responsible for maintaining their own professional / registrant standards.

Trainee interpreters should not be used to support NHS clinical appointments, however should be enabled to accompany a fully qualified interpreter, with the consent of the patient / carer.

Translation

A request for a translation / accessible format should be delivered within a reasonable timeframe which will determined by resources held locally and the need to commission a piece of work. If the request relates to a clinical appointment, the information should be delivered within 5 working days. If this timeframe cannot be met, an interim means of sharing the information should be explored e.g. use of an interpreter. Local process must be in place, identifying a contact point and system to ensure that requests are handled fairly, consistently and efficiently and that patients / carers are not disadvantaged by any delay.

Provision of information includes:

- Public health information – developed nationally by Public Health Scotland e.g. Flu vaccination, pandemic related guidance. May also include third sector organisation generated information e.g. Alzheimer Scotland, Chest, Heart and Stroke Scotland.
- Clinical patient information – produced locally to support patients to make informed choices about their healthcare and treatment options, including background on conditions, range of care and treatment available, including the risks and benefits of each option /non-treatment, information enabling informed consent and information associated with self – care / rehabilitation.

- General patient information – produced locally, relates to patient / carer experience e.g. patient menus, activity timetable, visitor travel support, infection control.
- Specific patient information – relates to individual patients, clinical records, letters.

Patients, carers and staff should have timely access to appropriately and effectively translated information. Translated information to reinforce information given by an interpreter should be pre-empted and available immediately after the interpretation session.

Automated online translating systems / software must not be used as the quality of translations cannot be quality checked. In the absence of quality checking, the person giving this information is liable for any incorrect information imparted.

Prior to commissioning translation services, TSH has a duty to ask specifically about the language and dialect being translated to ensure that patients / carers can understand the translated information – the Chinese language includes in excess of 7 discrete languages including Mandarin, Cantonese, Huanese. Cultural considerations should also be identified e.g. a French interpreter may not have the local nuance required for a French speaker from the Ivory Coast.

Patients / carers whose first language is not English may be unable to read their own language, therefore this basic fact must be established at the outset to avoid costly translations being undertaken which are of no use.

The Board has a responsibility to translate all written information shared with patients / carers and to ensure that 24-hour communication support can be accessed. Images / diagrams that are integral to the information must also be translated.

Audio translations, in the format of an MP3 / CD, can be used if paper translation is likely to be costly / disproportionate to the request. It is the responsibility of TSH to ensure that the patient /carer has a means of listening to the recording prior to arranging this format. The English version of the document must be supplied in reference to images / diagrams, highlighting relevant page numbers.

In addition to the interpretation / translation of health care related information, as a long-term health care setting, all TSH patients must have equitable access to meaningfully engage in all interventions supporting recovery, including therapies, vocational, educational and health and wellbeing related activities. Mindful of the costs involved, efforts should be made to source resources from external peers / charitable organisations and specialist groups who may have information translated into the language required. TSH intranet ‘Equality and Diversity: Supporting Communication’ section includes all information which has been translated.

Staff should send a copy of all resources which have been translated to any language to the Person Centred Improvement Lead who maintains a database of all translated information and who will ensure the intranet resources are updated.

12. EQUITABLE ACCESS TO SUPPORT MECHANISMS

TSH staff should be aware of and understand the language and cultural barriers that can prevent patients and carers from engaging in healthcare services equitably and should respond to an individual’s language need in a way that ensures language support needs are met.

Senior managers are responsible for ensuring this policy is implemented correctly and that interpreting and translations services are managed and delivered appropriately. They should act as champions for change, support the development of local procedures, raise awareness and provide training where necessary.

The Board has a duty to demonstrate that there are processes in place to support mitigation of potential health inequalities in respect of enabling all patients and carers to access services which support the recovery journey. TSH Pre-Admission Specific Needs Assessment (appendix 2) supports a cohesive and anticipatory approach to this process in relation to patients. Early engagement with carers, supported by Social Work and the Person Centred Improvement Advisor, encourages a proactive, collaborative relationship to understanding and meeting needs.

Patients / carers may experience communication misunderstandings due to cultural differences and experience greater communication difficulties in stressful or emotional situations, or as a result of experiencing positive symptoms of mental illness. Understanding the individual needs of patients and carers is fundamental to understanding barriers to effective communication.

Individuals may come from cultures with different understandings of health and illness. Poor communication leads to poorer access to health information and widens health inequalities.

TSH supports staff to ensure that funding is available, where appropriate, for patients and carers to benefit from equitable access to services which support meaningful involvement in the recovery process.

Clinical Teams should complete the 'Referral for Language and Communication Support for Patient / Carers' (appendix 1) and submit to the Person Centred Improvement Lead via tsh.personcentredteam@nhs.scot - *note referrals for SLT are requests for clinical input available locally and should be used where clinically relevant*. This process will ensure that information which is already available through national networks can be sourced and shared without cost to TSH. The data will enable TSH to identify opportunities to reduce potential duplication, share best practice and adopt an inclusive approach to communicating with patients / carers with improved accessibility for staff, patients and carers.

13. GOVERNANCE

All healthcare staff should be aware of their legal and ethical responsibility to provide interpreting and translation services for patients and carers who have language support needs.

All generic written material provided to patients and carers must include TSH health literacy statement of intent detailed in section 14.

If the patient / carer is unable to read / understand this statement, it is the responsibility of the Clinical Team to ensure that the message is conveyed in the person's preferred format.

All requests from patients / carers for information to be provided in alternative formats must be referred using the referral form (appendix 1) within two working days and met within seven working days unless the information is unavailable in the preferred format. In this instance, a reasonable time frame must be agreed with the patient / carer, monitored by the person completing the referral form, whose responsibility it is to ensure the patient / carer is updated in respect of progress.

The Person Centred Improvement Lead is responsible for identifying any gaps in provision as part of Protected Characteristic Group monitoring processes. The PCISG are responsible for monitoring performance as part of the quarterly reporting process. Outputs are reported to Clinical Governance Group and the Board via the twelve-month service report.

The patient / carer does not have the authority to select interpretation / translation services. Where an independent contractor / third party organisation supplies a service within TSH environment, it is the responsibility of that organisation to fund the cost of any translation / interpretation support required. TSH is not required to cover this cost.

There is a well-established process to support rapid access to services via one provider (appendix 3). The budget supporting these services forms part of the wider Nursing Directorate budget, delegated to the Person Centred Improvement Lead, as part of funding required to deliver the equality work streams.

14. EQUALITY AND DIVERSITY

The Board is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and / or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based in what is proportionate and reasonable, we can provide information in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person Centred Improvement Lead on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures.

Patient pre-admission processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. Dementia, Autism, Intellectual Disability, sensory impairment). Rapid access to interpretation / translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith / religion / beliefs, highlighting any adapted practice required to support individual need in this respect.

Carers / Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and / or other aspects of the work of the Hospital relevant to their role.

The volunteer recruitment and induction process supports volunteers to highlight any barriers to communication, physical disability or anything else which would prevent them from contributing meaningfully to patient care and / or engage in other aspects of the work of the Hospital relevant to their role.

The EQIA considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

15. COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all TSH stakeholders via the intranet, through the staff bulletin and electronic mailing distribution systems.

Systematic monitoring and review of local / contracted services should be undertaken, including feedback from stakeholders using the services.

The Person Centred Improvement Lead is responsible for producing annual governance reports, including service usage (where the data does not compromise patient / carer confidentiality), detailing:

- Patient demographic e.g. age, diagnosis, barrier to communication e.g. sensory impairment, language.
- Preferred language type e.g. BSL, Chinese.
- Method e.g. interpretation, translation, video.
- Information type e.g. public health, clinical, general, specific.
- Purpose e.g. psychological therapy, CPA / Tribunal / Court process.
- Cost.
- Feedback including compliments, concerns and complaints.
- A detailed record of usage including date, time and duration of input.

The above report forms part of the Person Centred Improvement Steering Group work plan with responsibility allocated to this group for the monitoring of this policy.

The governance report will be included within the 12-month Person Centred Improvement Service Report presented to the Clinical Governance Committee.

This policy will be reviewed every three years or earlier if required.

16. STAKEHOLDER ENGAGEMENT

Key Stakeholders	Consulted (Y/N)
Patients	Y
Staff	Y
Volunteers	Y
Carers	Y
External Partners	Y
TSH Board	Y

This policy has been widely consulted both internally and externally with partners who specialise in many needs associated with barriers to communication. The content reflects national guidance, which has been tailored to meet the specific needs of TSH stakeholders.

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Appendix 1

The State Hospital Referral for Language / Communication Support for Patients / Carers

Please use the Speech and Language Therapy Referral Form, on the intranet, to request this specialist clinical input, which differs from this request for different types of communication support.

Patient or Carer?		**Name**	
Ward		**Carer's contact details**	
Keyworker's Name		**Consultant Psychiatrist**	
Referrer's Name		**Designation**	

Please describe barrier(s) to effective communication e.g. language (state which language the patient / carer uses as their first language), sensory impairment:

Please highlight the impact on meaningful engagement e.g. impact on achieving care and treatment plan objectives / engage in legal processes / ability of a carer to support the patient's recovery journey:

Type of input requested e.g. sourcing solution(s) to need(s) / advice / interpreter / translator:

Date and time input required:

Anticipated duration:

Have wider staff groups who may wish to engage with the patient / carer been made aware of the opportunity to engage and included within the input brief?

Date discussed by Clinical Team:

Where carer needs have been identified, the patient has consented to the carer being involved in his care and treatment and I have discussed communication support with the carer named above who has consented to being contacted by the Person Centred Improvement Lead.

***Approved by:**

Consultant Psychiatrist:

Lead Nurse:

Senior Charge Nurse:

***Requires one signature*

Date:

Please send FAO Person Centred Improvement lead to:
tsh.personcentredimprovementeam@nhs.scot

……..

Date received by Person Centred Improvement Lead / Associate Medical Director / Director of Nursing, AHPs and Operations (or cover):

Date Procurement Team contacted to procure service:

Date confirmation sent to Consultant Psychiatrist, Senior Charge Nurse, Lead Nurse and person submitting referral:

Appendix 2

The State Hospital Pre- Admission Specific Needs Information

1. Patient Details			
Name:		Preferred first name (if different):	
DoB:		CHI No:	

2. Communication	
What language(s) does the patient speak?	Please specify:
Interpreter required? *Yes ☐ No ☐	*Please provide details of arrangements in place, including name and contact no.:
Translator required? *Yes ☐ No ☐	*Please provide details of arrangements in place, including name and contact no.:
Speech difficulty? *Yes ☐ No ☐	*Please specify:
Learning disability? *Yes ☐ No ☐	*Please specify:
Learning difficulty (e.g. dyslexia)? *Yes ☐ No ☐	*Please specify:
Literacy skill deficits? Reading: Yes ☐ No ☐ Writing: Yes ☐ No ☐	

3. Senses	
Eyesight ☐ Normal vision ☐ Registered blind ☐ Glasses: ☐ Distance ☐ Reading ☐ Contact Lenses	Hearing ☐ Normal ☐ Hearing impaired ☐ Hearing aid: ☐ Left ear ☐ Right ear

4. Nutrition and Hydration	
Special diet required? (e.g. vegetarian, halal, kosher, gluten free) *Yes ☐ No ☐	Please specify and include rationale e.g. cultural, allergies, intolerances:
Prescribed Meal Replacements / Supplements? *Yes ☐ No ☐	*Please specify:
Swallowing difficulties? *Yes ☐ No ☐	*Please specify:

5. Mobility	
Patient fully mobile/independent? Yes ☐ *No ☐	*Please specify:
Diagnosis affecting mobility e.g. dyspraxia, Parkinson's, M.S.? *Yes ☐ No ☐	*Please specify:
Uses aids and/or adaptations? *Yes ☐ No ☐	*Please specify:
6. Spiritual and Pastoral Care	
Has the patient disclosed his religion? *Yes ☐ No ☐	*Please specify:
Is there anything with regard to faith or culture that we need to know about in order to support continuity in this respect (e.g. access to specific faith related people including the Chaplaincy Team/ items/ environments/ activities/medicine ingredients)? *Yes ☐ No ☐	*Please specify:
7. Smoking Status	
Does the patient currently smoke tobacco/cigarettes? *Yes ☐ No ☐	*Please specify: Number per day: Frequency:
Is the patient currently using nicotine replacement products? *Yes ☐ No ☐	*Please specify: Product: Strength (mg): Frequency:
8. Contact Details	
Solicitor Name:	Telephone No.
Other Contacts Name:	Telephone No.
Other Contacts Name:	Telephone No.

Name of person completing form:	
Designation:	
Date:	
Planned admission date: *Yes ☐ No ☐	*Please specify date:

Appendix 3

The State Hospital Procedure for Working with Interpreters / Communication Support Professionals

The Chair of the meeting is responsible for ensuring that the process to engage an interpreter / Communication Support professional (CSP) is followed. If the input is on a 1:1 basis, the person commissioning the interpreting / CSP service will assume this responsibility, communicating with the Consultant Psychiatrist, Senior Charge Nurse and Person Centred Improvement Lead.

The interpreter / CSP must not be left alone at any time with the patient.

Before engaging an interpreter / CSP:

- Secure the patient / carer's consent to engage with an interpreter / CSP.
- Clarify the language and dialect spoken by the patient / carer and liaise with the relevant interpreter / CSP.
- Consider the appropriateness of the interpreter / CSP in terms of age / gender.
- Establish how long input is likely to be required.
- Adapt terminology to the level of the patient / carer's understanding.
- Establish whether any electronic equipment is required by the interpreter / CSP and ensure this is detailed on the Visitor Authorisation Form.
- Review available Speech and Language Therapy reports for specific advice.

Prior to input:

- Provide the patient / carer, interpreter / CSP with a summary of the aims / objectives of the session and definitions of any technical terms.
- Engage with all members of the Clinical Team, Skye Centre staff including the Patients' Bank staff, the patient's Advocate and anyone else who may require to communicate with the patient / carer e.g. Mental Health Officer, Person Centred Improvement Team, including the Hospital Chaplains. Co-ordinate involvement to make best use of the interpreter / CSP time.
- Develop a timetable of input with clearly defined session times, building in comfort breaks (10 or 15 minutes every hour) and disseminate to all involved.
- Allow double the time a session such as this would take in the absence of interpreter / CSP input and allow time to speak with the interpreter / CSP afterwards about issues or observations they may wish to share with you.
- Be clear about method of input and explicit if there is a need for verbatim translation.
- Ensure the interpreter / CSP has adequate time for introductions with the patient / carer and to inform the patient / carer about their role.
- Interpreter / CSP should be aware of any tailored plans in place to engage and communicate with the patient / carer.
- Book a room which is in a quiet area and ensure appropriate staffing is in place.
- In the event of a meeting where there are large numbers of people in the room e.g. CPA Meeting, Tribunal, ensure the seating is laid out in such a way that the interpreter / CSP and the patient / carer can make eye contact with the whole group.

- Ensure the patient / carer has been briefed so that they are prepared and have an opportunity to prepare questions, ask about decisions etc.
- Complete the Visitor Authorisation Form and ensure the details are with Reception.
- Ensure the environment supports use of technology where required.

During the session:

- The Chair is responsible for confirming that the room has been set up to ensure everyone present can be seen and heard by the patient / carer.
- Introduce the interpreter / CSP to the patient / carer and others present. Ensure everyone is aware of the role and purpose of the interpreter / CSP.
- Chair must stress the confidential nature of the meeting.
- All communication must be directed to the patient / carer and not through the interpreter / CSP e.g. “what is your name?” to the patient / carer not “ask him what his name is” directed to the interpreter / CSP.
- Avoid the use of jargon, use plain English. If technical language or jargon is unavoidable, the interpreter / CSP may need to take notes to assist in explaining to the patient / carer.
- Establish at the outset if ‘consecutive interpreting’, i.e. the interpreter waits while you speak and relays the message while you wait or ‘simultaneous interpreting’ (the interpreter interprets what you are saying as you say it) will be used.
- Remember that the interpreter / CSP is not there to provide advocacy or emotional support to the patient / carer.
- The interpreter / CSP should not be asked for advice or explanations other than on linguistic or cultural issues.

The interpreter / CSP may only intervene:

- To clarify understanding.
- To ask individuals to accommodate the process by speaking louder or slower.
- To alert the parties to a missed cultural inference, and ask for an explanation which they will interpret.
- To alert that, despite correct interpretation, the message has not been understood.

Concluding the session:

- The Chair should check that the patient / carer has understood everything.
- The patient / carer should be afforded the time to ask any supplementary questions.
- The Chair should meet with the interpreter /CSP immediately after the end of the session to offer support should same be required.
- The Chair should provide written feedback to the Person Centred Improvement Lead in the event of any issues or concerns.
- The Chair / individual responsible for commissioning the interpreter / CSP input must complete the attached form and return it within 7 days to the Person Centred Improvement Lead.

Following the session:

- Where virtual interpretation services have been utilised, the Virtual Interpretation Sessions Form (appendix 4) must be completed by supervising staff and sent to the Procurement Team.

Booking Process

1. Prior to booking, The State Hospital Referral for Language / Communication Support for Patients / Carers form (appendix 1) must be completed.
2. Requests for input must be authorised by the Person Centred Improvement Lead or, **in her absence**, the Associate Medical Director / Director of Nursing, AHPs and Operations (or on call cover) via email:
3. A minimum notice period of 72hrs is required for face-to-face input. Emergency consultations can take place via video link / telephone. 5 working days are required to support translation, which should be taken into account if documents are required to support engagement within a face-to-face meeting.
4. Once approved, a confirmation email will be sent to the requestor and to the Procurement Department.
5. The Procurement Department will book all services confirming the name of the interpreter / CSP to the requestor.
6. In the event of any disagreement between the requestor and the Person Centred Improvement Lead or Director of Associate Medical Director / Nursing, AHPs and Operations (or cover) the Medical Director will be asked to mediate.

Any planned out of hours booking must follow the above process.

The only exception to the above booking process will be when services require to be booked urgently on an emergency basis out of hours.

Procedure for Booking Interpreting / CSP Services out with 9-5 hours

Service Provider
Global Connections (Scotland) Ltd: 0141 352 5663 (24 hours).
If Global Connections are unable to accommodate the request, Global Languages Glasgow can be commissioned: 0141 429 3429 (24 hours).
Most languages are available at short notice. Most frequently used e.g. Polish, Romanian & Arabic are easier to arrange than the less commonly used languages in the UK.

1. Obtain authorisation from senior manager listed above.
2. Telephone Global Connections with the following details:
    - Language / CSP required.
    - Time and date of visit.
    - Approximate duration of visit.
    - Order No. for 2022/23 is DE11497741

DO NOT PROVIDE ANY PERSONAL DETAILS OF THE PATIENT TO BE VISITED.

3. Note the Job Number and name of Interpreter / CSP attending.
4. Complete Visitor Authorisation Form and inform Reception of expected visitor.
5. Email the Procurement Department tsh.procurement@nhs.scot and tsh.personcentredimprovementteam@nhs.scot to inform them you have made a booking and include all of the above details.

Appendix 4

The State Hospital Virtual Interpretation Sessions

Name of Interpreter			
Language			
Input type: video/telephone			
Job No. (if known			
Date of session			
Start time		**End time**	
Form completed by			
Any additional information/comments			

To be completed following the sessions and emailed to: tsh.procurement@nhs.scot

Appendix 5

Interpreting and Translation Costs Interpreting and Translation Costs, Terms and Conditions

Face to Face Interpreting Services - (Diploma in Public Service Interpreting / Equivalent)		
Minimum 2 hours		**Per hour**
Weekdays 8am-6pm		£25.80
Weekdays 6pm-12pm		£32.00
Weekdays 12pm-8am		£35.80
Weekends/Public Holidays 12pm Friday – 8am Monday		£35.80
Cancellation Fee		£20.00
Face to Face Interpreting Services - Standard Interpreter		
Weekdays 8am-6pm		£21.80
Weekdays 6pm-12pm		£27.80
Weekdays 12pm-8am		£30.20
Weekends 12pm Friday – 8am Monday / Public Holidays		£30.20
Cancellation Fee		£16.90
Remote Video Interpreting Services - Standard Interpreter		**Rate per minute**
		£0.48
Telephone Interpreting Services	Pre-Booked	£0.48
	On Demand	£0.53
Translation Services		**Per word**
Relating to submitted document word count)		£0.08
For secondary proof reading		£0.04
Transcription Services		**Per hour**
Fee Per Hour (Per Hour of Recording Time)		£225.00

Face to Face Interpreting

1. Hourly rates are inclusive of all costs associated with delivery of interpreting services, but not necessarily limited to, all travel and other reasonable out of pocket expenses.

2. A minimum fee of 2 x the agreed hourly rate will be payable to the interpreter where the duration of attendance at a face to face interpreting session lasts less than 2 hours.

3. The cancellation fee will apply in circumstances where the request for input is cancelled with less than 24 hours' notice.

Remote Video / Telephone Interpreting

1. Cost is applicable from the time connected to the interpreter, charged by the minute.

2. There are no minimum call duration charges.

Translation

1. Prices are inclusive of all costs associated with delivery of translation services, including, but not necessarily limited to, all travel and other reasonable out of pocket expenses.

2. Prices are for translation into and out of English.

3. Prices will be applied on a pro rata basis against the submitted document word count e.g. the price for a completed translation from a submitted document with 750 words will be: Rate per submitted word x 750.

Transcription

1. Prices are inclusive of all costs associated with delivery of transcription services, including, but not necessarily limited to, all travel and other reasonable out of pocket expenses.

2. Prices are for transcription into and out of English

3. Prices will be applied on a pro rata basis against the length of the media to be transcribed e.g. the price for transcription of a CD comprising 1.5 hours of audio will be: Rate per hour x 1.

Travel & Subsistence Arrangements for Interpreters

1. The Contractor will provide a face-to-face interpreter from within 45 miles of the location that the input is required. Where ever possible local interpreters will be provided.

2. In exceptional circumstances an interpreter may be sourced from more than 45 miles of the location of the assignment. In these circumstances the contractor will provide justification why that is the case for TSH to review and agree prior to confirming the order.

3. Where TSH accepts such an interpreter, TSH will pay travel and subsistence costs.

4. Once it has been established and agreed that the journey is unavoidable, and prior to the journey being undertaken, TSH must be content that that the most effective method of travel is selected from the following:
    - public transport (including bus, rail, air and ferry).
    - official allocated car if available.
    - hired car.
    - taxi hire.
    - privately owned motor vehicle.

    The aim is to use the most efficient, economic and environmentally sound means of travel, whilst minimising chargeable time. The contractor must consider the range of fare options available. This should include special fare promotions, day returns, saver and season tickets and any other fare offers where their use does not impair the efficiency of the journey being undertaken. Low carbon transport is favoured.

5. TSH must satisfy themselves that journey and means of travel are fair and reasonable before the journey is undertaken. If the journey is undertaken without prior approval from TSH, or the means of travel used are different from what is agreed, TSH has the right not to pay travel and subsistence costs.

Travel expenses

1. Interpreters should receive the maximum of these rates where possible, agreed in advance with TSH.

2. Travel by public transport is encouraged and will be paid at cost and on presentation of properly receipted invoices only.

3. Only rail travel by Standard class will be paid, only air travel by Economy class will be paid.

4. Where travel by car is unavoidable, mileage rates the following rates will apply:

Mileage Type	**Rate**
Motor Rate	£0.45 per mile
Passenger Supplement	£0.05 per passenger
Equipment Supplement	£0.02 per mile

5. Mileage will be paid for the total distance of the journey less the 45 miles each way (90 miles return).

6. Travel by air will be restricted to exceptional circumstances and must be agreed in advance with TSH.

7. Travel time will only be paid in the following circumstances and must be agreed in advance with TSH:

    - Where the contractor is required to source an interpreter from out with the 45 mile each way maximum distance **and** travel to and from that assignment exceeds 90 minutes each way.
    - Where an overnight stay is required to fulfil an assignment (travel time will be paid on the day of travel).

8. In both circumstances detailed above, travel time will be paid at 50% of the applicable hourly rate for the assignment and will be limited to the actual time spent travelling.

9. For the purposes of travel time, the point of origin for the journey will be the closest to the place of the assignment from either:

    - the place of business of the contractor
    - the home of the interpreter

Subsistence

1. 24-hour subsistence will only be paid where all three of the following circumstances apply and must be agreed in advance with TSH:

    - Where an interpreter incurs costs for overnight accommodation.
    - Where the contractor is required to source an interpreter from out with the 45 miles each way maximum distance; and

- Where travel to and from that assignment exceeds 90 minutes each way.

2. 24-hour subsistence comprises the receipted cost of bed, breakfast and dinner up to the capped limit of:

    - £75.00 for bed and breakfast
    - £23.50 for dinner

3. Expenditure incurred on alcoholic drinks will not be reimbursed.

4. Claims for 24-hour subsistence must be supported by an original itemised receipt attached to the invoice. Claims that are not supported by an itemised original receipt attached to the invoice will not be reimbursed unless a satisfactory explanation is provided to the TSH in writing.

5. In exceptional circumstances an interpreter may be unable to secure bed and breakfast costs within the capped limits. The interpreter involved must have made reasonable efforts to find suitable accommodation within the capped limits. This includes having attempted to secure accommodation using the services of TSH travel booking agent. In each instance where subsistence is likely to be incurred over the capped limits, prior approval of TSH must be requested and obtained in advance. In these circumstances the contractor will provide justification why that is the case for TSH to review prior to confirming the order. In such circumstances TSH has sole discretion to accept or refuse services from the interpreter proposed.