The Royal Wolverhampton NHS Trust

Policy Number OP47
Interpreting and Communication Policy and Procedure

Contents

Sections		**Page**
1.0	Policy Statement	2
2.0	Definitions	2
3.0	Accountabilities	3
4.0	Policy Detail	5
5.0	Policy Financial Risk Assessment	15
6.0	Equality Impact Assessment	15
7.0	Policy Maintenance	15
8.0	Communication and Training	15
9.0	Audit Process	16
10.0	References / Bibliography	16

Appendix 1 Guidance on Interpreter Service Identification (flowchart)

Appendix 2 Interpreter Request Authorisation Form

1.0 Policy statement

The purpose of this policy is to provide details of how to access interpreting services to aid communication for patients and service users. The policy specifically covers patients and service users who cannot speak, read or understand the English Language at a level that allows them to interact effectively with clinical or non-clinical staff. The policy also covers support for patients and service users who are d/Deaf, blind, Deafblind, have dual sensory loss, learning disabilities and dyslexia.

2.0 Definitions

Interpreting: Is the process of orally converting spoken words from one language to another or between one language or another.[1] This covers the conversion of speech from one language (including British Sign Language (BSL), other sign languages) to another and includes palantype (conversion of spoken to written speech). Language interpreting can be provided by telephone or face to face.

Translation: Can be defined as the process of converting written text or words from one language to another.[2] The written transmission of meaning from one language to another, which is easily understood by the reader. This covers the conversion of written text from one language or format to another. This also includes conversion to easy read and the conversion of written information into Braille and other pictorial formats.

Interpreter: Is someone who is not only fully multilingual but also has the ability and training to be able to work between two languages and facilitate communication between two people. (Reference – Association of Sign Language Interpreters.)

Communication support: A variety of ways of supporting communication with people who do not use the conventional forms of spoken or written English, including Braille, picture boards, easy read, Makaton and other tactile forms of writing, lip-reading and lip-speaking, and various communication technologies, such as speech- to- text readers

d/Deaf: Conventionally the use of the word deaf (with a lower case 'd') refers to any person with a significant hearing loss, whereas Deaf (with a capital D) refers to a person whose preferred language is British Sign Language. (Association of Sign Language Interpreters). Do not assume that all Deaf people use BSL.

Patient: Includes service users or their representative. Carers and parents are also covered under this policy for interpreting and translation of information in relation to disability. Interpreting does not include advocating for a patient.

Disability **:** A person has a disability if they have a physical, sensory or mental health disability, learning disability or difficulty which has a substantial and long-term

[1] https://www.iti.org.uk/about-iti/our-background-and-values
[2] https://www.iti.org.uk/about-iti/our-background-and-values

adverse effect on their ability to carry out normal day-to-day activities. (From the Equality Act 2010).

3.0 Accountabilities

3.1 Chief Nurse and Chief Medical Officer

Accountable to the Trust Board for ensuring compliance with all standards contained with this document.

3.2 Deputy Chief Operating Officers

Responsible for implementing the policy and ensuring staff are made aware of the contents of the policy document. The Deputy Chief Operating Officers will implement appropriate systems at Divisional and Directorate level to monitor usage of interpreter services and to ensure the service remains within budget.

3.3 Appointment Team / Nurse / Doctor /Dentist/ Allied Health Professional (AHP)

Before booking an interpreter, the specific language (and ideally dialect) required must be identified. A Language Identification Card is available to enable patients to visually identify their own language.

The appointments team is responsible for booking interpreters when required. Language needs are recorded on the referral letter or previously flagged on the Patient Administration System (PAS) and for newly identified patients.

The Clinician is responsible for assessing and verifying information and communication needs of patients and determining, based on the criteria set out in this policy, if alternative formats (e.g., telephone or face-to-face language interpreting or sign language interpretation is required). This must be done as part of mainstream processes such as at:

- New appointments,
- Initial contact or service registration,
- Outpatient reviews or care plan reviews,
- Confirming that needs are already captured on manual or electronic flagging systems or needs that are received via a referral are correct, and
- Utilising the learning disabilities communication passport (as appropriate).

Completing the alert card on the front of the patient's notes indicating the following.

- The communication and information needs of the patient (e.g., larger print size 16 Arial documents, e-mail, text message etc.), that an

  - interpreter is required, and the specified language / sign language interpreter required.
  - Any alternative methods of communication and information in order to provide a seamless and proactive service delivery e.g., noting a second language if the preferred (first) language is not available.
  - That the patient has been asked about their communication and information needs and there are no requirements.

- To ensure electronic flagging system(s) have been updated with information and communication needs or state that there are none.
- Organise communication and information needs when required and ensure that any automatically generated standard formats are not provided to patients.

3.4 Head of Patient Experience and Public Involvement (HOPE)/Procurement

Responsible for the provision and usage, in conjunction with the Chief Operating Officer, of language interpreting services, language translation and British Sign Language which meet national agreed standards. The HOPE will monitor the quality of the service provider by ensuring that at least two formal contract monitoring review meeting take place annually.

3.5 All staff

All staff are responsible for complying with this policy. Their other responsibilities are detailed below.

- Identifying the need for an interpreter and, or any communication and information needs.
- Identifying the language (and where possible the dialect) required.
- Ensure consent of patient is obtained where the need for interpreter is required. See also consent below.
- Adhere to booking procedures outlined in this document.
- Book interpreters as appropriate.
- Document interaction and electronic flagging interaction takes place stating communication and information needs or none (as appropriate).
- Organise and provide communication and information needs such as interpreters, alternative formats of documentation, ensuring that any automatically generated standard formats are not provided to patients.
- Any concerns regarding performance and quality of the interpreters or written translations should be made to the interpreting and translation service provider directly, details on the Intranet.

3.6 Head of ICT

To ensure IT systems are compliant with the requirements set out within the Accessible Information Specification and this policy.

3.7 The Interpreter

Interpreters are used solely to provide a clear channel of communication between the clinician and the patient. They will give a direct rendering of the speech between all parties in the correct tone without adding, omitting or summarising information and without otherwise influencing the discussion.

The interpreter should not be used as a form of direct support to the patient or provide any other service e.g., counselling. They are there to repeat what the clinician and the patient say to each other in a language that both parties can understand.

The interpreter will check at regular intervals that understanding is maintained and will only intervene to clarify potential cultural misunderstandings.

Trained interpreters are bound to maintain confidentiality and adhere to the Code of Ethics for Interpreters and Translators.

The interpreter will refrain from using any non-verbal signs and only use spoken language as given by the patient and clinician. Any body language or communication cues should be ignored as not relevant to the process of interpreting.

4.0 Policy Detail

4.1 Legal and Policy Context

The Trust is committed to ensuring that everyone whose first language is not spoken English receives the support and information that they need to access services fairly, to communicate with health care staff effectively, and to make informed decisions about their care and treatment and, where relevant, that of a child for whom they have parental responsibility.

Although there are ever increasing cost pressures, we must remember that as part of equalities legislation patients must not be victimised, bullied or discriminated against, and the Trust should be meeting individual needs. The Trust also needs to have regard to promoting equality of opportunity. If patients need interpreting services, they must receive them as patient safety must always come first.

This policy sets out to ensure the Trust meets its commitments to the following.

- The commissioning and provision of good local communication support is a requirement of the **Equality Act 2010** which requires public bodies to make ‘reasonable adjustments’. These include providing additional aids or services such as providing communication support including British Sign Language, and providing easy read information for patients with learning disabilities. Disabled people should not be put at a disadvantage compared to non-disabled people.

- **To help comply with the Human Rights Act 1998 - including the core values FREDA (Fairness, Respect, Equality, Dignity, Autonomy).**
- The principles of the NHS Constitution – including the 7 principles which are underpinned by the NHS values.
- **Health Inequalities: Health and Social Care Act 2012 -** The Act placed a duty on health providers to pay due regard to reducing health inequalities. An individual's chance of enjoying good health is determined by the social and economic conditions in which they are born, grow, work and live. Such inequalities are reinforced by factors such as poor housing, health behaviours or risk factors such as smoking and diet, physical activity, and unequal access to health services.
- NHS England's **Accessible Information Standard**: part of this standard is the Accessible Information Specification. The Trust MUST ensure that **disabled patients** receive information in accessible ways, and that they have appropriate support to help them communicate. For example, accessible information includes alternative formats such as large print, easy read, braille and via e-mail. Communication support can include offering a British Sign Language interpreter, a Deafblind manual interpreter or advocate.
- The **Equality Delivery System**, which is around improving patient access and experience. By providing professional interpreting and translation services, communication between staff and patients and service users can be improved, thus supporting people to become involved in decision making about their care.
- The Care Quality Commission (CQC) is the independent regulator of health and social care services in England. Providers are required to assure the CQC that the care they deliver is safe, appropriate and effective by complying with the fundamental standards which include person-centred care, dignity and respect, safety and safeguarding are being met.

By providing patient centred care that is truly based on individual needs, the Trust will be able to meet its legal, moral and social obligations in relation to providing accessible communication and information needs. This is also reflected in the social model of disability, as the Trust can remove barriers to accessing services.

4.2 Booking Interpreters - Identifying the most appropriate service

It is important that the most appropriate interpreting service is accessed based on the individual needs of the patient. The Trust is committed to the use of technology in improving accessibility to all its services in the most cost effective and safe way. It will seek to provide an interpreting and translation service which is predominantly based on digital solutions such as telephone and video.

In the majority of circumstances, the preferred option for language interpreting services will be the use of a **telephone interpreting**. Face to Face interpreting must only be used where there is a clear patient benefit and the criteria for use have been met (See appendix 1).

Sign language interpretation must be used following assessment and identification this is the preferred option for the patient.

4.3 Telephone Interpreting

Telephone interpreting MUST be the first option used taking into account the following reasons and factors and the criteria in Appendix 1).

- The equipment required to deliver effective telephone interpreting communication should be readily available. No special equipment is required in most situations other than a telephone and headsets. Telephone interpreting will involve 3 (or more) parties involved in the conversation and therefore it may be necessary to put the phone on loudspeaker rather than pass a headset from person to person. (this is important to consider in reducing any Infection Prevention risks).
- The service is also almost instantly available removing the reliance on interpreters arriving at the destination on time.
- In the requirement for a rare language a telephone interpreter is the better option whereas a face-to-face interpreter with the relevant language may be based far from the Trust.
- Telephone interpreting is more cost effective compared with other options against the background of increasing demand and rising costs. It is charged per minute and the Trust only pays for the time on the call. Face to face bookings are for a minimum of one hour.
- Some service users who do not speak English take great comfort from the anonymity of a telephone interpreter, particularly in small or closely knit communities. Some service users may feel a level of distress due to cultural or social pressures from within their community. If the service user is forced to talk to their practitioner with another member of their community in the room, even if that person is a professional interpreter, they may feel unable to speak openly and honestly.
- The use of telephone interpreting reduces the need for additional footfall and helps minimise travel, parking and mileage costs benefiting the Trust financially and the environment.

Telephone interpreting must be regarded as the first option in all circumstances except when one or more of the following applies.

- The patient or service user uses non-verbal communication such as British Sign Language, DeafBlind Manual, Makaton etc.
- The patient has a communication, cognitive or learning disability which would make telephone interpreting difficult.
- Child or adult safeguarding. Staff need to work with the interpreting provider to ensure that the most appropriate service (either telephone or face-to-face) is used for children, young people and vulnerable adults (including anyone who may be known to the safeguarding team). Each case must be assessed on its own merits e.g., an out of area interpreter may be required.
- Where conversations need to be recorded for legal reasons.
- Bereavement or breaking significant or bad news.
- Ethically difficult or challenging situations.

This list is not exhaustive. Please see Appendix 1 for more detailed guidance.

When using telephone interpreting, ensure that you record the interpreter's name, ID number, language used and the date and time of the call in the patient's notes.

Information of how to use telephone interpreting services is on the Intranet.

4.4 When a face-to-face Interpreter MUST be used

Face-to-face interpreting is only available for situations where effective communication is critical to patient care outcomes.

The Trust WILL support face to face interpreting in the following circumstances.

- Consent for surgical intervention or invasive procedures.
- New diagnosis.
- Breaking bad news.
- Where the patient is considered particularly vulnerable, e.g., a child, an adult with dementia, mental health or a learning disability.
- Where telephone or video are not are suitable options.
- Complex assessments.

It is not appropriate to use face-to-face interpreting when:

- Early stages of unplanned or unscheduled care, eg emergency pathways where immediate intervention may be required.
- Basic care or advanced care where formal written consent is not required,
- Surgical admissions (operations or assessments – history taking),
- Pre-post-operative assessments.
- Clarifying personal details, determining condition, general discussions or /help on general care, toileting, feeding etc.,
- The appointments are for routine and reoccurring services, and
- The appointments are non-critical and low level.
- Another option such as telephone or video can be used and would be deemed suitable for the nature of the consultation/intervention.

Routine nurse led preassessment clinics could be telephone however more complex assessments requiring anaesthetic review are much less common but likely to require some clinical examination and in depth discussion re risks/benefits - Ideally F2F would be more appropriate (but if not available then telephone would be acceptable and preferred).

Where a face-to-face interpreter is requested in the above situations the requesting department will need to provide adequate justification.

If, following patient assessment using the above criteria, a face-to-face interpreter is required, this will need to be booked via the Trust approved external provider. To ensure the provision of a face-to-face interpreter, adequate notice must be given to the provider. The shorter the notice given the less likelihood the availability of face to face interpreter.

Please see **attached flowchart** (Appendix 1) for guidance on the most appropriate interpreting service to use. The above list is not exhaustive.

Medical Consent If the patient is not offered as much information as they reasonably need to make their decision, and in a form they can understand, their consent will not be valid. Consent must be given voluntarily: not under any form of duress or undue influence from health professionals, family or friends. For further information on consent please refer to the Consent Policy CP06.

Where consent is required, and a face-to-face interpreter is not available, clinicians should consider a contingency plan, including other interpreting options to enable informed consent.

4.5 Video Interpreting

The use of technology provides a flexible option in video interpreting. It has most of the benefits of a face-to-face interpreter with the added advantage of a remote and instance service. Al that is required is a device with a camera, microphone and WiFi. Staff should be encouraged to use this agile option for routine appointments. Please check with your directorate on availability of suitable devices (iPads).

4.6 Interpreting – British Sign Language

This, or lip-reading, are often the methods of choice for ensuring maximum effective communication with people who are Deaf. People who have a hearing impairment may prefer other forms of communication; they must be discussed with the patient or service user as part of the assessment. Do not assume all Deaf people use BSL; occasionally, in the case of deaf people who do not speak English, a relay interpreter may be required.

4.7 Use of carers, family and friends

Carers, relatives, friends, other patients, children or partners should not be used as interpreters unless exceptional circumstances prevail; the use of an unskilled person to interpret is inappropriate and may lead to risk of misunderstanding, resulting in the intervention of inappropriate health care / treatment. This is of particular importance in good safeguarding practice to ensure that the true voice of the patient is heard.

It may be appropriate in an emergency or acute situation for a carer, friend or family member to communicate basic information, however, an interpreter must be requested at the earliest opportunity. Telephone interpreters are usually instantly available and should be used in such emergency situations.

The use of carers, family and friends is only acceptable for the process of consent for

surgical intervention or invasive procedures in urgent and emergency situations when no other interpreter can be accessed. prevents you from obtaining an interpreter.

4.8 Use of Trust staff

Staff members who are not registered with accredited interpreter services may be asked to help communicate basic information about care or personal details but must not be used to interpret clinical information, medical terminology or to facilitate decision making about clinical care. If more than basic information is needed then an external, approved interpreter must be arranged.

Please note sections 4.7 and 4.8: that if there is a failure to provide a qualified interpreter, this may leave the Trust open to challenge should the interpretation of the information given by a staff member or patient representative prove to have been misconstrued or misunderstood.

Interpreters are qualified to deliver medical terminology in the language delivered. It should not be assumed that a staff member will accurately interpret such information because they may be fluent in a non-english speaking language. Dialects play an important role in the accuracy of the language being interpreted.

The use of Trust staff is NOT acceptable for the process of consent for surgical intervention or invasive procedures unless the urgency of the clinical situation prevents you from obtaining an interpreter.

4.9 Children, young people and vulnerable adults

Children and young people should not be asked to interpret. A child may communicate very basic information in an emergency; however, telephone, video and face-to-face interpreting must be arranged as a matter of priority.

A child or young person must be offered the use of a professional face-to-face interpreter.

Staff need to work with the interpreting provider to ensure that the most appropriate service (either telephone, video or face to face) is used for children, young people and vulnerable adults (including anyone who may be known to the safeguarding team). Each case must be assessed on its own merits e.g., an out of area interpreter may be required.

If there are issues related to child protection or vulnerable adults, then a professional interpreter must always be used even to communicate basic information. (See appendix 1).

4.10 Interpreting – refusal of patient to use an accredited Interpreter

When a patient refuses an interpreter and understands the implications of using a family member to interpret, this will be facilitated. It must be recorded in the patient's

notes that this was their choice, and that they declined the interpreting services offered. This decision must be made by the patient and not by a family member on their behalf.

Staff must write this declaration; sign, date and stamp it using their professional stamp with their registration number.

'[Patient or service user's name] has declined the use of a trained, qualified interpreter'.

4.11 Duration and booking face to face Interpreters

Face-to-face interpreters must only be booked for a **maximum of one and a half hours**. However, where it is judged that the face-to-face interpreting session will last longer than this, approval must be obtained from the Matron or Service Head to proceed with the booking.

Where the session is expected to be over 1.5 hours, complete the Interpreting Advice Form, and return it for authorisation. If this form is not completed and authorised, your department may incur the costs of the interpreting session.

The only exceptions to the one and a half hour booking are for surgery and maternity childbirth services, who can book for a maximum of 3 hours e.g., for labour where a complex delivery is anticipated.

4.12 Cancelled appointments / treatments

In the event of a clinic appointment, inpatient or day case treatment being cancelled, staff should check to establish whether an interpreter has been booked. It is important to ensure that the process of cancellation must include the appropriate action to cancel and rebook the interpreter.

Any interpreting charges arising from cancelled appointments where the service provider has not been notified will be cross charged to the respective service line budget for payment.

4.13 Information Governance

The Trust changed its interpreting supplier in January 2020. The changeover brought attention to the issue of protecting patient identity in situations where a patient presents their medical assessment or history in written form in a language other than English. The translation process must ensure that the identity of the patient is protected. This is particularly relevant when the service provider is using third party agencies or individuals for carrying out the translations.

This scenario was addressed as part of the Data Protection Impact Assessment carried out in relation to the changeover. The risk assessment highlighted that the declaration of

the external interpreting supplier was not conveyed to patients and other stakeholders who do not speak English. This situation has now been rectified. The declaration has now been translated into the fifteen most prevalent community languages and placed on the RWT website 'Declarations' page. In order to signpost the location of the declaration the national flags that relate to speakers of those languages has been hyperlinked to the translations.

If you are arranging for a document or file to be translated into English – please ensure that Patient Identifiable data is removed before sending the file to the translation company.

4.14 Funding

The funding for **oral interpreting** (face-to-face, video and telephone) services is met from a designated budget held on behalf of the Trust by the Patient Experience Department. Given the pressure on this budget, consideration may be given in the future to devolving this to the relevant end users of the service.

Where it is judged that the face-to-face interpreting session will last longer than an hour, approval must be obtained from the Matron or Service Head to proceed with the booking. In the event of this not happening or not being evidenced, the full cost of the session(s) will be cross charged to the respective service line budget for payment.

In the event of the interpreter being cancelled and this information not being passed on to the service provider, there will be a cross charge made the requesting service.

The cost for written translations will be met by the service requesting the translation.

4.15 Written materials

Written documents must be clear and easy to understand, see the Plain English campaign website for further information.

It should be remembered that people whose first language is British Sign Language (BSL) will not necessarily understand standard written English. BSL users might request documents written in BSL English. See table below.

Information for patients must not be of poor quality e.g., a photocopy of a photocopy. Refer to OP46 Development of Parent / Carer Information for guidance on the development of written, printed or published information given to patients, relatives or carers about their clinical treatment.

4.16 Languages

Requests for written materials to be translated into another language must be directed to the appropriate service provider; please refer to the Intranet.

The cost for translation will be charged to the service requesting the material;

note: translations are usually priced on word count.

All information that is available for people who read English should be made available in different languages for people who do not read English. Written materials should only be translated upon request. Please note that it is not always necessary to translate all documents into other languages in advance. Consideration should be given as to whether there will be a demand for translated materials, it may be appropriate to translate key points.

Before you order a written translation ENSURE you confirm that the patient is able to read their spoken language.

IMPORTANT: If a clinician had any queries regarding verification of the translation for an individual patient, and if there were concerns as to whether inaccurate translation could lead to the wrong treatment, then the clinician must seek clarification accordingly.

If it is found that inaccurate language translations have been provided, this must be raised (by the person who has requested the translation) as a complaint directly to the translation service provider (see intranet).

4.17 Easy read

Easy read is a format that can help learning disabled people understand written information. Please contact the Learning Disabilities Specialist Nurse.

4.18 Braille

Braille is a system of touch reading and writing specifically for blind people. The alphabet and numbers are represented by raised dots which are felt with the fingertips.

4.19 Larger Print

Simply enlarging documents on a photocopier would not constitute a large print document. People will have different needs; for instance, someone may want a document in size 14 Arial on cream paper whereas someone else may require size 16 Arial on white paper with double line spacing.

4.20 Websites

If people are signposted to the Trust's website for information, this too must be accessible or the information must be provided in another accessible way.

4.21 How to obtain alternative formats

Regardless of what formats are requested, the Trust has a legal duty to provide reasonable adjustments and produce information in accessible ways. Staff must

enquire about a patient's individual needs, record them and provide them (as far as is reasonably possible).

Patients should not experience a second-class service when providing alternative formats. Below is a table of where to source some alternative formats.

Alternative formats	Details	Service provided by
Language translation	Documents translated into different languages	Via the Trust's external service provider, go to Intranet
Easy read	Easy read	Learning Disabilities Specialist Nurse for advice
Information produced by Clinical Illustration (MI / WCA number must be present)	Larger print	Clinical Illustration
	Alternative paper colours	
	Alternative font colours	
Multi-media requests (MI / WCA number must be present)	Electronic versions (e.g., PDF of document or audio).	Clinical Illustration
Braille	Electronic versions of documents can usually be translated into Braille	Contact Equality and Diversity Officer
BSL English	English that reflects the structure of British Sign Language	Trust's BSL provider – details available on the intranet EDI Page

If the format you need is not here, contact Trust's Equality and Diversity Officer

4.22 Communication aids

There are a range of communication aids and methods that can be utilised, a few examples are given below.

Portable Induction Loops – this system is for people who use a hearing aid, it reduces or eliminates background noise.

Fixed Induction Loops – These enable hearing aid users to hear better when using RWT reception points and other facilities.

Next generation text – this is a three way facility; You talk to a relay assistant, they type information to a patient, who then types back to the relay assistant. The relay

assistant then verbally relays the message to you. For more information go to Next Generation Text.

SMS text messaging – Utilise mobile phones to send text messages.

E-mail / electronic information – use e-mail to send messages to patients/service users.

Please remember **confidentiality and data protection** with all of these methods.

Appointments - longer appointment times to allow alternative methods of communication and to ensure communication has been understood. This may help a range of people including, people who stammer, have hearing impairments, have a learning disability, are deaf, people who require advocacy support or an interpreter etc.

5.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation of this policy require additional revenue resources	No
3	Does the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff.	No
	Other comments	

6.0 Equality Impact Assessment

The policy is written to meet the needs of all patients but specifically acknowledges the needs of people with the protected characteristics of age, race and disability.

Therefore, this policy specifically addresses the need to provide reasonable adjustments for disabled people such as providing alternative formats e.g., larger print, translations or providing sign language interpreters.

It also addresses the need to provide fair access for people who speak or read a different language through the use of interpreters and alternative formats. The specificity of this policy does not adversely affect any other equality groups.

7.0 Maintenance

The Head of Patient Experience and Public Involvement will coordinate the review of the policy, ensuring it is kept up to date.

The policy committee will approve any changes.

8.0 Communication and Training*

The policy will be communicated via divisional structures and accessible on the Trust intranet.

Guidance on interpreting and translation is available on the Equality and Diversity page of the Intranet.

Additional training will be provided to support the transition to telephone interpreting including training sessions, ward walks and promotional posters and leaflets. Information will be circulated via the all user bulletin and intranet as required.

9.0 Audit Process

Criteria	Lead	Monitoring Method All Monthly	Committee
A high quality service is available	Head of Patient Experience and Public Involvement	Management reports from provider to head of patient experience and public involvement and monitoring of the following five KPIs:	Information not reported to committee however any concerns would be escalated to Deputy Chief Nurse
		95% of all assignments requested by the Trust must be fulfilled by the suppliers within the agreed 3 day	
		95% of interpreters offered to the Trust must be of an NVQ Level 3 or higher	
		No more than a 10% of assignments arranged must result in a cancellation or 'No Show' by the interpreter	

		80% of urgent same day assignments requests shall be fulfilled	
		95% of invoices must be received within 21 days of assignment booking	

10.0 References - Legal, professional or national guidelines

1. Brighton and Sussex University Hospitals (September 2015). '*Accessible Communications Guidelines*'.

2. Department of health: the equality and human rights group. (2004) '*Guidance on developing local communication support services and strategies*'

3. Department of Health. (27 July 2015), '*The NHS Constitution for England*' © Crown Copyright 2015. 2904149. Produced by Williams Lea for the Department of Health. NHS Constitution (2015) www.orderline.dh.gov.uk quote 2900013 The NHS Constitution.

4. Equality and Human Rights Commission. (January 2011), '*Equality Act 2010 Statutory Code of Practice Services, public functions and associations'* © Crown Copyright 2011. London : The Stationery Office Limited. www.equalityhumanrights.com www.tsoshop.co.uk

5. Equality and Human Rights Group. (October 2008), '*Human Rights in Healthcare A framework for local action (2nd Edition)'* © Crown copyright 2008. 289869. Gateway ref 10482. London: Department of Health. www.orderline.dh.gov.uk : www.dh.gov.uk/publications http://webarchive.nationalarchives.gov.uk/search/?lang=en&where=text&query=Human+rights+in+healthcare&noneW=&exactW=&format=all&search_type=category&site=&x=0&y=0 [accessed 3.6.2016]

6. Human Rights Act (1998) (Article 14 - *Prohibition of discrimination*) http://www.legislation.gov.uk/ukpga/1998/42/contents [accessed 2.2.2.16]

7. NHS England. (3 July 2015), '*SCCI1605 Accessible Information Specification*'. Publications Gateway Reference number : 03571. NHS England, Patients and Information. https://www.england.nhs.uk/wp-content/uploads/2015/07/access-info-spec-fin.pdf http://www.england.nhs.uk/accessibleinfo [accessed 3.11.2015]

8. NICE National Institute for Health and Care Excellence. (February 2012) '*Clinical guidelines CG138. Patient experience in adult NHS services: improving the experience of care for people using adult NHS services'* http://publications.nice.org.uk/patient-experience-in-adult-nhs-services-improving-the-experience-of-care-for-people-using-adult-

cg138/guidance#enabling-patients-to-actively-participate-in-their-care [accessed 2.2.2016]

9. NICE National Institute for Health and Care Excellence. (February 2012) '*Sharing and Learning Database Crossing the language barrier with a dedicated Mental Health Interpreting Service'* http://www.nice.org.uk/usingguidance/sharedlearningimplementingniceguidance/examplesofimplementation/eximpresults.jsp?o=418 (last updated 3.2.2011) [accessed 12.4.2013]

10. NICE National Institute for Health and Care Excellence. (September 2010) 'NICE CLINICAL GUIDANCE 110 : *Pregnancy and complex social factors A model for service provision for pregnant women with complex social factors*'

11. Public Health England. (no date) 'Interpreter Guidelines'

12. The Royal New Zealand College of General Practitioners. (2012) '*Improving Communication for Patients with Limited English Proficiency A critical review of a practice process to improve patient experience and equity*' ISBN : 978-0-9864536-9-4 http://www.rnzcgp.org.nz/assets/documents/Standards--Policy/LimitedEnglishProficiencyModule4web.pdf [accessed 2.2.2016]

Document Control

Reference Number and Policy Name: OP 47 Interpreting and Communication Policy and Procedure	**Version 7.1**		**Status: Final**	**Author: Head of Patient Experience and Public Involvement** **Sponsor: Chief Nurse**
Version / Amendment History	Version	Date	Author	Reason
	1	Dec 2004	Head of Patient Experience	Update
	2	Nov 2006	Head of Patient Experience	Update
	3	Sept 2008	Head of Patient Experience	Update
	4	February 2012	Head of Patient Experience	Update
	5	March 2016	Head of Patient Experience and Public Involvement	Update to incorporate key information about legal and mandatory requirements. Change name to incorporate communicating with patients/service users.
	6 (this version)	February 2019	Head of Patient Experience and Public Involvement	Update
	6.1	July 2022	Head of Patient Experience and Public Involvement	Extension Applied
	6.2	September 2022	Head of Patient Experience and Public Involvement	Extension Applied
	6.3	October 2022	Head of Patient Experience and Public Involvement	Extension Applied
	6.4	March	Head of Patient	Extension Applied

		2023	Experience and Public Involvement	
	6.5	June 2023	Head of Patient Experience and Public Involvement	Extension Applied
	7	August 2023	Head of Patient Experience and Public Involvement	Full Review
	7.1	December 2023	Head of Patient Experience and Public Involvement	Minor updates to Appendices 1 & 2
Intended Recipients			All staff who need to access interpreting services for patients/service users	
Consultation Group			All staff internally through internal consultation via the Patient Experience Groups and Forums which include a variety of staff from the following: Chief Operating Officer Deputy Chief Operating Officers Heads of Nursing Head of Governance LD Specialist Nurse Divisional Management Teams Deputy Chief Nurses Senior Management Team The patient voice through the Patient Involvement Partners Healthwatch Current Trust Interpreting Providers	
Name and date of Trust level committee where reviewed			Trust Policy Group - August 2023 Trust Policy Group Virtual Approval – December 2023 – V7.1	
Name and date of final approval committee			Trust Management Committee – September 2023	
Date of Policy issue			December 2023	
Review Date and Frequency [standard review frequency is 3 yearly unless otherwise indicated]			August 2026 - 3 yearly	
Training and Dissemination			Through induction / local training	
To be read in conjunction with				

Initial Equality Impact Assessment [all policies]	Completed: Yes
Full Equality Impact assessment [as required]	Completed: No
Contact for Review	Head of Patient Experience and Public Involvement (HOPE)
Implementation plan / arrangements [Name implementation lead]	Head of Patient Experience and Public Involvement (HOPE)
Monitoring arrangements and Committee	Information not reported to committee, however any concerns would be escalated to Deputy Director of Nursing – Quality & Safety.
Document summary / key issues covered:	The procedure for accessing interpreting services including telephone, face to face and British Sign Language (BSL)

The Royal Wolverhampton NHS Trust

Guidance on Interpreter Service Identification

The clinician / person responsible for patient care decides if the patient/service user requires interpreting support based on their needs. Identify language needs:-
Whilst this is intended as a guide, it is for the clinician to determine the best method of interpreting needed for the patient having considered all options available.

If BSL Interpreter required, book accordingly – details on the intranet		
Patient/service user with little or no spoken English Flowchart (language interpreter required)		
Criteria (Type of Interaction)	Examples	Type of provision
Basic Care or advanced care where consent is not required.	**Personal details, determining condition, discussions/help on toileting and feeding. General conversation.** **When a patient has to be advised of medical terminology, and process of treatment plans/pathways** **Outpatient – first appointment diagnosis or new health issue unless there is bad news to convey or a need to consent for an invasive investigation or treatment.** Routine nurse led preassessment clinics could be telephone however more complex assessments requiring anaesthetic review are much less common but likely to require some clinical examination and in depth discussion re risks/benefits - Ideally F2F would be more appropriate (but if not available then telephone would be acceptable and preferred). **Surgical Admissions** (operations) or assessments (history taking) **Pre/post-operative assessments** (e.g., Therapy group sessions) Review of stable conditions	**Use telephone interpreting** Default use of relative / friend / carer / staff (18+) is not appropriate unless no other option is available: consider patient's view of this with their consent. If patient declines use of interpreter, record information in patient notes.
Early stages of unplanned or unscheduled care	Emergency Department, MIU's, Out of Hours, MAD, CDU, Emergency Maternity Admissions, Drop-in Clinics etc.	**Use telephone interpreting** Default use of relative / friend / carer / staff (18+) is not appropriate. If no other option is available consider patient's view of this with their consent. If patient declines use of interpreter, record information on patient notes.
Complex Communication or Discussions about protection/safety issues	**New diagnosis** **Breaking bad news** **Complex review** (only with senior manager's authorisation) e.g.: physio appointment with new exercises for ongoing treatment after a stroke **Communicating with a child or if the patient is vulnerable e.g.,** patients with dementia, mental health or a learning disability, children and elderly patients etc. **Multi professional meetings (involving patient)**	**Approved Face to Face external interpreter required.** If non available, video or telephone to be used.
Obtaining consent	**Consent for surgical intervention or invasive procedure*** (including anaesthetic pre-assessment for surgery (nurse led)), chemotherapy and radiotherapy	**Approved Face to Face external interpreter required.** If non available, video or telephone to be used.

		Where consent is required, and a face to face or video interpreter is not available, clinicians should consider a contingency plan, including other interpreting options to enable informed consent.
Please see policy for requirements relating to the length of time of interpreting required. There may be some instances where authorisation from senior manager is required prior to booking (over 1.5 hours) or, in the case of appointments expected to last over 3 hours, the completion of a form will be required. There are limited exceptions to this. **If the session is expected to be over 3 hours. If this form is not completed and authorised, your department may incur the costs of the interpreting session.**		
Please consider that the use of alternative methods of interpreting rather than face to face does not offer any less of a standard of interpreting – no body cues, prompts or body language can be considered from the interpreter – their role is purely to relay the actual spoken language only. The provision of telephone or video interpreting, in the majority of cases, will mean instant access and provision and will not need to be pre-booked or need to be cancelled.		

Authorisation number	AUT

Interpreter Request Authorisation Form

Complete this form for **requesting** a **face- to- face language interpreter** for sessions anticipated to be **over 1.5 hours**.

*__Contact details__ (of person requesting interpreter)

Name		Address and post code	
Tele number			
E-mail			
Fax number			

***Appointment details** (where patient/interpreter will be attending)

Onsite contact name		Patient's name	
Venue address (include zone and location number if applicable)		Hospital number	
		Language required	
		Second language	
		**Preferred gender of interpreter	
		Appointment date	
		Start time	
Postcode		End time	
Contact number		Approximate Duration	
Additional instructions			

***State reasons why the interpreter will be required for over 1.5 hours**

All assignments are treated in the strictest confidence. If you believe this assignment is particularly sensitive, please tick this box ☐

*To be completed and by a senior manager (e-mail will act as electronic signature if sent/cc senior member of staff)

Authorised by (name)		**Signature or e-mail address if sending via e-mail**	
Title		**Tele**	

Division 1	✓
Diagnostics Service Group	
Theatres/ICCU Service Group	
Cardiology/Cardiothoracic Service Group	
Surgical Services Group	
Trauma and Orthopaedic Services	
Women and Children's Services	
Ophthalmology/Head and Neck Services Group	

Division 2	✓
Children's Services Group	
Adult Community Services Group	
Rehab and Ambulatory Medical Group	
Medical Group	
Emergency Services Group	
Therapies and Pharmacy Group	
Oncology and Haematology Group	

Corporate	✓
Chaplaincy	
Clinical Audit	
Education and training	
Estates and Facilities	
Finance	
Governance and Legal	
Health Records	
Human Resources	
Infection Prevention	
Information Services	
Medical Illustration	
Medical Physics	
Occupational Health	
Patient Experience Services	
Patient Transport	
Procurement	
Research and Development	

Send form (via e-mail with *Interpreter Request, your department and appointment date* in the subject header) **to**:-

Equality and Diversity Officer
Patient Experience Team
Patient Information Centre (PIC)
Royal Wolverhampton NHS Trust
New Cross Hospital, Zone C, location C2
Wednesfield Road, **WOLVERHAMPTON**, WV10 OQP

E-mail rwh-tr.EqualityandDiversity@nhs.net
Tel 694479 / 695362

Opening hours Monday to Friday 8.30am – 4.30pm, (excluding bank holidays). If request is out of hours, contact Word360 directly (0121 554 1981 teamwork@word360.co.uk) Send this form advising that the session has taken place.

For urgent requests, call Equality and Diversity Officer/PALS team, complete and send form.

*Mandatory fields – request form will be rejected if not completed.
**The gender of an interpreter can be requested, however, there is no guarantee this can be provided.

This form will be sent to relevant personnel (internal/external).