

NHSScotland Interpreting, Communication Support and Translation National Policy

Enabling equitable access to safe, effective and
person-centred healthcare services through spoken,
signed and written language communication support

Citation:

Public Health Scotland. NHSScotland Interpreting, Communication Support and Translation National Policy. Enabling equitable access to safe, effective and person-centred healthcare services through spoken, signed and written language communication support. Edinburgh: PHS; 2020.

We would like to thank the members of the National Working Group for this policy for their insight and guidance, and for facilitating the views of interpretation service users.

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1. Introduction

NHSScotland is committed to providing high-quality healthcare services¹ that are person-centred, safe and effective. Good communication is a vital component in delivering high-quality healthcare and in enabling equitable and inclusive access to services and health information.

NHS Boards and their partners are responsible for the commissioning and delivery of interpretation and translation services. This policy will ensure that NHSScotland has a clear, consistent, transparent and fair approach to the provision of information and communication support for all, in line with policy and legal requirements (see [Appendix 1](#)) The policy covers all of NHSScotland's 'corporate business', including both internal and external communication, and should be followed by all NHSScotland staff. Further clarity of scope can be found below.

Local NHS Equality and Diversity Leads should be contacted for further guidance or support in providing interpretation and translation support services.

1.1 Purpose

The purpose of this policy is to provide guidance on NHSScotland responsibilities to patients and carers who require support from interpreting or translation services. It will help to ensure that patients and carers have equal access to excellent patient care by helping staff to understand patients' and service users' healthcare needs. It will support staff to understand the interpreting and communication support they need to put in place to ensure that patients who do not speak or use English have equitable access to the health services they provide. This policy covers both interpreting and translation.

¹ Healthcare refers to provision of health and social care services by the NHS and health and social care partners.

Interpreting is the facilitation of spoken or signed language communication between users of different languages – not just the meaning of the individual words, but the essence of the meaning too. For the purpose of this policy, interpreting includes spoken language interpreting, British Sign Language (BSL) interpreting, remote interpreting, lip speaking and note taking, and tactile BSL. Translation is the process of transferring written text from one language into another; or from English written text to BSL sign captured on video.

Responsibility for providing an interpreter or translation is with the NHS and not the service user. Local NHS Boards must ensure that the appropriate type of interpreting service (telephone, face-to-face or online) is booked and provided to meet the individual's health and language needs, where practically possible. It is acknowledged, however, that limitations to the provision of face-to-face interpreting services may occur, for example in emergency situations or rural areas, where there may be limited access to interpreters to enable face-to-face interpretation.

NHS Boards should be familiar with the demographics of their local area and should assess which spoken and signed languages are used among their local population. This will help services effectively plan for the language interpreting and translation services that may be required.

1.2 Scope

This policy provides a common set of standards for interpretation, translation, transcription and communication support. It also includes the accessibility of information, published documents and digital content. The policy aims to:

- describe accessible information and communication and why it is important
- define the roles and responsibilities of NHSScotland staff with regards to accessible information and communication

- provide advice about some of the more common information formats and communication support that may be needed
- explain the policy and how it relates to local procedures associated with arranging and procuring interpretation, translation, transcription and other forms of communication support.

The scope of the policy includes:

- communication, including methods available for people to contact NHSScotland and support for patients in appointments
- information, including all information published by NHSScotland whether hard copy or electronic, including the accessibility of documents, online content, and the availability of information in accessible formats
- addressing communication needs, including arranging professional interpreting and adapting behaviour to support individuals or groups of patients
- support for communication needs for all patients whose first language is not English, including BSL and for Deafblind patients who use tactile BSL
- the accessibility of internal communication, information, engagement and consultation exercises for NHSScotland staff
- the accessibility of information required and used by staff in their work, including national electronic systems.

Not included in the scope of the policy:

- Although we recognise the importance of clear, understandable communication for all, the scope of this policy does not cover the provision of wider communication support needs and methods, or

accessible information services. Wider communication support needs for patients may present due to neurological impairment (such as aphasia, brain injury, stroke), physical disability, autism or mental health condition, and so on. Advice should be sought from local speech and language therapists to ensure effective communication support is provided for those patients who require it.

This policy applies to and benefits:

- NHSScotland staff across all NHS Boards (local and national) and partner agencies or contracted healthcare service providers (unless otherwise stated) and in all health and social care settings where NHS services are provided by NHS staff. It aims to ensure that all staff comply with their legal and moral duty to reduce inequalities between service users and provide equitable access to healthcare services under the Equality Act (2010) and BSL (Scotland) Act 2015
- patients, their family members and carers (anyone who supports the patient formally or informally) who require interpreting and translation support
- healthcare staff, by enabling and ensuring effective communication during healthcare interactions.

For definition of terms see [Appendix 2](#).

2. COVID-19: Use of interpreting and translation support services

Despite the challenges associated with COVID-19, NHSScotland continues to be committed to providing high-quality healthcare services that are person-centred, safe and effective. This national policy outlines best practice for the provision and use of interpreting and translation services. While health and care service provision has changed to account for COVID-19, we would still encourage you to follow best practice and the further guidance set out below.

When determining whether there should be face-to-face provision of interpreting or translation support, each case should be assessed and determined on a patient and case-by-case basis, using the information detailing patient's communication support requirements as identified in the patient needs information or case files. Where it is deemed that face-to-face interpreting or translation support is required, the appropriate mitigation measures should then be put in place.

The following should be considered:

- 1) What is the need for a face-to-face appointment? Each case should be considered on an individual basis.
- 2) What is the risk of a face-to-face appointment, for the patient, interpreter or communication support worker and healthcare professional?
- 3) If a face-to-face appointment is required, what measures need to be put in place to mitigate the risk for the patient, interpreter or communication support worker and healthcare professional?

2.1 Governance of services

In addition to the governance requirements set out (see section 8, [Governance](#)), risk assessment should be built into the monitoring and governance arrangements for interpretation and translation service provision.

2.2 Patient communication

The additional communication needs of patients should be considered ahead of any communication with that patient and the communication method adapted to account for identified needs.

As with face-to-face interpreting, responsibility for providing an interpreter for remote telephone or video consultations is with the NHS, through the interpreting and translation services, and not the service user.

2.3 Telephone consultations

Where a telephone consultation is taking place, telephone interpreting should be arranged through local processes. It should be noted that telephone consultations are not suitable for all patients, for example BSL users, those with cognitive impairment or children over two years who are lingual.

2.4 Video consultations – Near Me/Attend Anywhere

Where a telephone consultation is not appropriate, a video consultation, for example through Near Me or similar video consultation technology, may be arranged. For further information on Near Me visit www.nearme.scot. For local arrangements to arrange translation or interpreting for a video consultation interpreting please contact your local interpreting and translation service.

2.5 Provision for Deafblind service users

For Deafblind service users, due to their dual sensory impairment, it is recommended that remote consultations are the preferred option. This would take place in the Deafblind users' home with a guide communicator and the use of personal protective equipment (PPE) by both parties. If the Deafblind person is also a BSL user, a BSL/English interpreter will still be required, and the local interpreting and translation service should book this. Remote

consultations will reduce the risk of Deafblind users having to travel by public transport. For further advice on guide communicators contact Deafblind Scotland www.dbscotland.org.uk

3. Why interpreting, communication support and translation are important

Effective and accessible communication is vital for the provision of high-quality services and care. Good communication, both verbal and written, lies at the centre of successful, person-centred healthcare. It enables service users to fully participate in their care, express their needs, feel understood and make informed decisions, improving the service users' overall healthcare experience. It enables staff to discharge their duty of care equitably by using interpreting and communication support for patients they cannot communicate with. It also contributes to effective prevention and health improvement activity to support the patient to improve their own health.

3.1 Interpreting and communication support

NHS staff should be aware that people who require interpreting:

- can find it difficult to access language support in the health service, leading them to experience inequitable access to health services and information
- need to be identified quickly by staff so that appropriate language support can be put in place
- may not understand information written in English
- may also experience communication misunderstandings due to cultural differences
- may experience greater communication difficulties in stressful or emotional situations
- will also have difficulty understanding written healthcare information and messages.

NHS staff should therefore understand that when they cannot communicate with a patient directly, language difficulties can occur. Therefore they need to ensure that the most appropriate interpretation or communication support service is in place for delivery of person-centred care.

3.2 Translation

Patients, family members, carers and healthcare professionals should have timely access to appropriately and effectively translated information that will enable and support their healthcare. Information can act as a back-up to reinforce information that has been given verbally by an interpreter.

NHS Boards must meet service users' translation needs. Responsibility for provision of translations is with the NHS and not the service user. Service providers should ask about service users' language needs before producing a translation. Translation of written materials is costly and it should be noted that service users whose first language is not English might not be able to read their own language. This should also be clarified with the patient.

3.3 Patient safety and risk management

3.3.1 What is the risk?

From a patient safety and quality perspective, communication barriers between patients and healthcare staff reduce the quality of healthcare delivered. Language, cultural and communication barriers increase the risk of misunderstanding between the patient, family member or carer and healthcare staff member.

Provision of interpreters and language support enables people to participate and make more informed choices about their care. For staff, it supports communication with patients, assists with diagnosis, and helps in the process of obtaining informed consent. It also promotes effective and efficient use of resources.

Poor communication contributes to non-compliance with treatment, cancelled or missed appointments, repeat admissions, delayed discharge and exposure to litigation for negligence and errors.

Interpreting services address a number of risks for both service users and staff. For example, individuals who do not have an effective language support intervention in an appointment with a health professional cannot do the following without an interpreter:

- Give informed consent – this is not legal without proper and understood explanation.
- Ask questions or seek assistance.
- Provide information to the healthcare professional.
- Be aware of what services are available to them.
- Use medication properly or follow care plans.
- May not understand how to use NHS services.
- May not understand their rights and responsibilities within the healthcare system.

In addition, the 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.

3.3.2 Bilingual staff members

Healthcare staff who are bilingual but not registered with an accredited interpretation or translation service should not act as an interpreter or translator. A professional interpreter/translator is more appropriate to ensure accurate, high-quality interpretation/translation. They are also covered by indemnity insurance in case of an error. If a staff member is a qualified

interpreter there are no legal or liability issues, however as staff members there could still be issues of conflict regarding their ability to do both roles.

Other reasons not to use bilingual staff to interpret or translate include:

- taking staff away from their own job
- not knowing their language ability if they're not a native speaker
- not knowing their English ability unless they have been language tested for their role
- it would be an ad hoc arrangement which appointment systems cannot rely upon
- the potential to double up on staff and waste money
- not being covered by indemnity insurance if interpreting is not an official role of theirs.

Bilingual staff who are involved directly in the care of the patient can use their language skills for social/friendly chat with the patient until the interpreter arrives, or in between booked interpreters in an in-patient setting. This should never be a clinical discussion, but can be social chat to engage with the patient who may be feeling isolated due to a language barrier.

3.3.3 Family, friends and carers

NHSScotland does not recommend using service users' family members, friends or carers for interpretation or translation. Family members, friends and carers may wish to act as interpreters, and they do have the advantage of knowing the patient and speaking the same language. However, it is not appropriate to use a family member, friend or carer as an interpreter except in exceptional circumstances when no other alternatives are available, for

example in an emergency department when the patient cannot use telephone interpreting to describe their condition.

Telephone interpreting for spoken languages and online interpreting for BSL should be in place to ensure quick access to professional interpreters at short notice for those whose first language is not English. The use of a professional language support service can ensure independence, impartiality and confidentiality. By providing an independent interpreter, the patient and healthcare professional can be assured of good-quality interpretation.

3.3.4 Reasons not to use family, friends and carers as interpreters

Inaccuracy of interpretation

- Accurate and vital information may be left out as the family member or friend may change the information given due to a lack of knowledge or understanding of the situation or terminology. They may also be unwilling to say they do not understand something that has been said, leading to a breakdown in communication.

Filtering of information

- Family or friends may wish to protect the service user from bad news and therefore may filter the information they provide. Likewise, they may omit abusive language so as not to offend the practitioner. This information could be vital, for example when assessing the mental state of the service user. **For suspected child protection issues, staff must provide a separate interpreter, to allow the child's voice to be heard.**

Loss of confidentiality

- The service user may not want to discuss certain sensitive or personal issues in front of family or friends. There could be issues, such as family problems or crises, which are having an impact on the service

user which they may not feel able to disclose, due to the family or friend's presence. This could ultimately impact on the health or safety of the service user and clinical outcomes.

Conflict of interest

- There may be a conflict of interest between the service user and their family or friend which could result in vital information being withheld or not passed on.

Vulnerability of patient with regard to gender-based violence

- Patients who have been trafficked or who are subject to gender-based violence can be misrepresented by a person who does not have the protection of their wellbeing as a priority.

Children should never be used as interpreters

- It is never appropriate under any circumstances to use a child under the age of 16 as an interpreter. Using children may have harmful effects on the child. Service users who bring a child as a language support should be discouraged from doing so. Interpreting, particularly in health settings, is a serious responsibility and should not be placed upon a child to undertake.

In an emergency situation a child could be used to gather vital information as to what has happened to the patient, but cannot be used to interpret. Telephone interpreting and online BSL should be used until a face-to-face interpreter arrives.

3.3.5 Where a patient refuses professional interpreting support

If a patient wishes to use a friend, family member or carer as an interpreter, the importance of using a professionally trained interpreter must be explained to them, through a professional interpreter. Healthcare services have a duty to ensure that all interpreting is accurate, clear and consistent. Using a professional interpreter ensures that the information that needs to be shared with the patient is accurately interpreted. It also protects patients from coercion, hidden adult or child protection issues and can help identify those patients potentially involved in or at risk of human trafficking, gender-based violence and other forms of abuse.

If the patient continues to insist on using a friend, family member or carer to interpret, **it must be documented in the service user's healthcare record and signed by the patient** to say that this was their personal request. The patient's informed consent to this must be in their own language and be sought from them independently of the family member, friend or carer. Only the clinician, patient and interpreter should be present during this conversation to safeguard against possible coercion.

Where there are concerns for child safety or gender-based violence an NHS interpreter should also be present at all appointments.

For children, a face-to-face interpreter must always be provided. If there are suspected child protection issues, staff must provide a separate interpreter to the parent, to allow the child's voice to be heard.

4. Provision of interpreting/communication support

Interpreting support should be provided in all patient settings, for both in-patient hospital stays and out-patient appointments within acute and community services.

Access to professional interpreters must be 24 hours a day to match the provision of NHS services. All services must have access to interpreting support for patients at short notice and outwith daytime provision.

Carers or immediate family members who are providing support for the patient should be given interpreting and translation support where they have a language support need. NHSScotland has the responsibility to consider carers' needs and their wellbeing when providing care for a patient. Accurate information and advice are a priority; therefore good communication with carers is essential.

4.1 Establishing the need for an interpreter or communication support

The ability of healthcare staff to communicate with service users/carers is fundamental to safe and effective clinical care. An interpreter/communication support should be booked when a service user is unable to communicate or understand English well enough to participate in their appointment or procedure.

An interpreter/communication support must be provided when:

- the patient's first or preferred spoken language is not English, or they speak some English but require an interpreter to explain detailed clinical information or understand complex explanations of the appointment or their treatment
- the patient's first language is British Sign Language

- the patient is Deafblind (dual sensory impaired) and uses manual/tactile sign
- the patient requests interpreting support
- the patient has a hearing impairment, is a lip reader or uses an electronic note taker
- the patient is Deafblind (dual sensory impaired) and requires a guide/communicator.

See [Appendix 3](#) for more information on identifying the need for an interpreter.

4.2 Types of interpreting/communication support

Different types of interpretation/communication support services are available.

Interpreting relates to languages specifically, and communication support relates to the additional support a person requires to understand English.

These include the following:

- Spoken language interpreting
 - Telephone interpreting (preferred option)
 - Face-to-face interpreting
- British Sign Language interpreting
 - Face-to-face interpreting (preferred option)
 - Remote video relay interpreting
 - Tactile or manual signing
- Other communications support
 - Note taking
 - Lip speaking

- Guide communicators

4.3 Provision of interpretation and communication support

4.3.1 Spoken language – telephone interpreting

For spoken community language users, telephone interpreters should be used as the initial and principal form of language support. Telephone interpreting services for spoken languages is available 24 hours a day, 365 days a year.

The benefits of telephone interpreting are laid out in [Appendix 4](#).

4.3.2 Spoken language – face-to-face interpreting

Telephone interpreting services are not always the most suitable option depending on the healthcare situation or the language need of the service user. In certain situations, face-to-face interpreters should be used instead, for example for long or complex consultations, for all children under the age of 16 and/or for a child's parent/carer. Face-to-face interpreters are also best for sensitive, vulnerable or traumatic cases, gender-based violence, mental health appointments, complex maternity appointments and palliative care. For these appointments, a face-to-face interpreter should always be used to support patients to get the best outcomes for their treatment and to ensure Health Boards meet the three Quality Ambitions of the Quality Strategy: safe, person-centred and effective.

The benefits of face-to-face interpreting are laid out in [Appendix 5](#).

4.3.3 British Sign Language users – face-to-face interpreting

It is a legal requirement to ensure the provision of BSL interpreters for BSL users as this is their first language, rather than English. Face-to-face interpreting for BSL is the preferred and main method of delivering interpreting.

4.3.4 Deaf relay interpreting and International Sign Language

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 to enable professional communication support in their appointments. All Boards should have access to deaf relay and International Sign Language interpreters for these patients.

4.3.5 BSL – video interpreting

Video interpreting is a growing area for BSL interpreting but it can present challenges due to difficulty seeing the visual hand gestures and signs on a screen due to glare from the screen or difficulty concentrating, or poor internet connection. Using a screen can also cause eye strain for people with visual impairment. It is therefore not the main format in which to provide BSL interpreting.

Prior to the COVID-19 pandemic, video interpreting should only have been used in certain circumstances, such as an emergency or for short routine appointments (such as taking bloods or immunisations), where a BSL user has agreed in advance to use video interpreting or while waiting for a face-to-face interpreter to arrive. Given the increased use of video consultations during the COVID-19 pandemic, providers should account for the potential varied experience of BSL users and ensure that BSL users are confident and able to do video consultations.

NHS Boards should have access to BSL video interpreting services to ensure they can meet on demand, unplanned appointments.

A face-to-face BSL interpreter should be sought as soon as possible for any emergency situations, even when online is available.

4.3.6 Deafblind manual

For Deafblind tactile BSL users, the guide/communicator must be in the room with the service user to enable effective communication through signing using touch. This will take a much longer time than BSL or other forms of interpreting and this must be accounted for in each appointment.

4.3.7 Note takers – face to face

A note taker should be provided for those whose first language is English but cannot hear well enough to understand speech. A note taker is a professional using specific software to record what is said and relay it to the patient with a hearing loss in real time. This is the preferred mode of delivery for those who require note taking.

4.3.8 Note takers – remote

Remote note takers use technology to deliver note taking to the clinician or patient device from a remote location. The reliance on technology for this approach means that it should be tested in the environment in which it is intended to be used before the patient is there. Remote note taking should be available in Boards to enable emergency responses for those with a hearing loss.

4.3.9 Lip speakers

Lip speakers are professionals who re-state what is being said to a person with a hearing loss who reads lips proficiently. It is the preferred communication support method for some people with a hearing loss. Boards should have access to booking lip speakers for these patients.

4.4 Quality of provision

4.4.1 Timeliness

Patients, family members or carers requiring an interpreter should not be disadvantaged in terms of the timeliness of their access to healthcare services and information. Interpreting and translation service providers should be contacted as soon as possible to arrange an appropriate appointment time.

Patients whose first language is not English should not have their Referral to Treatment waiting time guarantee breached through not having interpreting support and delaying the onset of treatment as a result.

It is acknowledged that there are not enough interpreters available on occasions. In this instance staff should use telephone interpreting and online BSL interpreting to ensure there is no delay in initiating or completing the patient's treatment. Staff could also liaise with the patient where possible to find an alternative appointment date that they are happy with while managing the patient's expectations.

Staff should also note that using interpreters in consultations will mean extra time is required, so double appointments should be booked where necessary.

4.4.2 Face-to-face interpreting services

Specific circumstances may mean it is most appropriate for a service user to have a face-to-face interpreter and the same interpreter. Good practice indicates that where a patient requires continuity of care (for example, end-of-life care) they should be able to access the same interpreter wherever this is practicable.

NHS staff should seek to ensure continuity of interpreters is offered in the following circumstances:

- Mental health appointments.
- Trauma-related appointments.

- Sensitive or vulnerable appointments.
- Maternity appointments.
- A series of therapeutic interventions.
- End-of-life care.
- For patients with additional vulnerabilities such as dementia.
- All appointments for children (whether the child or their parent/carer require an interpreter). Where there are concerns around the child's safety or welfare, interpreters must be used to interview children alone without a parent or carer present to clarify the child's version of events and to enable their wishes and feelings to be understood. This must be done with a staff member present.
- Where further appointments are scheduled between the clinician and patient, the same interpreter should be used where possible. The same booking procedures should be followed: booking of the interpreter must be arranged with the interpreting service, and not with the individual interpreter.

4.4.3 Support for sensitive, vulnerable or traumatic appointments

All interpreters of both spoken and sign languages should be aware of the potentially sensitive and emotive situations that they may encounter and should have appropriate support structures in place in case of the need to debrief or seek appropriate counselling (following interpreting for a vulnerable or sensitive case, such as a child, victim of violence, asylum seeker, and so on).

NHS staff should also be aware of and considerate of situations of a sensitive or vulnerable nature (such as cases involving migrants, refugees or asylum seekers, or violent or abusive cases) which may require additional emotional

support for patients, family members, clinicians and interpreters who are subject to hearing and interpreting sensitive and vulnerable information.

Any contracted agency that is providing interpreting for a Health Board should include a support element for interpreters experiencing sensitive or traumatic appointments. For NHS Boards who provide interpreting support or for independent interpreters support should be offered by the Health Board through Occupational Therapy or other means.

4.4.4 Qualifications and registration of interpreters and translators

There are many qualifications for spoken and sign language interpreters and translators. NHSScotland must seek to provide the most experienced and appropriately trained interpreters and translators to meet the needs of the service user, the organisation and its broad spectrum of healthcare. NHS staff must be aware of the minimum qualification standards that interpreters must hold, especially for BSL interpretation.

Spoken language interpreters and translators should hold a professional qualification for interpreting and/or translation where possible. It is acknowledged, however, that it is not always possible to obtain a qualified interpreter for rarer and lesser spoken community languages. In these circumstances the use of an unqualified interpreter is acceptable. All unqualified spoken language interpreters should be language tested by an accredited agency and trained in medical language and how the NHS works before taking on NHS appointments.

For British Sign Language interpretation, all interpreters and translators must be fully qualified and fully registered with an appropriate governing body such as National Registers of Communication Professionals Working with Deaf and Deafblind People (NRCDP) or Scottish Register of Language Professionals with the Deaf Community (SRLPDC). Trainee interpreters should not be used in NHS clinical appointments.

All interpreters should be Disclosure Scotland checked and have an agreed code of conduct for working in healthcare settings. All BSL interpreters working within healthcare settings must have undertaken additional healthcare interpreter training and have previous experience of working within healthcare settings.

Trainee BSL interpreters should never be the primary interpreter for a clinical appointment. Trainee interpreters may not have the experience or have developed the skills or vocabulary to interpret for clinical appointments. By not using trainee interpreters, any potential risks are averted and an accurate interpretation for the consultation can be provided.

Where a trainee BSL interpreter is present at an appointment they must be accompanied by a fully qualified interpreter and consent must be provided by the BSL service user if the trainee wishes to practise their interpreting.

NHS Boards should look at opportunities available to support interpreters' professional development, as well as providing opportunities for trainees (who are working towards a full qualification) to shadow qualified BSL interpreters and develop their experience and skills.

5. Translation and accessible formats

Effective information is a vital component of patient-centred care. Many people cannot access information provided. This may be because they have a visual impairment, cannot read English, only read/understand another language or have a learning disability. Children and young people also have specific communication requirements.

Wherever possible, all printed documents should also adhere to the following simple guidelines to support accessibility:

- Use a minimum font size of 12, preferably 14.
- Use a sans serif font such as Arial.
- Align text to the left and do not 'justify' text.
- Ensure plenty of white space on documents, and if appropriate add a double space between paragraphs.
- Print on matt and not gloss paper.
- Include page numbers.
- If printing double-sided, ensure that the paper is of sufficient thickness to avoid text showing through from the other side.
- Avoid inverse text.
- Avoid printing text over images.
- Include the 'accessible communication statement' in a prominent position (see page 29).

5.1 Establishing the need for translations and accessible formats

The provision of health information is delivered both nationally by NHS inform and locally by geographic Health Boards. There are four types of information for patients:

- Public health information.
- Clinical patient information.
- General patient information.
- Specific patient information.

5.1.1 Public health information

This is largely the remit of the Public Health Directorate in each Board and all materials are either developed nationally by Public Health Scotland; locally in response to an assessment of need and an associated information gap; or quality-assured information produced by charities/third sector organisations.

5.1.2 Clinical patient information

This describes information that will support patients in making informed choices about their healthcare and treatment options; providing background information on conditions; information about the range of treatment and care options available; the risks and benefits associated with each option or with non-treatment; information enabling informed consent; and information associated with self-care/rehabilitation. These are produced locally by each Health Board to meet its local need.

5.1.3 General patient information

This relates to patient experience and is produced as written materials on a local Health Board basis such as the Infection Control leaflets or Food in Hospitals booklets.

5.1.4 Specific patient information

This relates to individual patients and largely reflects patient letters/communication and patient clinical records.

Patient information should be produced in such a way that it is accessible to all and addresses health literacy. Good health literacy is a key determinant of good health. It can improve the patient's access to and use of healthcare, their interaction with health service providers, their ability to care for their own health and the health of others, and be involved in decision-making about health in society.²

The provision of interpreting and translation services also applies to immediate family members or carers who are supporting the patient. Patients, family members, carers and healthcare professionals should have timely access to appropriately and effectively translated information that will enable and support their healthcare. Translated information can act as a backup to reinforce information that has been given verbally by an interpreter.

NHS Boards must make every effort to meet service users' translation needs. Responsibility for provision of translations is with the NHS and not the service user.

² Making it Easier, A Health Literacy Action Plan for Scotland: www.alliance-scotland.org.uk/wp-content/uploads/2017/11/Making-It-Easier-A-Health-Literacy-Plan-for-Scotland.pdf

This does not mean that multiple formats or different versions of every document are always produced; rather that accessibility should be built into the development or standard of the document as far as possible.

5.1.5 Proactive publication

Proactive publication of accessible formats of documents alongside standard documents should be considered, and is most likely to be appropriate, when they:

- are targeted at the whole population and those requiring accessible formats are likely to request it, for example complaints procedures
- support proactive informed consent for a service to be delivered, such as immunisation or screening
- convey messages which have direct relevance to people with a need for information in an accessible format, such as access to learning disability services.

There is no national minimum requirement as to the type of information that should be translated in advance. This will be up to each Board to implement locally. It is more important to be responsive to the needs of patients/service users, accounting for the Equality Act and the BSL Act, with a robust local process in place.

When considering the publication of documents (including whether versions in accessible formats should be made available), consideration should also be given to the Equality Act 2010 to ensure that people with a disability are not put at a disadvantage when compared to people who are not disabled, and to advance equality of opportunity between different groups.

Generally, if a patient's first language or preferred language is not English, or if they require an accessible format, this should be considered for any leaflets or other information normally issued as part of patient care.

All NHSScotland publications should include an accessibility statement, for example:

‘This information can be made available in other formats such as easy read, large print, other languages and British Sign Language. Please contact [insert]...’

At national level, these other languages are as follows:

- Arabic
- Polish
- Simplified Chinese (Mandarin)

This language profile may vary across Scotland, and NHS Boards should account for and provide for their local languages profile.

5.1.6 Information for staff

Service managers must also support their staff who require particular support in relation to information they require at work. This should be addressed in line with local HR policies. This includes ensuring staff who require information in different formats to enable them to fulfil their work role receive the necessary support, including e-learning materials.

5.2 Types of translation

Information format is driven by the needs of the patient and the type of information required. Options include direct translation from one language to another, such as a spoken language or BSL. Audio versions of leaflets can be produced for those who cannot read or are visually impaired. Audio versions can also be done in different languages. Easy read version can be produced for those with a learning disability. The format must meet the needs of the specific patient and are usually done on request.

5.3 Provision of translation

A request for a translation or accessible format should be delivered within a reasonable timeframe if the information is not linked to a clinical appointment. For translation requests that do relate to a clinical appointment the translation should be delivered within five working days. If this cannot be met an alternative means to deliver that information would need to be explored, such as a member of staff meeting the patient to ensure they have understood instructions. Or calling the patient through a telephone or online interpreter should be considered.

Steps must also be taken to ensure that any requests received for accessible formats can be handled fairly, consistently and efficiently, and that individuals are not disadvantaged by any delay in receiving information in an accessible format.

Managing requests for translations requires each Board to:

- identify a contact point and system for the management of requests for accessible languages and formats
- minimise 'turnaround times', meaning the amount of time an individual must wait between requesting information in a particular format and receiving it
- have a process for 'time-critical' resources, such as to enable a patient to comply with instructions for appointments.

5.3.1 Written translations into another language

Where written information that has been produced by the NHS Board is provided, a written translation or an appropriate spoken interpretation of the written information should be provided in the service user's preferred language. Information should be like for like where possible. Images and diagrams that are integral to the information should also be translated.

5.3.2 Audio translations into another language

For patients who cannot read the language that they speak, audio versions of the information can be produced. Audio can also be used if a paper translation would be extremely expensive and disproportionate to the request made. An audio translation can be provided as an MP3 file or as a CD.

Ensure the patient has a means of listening to the recording before arranging it. Any resource that requires picture can also be recorded in audio but the English version should also be given to the patient and the recording should include references to diagrams with figure numbers and or page numbers.

5.3.3 Using an interpreter

An interpreter could be used to enable staff to read information to the patient. Interpreters **should not** be left alone with the patient or read information to a patient themselves. It should be noted that information which is reference material for the patient to use again and again is not appropriate for this method. An example where this works well is for patients' records which are from another country and can be read to a clinician for information.

5.3.4 BSL

The production of a BSL video version of information will ensure equitable accessible to people who are D/deaf who use this language. BSL videos should be commissioned from an organisation which specialise in their production, as skill is required in interpreting the information and in interpreting 'to camera'. Alternatively D/deaf people can be supported to make translations of English into BSL. BSL videos should also include subtitles or closed captions as standard.

It should be noted that the ability of people who are D/deaf to read and understand written English varies considerably and it should not be assumed that having a conversation via written notes is an appropriate way of holding a dialogue. Similarly, it should not be assumed that because someone is using one or more hearing aids they no longer need any support to communicate. They may, for instance, be supporting their hearing via lip reading. The

person's communication needs must be established with them in the first instance.

It should not be assumed that a BSL user can communicate in written English. Use of a pen and paper or lip reading are not usually appropriate as many BSL users' first language is not English. However, some D/deaf people can lip read and read written English and may use a lip speaker or note taker to help them communicate.

See [Appendix 6](#) for best practice guidelines on making a BSL video version of information.

5.3.5 Deafblind

A person who is Deafblind may need written information in an accessible format, such as audio, Braille, Moon or via email.

Braille and Moon are tactile communication methods used by some people who are visually impaired or Deafblind.

Staff should not make assumptions as to what format a Deafblind person may require. Some Deafblind people may now use screen readers and other assistive technologies, and many people who are blind now identify email/online information as their preferred information format. See [Appendix 7](#) for guidance about creating accessible PDFs.

5.3.6 Hearing loss

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

5.3.7 Visual impairment

A person who is blind or has visual loss may need information that is usually written down or provided in standard print to be provided in an accessible format such as:

- audio (on CD or as an MP3 file)

- Braille
- email
- large print (from 16 point upwards)
- Moon.

Note that people who are blind or have visual loss may require information to be sent or shared with them electronically (via email) instead of in a written or printed format. This is because use of email enables the recipient to use (their own) assistive technology or software, for example a screen reader which converts text to speech. Depending on the software or assistive technology used, a person who is blind or has visual loss may require information sent to them electronically (emailed) in one or more specific formats such as plain text (with or without attachments), HTML, and with attachments in Word or PDF format.

Although only a relatively small number of people who are blind now identify Braille as their preferred format, Braille remains an important communication format for many people who are blind, particularly older people, and may be some people's only means of communication.

Transcription of information into Braille should be undertaken by an organisation which specialises in production of this format. Braille documents should be protected from damage when being posted with protective packaging and a clear 'do not bend' instruction.

5.3.8 Learning disability

A person who has a learning disability may need information which is usually provided in standard English provided in an accessible format such as easy read or Makaton.

It should be noted that the level of a person's learning disability will have a significant impact on their ability to communicate and therefore level of support needed. People with a mild or moderate learning disability may be

living independently and need information in easy read format and verbal information explained more slowly and simply. A person with a more severe or profound learning disability is likely to be supported by one or more carers and will need additional support to communicate, including using a communication tool or aid and/or being supported by a communication support worker. People with a more severe learning disability may be more likely to communicate in non-verbal and non-traditional ways.

5.4. Quality

The use of a professional translation service can ensure independence, impartiality and confidentiality. There is currently no nationally recognised framework of suppliers for the NHS.

Automated online translating systems or software must not be used as the quality of the translations cannot be quality checked. If translated information is given out without having gone through a quality-assured process for translation, then the person giving out this information is liable for any incorrect information issued.

6.Roles and responsibilities

6.1 NHS Boards

It is the NHS Board's responsibility to provide professional interpretation and translation services for all patients, immediate family members and carers who require it. This is to meet the service user's rights to effective communication and equitable access to high-quality, person-centred services.

NHS Boards should consider their local/national data on local population need, including translation and interpretation needs, when developing and resourcing services. This information should be used in the procurement of services operating in the place of the Health Board.

6.2 Clinical staff

All healthcare staff should be aware of their legal and ethical responsibility to provide interpreting and translation services for patients, immediate family members and carers who have language support needs. Staff should be aware of and understand the language and cultural barriers that can prevent service users accessing healthcare services and information equitably and should respond to an individual's language need in a way that ensures language support needs are met. This ensures that individuals whose first language is not spoken or written English, who are D/deaf or hearing impaired, Deafblind, blind or visually impaired are provided with the necessary language support services to help them understand and participate in their care.

Staff should be aware that language support services are provided to service users free of charge. Costs are met by the individual NHS Board and must not be passed on to any member of the public.

Clinical staff should note that if no spoken language interpreter is available, where possible, telephone interpreting should be used for the appointment to go ahead, if it is an appropriate appointment type or to explain the re-appointing process.

6.3 Administrative staff

It is the responsibility of NHS administrative staff to organise and book the appropriate interpreting and translation support service as soon as an individual's language need is known. It is not the responsibility of the patient, family member or carer. NHS Boards should be cautious not to direct all language support requests to one individual, such as a BSL liaison officer, to avoid becoming reliant on one person for appointment bookings; this is the responsibility of all staff.

Interpreting support should be booked automatically and only cancelled if a service user opts out for minor routine appointments, such as immunisations and blood taking.

Staff should be familiar with the booking system and local processes in place, and should also be able to effectively communicate appointment information to the service user in an accessible format.

Staff should encourage and enable all patients who cannot communicate primarily in English to receive information in a language or format that is understood via the use of interpreting or translation services.

The whole patient journey should be considered when organising appointments to ensure that the service supports patients throughout their care. For example, meeting patients from the waiting area, booking future appointments at the reception desk immediately after an appointment, and collecting prescriptions.

Medical records staff should be mindful of the referral to treatment time directives and ensure that patients are not being breached due to non provision of interpreting support.

6.4 Senior leadership

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

6.5 Interpreters

All interpreters and translators must follow an agreed code of conduct as part of their contractual agreements. It is expected that they will work professionally and provide a high standard of service, displaying impartiality during each appointment.

Each interpreter should be aware of their own limitations and the type of situations that they can manage. Interpreters should not accept bookings beyond their qualification and experience. Both healthcare staff and interpreters should not assume that an interpreter can carry out all medical or healthcare interpreting jobs. It is important that the interpreter has experience within a healthcare setting and that they have knowledge of the relevant medical vocabulary required within specified medical specialties – for example mental health, oncology, palliative care, paediatrics, gynaecology, and so on.

All interpreters and translators are responsible for maintaining their own continuing professional development (CPD) to maintain the minimum standards as a registered member. Interpreters should aim to develop their language and intercultural experience and skills within healthcare settings by attending relevant training courses and seeking professional support.

<p>To ensure appropriate and robust levels of safeguarding, children must have independent interpreters in their own right.</p>

6.6 Agencies

Agencies should ensure that their interpreters and translators are suitably qualified and registered. They should ensure that their interpreters and translators have the right skillset for the health appointment allocated, such as the healthcare experience, vocabulary and emotional resilience to be able to accurately interpret or translate information between the service user and service provider. Agencies should support their staff members' development and training needs.

Agencies should have robust information governance processes in place to safeguard personal data of any healthcare service users using language support services. Agencies are also responsible for ensuring that interpreters and translators have undergone appropriate Disclosure Scotland checks to work in this sector.

Where an interpreter undertakes an assignment that is sensitive, vulnerable or traumatic in nature (for example working with refugees, asylum seekers, victims of violence, palliative paediatric cases, and so on), emotional and follow-up support should be provided by the responsible agency for the interpreter or translator to ensure their emotional wellbeing is supported. Debrief sessions with the healthcare practitioner should also be considered.

6.7 Training for NHS staff

Managers are responsible for ensuring that staff members are aware of this policy, their own local procedures, and for advising their staff on compliance with the policy. They are also responsible for ensuring that staff are effectively supported in delivering the requirements of the policy.

- Staff should receive training where necessary so that they are confident about booking and working with interpreters in multilingual and intercultural settings.

- Staff should also be aware and informed of an individual's language, communication and cultural barriers to effective communication and safe patient care.
- Staff should be trained and equipped to recognise an individual's needs and be able to respond appropriately.

There are e-learning resources to complement locally developed training. These include the modules [BSL and tactile BSL awareness](#) and [Making communication better](#), located on TURAS learn.

7. Finance

Interpreting and translation services are funded locally at NHS Board level. There is no national central budget for meeting the costs of interpreting and translation. All interpreting and translation costs to support healthcare interactions must be met by the NHS Board delivering the healthcare services. Costs **must not** be passed on to patients, family members, carers or other individuals using the service.

All budget holders for patient-facing clinical services should be aware of their legal requirements to provide interpreting and translation services for patients and their family members or carers who require it. Staff with delegated budgetary authority are responsible for ensuring that appropriate funding is available for these services. When developing programme budgets, funding should be identified for interpretation and translation services, and protocols put in place to monitor and authorise spend. Services should be monitored regularly to ensure that they are cost effective, high quality and achieve their intended impact.

At present there is no national contract for procuring interpreting and translation services. NHS Boards are to determine which interpreting and translation services they wish to contract. The patient or service user does not have the authority to select an independent interpreter or translator or an agency of their choosing – this is to avoid any conflicts of interest (see [NHSScotland Competency Framework for Interpreting](#)). NHS Boards are advised to recruit either internal interpreters for commonly spoken or signed languages or externally contracted services for rarer language needs if there is high enough local need. NHS Boards should follow their own local procurement procedures for contracting these services.

Where an independent contractor/third party organisation/provider (independent of the NHS Board) supplies a service on an NHS Board's premises, it is the responsibility of the third party to fund any interpreting or translation support that may be required. The NHS Board is not required to

fund interpreting or translation services for third party organisations or services.

However, to ensure support throughout the patient pathway, NHS Boards should ensure arrangements are in place for interpretation and translation for all services that are part of this pathway. Funding across the pathway will provide support for patients and healthcare staff for communication in clinical situations. Translation of healthcare records, professional-to-professional communications and letters from or to patients should also be included.

8. Governance – monitoring and quality improvement

Senior management should ensure that appropriate governance of interpreting and translation services is in place. This should include systematic monitoring and review of local/contracted services and procedures, ensuring the booking and delivery of language support processes are consistently applied and coordinated across the whole organisation, as well as ensuring that services are delivered that meet the required standard and needs of individual users.

8.1 Key governance outcomes

- Documentation is fit for purpose and auditable.
- Services are routinely monitored to ensure they are meeting patients' and practitioners' needs, including checks that interpreters are suitably qualified and registered, appointments are being kept and services are cost effective to ensure continuous improvement.
- Through an appropriate engagement strategy, level of compliments, comments and complaints are recorded to monitor service users' level of satisfaction.

8.1.1 Documentation

Governance reports should be produced on service usage and compliance, expenditure, quality and service user satisfaction by the NHS Board, if the service is in house, and by the provider if it is a purchased service.

Senior management is responsible for ensuring the effective use of resources and cost-effective services.

For the purposes of audit, local NHS Boards should have relevant documentation in place, such as a 'job sheet', to record the use of an interpreter or translator. This documentation should clearly state the date,

time and length of the appointment, the clinician and department, the interpreting or translation agency and patient identification number.

8.1.2 Monitoring and evaluation of services

Interpreting and translation services and associated processes (including booking, documentation and feedback) should be regularly monitored and reported. Governance reports should be produced on service usage and compliance, expenditure and quality, including service users', service providers' and interpreters'/translators' satisfaction feedback. This should be used to inform and improve interpreting and translation services and processes. Services should also be reviewed and evaluated to ensure that they meet the requirements for the Equality Act 2010.

NHS Boards should also continually monitor and be aware of their local population's language and cultural needs to enable effective service planning and budgeting for interpreting and translation services.

8.1.3 Engagement

When developing local procedures and processes, interpreters, translators and service users should be involved in the planning to ensure that services meet their needs. Staff, interpreters and patients should be regularly engaged to provide feedback on the quality, effectiveness and efficiency of communication support and translations services. This can be done through a managed contract or in-house patient engagement activity.

8.1.4 Complaints

All NHS Boards should have local processes in place to enable patients and clinicians to provide feedback on their service experiences in their first or preferred language or format (written, spoken, signed, or in Braille, audio, video, and so on). This may require different forms of engagement with staff and patients. Interpreters and translators should also be given the opportunity to feed back on their experiences and provide suggestions on how services could be improved further.

Documentation on how to access feedback processes should be available in different languages and formats including written, spoken and accessible formats such as Braille or BSL video. NHS Boards must ensure a system is in place that enables patients and clinical staff to access the feedback and complaints service directly. This service must be independent of the individual interpreter or service agency that the feedback or complaint is about. Where requested by a service user or clinician, NHS Boards should provide details of the supplier agency, registered body or interpreter. Any response to service users should be given in their preferred language.

Interpreting service agencies are also recommended to collect their own feedback and collate and publish this data on comments and their resolution in a service satisfaction report.

8.2 Review

This policy will be kept under review in relation to Scottish Government developments and implementation of the British Sign Language Scotland (2015) Act or reviewed at a minimum of every three years or before if there are significant changes to laws or practice. Further revisions will be made in light of changes in local demographics, technology or service delivery models. This may involve different forms of engagement with service users, healthcare staff and interpreters/translators. Any changes that impact on this current policy should be reported to the Equality Team in Scottish Government.

NHS Boards are also recommended to review their local demographics, technology and service delivery models at regular intervals.

8.2.1 Equality Impact Assessment (EQIA)

The NHSScotland National Interpreting, Communication Support and Translation Policy and associated procedures have been equality impact assessed to make sure that the identified groups are not disadvantaged or discriminated against.

8.3 Engagement in development of this policy

The policy has been developed to meet the diverse language support needs of patients, family members, carers and healthcare practitioners to enable effective communication with clinicians and NHS staff members. It has taken into account the views of service users, healthcare staff and interpreters.

The development and review of this policy will continue to be informed by ongoing feedback from staff, service users, interpreters and translators.

Appendix 1

Legislative context

There is a fundamental legal, ethical and moral requirement to provide interpreting and translation support services to patients, immediate family members and their carers who require it. All service users whose first language is not English must not be disadvantaged in terms of access to and quality of healthcare received ([Equality Act 2010](#)). They have a legal right to effective communication in a form, language and manner that enables them to interact with and participate in their healthcare and understand any information provided. All patients have a legal, ethical and moral right to determine what happens to their own bodies under the Equality Act 2010. For some individuals, this can only be guaranteed if language support is provided.

Equality Act 2010

The Equality Act 2010³ and the Public Sector Equality Duty (s. 149 of the Equality Act 2010) places a legal duty on public authorities to provide barrier-free access to those with protected characteristics, including race and disability. A key priority for staff is to identify individuals' needs for interpreting and translation support. Cultural considerations, as well as language needs, should be identified and supported throughout the patient's journey.

Therefore, as one of the actions in the NHSScotland BSL Improvement Plan⁴ agreed by NHSScotland chief executives, this policy has been developed to ensure that NHSScotland has an updated, clear, consistent and equitable approach to the provision of interpreting and translation support services for patients, their family members and/or carers who have limited ability to communicate in English.

³ Equality Act, 2010 www.gov.uk/guidance/equality-act-2010-guidance

⁴ NHSScotland BSL Improvement Plan, NHS Health Scotland, March 2017.

There are a number of relevant legislative and policy drivers underpinning the need for this policy in addition to the Equality Act, including:

BSL (Scotland) Act 2015⁵

All public sector bodies have a requirement to develop action plans to promote the use of BSL in their services. The BSL (Scotland) Act 2015 requires that all patients have access to information and services they need to ensure equitable access to NHS services at every stage in their lives. To ensure equitable access to services, access to BSL users interpreting provision is key as well as promotion of BSL as a language.

New Scots Refugee Integration Strategy 2018–2022⁶

The aim of the New Scots strategy is for a welcoming Scotland where refugees and asylum seekers are able to rebuild their lives from the day they arrive. The New Scots strategy sees integration as a long-term, two-way process, involving positive change in both individuals and host communities, which leads to cohesive, diverse communities. The New Scots strategy has five principles:

- Integration from day one
- A rights-based approach
- Refugee involvement
- Inclusive communities
- Partnership and collaboration.

⁵ BSL (Scotland) Act 2015: www.legislation.gov.uk/asp/2015/11/contents/enacted

⁶ New Scots Refugee Integration Strategy, January 2018, Scottish Government: <https://beta.gov.scot/publications/new-scots-refugee-integration-strategy-2018-2022/>

Patient rights

The Patient Rights (Scotland) Act 2011⁷ aims to improve patients' experiences of using health services and to support people to become more involved in their health and healthcare efficiently and effectively. Action to deliver the rights and principles should be proportionate and appropriate to the circumstances and should balance the rights of individual patients with the effects on the rights of other patients. It should also take into account resources available and the responsibility of the Health Board to use resources efficiently and effectively.

The European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)⁸ protects the human rights of people in countries that belong to the Council of Europe. This includes the UK.

The Human Rights Act (1998) is the enabler of the European Convention in the UK. The rights include the right to life; the right to respect for private and family life; and the right to freedom of religion and belief. Public authorities must follow the Human Rights Act. They must respect and protect human rights, unless there's a law which prevents it. The Human Rights Act says they must act in a way which is compatible with human rights, including in making policies.

The United Nations Convention on the Rights of the Child (1989) (UNCRC)⁹ is a legally binding international agreement setting out the civil, political,

⁷ Patient Rights (Scotland) Act 2011: www.legislation.gov.uk/asp/2011/5/contents

⁸ European Convention for the Protection of Human Rights and Fundamental Freedoms, 1950, European Court of Human Rights and Council of Europe: www.echr.coe.int/Documents/Convention_ENG.pdf

⁹ The United Nations Convention on the Rights of the Child, 1989: www.unicef.org.uk/what-we-do/un-convention-child-rights/

economic, social and cultural rights of every child, regardless of their race, religion or abilities. The UNCRC consists of 54 articles that set out children's rights and how governments should work together to make them available to all children. Under the terms of the convention, governments are required to meet children's basic needs and help them reach their full potential. Central to this is the acknowledgment that every child has basic fundamental rights.

These include the right to:

- life, survival and development
- protection from violence, abuse or neglect
- an education that enables children to fulfil their potential
- be raised by, or have a relationship with, their parents
- express their opinions and be listened to.

The Carers (Scotland) Act 2016¹⁰ provides a legal framework for the NHS to ensure those providing unpaid care for family and friends are supported with their own health and wellbeing. The overall aim of the act is for carers to be supported to continue to care, for as long as they choose, in better health and to have a life alongside caring. It aims to ensure that carers have access to information and advice and this would include provision of interpreters and translated material as required.

¹⁰ Carers (Scotland) Act 2016, Scottish Government:
www2.gov.scot/Topics/Health/Support-Social-Care/Unpaid-Carers/Implementation/Carers-scotland-act-2016

Realistic medicine¹¹

This includes working better to build a personalised approach to care, and changing to a shared decision-making style.

¹¹ Realising Realistic Medicine, Scottish Government, 2017:

www.gov.scot/news/realising-realistic-medicine/

Appendix 2

Definitions

Braille: A tactile reading and writing system used by people who are blind, Deafblind and visually impaired who cannot access print materials. It uses raised dots to represent the letters of the print alphabet. It also includes symbols to represent punctuation, mathematics and scientific characters, music, computer notation and community languages.

British Sign Language (BSL): The first, only, or preferred language of many people who are D/deaf. It is a registered language in its own right, with its own grammar and syntax. It is a visual-gestural language which bears little resemblance to English. Translation of a document into BSL requires the production of a BSL video version to ensure that it is accessible to people who are D/deaf who use this language. BSL videos should also include subtitles or closed captions as standard.

BSL/English interpreter: Someone who is bilingual and has the qualification to be able to work between the two languages (English and British Sign Language) and facilitate communication between people.

Contact Scotland is a video relay service for D/deaf and Deafblind people who call public sector bodies such as the NHS free of charge.

<http://contactscotland-bsl.org>

Deafblind guide/communicator: A professional communicator who enables communication between Deafblind people and others. Different skills and techniques can be used to facilitate communication, including Deafblind manual or hands-on signing (tactile BSL). In their role as a guide, they will also escort dual-sensory impaired people from their homes to the Deafblind person's destination of choice. They can also provide support during an appointment by taking notes if necessary.

Deafblind manual alphabet: Using the index finger as a 'pen' the guide/communicator points to different finger positions on the Deafblind person's hand or draws letter shapes on the Deafblind person's palm.

Deafblindness or dual sensory impairment: People who are Deafblind can neither see nor hear, to the extent that their communication, mobility and access to information is significantly impaired. Some Deafblind people have enough sight to use BSL interpreters, whereas others do not and use tactile or manual sign.

Electronic and manual note takers: These work with people who are D/deaf or hard of hearing, who are comfortable reading English. The electronic note taker types a summary of what is being said on a computer and this information appears on the D/deaf person's screen. **Please note:** not all D/deaf people are able to read or understand written English and if they can it may not be their first or preferred language. BSL interpretation should therefore be used.

Finger spelling: This is a system where all letters of the English alphabet can be drawn on the hands. It is also known as the manual alphabet. Finger spelling is used by some BSL users to aid understanding by spelling the names of people and places which might be unfamiliar.

Interpreter: Someone who is (at least) bilingual and has the ability and training to be able to work between two languages and facilitate communication between people.

Interpreting: Defined as the **oral** transmission of meaning from one language to another that is easily understood by the listener/receiver. This includes the conversion of spoken language into British Sign Language (BSL), which is a recognised language in its own right.

Lip speaking/reading: Lip speakers repeat what is being said without using their voice. They produce the shape of words clearly with the flow, rhythm and

phrasing of speech. They use natural gestures and facial expressions to help the person who is lip reading to follow what is being said.

Makaton: A language programme that uses symbols, signs and speech to enable people to communicate. This programme is used with people with a cognitive impairment or specific language impairment including neurological disorders. It includes manual signs and graphic symbols so is used for communication support as well as written information.

Moon: The Moon system of embossed reading is a writing system for the blind. The Moon alphabet has embossed shapes which can be read by touch. Some of the Moon letters resemble the letters of the Latin alphabet, or other simplified letters or shapes. The Moon alphabet is easier to learn than Braille, particularly for people who lose their sight later in life.

Remote/online interpreting: Video interpretation uses a face-to-face interpreter in a fixed geographical point accessed through video technology. The service requires a camera and mic on the receiving device, such as a computer, tablet or phone. It can be used for spoken languages as well as sign language.

Tactile BSL: This is used by people who are Deafblind. It is a form of British Sign Language that uses touch (hands-on) as a medium to communicate.

Transcription: The process of producing a written copy of something, including the representations of speech or signing in written form.

Translation: The **written** transmission of meaning from one language to another that is easily understood by the reader. Translation does not strictly have to be into text – this also includes the conversion of written information into audio, Braille or Moon, or the production of visual formats to transfer information using British Sign Language (BSL). Translation of documents can include the reading to the patient of a letter (or source of information) into the language required by the patient – known as sight translation.

Appendix 3

Identifying service users' spoken or signed language needs

Staff who are responsible for arranging and booking interpreting and translation services should ensure that they are appropriately equipped and resourced to respond to individuals' needs.

Patients, immediate family members and their carers should be asked about their personal language preferences as early as possible and this should be clearly highlighted within the patient's record. This should detail the service user's language or dialect requirements. Some languages such as Kurdish have local dialectal differences, such as Kurdish Sorani or Kurdish Kurmanji, and the dialect is needed to ensure the correct interpreter is provided. Additionally any cultural needs should also be noted, for example a French interpreter from France may not have the local nuance required for a French speaker from the Ivory Coast. Where possible a cultural match should be made. Any gender preferences should be noted and acted upon where possible as with clinicians.

The first thing to identify is the person's preferred language and method of communication in advance of booking any support. For example, find out if they are a BSL user, community language speaker or require written information in an accessible format, such as Braille. Staff should also note the most appropriate method of interpretation or translation support, such as telephone, face-to-face or video relay interpreting, lip reading/speaking, and so on.

This may be recorded in the patient's paper or electronic record or detailed in the referral letter. If the preferred language is not stated, then use a language identification card, to allow the patient to point to their required language. The language or communication support need should then be documented clearly in their records. This also includes recording any language support needs that

family members or carers may have, so that the appropriate services can be booked for them.

If a service user's first language is not English, but they state that they are able to communicate in English to a high standard and do not require an interpreter, respect their wishes for no language support to be provided. However, their need for language support should be inquired about for future appointments in case their preferences change. It should also be noted that a person who might usually cope well with speaking English as a second language may find it more difficult to communicate effectively in stressful situations. Therefore, for more complex, challenging or sensitive appointments an interpreter for their primary language should be provided. In circumstances requiring consent or giving bad news an interpreter should also be provided.

For translation of written information and documents, staff should establish whether the best approach is to use an interpreter to read or sign information or whether to provide the information in an individual's first language – spoken or signed, or via a tactile writing method, such as Braille.

For spoken languages it should be ascertained in advance that the patient can read their own language.

Staff should be aware of how to access interpretation and translation services 24 hours a day, seven days a week. All routine appointments should be made during core daytime hours and made in advance wherever possible. For emergency appointments an interpreter should be provided as soon as possible, either by telephone, video relay or face-to-face depending on the service user's language need.

Appendix 4

Benefits of telephone interpreting

The benefits of telephone interpreting include:

- Immediate availability for most languages.
- Dealing with ad hoc or unplanned appointments.
- Anonymity for the patient, particularly for small communities.
- Can be less intrusive to the consultation setting.
- Allows quick resolution to a situation.
- Responds to emergency and urgent situations, rather than wait for a face-to-face interpreter.
- Cost effective for an appointment which is less than 60 minutes.
- Useful for setting up a future interpreting session that is face-to-face or to confirm an appointment.
- Establishing the patient's language if it is not apparent.
- Calling out to patients to invite in for appointments.

Appendix 5

Benefits of face-to-face interpreting

The benefits of face-to-face interpreting include:

- Allows good eye contact and ability to see body language of the patient, the staff member and the interpreter.
- Beneficial when working with sensitive issues, for example trauma, gender-based violence and child protection cases.
- Appropriate for dealing with bereavement and breaking bad news.
- Helpful if the consultation involves therapeutic counselling.
- A more cost-effective form of interpreting for longer appointments, however, local cost thresholds will differ across NHS Boards.

Appendix 6

Best practice guides for translating materials into BSL

Below are the best practice guides to ensure Public Health Scotland and NHS 24 have accounted for everything, and are modelling the best practice in BSL translations.

Best practice	Action
Use an appropriately qualified signer.	<p>Use D/deaf people to sign as this has been requested by D/deaf people.</p> <p>Have two people having a conversation rather than a straight-to-camera piece.</p> <p>Have another interpreter to stay behind the camera and review the BSL information being signed as they are filming. This is to double check the BSL interpretation is accurate and accessible.</p>
Use a clean/plain background.	<p>Avoid use of white background. Use a light blue background.</p> <p>Make sure there is a clear contrast between the background colour and the colour of any text or images.</p> <p>Make sure the person interpreting is wearing plain clothes for higher contrast.</p>
Use appropriate signer for target audience and content.	<p>Use an appropriate person to sign the information, for example gender sensitivity could be important.</p>

Best practice	Action
Include opening and end graphics to introduce and close video.	<p>This has to be a clear graphic.</p> <p>Preferably have a delayed graphic to give opportunity to understand the clip.</p>
Include voice over.	Add a clear voice over in plain English to match signing.
Use subtitles.	<p>Subtitles should be of reasonable size with a black background and yellow text.</p> <p>They should also describe environmental information, for example 'soft music playing', 'phone ringing', 'door slams' and so on as appropriate.</p>
Length of film clips.	<p>Film clips to be no more than 5–7 minutes each.</p> <p>Create chapters to keep the attention of the audience.</p>

Appendix 7

Guidance on how to make an accessible PDF

Most documents are now produced electronically and make their way to people in various forms, such as email attachments and website downloads.

In order for these documents to be read by someone using assisted technology, such as a speech synthesiser, Braille keyboard or large print display, it is vital that they are produced in an accessible format.

Producing accessible Word documents

Accessibility depends on how well your document is structured and formatted at the start. By applying the 'styles and formatting' options correctly and following some basic guidelines, you can make your Word documents accessible to people with a range of different impairments.

A well-formatted Word document can also be easily converted into an accessible PDF file using Adobe Acrobat. A PDF (Portable Document Format) file means that your documents cannot be changed and is recommended when placing on websites.

Further information

The Scottish Accessible Information Forum provides detailed guidelines and offers short training courses on making e-communication accessible.

www.saifscotland.org.uk

Commissioning Accessible Documents: A PDF is the common format used by designers to ensure that documents retain their original layout and design when viewed on screen or printed out.

When commissioning design and print, ensure that the supplier is asked to provide the document in an accessible PDF format. Creating an accessible or 'tagged' PDF requires more steps than the traditional conversion method and suppliers should have the knowledge and ability to achieve this.

This makes all the difference to someone using assisted technology. For example, a blind or partially sighted person using a screen reader would be unable to identify any content from a basic or 'unstructured' PDF. Accessible PDFs allow the reader to access both the content and style of the information presented.

Appendix 8

Communicating with patients with language support needs outwith appointments

Staff should ensure that patients who have specific language needs are called to their appointment in a way that eliminates the opportunity for appointments to be missed. Examples include sending a translated appointment letter or in Braille, or using the video relay system ([ContactScotland-BSL](#)) to contact a British Sign Language user.

Where a service user with a language support need has arrived for an appointment, staff should be aware of their arrival and approach the service user in the waiting area when their appointment is called.

Contacting a D/deaf patient over the phone/tablet device

Where a D/deaf person or BSL user wishes to provide feedback or make a complaint, ContactScotland-BSL can be used as an interpreting support. The Scottish Government currently funds an NHS24 online British Sign Language (BSL) video relay interpreting service, which aims to improve access to health services for people in Scotland who are D/deaf, deafened or are BSL users. Health professionals and administrative support colleagues should be aware of the service and encourage their service users to register and download the relevant smartphone or tablet application ('app') from the [contactSCOTLAND](#) website. ContactSCOTLAND-BSL is available on 0131 510 4555 or <https://contactscotland-bsl.org>

The system can be used by the service user and service provider to make contact regarding making, confirming, cancelling or amending appointments over the phone. This service is designed to be used to make initial contact or in emergency situations. It does not replace face-to-face BSL interpreting in clinical situations.

Deaf patients may also choose to use the Relay UK app (previously Next Generation text) using the medium of typing text via a relay operator.

Many Relay UK app and textphone users have TextNumbers. These are unique numbers that connect callers to the D/deaf person and a relay assistant without having to dial **18002** first. TextNumbers start with **03306** or **07777**.

If the number does not start with either of these, dial **18002** followed by the full phone number (including the dialling code). For example, dial 18002 0141 555 5555 and wait for the operator to connect with the D/deaf person.

Appendix 9

Accessible information – good practice

- Check the patient/user's preferred language or format.
- For spoken language check the patient/user can read in the requested language. They may speak one language but read in another. Some spoken languages do not have a written form.
- A good translation is dependent on a good English language version. This includes cultural sensitivity, accessibility and use of plain English, which all help to produce a good quality translation. For example, the English language content of a healthy eating leaflet needs to reflect cultural food examples and not just rely on European food examples for a Chinese language version.
- Not all visually impaired people read Braille – check beforehand.
- Many visually impaired people have assistive technology so make sure any document you produce is an accessible PDF.
- Make sure that your Board is the copyright holder. If not you will need to contact the copyright holder to obtain a translation or permission to produce one.
- Check whether existing translations or formats already exist in other NHS Boards. There is no point in duplicating work unnecessarily.
- Check that you have the latest version of the English language version before commissioning your translation. Make sure it is still current, relevant and not undergoing a review (in which case it may be better to wait until the review is completed). The use of versions and dates on documents is recommended, as is a process for regularly reviewing and responding to updates to content.

- Check longevity of the information. In some cases using an interpreter to relay information would be more appropriate, for example information that is very specific to one patient, or changeable such as cancer drug regimes, unless it is needed as a future reference for the patient.
- The translator should proofread and check their translation. You should have assurance that this has been done as you will be unable to check yourself unless you read the language. Any errors should be managed by the translation agency, including print costs for any errors.
- Once the translation is produced, as with spoken communication, healthcare staff must satisfy themselves that the patient understands the written document. This may require the assistance of an interpreter. This would allow you to ask questions to check the patient/service user has understood the information and provides an opportunity to clarify anything that is not clear.
- As with all information governance, you should ensure that you comply with your own local Board's policy around the transfer and use of information and personal data.

Other formats of this publication are available on request at:



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Published by Public Health Scotland
1 South Gyle Crescent
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Established on 1 April 2020,
Public Health Scotland is Scotland's
national public agency for
improving and protecting the health
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