healthwatch Bath and North East Somerset

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How are language and communication needs met for patients in hospital?

Neighbourhood health and wellbeing insights – June 2026

Contents

Executive summary

Good communication is essential for safe and good quality care in hospital. This report looks at how well patients' language and communication needs are understood and met at the Royal United Hospitals (RUH), especially for people who may face barriers. This includes people who do not speak English well, and those with learning disabilities, autism, dementia, or sensory impairments.

We heard from around 115 patients, carers and staff. Their feedback shows that there are examples of good practice, but support is not consistent across the hospital. In many cases, patients' experiences depend on the individual staff member or ward, rather than on clear systems that work for everyone.

Key findings

Good communication makes a real difference. When it works well, patients feel safe, respected and understood. When it does not, people can feel anxious, confused and unsupported. In some cases, poor communication can affect a patient's care or recovery.

A common problem is that communication needs are not identified early enough. Often, these needs are only picked up when a patient arrives in hospital. Even when information is recorded, for example in a hospital passport or notes, it is not always read or used by staff. This means patients and carers often have to repeat the same information many times.

There is no consistent way of recording and sharing communication needs across the hospital. This means some needs can be missed, especially hearing loss or less visible communication difficulties.

Specialist support teams, such as speech and language therapy, learning disability and dementia services, are highly valued and make a big difference when involved. However, they cannot always support every patient who needs help.

The hospital environment can also make communication more difficult. Busy, noisy wards, especially in emergency areas, can be overwhelming and make it harder for patients to understand or express themselves. Small practical changes can help, but these are not used consistently.

The role of family members and carers is very important, but there is not always clear guidance on how they should be involved. This leads to confusion and inconsistent practice.

Across all feedback, one message stood out clearly: "Ask me what my communication needs are."

Recommendations

The following recommendations have been developed based on the feedback and ideas received from contributors to this report.

Improving communication will require both better systems and changes to how staff work.

Staff should always ask patients how they prefer to communicate and take time to listen. This should be a routine part of care for all patients.

Training should be strengthened so that all staff feel confident supporting people with a wide range of communication needs. This should include practical skills, not just awareness.

There needs to be a clear and consistent way to record communication needs so that all staff can see and use this information.

Existing tools, such as hospital passports and 'This is Me' documents, should be simpler and easier to use, with key information easy to find and clearly visible.

Clear guidance is needed on how family members and carers can support communication, so that staff and patients know what is expected.

Finally, simple practical changes can make a big difference. This includes improving access to interpreting services, using communication aids, and making small changes to reduce noise and distractions in hospital environments.

Why explore language and communication needs in hospital?

We know from the amount of feedback Healthwatch Bath and North East Somerset (B&NES) receives, how essential good communication is for good

health care – and that equally, poor communication can impact negatively on people's healthcare experiences in both primary and secondary care.

Where people have an additional language or communication need, or face communication barriers, then service providers including hospitals need to account for these needs, and take steps to ensure that patients in their care are able to:

- understand their treatment and care from staff
- communicate their needs and wishes back to staff

After hearing examples about the impact of a lack of communication in hospital from members of Bath Ethnic Minority Senior Citizens Association (BEMSCA), and via other feedback sources, we decided to explore how language and communication needs are met in hospital.

We discussed our proposal to undertake a focussed exploration of how language and communication needs are met at the Royal United Hospitals Trust (RUH) with their Patient Experience Team and started work at the end of 2025.

Background

Range and extent of communication needs

There are a number of population groups who have communication needs. This includes:

- 1.5% of people do not speak English well and 0.3% do not speak English at all (ONS, 2021 Census).
- 2.15% of the adult population have a learning disability, with a slightly higher figure for children 2.5% (MENCAP).
- Around 1% of the population is diagnosed with autism spectrum disorder (National Autistic Society). Difficulties with social interaction – including communication – are a key diagnostic feature.
- 4.2% of the adult population over the age of 65 years are diagnosed with dementia (Office of Health Improvement and Disparities) where the impact on communications increases in line with progression of the disease.
- 2.9% of the UK population are estimated to be living with sight loss (RNIB) impacting their ability to understand and respond to visual communications.

A further 2.4 million people have hearing impairments that impacts their ability to understand most everyday speech (RNID). As hearing loss tends to increase with age as do hospital admissions, this group is very likely to form the largest

cohort of people in hospital who face communication barriers. Individuals may of course experience multiple communication barriers.

‘Health based’ temporary communication needs

A number of people we engaged with raised that temporary physical conditions could also impact on someone’s capacity for communication. Examples included ‘being in extreme pain’ from a survey respondent, someone coming round from an operation, and someone being drunk or under the influence of illegal substances from staff.

Whilst these issues do not form part of our research some of the findings and recommendations may still be relevant in these types of circumstances.

Strategy and policy commitments on meeting communication needs at the RUH

The RUH recognises in its strategies and plans, the importance of good and effective communication. For example, the RUH Trust Strategy includes, under ‘the people we care for’ the objective of “communicating well, listening and acting on what matters most to you”.

In addition, the Vulnerable People strategy sets out in further details some of the communication needs of patients with particular conditions and vulnerabilities. Key aspects include:

- staff asking individuals how they would like to be communicated with
- tailoring interactions to meet needs
- checking back with patients that they have understood the communications.

The strategy also recognises the importance of training for staff to be able to meet the goals set out in the strategy.

As with any strategy or policy, it is the implementation in practice that matters to patients and our research aimed to explore this by listening to patients, carers and staff at the RUH.

What we did

Hearing from patients with language and communication needs

Having considered the range of language and communication needs that people experience in B&NES we connected with relevant local voluntary and community organisations that are led by or work with these different ‘communities of interest’ to invite them to take part in the study.

We asked that respondents had either been hospital patients within the last 12 months or were a carer or family member of a patient.

Methods of engagement included:

- organising focus groups
- attending member activity sessions
- one-to-one conversations with organisation staff and individuals
- inviting feedback via email
- gathering views at events

We also ran an online survey (appendix 2), which was also available as a print version.

What did we ask patients and their carers?

We asked participants about their experience of being in hospital as either inpatients or outpatients over the past 12 months, focusing on their experiences of communication in hospital around the following questions:

- what went well
- what could have been better
- what would they change

Where relevant we also asked about the use of hospital passports and similar documents and what aids people used to try and help communications.

RUH based engagement

In addition to the focused engagements and online survey we undertook two open sessions in public areas at the RUH in December 2025 and March 2026 to gather feedback from visitors and staff.

At these open engagement events we framed questions slightly differently so they could be answered by either staff members and patients or visitors. We asked:

- What language and communication challenges do they or their patients have?
- When do they come across these types of challenges? What part of the patient journey?
- What helps good communication for patients?

Ward visits

Our original intention had been to undertake a small number of observational visits to wards, and to speak with patients and their visitors to gain additional direct insights. In the end, the timing of our project coincided with the Winter pressures period and high levels of infection continuing beyond the New Year, so we decided to not go ahead with this element of the study.

Who did we hear from

Altogether we heard from 115 people through engagements and the survey.

Engagement sessions were held as follows:

- Bath Welcomes Refugees and BEMSCA – focus groups and one-to-one meetings to gather views of people with no or limited English.
- Stroke Association - focus group for stroke survivors with aphasia and their carers.
- SWALLOW and Bath Gateway Out and About Club – one-to-one calls and feedback via email to gather views of people with a learning disability.
- ReMind and Alzheimer's Society - attended lived experience group and activity sessions to gather feedback from people with dementia and their carers.
- Bath College to capture the views of young people on what's important to meet communication needs of people in hospital who are neurodivergent.
- Met with an autism trainer and communicator.

At the RUH open engagement sessions we heard from a wide range of staff including porters, cleaners, support workers, volunteers, nurses as well as members of the Patient Experience Team and family visitors and patients.

Survey responses

We promoted the survey widely via events, social media and at the RUH itself and heard from 23 people which included patients and family members/carers.

Demographic details for these individuals can be found in appendix 1. The majority (18) had attended RUH with others having also attended Great Western and Salisbury District hospitals, and another out of area hospital.

Individuals shared a range of different communication needs, with sight loss, dementia and dyspraxia also being specified in 'other'.

Quotes from survey respondents have been included only where they relate to the RUH.

Focused conversations with staff

in addition to engaging with staff via open engagements, we wanted to hear from staff who have a particular focus on communication support. We held sessions with:

- Health Inequality Officer and Patient Experience Team
- Dementia lead nurse
- Learning Disability and Autism lead nurse
- Family Liaison Facilitator
- Digital Access Team and Deaf Champions

We also met with other people based in the RUH but employed by partner organisations:

- Community Connectors with Age UK and the Community Wellbeing Hub

We asked about:

- their role in relation to communications
- the communication needs they come across
- the communication support available
- how well hospital processes support communication, and
- their overall thoughts and views on meeting communication needs

How is feedback set out in the report?

Feedback has been analysed across the survey, direct engagements and meetings with staff from the RUH and other organisations. This is set out by themes and includes views on 'what worked well?', 'what worked less well?' and 'what changes would they like to see?'.

Quotes are identified according to their source i.e. survey respondent, group engaged, patient, carer or member of staff.

What we heard

1. Support from specialist teams and therapies

Where we received feedback about the support of specialist teams it was all positive, this included the SALT and the Learning Disability team.

We didn't hear any specific feedback about the Dementia team.

What went well?

Stroke Unit patients found access to support from **physiotherapy and speech and language therapy** (SALT) invaluable as they were able to support their specific needs:

"SALT was my best friend" (member of Aphasia focus group)

"Have access to SALT and physio to help me write things down. Some people with aphasia can read, others can't"

The support of the **Learning Disability (LD) team** was positive for everyone who mentioned this

"The LD staff were invaluable in supporting P's care on the wards. They were able to liaise between family members and ward staff and P – having the time and skills to help overcome communication barriers and were better at being able to understand P's speech." (member of staff from SWALLOW)

"The LD team were very helpful and could help liaise between SWALLOW and L and the ward staff. They made regular checks and calls." (member of staff from SWALLOW)

"Very kind, caring and respectful" (member of Bath Gateway Out and About Club (BGOAC)).

"They really listened to me, 100%" (member of BGOAC)

"They gave good advice" (member of BGOAC)

What staff told us

The **Learning Disability and Autism support team** aim to support staff with both training and equipping them to care for patients with learning disability and autism and support in circumstances where this is particularly needed – in this way they are also supporting patients to help make sure they are understood and understand.

They also help inpatients to complete a Hospital Passport if they don't currently have one but would find this helpful. Currently around 45% of patients with a learning disability have a passport, although it is recognised that some people don't want one.

One of the drivers for the team is LeDeR (**Learning from the lives and deaths of people with a learning disability and autistic people).** This was established to reduce the very real health inequality of people dying at a younger age *because* they've got a learning disability or are autistic. Addressing communication challenges for people with a learning disability or who are autistic in hospitals and across the health care system is a key part of reducing this inequality.

The **Dementia team** focus on inpatient support to

- support staff in managing patients with dementia if there are difficult communications and behaviours
- provide training and education for staff across the RUH
- liaise with and support carers including completing or updating the 'This is Me' document

The dementia team recognised that the multiple communication needs of patients with dementia can be very challenging for patients and staff in a hospital environment. Effective communication needs staff who are trained and have sufficient time to take a 'problem solving approach' and the input of family and carers to make sense of someone's individual behaviours and needs. This should be included within the 'This is Me' document.

They shared an example:

"If someone is fiddling with the blanket it might mean they need to go to the toilet, but staff will only know this if they gather information from family and carers and make this info accessible to ward staff."

However, regardless of their apparent level of understanding or ability to respond verbally, their approach is that someone with dementia should not be assumed to lack capacity or be spoken to in an infantile way – however advanced their condition.

Where is communication support integrated well across the ward?

The model of working in the Acute Stroke Unit was described as an example good practice:

> "communication issues being strongly integrated in to the ward – so they have a positive model of working that brings ward staff, internal therapies (SALT, physiotherapy, ophthalmology) and external charity experts together. So there are resources available to support communications which work together."
>
> - member of staff)

2. How are communication needs recognised?

In order to provide support to meet communication needs there first needs to be recognition that these needs exist, with the staff and processes in place to ensure that patients' needs are identified and visibly recorded, especially as communication needs are not necessarily visible or apparent.

We heard from our conversations with staff that very often communication needs are only flagged when a patient is at their appointment or arrives as an inpatient, rather than information being available in advance.

The Hospital Passport provides a standard form for people with a learning disability or autism to set out their needs including for communication.

'This is Me' provides a similar template for patients with dementia.

Patient white boards above or by the bed would tend to only include information about people who use British Sign Language (BSL)or who speak other languages.

Otherwise, any communication needs should be included in patient records, including the patient safety brief (handover) sheet. However, there is, according to staff, currently no standardised way of recording patients' communication needs in hospital records.

We heard from patients and family carers that staff did not always appear to read hospital passports or 'This is Me' documents or patient notes and would therefore miss that there was a need for language or communication support or understand the extent of these needs.

This impacted when patients moved wards or at staff handovers, when a frequent complaint was that they were having to repeat the same information time and again.

There may also be a lack of knowledge amongst patients and carers about passports and 'This is Me', and some people may decide they do not wish to complete the document.

7 out of the 8 people we heard from via BGOAC with a learning disability had a hospital passport, with the 8th person saying they had lost theirs.

However, when asked in the survey about whether they, or the patient had a hospital passport or similar document, only 3 out of the survey respondents answered yes, and one of these had been provided since they were in hospital. Others asked what they were and how could they get hold of one. A respondent who was replying on behalf of someone with autism, said:

"He doesn't want to be identified as autistic as he thinks staff will talk down to him." (survey respondent)

We heard from an autism communicator and trainer that they recommended a specific Autism passport to ensure that as autistic people their communication needs were fully recognised and addressed. This could help patients who are autistic and who currently feel they have to 'mask to appear neurotypical' and are too often left feeling 'dehumanised' by reactions from hospital staff.

What went well?

"The consultant (at an appointment for another issue), didn't pick up that my wife has dementia until I pointed it out after a while. They did though give plenty

of time for the appointment, so it was an overall positive experience" (Dementia group feedback)

"My passport was bought to me, and I was offered things I might needed" (member of BGOAC)

What went less well?

"I got very distressed every time my husband left for home who usually helps me and who I trust. It turned out, they had not checked my file to realise I was autistic. They were getting the autism nurse to call me to put a hospital passport in my file, but no one has contacted me" (Survey respondent)

"Because they look at me and assume I understand everything because they can't see the struggles I have. No one knew I was struggling - even though I did attend with a support worker. They just assume I can understand everything ok. I don't know when I have or haven't understood something in the way you intended or if it's like the police question incident." (Survey respondent)

Where there is an additional physical or sensory need this compounds the importance of understanding and proactively asking about a patient's communication needs:

"My mother wanted to go to the loo one night and was unable to find the loo and got lost due to her blindness. She had been placed in the furthest bed from the loo, and nobody had shown her where it was" (survey respondent)

Feedback from a member of staff at SWALLOW highlighted that where someone has complex physical and learning disabilities it is of greater importance to understanding that a lack of communication ability can impact additionally on their physical needs:

"When P was moved on to the respiratory ward she was given the call bell and advised to press it if she needed any help. She was unable to use the call bell, for both physical reasons and also due to her learning disability and understanding this was what she could or should do."

The carer said that staff needed to check in regularly with K to see if she had all she needed, not rely on her using an aid that was not accessible to her.

This compared with their experience in Intensive Care, where the family felt that the higher level of supervision and monitoring gave them the comfort that their family member's lack of communication would be less likely to impact on their care:

"It felt like Intensive Care was a more 'more equal' setting for 'P' as all the patients there had very high care needs and so staff were always around and able to monitor what was happening. They weren't left without regular monitoring and this made it easier for (family) not being there overnight as we knew P's needs would be well met." (feedback from SWALLOW)

What did staff tell us?

In relation to patients with communication difficulties due to dementia, we heard that "the Patient record will include info from the Dementia Team if they're aware of patient, but that if this isn't read by staff it can lead to problems… If slightly more time is taken to read patient info there would be a higher chance of 'getting it right first time' – saving time in the longer run".

In relation to the Hospital passport and other ID documents, staff highlighted that the length of the Passport at 9 pages long can be a challenge, especially for example in the Emergency Department (ED) where nurses have only have two minutes to read through any documentation before having to start an assessment. Having the most important information in an easy and quick to read format, for example, in bullet points would help.

The LD team reported that they are creating a 1-page profile which focuses on distress behaviours /sensory environmental challenges, communication of pain, but to go through and add this for all Hospital Passports would be a huge task. They are exploring prioritising this for people with complex needs where it is more important to get it right.

Similarly, we heard from staff that work is underway to develop an alternative 'quick read' version of the full 'This is Me' document which at seven pages is time consuming to complete and to read.

The new document to be called 'What matters to me' is a one page, plus guidance document and is designed for any patient who cannot express their needs, which, as well as people with dementia could include people who have aphasia, or are Autistic. It will be up to wards to consider it for each individual patient.

Whichever document that is used to personalise care (Hospital Passport, This is Me or What Matters to Me) should be clearly in place for inpatients by their bedside or room door.

We heard that for both non-English speakers and people that use sign language this would be highlighted on the patient safety briefing (digital record) and the whiteboard and there are communication cards available.

This potentially leaves people who have hearing loss, which is a very common communication need in hospital, without a visible indicator of their communication need. As one member of staff commented:

"It can become so familiar that patients do not seem to understand what is being said that everyone gets used to it, and that this is likely to impact patient care if someone has not answered a question correctly just because they can't hear but don't like to admit it." (member of staff)

Systems level requirements – the Reasonable Adjustment Digital Flag

We heard that there is currently no standardised way of recording patients' communication needs in hospital records, so information may or may not be included, it could be hidden within lengthy information or not readily visible.

We also heard that staff do not always complete all the information requested on the patient record, even where it is mandatory, for example in 30% of patient records there is no record of ethnicity. For staff to complete information about communication and language requirements they will need to understand the value and use of the information.

There is however, a requirement, due to be met in September 2026, for a Reasonable Adjustment Digital Flag to be included in all NHS or hospital records as part of the Integrated Care Record, which aims to enable one patient record to be shared and accessible across primary and secondary care.

This should mean that information is recorded in a standard way that is flagged up as a requirement and that wherever the communication need / reasonable adjustment is initially recorded it is available to all health/medical providers.

The issue of the electronic patient record and the Digital Flag for reasonable adjustment is a health inequality issue.

However, not all interactions in hospital are via an electronic system. In addition to the electronic record being in place and with this flag - having a simple A4 sheet by someone's bed which includes their communication support need, such as What Matters to Me', should make it easier for all staff / visitors to act accordingly - and to build knowledge and awareness across the hospital.

As a member of staff put it, what is needed is - "Digital plus hard copy plus staff".

3. The hospital environment

Recognition of the impact of the environment for patients with communication and language needs:

We heard from both staff, patients and families about how the hospital environment can impact someone's health and communication. Feedback included a recognition of where staff had tried to make the environment more welcoming and recognition of the challenges in a busy hospital.

What went well?

"My daughter has autism and struggles with language and understanding. Each time we come to RUH or PAU you have always gone above and beyond to find her somewhere quieter or at one point you had an autism fidget box. But I haven't seen that at recent visits. That was extremely helpful and maybe something to consider again?" (Survey respondent)

What went less well?

"The wards were very noisy which doesn't help when someone has had a stroke. Recent studies have shown how calm, peaceful surroundings and allowing periods of darkness can help healing. Less distractions also help with communication." (member of Aphasia focus group)

"As someone with a hearing impairment I've found that the way the reception is organised in audiology is unhelpful – the desk is very wide and the staff are a long way away – so it means you have to shout to be heard!" (staff member, engagement at RUH)

What did staff tell us?

We also heard from members of staff who were well aware of the impact of the environment particularly in the Emergency Department for people who are neurodiverse.

"It's more difficult to make reasonable adjustments in A&E, for example to try and provide a clam space" (member of staff, engagement at RUH)

"It's loud, there are lots of lights, lots of people. There's not much privacy. There are not many side rooms. So, a difficult environment for people who struggle with noise and other sort of stimulations, that can easily lead to sensory overload." (member of staff)

"all of these are extra stimuli in the environment that can create sensory overload for somebody. And then people wonder why people shut down in hospital and they don't talk…" (member of staff)

The Learning Disability and Autism team said they look for practical changes that will help such as small, cheap disposable earplugs, or they ask if wards can turn lights down outside someone's room, where possible.

4. Support with translation and interpreting

There was mixed feedback in relation to the provision of interpreting support, which is currently provided by Language Empire. It was noted that there has been a move to online virtual interpreting away from face to face interpreting dependent on the needs and purpose of the conversation. The examples about interpreting and translation support shared relate to specific conversations that needed to be held, such as explanation of treatment, or seeking consent to treatment rather than everyday care, such as provision of meals for in patients.

There was also some concern about a lack of clarity when it came to family members or friends being used as interpreters.

The RUH have BSL interpreting services including an online BSL service that is available.

What went well?

"My first appointment with the hospital was over the phone and when the Doctor started speaking to me in English I asked for an interpreter – so they gave me a new appointment in hospital a few days later with an in person interpreter. They used the interpreter to explain the treatment and risks and to enable me to sign the consent form" (service user of BWR via an interpreter)

"I felt that the RUH did their best with trying to provide translation, and that it was better than at (another) hospital or my GP" (service user, BWR)

What went less well?

In connection with the provision of sign language we heard:

"Lack of communication with nurses day and night. Rely on my family instead of me. No wipe board, no BSL interpreter provided on both admissions. None being written down." (Survey respondent)

In relation to the provision of interpreting and translating for non-English speakers we heard concerns about both a lack of access and the quality of interpreting, including from our focus group with Bath Welcomes Refugees.

"No interpreter or video call when admitted in A&E and Gynaecology and discharge and during the day." (Survey respondent)

"On one occasion the RUH tried 4 times to get an interpreter but I ended up having to take a relative with me to an outpatient appointment." (member of BWR focus group)

"I had a phone call with the radiology and coronary unit to organise a pre-op appointment with an interpreter which they agreed to provide, but when I arrived at the appointment the main receptionist said they did not have an interpreter available. So my appointment has been rescheduled for 3 months time". (member of BWR focus group)

"I found that a phone interpreter used in November wasn't of a good standard (for cardiology). When I received a translation of my case history it wasn't correct and it was also only provided in English. It included info that had been wrongly recorded. I am also still waiting to receive full report." (member of BWR focus group)

"I felt that the translator was only translating some information not everything and I felt like they were missing out important information, for example they described my symptoms but not their impact" (member of BWR focus group)

"I was also offered a Russian translator rather than Ukrainian - I can speak Russian but I would have preferred a Ukrainian interpreter." (member of BWR focus group)

"My English is good but when it came to technical or medical language I needed interpreting to be able to understand correctly – which wasn't available" (member of BWR focus group)

A different aspect of communication need was flagged up by one person, in relation to their difficulty in understanding strong accents:

"My English is good but I find strong accents from other countries or parts of the UK difficult to understand – it's like I'm having to translate it twice" (member of BWR focus group)

We also heard feedback from staff and members of BEMSCA (Bath Ethnic Minority Senior Citizens Association) based on their observations at the RUH:

"My sister whose English is not very good had a stay at the RUH, and despite the notice above her bed clearly saying 'vegetarian' she was given fish to eat. I'm concerned that this was because of the language barrier as English is not her first language and this made it difficult for her to explain the problem at the time." (BEMSCA feedback)

"I was visiting a family member in (St Martin's hospital) and I saw a patient in the same ward who was unable to speak and also unable to open her hand to hold a spoon, being left her meal and then this being taken away later without any assistance being given to help her to eat." (re: St Martin's Hospital) (BEMSCA)

Difficulties in relation to written information:

"I had an appointment with physiotherapy, but the documents were provided in English, I didn't feel like I was listened to. I also missed an appointment due to not understanding from the letter that I had to reply, meaning I was taken off the list" (member of BWR focus group)

"Letters were provided in English and I just had to work out them out on my own. When I had a phone call appointment I had to get a friend to translate – as I have a hearing problem as well" (member of BWR focus group)

Lack of consistency and clarity in accepting communication support from carers or friends

We heard varying feedback about whether or not family and friends were able to act as interpreters, especially in relation to patients needing support to translate from English to their own language and vice versa. There appears to be a lack of clarity as to when this is or is not permitted.

"I am supposed to help my friend with her appointment today to assist with the translation. The hospital called her to explain something, but she did not understand, and the doctor emailed her with the instructions. I asked my friend to pass me the phone number, and I called on her behalf. They were happy for me to help her during the appointment initially. After a few minutes, the doctor called me back, saying that, due to their policy, they have to decline my help and reschedule the appointment for a week later." (member of BWR focus group)

In many situations family and friends have been welcomed to assist:

"Having interpreters would have been the ideal but with my level of English and having a friend with his better level of English I was able to get by in the hospital. I did need some help for the explanation of the treatment and about consent but this was actually provided by my friend."

"Currently, it is a confusing situation due to the hospital's policies and procedures. Honestly, I have attended appointments with my friend several times already, and they were happy for me to assist her. No one ever mentioned the policies. However, not during the last visit, which seems odd." (member of BWR focus group)

What did staff tell us?

We heard from staff members during our foyer engagements at the RUH that they felt face to face interpreting was much better, both for patients and themselves, as they found telephone interpreting could be difficult to use, and that it was especially useful if the patient was neurodiverse.

"We use Language Empire translation if needed – it usually works okay although occasionally it won't be quite the right language; for example, if there are 2 types of a language like Bangladeshi – and they don't get the right one, they have to go back to LE to ask for the right translator." (Member of staff, RUH engagement)

Some staff told us they supported patients informally using their own personal language skills within their own team area and found this could be especially helpful as they understood the medical language in use in their work area. One member of staff we spoke to said they spoke 4 languages and felt this should be acknowledged in some way but it wasn't.

One member of staff felt that it was important to consider the gender of interpreters as for some cultures and religions they would want to have an interpreter of the same gender as the patient.

5. Communication aids in hospital

Communication aids can include patient owned items and those provided by the hospital, sometimes alongside 'Champion' roles.

Communication support boxes are provided in wards to support people with a range of communication and support needs.

Bobs boxes – for sight loss including plate guides to assist eating

Deaf Awareness boxes – a new resource (May 2026) for people with hearing loss including white boards and pens, batteries for hearing aids

Communication folders – general information to support patient -staff communication

In addition, the Family Liaison Facilitator (FLF) makes ward rounds with a trolley including communication aids such as picture cards for meals and drinks.

In relation to patients own aids we had a mix of feedback, including:

"Glasses and hearing aids – important not to lose!" (family visitor RUH engagement)

What went well?

"I was shown picture cards for meals instead of a written menu whilst I was in hospital– this worked okay" (service user of Bath Welcomes Refugees)

"If nurses and doctors write key points of information down in a notebook this can be shared back with me, as passing on communication from hospital staff via the patient can be tricky. However, there is not always time to do this, but it works well when time allows." (Family member, Aphasia focus group)

What went less well?

"The staff were not trained in how hearing aids operate. They assume the aids have batteries, but now even NHS aids are rechargeable. There was no plug available by the bed to charge them, so it was only when I visited that I could retrieve them and take them to the reception desk for charging. Staff did not know:

a) the value (£3000 in this case)

b) how to put them in the ear

c) that they needed charging, then checking that they had switched on

d) how absolutely crucial it was for her to have them charged, in and working.

Without them she spent 3 weeks unable to choose her meals, not understanding what was happening to her. Shocking. And me 200 miles away." (Survey response)

What did staff tell us?

One of the concerns patients and carers have for everyday items such as spectacles, hearing aids and dentures is that they may be easily lost, leaving the patient without the aid and potentially a hefty cost to replace. This was recognised by the staff we heard from.

"Training is across all staff to know impact/significance on patients of e.g. the importance of dentures in communication for a patient including cost so that staff may not just willy-nilly throw such items away but be aware of their importance." (member of staff)

The most frequent communication issue that the FLF comes across in her role is hearing loss, and with particular concerns being expressed about "hearing aids getting lost or stopping working; or where people just can't hear."

In addition, many items need recharging or battery replacement, including smart phones or tablets, and hearing aids.

As well as there being problems with patients being able to charge their own phones we heard from one member of staff that access to the internet can be patchy with varying strength of signal on wards, and that

"We are sometimes asked by patients if they can use our phones" (member of staff, RUH engagement)

"I've changed roles now but (in physiotherapy) we used to translate key phrases into the main languages to make it easier for non-English speakers to engage with the service. I'm not sure if this is still done?" (member of staff at RUH)

"We write down appointments if needed, for people who are Deaf or hard of hearing". (Member of administration/ reception staff, RUH)

A review of the RUH website indicated that some guidance for patients coming into hospital was contradictory, for example, the general advice on what to bring in to hospital advises people not to bring valuables in such as 'iphones and ipads' with them; however, advice in the section for people with Learning Disabilities and Autism is to bring a mobile phone / tablet with them.

These items are key communication aids for many people and having more consistent advice would be helpful.

'Deaf Awareness Champions' and new boxes

Approximately 40 Deaf Awareness champions operate across both in and out patient departments in the RUH with mix of staff members and volunteers. The Patient Experience Team have recently delivered 20 Deaf Awareness boxes to inpatient wards or ward clusters. The boxes include written guidance, communication aids with pictures e.g. for use with tea trolley, hearing aid tips and batteries, white boards and pens, and best practice poster. A small number of crescendo devices are also available.

6. How staff communicate with patients

Feedback gathered in this area included whether or not staff **take time** to communicate, **treat patients as individuals** and **listen to family and carers**. There were some particular issues around **staff handovers and discharge**.

Feedback was again very mixed.

When asked in the survey 'how well did they think their (or the patient's) communication needs were met whilst in hospital overall' only 3 people responded 'very well' or 'well', with 11 saying 'poorly' or 'very poorly'.

Only 2 individuals said that staff explained how they could meet their communication needs, or how the individuals could ask for help with their communication needs. 2 different people also said that they were provided with communication support or aid from hospital staff.

Only 3 individuals felt that their communication needs were met 'very well' (2 individuals) or 'well' (1 individual).

What went well?

Taking the time to communicate with patients as individuals

"The consultant or doctor (in dermatology) took lots of time to explain the treatment for my daughter – they showed us the medications and explained it all carefully to her as she is dyslexic. It was important that she had information provided in an accessible way that recognised impact of dyslexia" (family member, RUH engagement)

"Although there was no interpreter on the day of my surgery, I had had a good pre-op appointment previously, even though, again, there was no interpreter I had a friend with me who could help translate. I felt that the surgeon went through the process and consent form very carefully highlighting the key elements and checking that I understood. I felt that the surgeon engaged with me on a human level, which was very important to me" (member of BWR focus group)

Making space and listening to family and unpaid carers

Feedback from family members and unpaid carers of patients with dementia or Learning Disabilities highlighted how essential good engagement with hospital staff was to them. Feedback included being welcome to be with their family member on the ward or in appointments and how they were included in communications if they could not be present.

Feedback from the Aphasia focus group included:

"My wife came in two times a day, and helped to advocate for me"

"A&E were fantastic in enabling us (family) to accompany him, but it became 'a disaster' when he was taken up to the ward"

At one of the dementia groups we attended all the carers we spoke to felt that they as carers were communicated with well and that they had been able to stay at the hospital.

"I'm deaf and my wife's dementia is quite advanced now, so we usually have my son or daughter there for appointments to help communication. I feel the doctors do take time to make sure I hear what they're saying. We never leave my wife there on her own now."

For another family where the patient's specific communication needs were not stated, they shared that

"(the patient) asked if the doctor could include our family member in the ward round by using their speaker phone during their conversation so we could also hear. The doctor agreed and a nurse then did the same as we couldn't be there

for the ward round. This was very helpful as (patient) felt they wouldn't remember everything themselves." (family visitor, RUH engagement)

Reflecting on feedback and improving practice

We heard about 2 experiences which were initially negative, but which were improved when staff took time to listen and reflect on the impact of their communication:

"Family members were visiting our grandfather and there was some difficult news being shared by the doctor about his health. Other family members had to ask doctor to speak more quietly as he had been speaking in a loud voice which they felt was likely to be upsetting for our grandfather and the doctor did later come back and apologise to the family. It turned what was a negative experience into a positive experience that he listened to us." (Family visitor, RUH engagement)

The second example was from the aphasia focus group.

"At our first Ophthalmology appointment (after partner's stroke) they were lovely but they didn't have a clue. However, they did listen to my suggestions about what we needed, and what would help, such as providing a card and an eye patch, so next appointment was much better." (member of Aphasia focus group)

What went less well?

We heard from both survey respondents and through our direct engagements how patients and carers felt about the way in which staff sometimes spoke to them. They felt this reflected a lack of understanding on the staff's part of their communication needs and lack of knowledge about how they could communicate better with patients.

Patients spoken to in patronising language said they felt dehumanised and not treated as an individual.

"The impression (that some) staff gave me was that not being able to communicate means you're stupid or unintelligent" (member of Aphasia focus group)

"The doctors lack of understanding and thinking a lack of fluency means lack of intelligence. For example, a doctor said to me 'I'm a tummy doctor', instead of 'I'm a gastroenterologist.'" (member of Aphasia focus group)

"I have a Master's in Business but staff don't see my intelligence when they see me" (member of Aphasia focus group)

Some family carers reported that they felt their knowledge of and presence in support of their loved one was dismissed, for example a nurse spoke to a family member saying:

"We're used to patients who are difficult"

"We're used to patients who can't communicate"

Carers reported that they were not allowed to stay, but were then called in the middle of the night for them to come and help, when earlier they'd been told to leave at the shift change. (member of Aphasia focus group)

One survey respondent shared their bluntly put view that there was:

"No understanding at all about how to communicate with dementia patients. Staff still had the stupidity to think you had to shout!"

Carers also felt staff were frightened of not being able to communicate with patients as they didn't know how to, and so either ignored or avoided them instead. (member of Aphasia focus group)

Feedback from people with a **learning disability** suggested that they could be reluctant to ask questions or speak to staff, making it more important that staff took time to ask them about their needs, rather than assume everything was okay.

"I don't like to ask questions when they spoke to me about it at all" (BGOAC)

"I don't like to ask questions" (BGOAC)

Carers also expressed that they felt their family member with complex needs including a learning disability was sometimes spoken over by staff and that not enough effort was made to include them in conversation or acknowledge their presence.

"Doctors and nurses did sometimes speak over her and just speak to us as the family without including P in the conversation. She felt anxious in hospital and was more anxious when we left to go home at night." (SWALLOW member of staff)

Maybe, if staff had made more effort to include the patient in conversation along with the family, the patient may have felt more comfortable and safe in the hospital environment, after the family left?

For people with aphasia, carers felt it was necessary to allow time to get the answer right to a question. For example, one carer shared that:

"a person with aphasia might say or sign to say 'yes' when they mean 'no' and vice versa. For example, 'would you like a cup of tea? They need extra time to get the answer right." (member of Aphasia focus group)

"All levels of staff need to be aware and acknowledge that they're not the experts on someone's communication needs. They need to listen to the patients and their carers." (member of Aphasia focus group)

Providing time to explain health matters was important as one respondent said "Medical language can be hard to understand for anyone – even without dementia"

In relation to **staff handovers, moving wards and discharge** some particular issues were raised, as when communication is so important in ensuring good

care and treatment it was felt that this element of the patient record or passport should be prioritised for highlighting.

One of the frequent responses from patients and/or carers was the issue of having to repeat their story at shift handovers or move of wards, and this applied across patients with aphasia, dementia and learning disabilities.

This could be due to 'This is Me', hospital passport document or the communication element of the patient record not being flagged at the changeover or when the patient moved wards, and their use being dependent on the nurse in charge.

"One of my pet hates is having to tell the story over and over again". (member of Aphasia focus group)

"When P was moving to and from (different) wards the family had to explain (her needs) all over again which was frustrating, as the hospital passport was available." (member of SWALLOW staff)

And in relation to discharge:

"When I was discharged there was such a lot of information to share with me that it was too much to take in, even though my English is quite good. It would have been better to record the information so I could listen to it again later on." (member of BWR focus group)

What did staff tell us?

Staff recognised the challenge of time pressures, for example a nurse shared that:

"There are challenges especially in A&E where there are big time pressures for communicating well. There is more time when on the ward – especially around mental health and neurodiversity needs" (staff member, RUH engagement)

Another staff member said, "For some procedures such as phlebotomy (taking blood) it's a straightforward procedure so the need for communication is more limited and so less of a challenge except with regard to specific groups, except for example, for younger people who are neurodiverse" (staff member RUH engagement)

"If I can't understand what a patient is saying to me, I'll see if another member of staff who knows the patient better can help translate for me. For example, if a patient is Deaf." (member of administration / reception staff, RUH)

"Communication that is not working well due to hearing loss is an everyday and common experience, at the extreme, we have experienced being called to help when a patient was banging on their table with their cup (due to their frustration) disturbing other patients and staff" (Deaf Awareness Champion)

In relation to learning disability and autism, members of the LD team backed up the comments about some staff being scared to communicate with patients with learning disabilities and autism:

"there are often staff who are scared of people with learning disability and autism and fearful of conversations with people with learning disability or autism – they are afraid of getting it wrong or that they don't have the skills"

They felt that this was exacerbated by time pressures staff are under, as well as a lack of professional curiosity to look for what is needed or question the processes in place.

One of the most important messages they give to staff is to 'listen to the person before getting to the task' and if the task needs to be adjusted in some way then make efforts to do that.

Staff also related that for patients with dementia that is impacting their understanding and ability to express their needs, the RUH need a designated person they can communicate with, a family member, carer or partner, both for day-to-day care needs and for more legal aspects such as consent or discharge planning. If there is no Power of Attorney for health care then they have to take a common-sense approach.

If the Dementia team is involved, they are able to help smooth out interactions between departments and wards, which can be challenging when other departments are generic and don't have the expertise or experience in communicating with people with Dementia, including when there is no family support. This includes for example when a patient needs an X-ray or physiotherapy. If staff take time to read the patient information or record there would be a higher chance of 'getting it right first time' – and saving time in the longer run.

The FLF flagged an issue around communicating via family and friends in relation to safeguarding – as she is link between family and patient she can be blind to whatever situation she is called into – and has to be aware that there may be safeguarding concerns to consider e.g. family breakdown, before she can assist with communication.

In relation to **staff handovers, moving wards and discharge** staff shared views as follows:

"When we used to make calls after discharge one of the frequent comments we heard was that that people do get fed up with having to repeat themselves over again when see new doctor or when they move ward. Doctors may not always take the time to read the patients full communication needs/journal." (member of staff)

For those involved in supporting a patient's safe discharge home, from Age UK / Community Wellbeing Hub, understanding the patient's communication needs and being able to communicate with them was essential to ensure they are discharged with the support needed.

As they are not NHS workers and do not have access to digital patient records they rely on accurate information being shared on the referral form* (however this is received), this should set out any communication needs but there may be patients who fall through the gap.

They did used to be able to access the 'This is Me' document but this is now digital so is no longer available. Having access to the Hospital Passport for example can help ensure they give the support worker the information they need to provide support.

The FLF role is in place to support patients to communicate with their family in medical and surgical wards, primarily OPU, OP short stay, MAU and emergency department.

Often this is people who are elderly, with dementia or have learning difficulties, the FLF can help with use of a mobile phone, help sort hearing aids, and support virtual video calls. She also has communication aids such as laminated picture cards as part of a ward trolley round, with magazines and books.

The FLF works closely with the Digital Inclusion Team who help facilitate patients calls with their family around wellbeing for non-medical updates - they have their own mobile phones they can take along, or they can help with a patient's own phone or take radio etc.

However, limited resources reduced the FLF team from 3 to 1 worker, and the Digital Inclusion Team is due to be disbanded later in 2026.

We heard from hospital porters and other ancillary staff who work around the patient areas that they try to help if someone is, for example, lost, by asking and miming to see their appointment letter, so they can show them where they need to get to.

Reception staff said they were able to access training in Makaton and everyone completed the Oliver McGowan training.

7. The impact of poor communication

We did hear positive feedback from people about the care they received despite them feeling that their communication needs were not always well met, for example:

"K's care in general was very good and she was able to be safely discharged back home due to the care she received"

However, we also heard about negative impacts when communication did not go well. These ranged from specific impacts to more general experiences of care:

"My husband… couldn't reach staff or get their attention when his catheter was blocked so in panic he ended up pulling his catheter out himself" – (member of Aphasia focus group)

"P was also 'nil by mouth' due to her condition and this was clearly displayed above her bed. However, her family observed Healthcare staff offering her drinks. Due to her communication needs this could have been serious, as she may have indicated 'yes' when this was in contravention with her medical needs." (SWALLOW member of staff)

"Poor communication impacted my confidence, anxiety, weak, tired, angry, no idea what going on. no support provided." (Survey respondent)

"L is a very easy going and accepting person, and he was okay with the communication with staff – but he could 'dwell on things/worries' and if had had something he could refer back to, (information in easy read or simple language) it could have put his mind at rest." (SWALLOW member of staff)

"As example of visual communication support need… people being left their food by HCA and not being able to see it and not having the supporting tools which could enable them to feed themselves for example – so not eating their food." They felt this was a fairly common occurrence where there was a communication need. (member of staff)

An example of the way that poor communication could escalate causing impacts for both patient and hospital was shared by the lead nurse for Dementia:

"There could be someone who is not drinking because of a simple communication failure. For example, someone likes sugar in their tea, it's in their record but they can't say this themselves – so they don't drink their tea when it's given without sugar. (As well as not drinking enough) If people can't express their needs or what they would like then this leads to frustration and distress, and becoming agitated. This may lead to anti-psychotic meds begin given, leading to more time sleeping and then losing condition, which could then lead to longer stays in hospital beds and an unhappy patient."

8 . Inconsistency across the hospital

Staff who work across the hospital shared that they observe varied practice, ranging from what information is by people's beds in relation to their needs, and the level of focus on good communication across different wards.

We heard that take up and following of good practice on wards and in service areas is very dependent on the individual members of staff and leadership provided – as to how core they see this to their business. For example, each ward has a Hospital Communications folder but it is very variable between wards how much this is used. There is good practice in the RUH but it is not consistent across the hospital.

For example, whilst the Acute Stroke Unit has a clear focus and structure to support communication this is not the case across the whole hospital. Where there is no common emphasis on communication in other wards, staff are likely to have less knowledge and experience to use themselves and may also not

have regular communications and on hand support from internal therapies such as SALT. (member of staff)

Clear leadership at departmental and ward level is needed to ensure that:

the resources that are available are known and used such as Bobs boxes (for sight loss), new Deaf Awareness Boxes. And each ward has a communications box

That staff complete training regularly

That staff are encouraged and supported to use professional curiosity and problem-solving skills to support communication when it is difficult

9. What would people like to see changed?

We heard from many patients and carers with ideas for how communications could be improved, and these are set out below.

However, the overall top priority we heard across all groups was:

"Ask me what my communication needs are."

Listen to the patient

"Ask me what would help rather than make assumptions."

"For staff to ask what communication needs someone might have at the beginning."

Listen to the carer

"When a person has a carer supporting them, they must be included in the process"

Implement the schemes in place

"You may already have schemes in place. You could make them more well known"

"All healthcare staff and professionals to have an up to date understanding of communication needs of patients through use of the hospital passport and to understand and act on the implications of limited understanding and speech."

"Check the quality and standard of interpreters"

Training to improve understanding of needs

"Training in Makaton"

"(Training that includes) some sort of acknowledgement of who the stroke survivor was before the stroke, helps to understand the intelligence and full

person behind the stroke because it can feel dehumanising when staff assumes less capacity because of the language barrier."

Clear guidance on family and friends providing communication support

"Clear guidance for patients and hospital staff about when family or friends can assist with interpreting and translation so that people can be prepared with necessary consents in the future."

"Legal system does not allow carers/relatives to stay outside visiting hours, yet hospital staff are happy calling carers/relatives for communication support at odd hours. Pointing to the important function of carers/relatives but the lack of reasonable adjustment for them in a hospital setting."

A simple way to identify communication needs for all patients

"Having a communication ID card/ Aphasia ID, stating someone has had a stroke and how they prefer to communicate and be communicated with. Be great if SALT team could help with this. This may include 'what helps you to understand others'"

"Whiteboards by hospital beds flagging up someone with an additional communication need"

Better referrals to supportive therapies

"Making better communication channels to access SALT through a quick referral system, for staff in all wards to know to access SALT"

"Training for all staff about stroke and brain injury patients including for doctors and consultants, this to include what SALT can do"

Make every contact count

"Make every walk through the corridor /ward count - for staff to be aware of their surroundings in case someone is trying to get their attention."

"Recognise that some patients may not be able to use call bells to ask for assistance and that regular monitoring is the only option for these patients"

Communication aids to support patients and staff

"Having access to a phone that can facetime, which helps communicate with family and helps see facial expression and gestures - visual cues. Phones with emojis and being able to write out thoughts is helpful. Medical ID on Iphones is also helpful"

"Small handheld whiteboards to draw/write on is very helpful"

"If information could be provided in an easy read format / or simple language with un-joined up writing so that people with learning disabilities could keep the information and then be able to share back with visitors."

Take time to get it right first time

"Longer / double appointments to allow more time and with an interpreter arranged on a more automatic basis rather than having to request - especially where there is medical terminology to explain / to be able to provide consent to treatment and translated appointment letters and key documents"

"Reading the hospital passport or patient notes to understand their communication needs in advance. It's frustrating for carers to have to repeat stories – but if someone doesn't have a family member to speak for them, how are they supported?"

Views of young people

We asked Bath College students to "imagine you are in a healthcare role working with people with additional communication needs, such as being neurodivergent, what is important to make communication between staff and patients work well?"

Their responses are summarised below and resonate very closely with views expressed above from patients, carers and staff.

Listening / being understanding and empathetic	5
Calm safe environment	1
Being patient / taking time /being calm	3
Using eye contact	1
Have drawing book to use as option	1
Ask person how they want to be communicated with	1
Taking time to explain and repeat as necessary	2

Findings

Based on the feedback received from patients, carers and staff we identified the following findings that are common across different language and communication needs as well as findings that are specific to particular language or communication needs.

That the specialist support teams in place work well to meet patients' needs but face some limitations in terms of scope and time available

- That the quality of staff – patient communication has a real impact on patient experience and patient care and treatment
- That systems in place to identify and flag patients' communication needs are inconsistently applied
- That systems used to identify communication needs risk some communication difficulties such as hearing loss, being missed
- That systems to provide practical communication and language support are inconsistently applied with too much left to the individual leadership of wards and departments
- That the physical hospital environment and its 'busyness' can make communications difficult for some patients but there are often small adjustments that can be made to support better communications
- That there is a lack of clarity and consistency in how carers /family and friends are involved in helping to meet communication needs
- That for patients with learning disability and/or dementia there is a high reliance on family support, which leaves a question about the vulnerability of those patients without family support

Recommendations

To achieve consistently good patient – staff communication across the hospital to meet patients' additional communication and language needs requires changes in processes and in education, training and culture. Some elements may relate primarily to inpatients whist others are relevant across all types of patient treatment and care.

1. Communicate key messages regularly to all patient facing staff about the need to 'listen to the patient before getting to the task' and why this is important:

- Ask patients how they want to be communicated with.
- Listen to family and carers to understand patient communication needs.
- Understand when and how family and unpaid carers may be involved in communications support.
- Take time to read hospital passports and other patient records which include the patient's communication needs and preferences to save the constant repetition at handovers.

- Reminders of the importance of safekeeping of patient property that supports their communication (hearing aids, dentures and digital tools).
- Celebrating positive examples of good communication especially where communication is challenging.
- Explain why good communication matters for good care and the risks to care when it goes wrong.

2. Ensure training is undertaken across all levels and grades of staff to give staff the skills and tools needed to communicate effectively across the range of needs:

- Ensuring training on communication includes the importance and value of treating patients as individuals not just raising awareness of communication needs and provision of skills.
- Encouraging a problem-solving approach especially where patients have very limited and/or non-verbal communication to overcome the fear of 'getting it wrong'.
- Including patient stories and celebrating good practice.
- Understanding policy and practice in involving family or friends in communications support.

3. Make effective use of the tools and practices that support positive and effective communications:

- Develop and share staff and patient co-designed toolkits for practical adjustments that can be made in the hospital environment to support better communications for people with additional communication needs, from the common experience of hearing loss to neurodivergence.
- Ensure all ward and outpatient 'champions' (e.g. Dementia Champions, Deaf Awareness champions) complete required training and have an at least annual opportunity to share experiences and learn from each other.
- Consider how best to use and recognise staff with additional language skills within their departments and across the hospital.

4. Specifically in relation to patient facing care and treatment ensure that staff take the time and have the skills needed to:

- Read Hospital Passport/'This is Me' and other patient information relevant to their role so that the right support or means of communication is provided.
- Check that the patient has understood any questions or explanations and use 'communication ramps, white boards, or other support tools especially in relation to doctors' ward rounds and treatment explanations.

- Explain procedures and encourage patients to ask questions to check understanding, using communication tools to help if needed.
- Check patients' food choices and any support to eat /drink are provided to ensure patients recovery is not adversely impacted by their lack of communication to ask for help around mealtimes.
- Understand the non-verbal cues and clues from a non-verbal patient, such as fiddling with blanket or clothing to indicate need to go to toilet.

5. Communicate effectively with family and unpaid carers to support patients with communication needs by:

- Providing brief written updates so family and other unpaid carers and patients have access to key points of treatment and care.
- Involving carers by having family join consultation via phone, or using a diary/ day book/white board to give key points/updates.

6. Ensure the systems and processes to identify, record and flag patient communication needs are fit for purpose and enable all staff to readily recognise and understand how they should communicate with patients across the patient journey:

- Complete work to introduce the Reasonable Adjustment Digital Flag as part of the Integrated Care Record in line with national requirements.
- Ensure that basic information setting out patients' communication requirements are visibly provided by patients' beds including all types of language and communication needs (to include both hearing and understanding and the ability to express needs).
- Ensure that any work to develop new documents such as 'What matters to me' are co-produced or take into account the views of patients and carers to ensure they meet the needs of patients.
- Share any new processes and tools consistently across the hospital and staff groups to ensure understanding of the importance of recording communication needs data on systems and records and 'buy in' to implement new data recording processes.

Next steps

Healthwatch Bath and North East Somerset will:

- Publish its findings and recommendations on its website.
- Share report with RUH patient experience team and other appropriate voluntary organisations, health boards and council.
- Develop and share key points and recommendations in accessible and engaging ways such as posters, infographics and video that can be shared across the RUH and other local hospitals.
- Follow up with the Stroke Association and other patient led organisations involved in the project to explore what impact this work has made on patients and carers.
- Follow up with the Patient Experience team and Patient Experience Committee in 6 months' time to review the impact of the report's findings and recommendations – to include follow up observational ward visits at the RUH.

Acknowledgements

- Age UK Community Connectors
- Alzheimer's Society Singing for the Brain group
- Bath Gateway Out and About Club
- Bath College Careers fair and students
- Bath Welcomes Refugees
- BEMSCA
- Healthwatch Bath & NES volunteers
- ReMind Lived Experience Panel
- RUH, Patient Experience Team, Learning Disability and Autism, Dementia Team, Deaf Champions and Digital Inclusion Team, Equalities lead
- Stroke Association and members
- SWALLOW – South West Action for Learning and Living our Way

Provider response

Sharon Manhi, Head of Patient Experience, Royal United Hospitals Bath NHS Foundation Trust

In response to the concerns highlighted in the report regarding patients' communication needs, the Trust has identified three key areas of work during 2026–27:

- Meeting the Reasonable Adjustment Digital Flag requirements
- Developing an RUH Communication Passport
- Improving access to interpreting services

We recognise the report's key message that patients should be routinely asked about their communication needs and preferences, and that these needs should be consistently recorded, shared and acted upon. We also recognise the importance of supporting staff to feel confident in meeting a wide range of communication needs and of involving families and carers appropriately in supporting communication.

We understand that patients with communication needs and preferences are not always reliably identified, recorded or supported across the Trust. This can result in inequitable access to care, poorer patient experience, repetition of information, and a risk of non-compliance with the Accessible Information Standard.

The report highlights the importance of ensuring communication needs are recognised early, clearly visible to staff, and routinely considered throughout a patient's care journey. In response, the Trust will be undertaking a pilot aimed at improving the identification, recording and meeting of communication needs, while strengthening staff capability and system support.

The pilot will support safer, more personalised and equitable care for patients with additional communication needs.

The pilot will deliver:

- A system flag on electronic patient records titled "Additional Communication Needs", with a clear process for consistent recording and use, supporting implementation of the national Reasonable Adjustment Digital Flag requirements.
- Improved recording, sharing and meeting of communication needs to support compliance with the Accessible Information Standard.

- An RUH Communication Passport, co-produced with patients, families, carers and staff, to support personalised communication with patients and ensure key information is readily available at the point of care.
- A more consistent approach to identifying and communicating patients' needs across services, reducing the need for patients, families and carers to repeatedly provide the same information.
- Increased staff awareness and confidence in recognising and responding to a range of communication needs.

We know the important role that families and carers can play in supporting communication and helping staff understand what matters to the person, particularly when they may find it difficult to express their needs, wishes or preferences.

The Trust acknowledges that the hospital environment can affect communication and patient experience. Through this work, we will continue to promote reasonable adjustments and practical measures that support patients with sensory, cognitive and communication needs.

In addition, the Trust is working to improve access to interpreters. All patients and carers have the right to communicate in a language and manner that enables them to understand information about their care and treatment and make informed decisions. We are working with staff to ensure that interpretation needs are identified at the earliest opportunity and that interpreting services are used consistently and appropriately.

Where clinically appropriate and in line with individual preferences and needs, staff will be encouraged to consider telephone or video interpreting services to support timely access to communication support and reduce delays in care and treatment. We will continue to work with our interpreting provider to ensure that patients and carers can access high-quality interpreting services that enable them to understand information, express their views and preferences, and participate fully in decisions about their care throughout their healthcare journey.

Together, these initiatives will help ensure that communication needs and preferences are identified earlier, recorded more consistently, visible to staff, and acted upon in a way that improves patient experience, safety, equity and outcomes. They will also support delivery of the Accessible Information Standard and the national Reasonable Adjustment Digital Flag requirements.

Appendices

Appendix 1: Demographics of the people taking part in the survey

Appendix 2: Survey questions

To view or download appendices 1 – 2, please go to:
www.healthwatchbathnes.co.uk/how-are-language-and-communication-needs-met-patients-hospital

healthwatch
Bath and North East Somerset

Healthwatch Bath and North East Somerset
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