NHS England

PRINCIPLES FOR HIGH QUALITY INTERPRETING AND TRANSLATION SERVICES

[VERSION 1.19]

POLICY STATEMENT

The NHS is committed to providing high quality, equitable, effective healthcare services that are responsive to the needs of all patients.

Equality of access to health services is identified as a principle in several Acts and documents including:

- The NHS Constitution
- Equality Act 2010
- Public Sector Equality Duty 2011
- Health and Social Care Act 2012
- Human Rights Act (1998)
- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
- United Nations Convention on the Rights of the Child (1989)
- UN Convention on the Rights of Persons with Disabilities 2005
- Social Value Act 2013
- NHS England Accessible Information Standard (ISB 1605)

Purpose and scope

The purpose of this document is to set out the principles which are needed to ensure a safe, high quality interpreting and translation service in primary health care. It offers advice to primary care providers, commissioners, service providers and agencies, patients and carers on how to identify good practice.

Interpreters are present at appointments to provide services for patients, carers and clinicians. Failing to match a patient's first or preferred language can impact on patient experience and health outcomes, the frequency of missed appointments and the effectiveness of consultations. It may have serious implications such as misdiagnosis and treatment, ineffective interventions and, in extreme circumstances, preventable deaths.

The use of an inadequately trained (or no) interpreter poses risks for both the patient

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and healthcare provider. When this occurs neither the healthcare provider nor patient can be assured that accurate and effective communication is taking place. The error rate of untrained interpreters (including family and friends) may make their use more high risk, than having no interpreter at all.

These principles cover face to face (including manual or hands-on signing for Deafblind people) and remote interpreting including telephony and visual (or video) relay interpreting.

These principles complement the Accessible Information Standard (AIS) but are separate from it.

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PRINCIPLE 1: Access to services

Patients must be able to access primary care services in a way that ensures their language and communication needs do not prevent them receiving the same quality of healthcare as others.

1.1 Interpretation and translation should be provided free at the point of delivery, be of a high quality, accessible and responsive to a patient's linguistic and cultural identity.[1] Patients must not be asked to pay for interpreting services.

1.2 Patients already have the option to use an online system to book primary care appointments. Primary care providers should look at how systems can be adapted to meet the needs of patients who require interpreters including accessing the system in languages other than English and indicating the need for an interpreter to be booked.

1.3 Commissioners should seek to enable patients to book primary care appointments using services which are in the patients preferred language so that appointments made are appropriate to the need.

1.4 When an interpreter is required, additional time will be needed for the consultation. (Typically double that of a regular appointment.)

1.5 Language preferences and communication needs should be recorded in the patient's record and shared with other services when the patient is referred on (for example to secondary care services). A highly visible alert should be used to ensure staff are aware of the needs of the patient.[2]

1.6 Information relating to health and primary care services should be available within the practice in languages appropriate to local communities and using appropriate communication formats (such as written, audio and sign language video). [3]

1.7 Where the patient is a child or has a learning disability or limited language skills, their parent, guardian or carer must be able to access services in their preferred language (even where the patient themselves may use a different first language), including the use of British Sign Language[4].

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[1] Communication support, such as sign language interpreters for people with hearing loss, is likely to be considered a 'reasonable adjustment' as required under the Equality Act 2010

[2] The processes outlined in the Accessible Information Standard are explained at http://www.england.nhs.uk/accessibleinfo

[3] NHS England has translated a number of commonly used documents to assist practices [INSERT LINK TO WEBPAGE]

[4]Some patients may have limited skills in their own language and it should be noted that these people may require the use of relay (or specialist) interpreters in addition to an interpreter

PRINCIPLE 2: Booking of Interpreters

Staff working in primary care provider services should be aware of how to book interpreters across all languages including BSL and to book them when needed.

2.1 Where interpreting is required for a patient, the primary care provider is responsible for ensuring an interpreter is booked whenever an appointment is made.

2.2 The primary care provider should confirm to the patient in advance of the appointment that an interpreter has been booked.

2.3 Interpreters must be registered with an appropriate regulator (see Annex 1) and should be experienced and familiar with medical and health-related terminology.

2.4 All relevant staff, including reception and practice managers within primary care services, should be regularly provided with information by the commissioned agencies on the arrangements for booking interpreters. This should include what is provided, who the provider agency is (are), how to book and how to complain and respond to complaints by patients.

2.5 All staff within primary care services should be offered training (by the commissioned agencies) to raise awareness of the role of interpreting; the impact on patients and clinicians of high quality interpreting and appropriate types of interpreting for specific situations.

2.6 When commissioning services, equal weight should be placed on the quality and price of the service.

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PRINCIPLE 3: Timeliness of Access

Patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access.

3.1 Using appropriate formats and languages primary care providers should raise awareness with their patients that interpreters can be made available. Agencies commissioned to provide interpreting services should provide appropriate materials to practices as part of the commissioned service.

3.2 Patients should not be disadvantaged by waiting unnecessarily longer for their appointments or to access primary care services because an interpreter is

required.

3.3 On registration with a primary care service provider (or subsequently if their needs change), patients should be made aware of the different types of interpreting available (eg face-to-face, telephone, video remote interpreting / video relay services).

3.4 Staff within practices must ensure that patients who have specific language requirements or communication needs are called to their appointment in a way which eliminates the opportunity for appointments to be missed (for example directly approaching the patient in the waiting area when the appointment is called).

3.5 Reasonable arrangements should allow a patient using an interpreter to be placed higher up the appointment order if the clinician is running late so that the appointment can be fulfilled by the interpreter at limited additional costs.

PRINCIPLE 4: Personalised Approach

Patients can expect a personalised approach to their language and communication requirements recognising that "one size does not fit all".

4.1 Patients should be asked about their language requirements and communication needs at registration with a primary care provider (or subsequently should their needs change) and this should be indicates clearly in their patient record. This should include:

- language requirements, language preferences and communication needs
- preference regarding gender of interpreter (if they wish to express one)
- cultural identity (where appropriate) and religion/faith where this is relevant to the provision of interpreting
- special circumstances which may necessitate one form of interpretation over another (for example, specific circumstances may mean it is more appropriate for a patient to always have a face to face interpreter).

4.2 Good practice indicates that where a patient requires continuity of care (for example, end of life care) they should be enabled to access the same interpreter wherever this is practicable.

4.3 Interpreters should complete their assignment and role to the satisfaction of the patient and the healthcare professional and to the standards set out by

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their professional body.

4.4 Commissioners should consider how the service can support patients so that the whole occasion of care is facilitated, (for example, filling prescriptions at an *on-site* pharmacy or booking future appointments at the reception desk immediately after the appointment).[5]

4.5 Patients should always be offered a registered interpreter. The use of family, friends or unqualified interpreters is strongly discouraged in national and international guidance and would not be considered good practice.

4.6 If it is expressly desired by the patient that a family member or friend acts as 'interpreter' and provides language brokering services, the patient's informed consent to this must be in their own language and be sought from them independently of the family member/ friend.

4.7 The use of anyone under the age of 16 for 'interpretation' or language brokering is not acceptable under any circumstances other than when immediate and necessary treatment is required. In this case safeguarding and competency must be a consideration.

4.8 Professionals and primary care staff may use their language and communication skills to assist patients in making appointments or identifying communication requirements, (language brokering) but should not, other than where immediate and necessary treatment is required, take on the role of an interpreter unless this is part of their defined job role and they are qualified to do so. Staff used as interpreters this way must be covered by indemnity insurance.

4.9 Responsibility for clinical judgements rests with the professional primary care staff who should ensure that language requirements and communication needs are met in line with the principles outlined in these standards in order to fully participate in the consultation.

PRINCIPLE 5: Professionalism and Safeguarding

High ethical standards, a duty of confidentiality and safeguarding responsibilities are mandatory in primary care and this duty extends to interpreters.

5.1 Interpreters must be registered with an appropriate regulator, be suitably qualified and have the skills and training to work in primary care.

[5] Interpreters do not provide advocacy. This is an entirely different role which is not covered within the remit of these principles.

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5.2 Interpreters must have undergone appropriate checks and clearance in line with Independent Safeguarding Authority guidelines to work in this sector.

5.3 Where an agency is to be used (where interpreters are not directly employed by the practice for example) all interpreters must be directly employed by the interpreting provider agency (agency) or directly sub-contracted to them. The agency may not sub-contract to another company or organisation[6].

5.4 Interpreters must be trained annually to an appropriate level in relation to safeguarding. For telephony interpreting this will be at Level 1 and for face to face interpreters, at Level 2. Agencies are responsible for ensuring that staff and contractors have access to this training and development free of charge.

5.5 All interpreters must complete an annual Information Governance (IG) course.[7] Agencies are responsible for ensuring that staff and contractors have access to this training and development free of charge.

5.6 To safeguard disclosure of personal data, the agency must find a way to meet all information governance toolkit requirements for their interpreting staff / contractors to access appointments and related information. A secure online access system may be preferable.

5.8 Interpreters should introduce themselves and their role to all parties prior to the start of their assignment and explain the purpose of their role. (The Interpreter's Declaration.)

5.10 The interpreter is present only to facilitate communication during the appointment. They should not be asked to undertake additional/ ancillary duties during the appointment time. (eg those which may be delivered by a carer or advocate.)

5.11 Interpreters are present to interpret for everyone in that appointment including the patient, parents or carers, any representative / chaperone and healthcare professionals.

PRINCIPLE 6: Compliments, Comments, Concerns and Complaints

Patients and clinicians should be able to express their satisfaction with the interpreting service in their first or preferred language and formats (written, spoken, signed etc.) as appropriate.

[6] Sub-contracting further presents governance and accountability issues and creates the risk that patient information (including sensitive personal data) is disclosed to more parties than necessary.
[7] This could be done through the IG Training Tool provided by the Health and Social Care Information Centre (HSCIC) or another training tool that has been accredited by HSCIC

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6.1 Easy to follow and confidential procedures should be in place to enable feedback about the interpreting service. The compliments, comments and complaints procedure (CCCP) should be available in appropriate languages and formats including written, spoken and BSL signed video.

6.2 Any response to patients' comments should be in their own preferred language.

6.3 Patients should be able to access the CCCP directly. To do this patients will need to be made aware of who the supplier agency is and/ or details of the registering body as well as the interpreters full name.

6.4 Commissioners must ensure a system is in place that enables patients and clinical staff to complain about the interpreting service they have received. It must be independent of the individual interpreter and practice staff must be aware of how to access this and direct patients to this process.[8]

6.5 Interpreting service agencies should collate and publish data on comments and their resolution annually in a service satisfaction report. The service satisfaction report should be made available to commissioners, primary care providers for whom they are commissioned and on their own website.

PRINCIPLE 7: Translation of documents

Patients and healthcare professionals should have timely access to appropriately and effectively communicated documentation that will enable and support their healthcare.

7.1 Documents which are usually free to patients within GP practices and dental practices which may empower them to take more control of their own wellbeing and health should be available to patients in their preferred language and format at no additional charge. (Practices may wish to engage directly with the organisations that provide such literature.)

7.2 Documents translated for the benefit of patients must be translated by competent and appropriately trained translators and not by practice staff. Staff may be used to communicate simple messages such as future appointment dates or where staff are specifically trained to do this work.

7.3 Patients should be able to request their summary care records to be translated into their preferred language and format (including Easy Read, Braille and

[8] The NRCPD has an online complaints procedure relating to the range of interpreters on their register.

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other accessible formats) at no cost to themselves (over and above the standard cost of accessing their patient records).

7.4 Where patients register with a practice and are in possession of documents in languages other than English which relate to their health these should be translated into English at the earliest possible opportunity. This will ensure patient safety and continuance of care. These documents should be included into the patient record in both languages.

7.5 Letters to patients should be provided in their preferred language and in an appropriate format.

7.6 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.

7.7 The Accessible Information Standard specifically requires that for people with accessible information needs, information and communication should be provided in the first instance in their required format rather than in a standard format. This means printed letters should not be sent to people who need a different format.

7.8 Automated on-line translating systems or services such as Google-translate must not be used as the quality of the translations cannot be quality checked.

PRINCIPLE 8: Quality Assurance and Continuous Improvement

The interpreting service should be subject to systematic monitoring for quality assurance and to support continuous improvement to ensure it remains of a high quality and relevant to local needs.

8.1 Clear lines of accountability must be in place between the commissioner, healthcare professionals using the service, the agency and the freelance or directly employed interpreter providing the interpreting/translation service.

8.2 Accountability must be auditable and governance processes must be in place for interpreting and translation services. It must be clear who the commissioner is, who the providing agencies are, who the clients/ recipients of the service are and a clear trail of who has received the service and when.

8.3 Once commissioned the service should be subject to regular performance monitoring against the specification to ensure that the service continues to meet patient needs. This may include for example, checks to ensure that interpreters are suitably qualified and registered, appointments are being kept,

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governance is effective, costs are being monitored and the level of compliments, comments and complaints recorded.

8.4 Data on service satisfaction should be fed into a Continuous Improvement Plan (CIP) developed by the interpreting service provider/ agency. Commissioners, primary care providers, interpreter and patient representatives should be involved in the development of the CIP. The CIP should be available to patients and primary care providers. The CIP should support quality assurance of the interpreting service and compliance to these eight principles.

8.5 Information governance and data protection are significant features of a high quality and effective service. All agencies will be expected to comply with the information governance requirements set out in Annex 2.

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Annex 1 - Qualifications and Regulators

Qualifications and Regulators for Interpreters for Deaf People

Organisations should ensure that communication professionals working with Deaf, deafened and deafblind people (including British Sign Language interpreters and deafblind manual interpreters) used in health and social care settings are registered with the National Registers of Communication Professionals working with Deaf and Deafblind People (NRCPD).

Registration confirms they hold suitable qualification(s), are subject to a Code of Conduct and complaints process, have appropriate insurance, hold an enhanced disclosure from the Disclosure and Barring Service, and engage in continuing professional development. The NRCPD includes the following professional categories:

- Registered Interpreter for Deafblind People
- Registered Lipspeaker
- Registered Notetaker
- Registered Sign Language Interpreter
- Registered Sign Language Translator
- Registered Speech to Text Reporter

If it is impossible to engage an NRCPD Registrant, organisations MUST ensure that the communication and language professional holds relevant interpreting qualifications and, in the case of British Sign Language (BSL), has achieved BSL level 6 or an honours degree in their second language, in line with NRCPD registration requirements. They must also have appropriate insurance and an enhanced disclosure from the Disclosure and Barring Service. It is recommended that interpreters are asked to sign up to the online update service.

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Qualifications and Regulators for Interpreters for Spoken Languages

Spoken language interpreters should be registered with the National Register of Public Service Interpreters (NRPSI).

Requires discussions with key organisations

Spoken Face to Face interpreters including Video Interpreting

Will be determined based on research and advice from a range of partners including:

- NRPSI
- Nation Association of Linguists.

The minimum qualification for face to face interpretation in spoken language should be a National Vocational Qualification Level 6 with a health element or a Diploma in Public Services Interpreting (Health).

Telephone Interpreters

Will be determined based on research and advice from a range of partners including:

- NRPSI
- Nation Association of Linguists.

The minimum qualification for telephone interpreters should be a National Vocational Qualification Level 6 with a health element.

Translators

People used to translate written documents should hold at least one of the following qualifications:

- an honours degree in the relevant language and/or a degree in translation
- Qualifications and Credit Framework Level 7 qualification in translation such as the Institute of Linguists Educational Trust (IoLET) Diploma in Translation
- a masters level qualification in translation
- National Vocational Qualification Level 5 for special needs
- a recognised post graduate qualification in translation (for transcribers this should be the Diploma in Public Services Interpreting (health))
- Qualified Membership of Chartered Institute of Linguists or the Institute of Translating and Interpreting.

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Annex 2: Information Governance

The interpreting service provider agency and individual interpreters will be required to comply with NHS information governance requirements and be able to demonstrate they can process personal data and sensitive personal data in a secure, confidential manner, giving assurance to patients, clinicians and commissioners about the way they handle patient information.

A2.1 Where patient data is to be shared electronically the interpreting service will be required to have and maintain an N3 network connection, to enable to safe transfer of patient data between organisations providing NHS services. This may be facilitated by the provision of an NHS.net email account or a .gsi.gov.uk email account.

A2.2 All persons acting as interpreters must complete annual Information Governance (IG) Training. This could be done through the IG Training Tool provided by HSCIC or another training tool that has been accredited by HSCIC.

A2.3 Interpreters used by the service must either be directly employed by the contracted interpreting agency or directly sub-contracted to them. The agency must not sub-contract to another company or organisation (in past experience this has led to further levels of sub-contracting). Sub-contracting further than this presents governance and accountability issues, and responsibility for any actions, omissions, and impact becomes blurred and diluted. This also creates the risk that patient information (including sensitive personal data) is disclosed inappropriately to more parties than necessary, which could be construed as a breach of Data Protection (relevancy and proportionality).

A2.4 Agencies must find a way to enable interpreting staff to find out details of assignments in a way which meets all information governance requirements. It is therefore advised that they create a secure online portal for interpreting staff to access their appointments and related information. This system must provide a full audit trail of all accesses by anyone employed by the contracted agency. Audit trail functionality should include (but not limited to):

- Audit trail by staff username (to see who, when, and what they have accessed)
- Audit trail by patient (to see which staff members have accessed the record, when, and what they did).

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A2.5 For the contractor to comply with Data Protection Act 1998, patient information must:

- be kept no longer than necessary
- be used for the purpose intended, and only the minimum necessary used to achieve that purpose
- be accurate (subject to best endeavours of the contractor)
- be processed only for the purposes specified by the contractor
- kept securely, and disposed of securely when no longer required
- not be processed outside of the European Economic Area (EEA) without adequate safeguards and protections in the non-EEA country the processing is intended to take place
- be processed in accordance with the patient's rights

A2.6 In order to comply with Principle 1 of the Data Protection Act (DPA) patients must be provided with a Fair Processing Notice. This means that they are told by the contracted agency:

- who the data controller is for their data (this will usually be the contracted agency)
- what data might be held and for what purposes
- with whom their data may be shared and why
- the format their information may be held in and any rights associated with that format (patients have a right under Section 12 Data Protection Act to be given a copy of the logic involved where decisions are made about them solely by automated means).

A2.7 Processing of personal data by the contracted agency (or sub-contractor) will require a Schedule 2 condition.

A2.8 Processing of sensitive personal data by the contracted agency (or sub-contractor) will require a Schedule 3 condition, as well as a Schedule 2 condition[9].

A2.9 Contracted agencies will be required to report annually to their commissioner(s):

- the number of information governance breaches that have occurred in relation to the number of appointments/contacts for the year (ie 2 breaches out of 100,000 contacts)
- a report broken down by type of breach
- the remedial action that has been taken
- the steps that have been taken to prevent future occurrences.

A2.10 Identifiable data should only be shared with the commissioner when

[9] Processing includes almost everything that you do with data – obtaining, using, amending, disseminating, disclosing, altering, retaining and destruction of data.

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relevant and there is a lawful basis to do so.

A2.11 Patients will have the right under Section 7 DPA to submit a Subject Access Request to the contractor. The contractor must respond to this accordingly.

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