



**Primary Care Medical Services  
Interpretation and Translation  
Framework  
Project Initiation Document**

# Project Initiation Document

The aim of this PID is to define the project and form the contract between the Project Board and Project Manager. It provides a baseline against which the Board can assess progress, issues and ask on-going viability questions.

The PID also provides a useful single source of reference for others to quickly and easily find out what the project is about. It answers the following questions:

- What is the project aiming to achieve?
- Why it is important to achieve it?
- Who will be involved and what are their responsibilities?
- How and when will it happen?

## Version History:

Version	Date	Amendment History	Author
1.0	24.11.14	First draft	Rachel Snow-Miller
1.2	25.11.14	Second draft	Rachel Snow-Miller
1.3	25.11.14	Third draft with H Parkin comments	Rachel Snow-Miller
1.4	02.12.14	Third draft with K Holton comments	Rachel Snow-Miller

## Reviewers

This document must be reviewed by the following:

Name	Signature	Title / Responsibility	Date	Version
David Geddes		Head of Primary Care Commissioning		
Rosamond Roughton		National Director: Commissioning Development		

## Approvals

This document must be approved by the following:

Name	Signature	Title / Responsibility	Date	Version

## 1 Background and regulatory framework

## **1.1 Summary**

NHS England has an obligation to require that interpretation services are offered by primary medical services which it commissions to those patients who have a hearing loss or other protected characteristics.

NHS England has the opportunity to require that services it commissions make reasonable adjustments to the way services are provided in order to take account of the needs of those who do not speak English.

NHS England already funds some interpretation and translation services within primary medical services and there is a risk that if it were to withdraw this funding it may breach its duties under section 13G of the NHS Act as well as the public sector equality duty.

The picture of who currently pays for interpretation and translation services varies across the country and service delivery and quality is patchy.

## **1.2 The need for interpretation services**

Language barriers in the health care setting can lead to problems such as delay or denial of services, issues with medication management, and underutilisation of preventive services. Difficulty in communication may also limit clinicians' ability to understand patient symptoms and treat effectively. Language services, such as translation and interpretation, can facilitate communication and improve health care quality, patient experience, adherence to recommended care, health outcomes and reduce inequalities in health. Without appropriately understanding the treatment offered to them patients are unable to give informed consent to treatment,

## **1.3 Language use within England**

It is estimated that around 17% of the general population have deafness and will have a range of communication related requirements. Included in that group (around 0.1%) are Deaf people who use British Sign Language as their predominating or only language;

The 2011 UK Census indicated that over 8% of the population speak a main language other than English. It can be estimated that in the region of 864,000 residents of England (circa 1.6%) do not feel confident in their use of English.

## **1.4 Legislation and regulation**

Section 13G of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), states that NHS England, in the exercise of all its functions, must have regard to the need to reduce inequalities between patients with respect to:

- a) Their ability to access health services and
- b) The outcomes achieved for them by the provision of health services.

This strengthens the previous obligations to reduce health inequalities set out in the Equality Act 2010.

It is incumbent upon NHS England to remove or minimise disadvantage suffered by people who share relevant protected characteristics and take steps to meet their needs.

NHS England, CCGs, NHS trusts and NHS foundation trusts are all subject to the public sector equality duty as are private providers where they are exercising a public function, or where they are publicly funded. Therefore both commissioners and providers are required to have due regard to the public sector equality duty.

Section 29 of The Equality Act requires that all organisations providing a service to the public are subject to non-discrimination rules and have a more specific requirement to ensure that they do not treat someone worse, or do something that has an adverse impact due to them having particular protected characteristic.

Section 13Q of the NHS Act 2016 requires commissioners to involve service users and to do so in a way which meets their communications needs. In addition duties to involve patients and ensure choice (s14) may be impeded if appropriate interpretation and translations services are not available.

The NHS Constitution states that all commissioning bodies must assess the health requirements for their populations and take account of inequalities in access to and outcomes from healthcare services and commission the services they consider necessary to meet those needs.

Providers regulated by the CQC are subject to guidance in relation to meeting the required standards.

*“You must identify these communication needs for the people who use your services and ensure that you meet them.”*

## **1.5 Complaints**

There have been complaints through the Parliamentary and Health Services Ombudsman about how decisions are being made to allow access to sign services for people with protected characteristics.

There have been complaints to the area team regarding the variability of access to sign services in the London region.

## **1.6 Current funding structures**

It is difficult to baseline the resources already spent on I&T services within primary care however, it is estimated that this is in the region of £3.5M to £5M.

This is the current estimated figure. It should be noted that without any prevalence projections or recommendations on models of delivery, the costs could be significantly higher. The uptake of interpreting and translation services is not currently equitable and widely accessible to all those who require them, it is recognised that once the accessible information standard is introduced and a quality framework is developed these costs may increase.

Whilst the provider is clearly the entity with the legal responsibility to ensure I&T services for their patients, historically PCTs often funded this service. On the development of CCGs this money went one of three ways:

- i) The money was transferred to CCG budgets
- ii) The money was transferred to NHS England Area Team budgets
- iii) The money was transferred to local authority budgets via Public Health funding

In addition in some cases the providers funded the services themselves.

A recent audit has not been able to identify definitively where money was transferred to. Analysis of 2012/13 CCG and Area Team budgets has identified circa £5m which is nominally allocated to I&T services. It was also anticipated that this would be reduced to circa £3.5m in 2013/14.

When resources were available via PCTs it was often considered that the funding was not sufficient for local needs and recent evidence from Healthwatch has further highlighted that there are significant discrepancies across local footprints and neighbouring areas in terms of service available and who pays.

## **2 Definition**

### **2.1 Aims and objectives**

#### **Purpose of the work**

2.1.1 At the present time there is no one way of determining what is a good quality interpretation and translation service, This means both primary care providers who are receiving a service and those who may commission a service are not able to benchmark what a high quality service should be like for service users.

2.1.2 It is not clear what procurement frameworks are currently in place for providers to draw down against and ensure that a quality service is provided for patients.

2.1.3 The picture of who currently funds I&T services in primary care is messy. In some cases the CCG is funding a service and in some the area team. There is evidence of providers directly funding services in some cases and in some parts of the country there does not appear to be any service in place. There are views that some of the resources which have been set aside for this work is inadequate to meet need.

The purpose of the work is therefore five-fold:

- i) To work with service users and partners to define what a quality interpretation and translation service would look like based on evidence from around the country and abroad ie Sweden
- ii) To review what procurement frameworks are available to be drawn down against and to share this information more widely. If there is no framework in place which is relevant then to develop an appropriate procurement framework to support primary care services.
- iii) To gain agreement on how funding for I&T services might be best approached and work with partners to agree an equitable approach to support local health economies to determine the best way to fund local I&T services taking into account legal advice where appropriate
- iv) To develop an options appraisal that sets out potential commissioning options (from national through to regional and local) with recommendations for the most appropriate model taking into account VFM and service quality and also the Five Year Forward View and potential future models of service delivery
- v) To scope options for translating key NHS England documentation / patient information used in the course of primary care commissioning / contracting including identifying key primary care documentation for translation

## 2.2 Benefits

Specific benefits gained from this project will be:

### Quality and patient experience

- Patients who require information in more accessible formats or whose English language skills are poor will be assured of access to such leading to more effective treatment, earlier access to services and improve health care quality, patient experience, adherence to recommended care, health outcomes and reduce inequalities in health

### Inequalities

- Health inequalities will be reduced by ensuring a high quality service is available and NHS England will be able to demonstrate its compliance with the public sector duty

### Financial

- Increased value for money should be a product of this work however it must be noted that there is a risk that cost pressures may increase as a result of this project.

### Partnership working

- NHS England will need to work with a wide variety of partners to drive forward this project including:

- Race Equality Foundation
- RCGP
- GMC
- BMA
- Providers
- Crown Commercial Services

**Workforce:**

- The wider NHS primary care workforce should have increased knowledge of the responsibility in relation to providing accessible information and interpretation services

### 2.3 Project Deliverables

Major Deliverable	Description
<b>Quality framework</b>	Recognising the differing needs of those with protected characteristics and those with limited English proficiency (a) document/s which describes a high quality interpretation and translation service including quality measures, standards and expectations based on a rigorous evidence review (both nationally and across Europe where appropriate) including the use of new technologies where appropriate
<b>Scoping of existing frameworks</b>	A document which describes the quality and commissioning frameworks already in existence for the provision of I&T services within primary care settings across England.
<b>Commissioning options and modelling</b>	An options appraisal of the different commissioning opportunities available to providers and local health economies describing how these models may impact on both cost/value for money and service quality/user experience as well as administration and payment mechanisms.
<b>Policy document on I&amp;T funding</b>	An options appraisal document which is agreed by NHS England which sets out the options for funding I&T services within primary care and supports local health economies to determine the best way to fund services (eg NHS England, Local Authority, CCG, Local Area Team or Provider) and that maps potential demand for the services from the relevant populations

### 2.4 Scope and Exclusions

In scope:

This project looks only at primary care medical services.

- Engaging with:
  - service users,
  - primary care providers,
  - CCGs
  - Area teams
  - the representatives of primary care providers
  - providers of I&T services
  - other public sector partners who are engaging in similar work
- The development of the above products specifically for primary care services
- Accessible information for people with protected characteristics and interpretation and translation services for people with limited English proficiency (LEP)

Out of scope:

- This work will not consider services in the wider NHS such as in acute trusts or within local authority settings or other primary care settings such as dentists, community pharmacists and opticians
- Wider adjustments which may need to be made to meet the needs of people with disabilities or other protected characteristics

## **2.5 Dependencies**

The project is dependent on the following:

- Work already initiated by P&I directorate in relation to an accessible information standard.
- Work already in train by Nursing Directorate's Patient Experience Team on reviewing access to sign services

## **2.6 Constraints**

Timescales for this work are not clear but will be influenced by the GP contract negotiations, the political climate throughout the election period / post General Election (May 2015), and the publication of the accessible information standard. It is anticipated that part of the scoping of this work will further refine dates for each deliverable.

Work with partners will be a significant part of this project and their timetables will need to be considered.

## **2.7 Interfaces**

The programme will need to interface with work being led by other directorates, including the patients and information directorate work on an accessible information



standard. A beneficial two-way sharing of knowledge and evidence is expected between this programme and others.

A large number of internal and external stakeholders will be engaged including RCGP, BMA, GMC, BSA, Area Teams, CCGs, providers of services, service users.

## **3 Approach**

### **3.1 Overview**

The project will be led and managed by NHS England under Ros Roughton as SRO.

Work will be coordinated by a small project team, overseen by the Head of Primary Care Commissioning and led by Rachel Snow-Miller in an interim role. In addition support will be provided by a CSU which will be commissioned to work on this project and provide capacity to the team.

Project progress will be reported at regular intervals through project highlight reports. Communications, both internal and external, will be vital to the success of this project and a robust communications plan will be developed.

### **3.2 Assumptions**

The project approach has been defined with the following assumptions:

- the senior team support a project management approach to this project;
- the resource required to deliver the project have been identified and a business case has been agreed
- A CSU will be able to provide support to this project

### **3.3 Programme Plan**

A full programme plan will be developed once a CSU is in place to work alongside the team.

PID Sign off	w/c 01/12/14
CSU specification circulated	w/c 01/12/14
CSU expressions of interest	w/c 09/12/14
CSU expressions evaluated	w/c 17/12/14
CSU confirmed and in place	w/c 17/12/14
Full project plan agreed	w/c 12/01/15

### **3.4 Stakeholder Engagement & Communications**

Engagement with key stakeholders is already underway. A comprehensive engagement and communications plan will be developed, aligned with the forthcoming primary care communications strategy for NHS England.

## 4 Organisation and Capability

### 4.1 Governance

The SRO will be Rosamond Roughton, who will lead on reporting into the Primary Care Oversight Group. (TBC)

### 4.2 Project governance structure

Role	Name	Responsibilities/Accountabilities
SRO	Rosamond Roughton	The SRO champions the project, provides and/or ensures resources for the project and provides an understanding of overall project scope. The SRO is the lead decision-maker for the project. The role of the SRO is to clear the way for the Project Manager and the Project Team to carry out the work necessary to complete the project.
Programme Lead	Dr David Geddes	
Interim Programme Manager	Rachel Snow-Miller	The Project Manager is the overall manager responsible for defining, planning and delivering the project's products within the acceptable parameters of time, quality and budget agreed to within the Project Initiation Document (PID). The Project Manager is also the primary motivational influence and the central point of communication for the Project Team and the project stakeholders.
Steering Group	Membership tbc	This group will work in an advisory capacity to the Programme Lead and Programme Manager, giving expertise on how to stimulate and support the project and advising on aspects of implementation
Project Team	Provided via CSU	The project team translates the project strategy into actions and delivers products as assigned in the project plan within acceptable parameters of quality, cost and time. The team fully participates in all planning activities, providing the required input and expertise to plan and estimate tasks and to define products. User participation in a project is important. The project team's primary responsibility is to provide project support to the Project Manager. The project team will meet weekly in the first instance, subject to review.

## 5 Management Controls

### 5.1 Reporting

Report	Frequency	Audience
Highlight Report	Fortnightly	SRO
Risk Register	Monthly	SRO / Project Board

Close-out documentation	Project close	Project Board NHS England
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## 5.2 Change Control

Changes to the content of this PID following approval can only be authorised by the SRO.

## 5.3 Risks and Issues

These will be reported two-weekly to the SRO, except where very significant or urgent issues arise, when more rapid discussion may be needed.

## 5.4 Quality Management

Project quality will be monitored and maintained by the Project Team, reporting to the SRO.

### References

<http://www.ethnicity.ac.uk/medialibrary/briefings/dynamicsofdiversity/who-can-and-cannot-speak-english.pdf>

<http://www.ahrq.gov/research/findings/factsheets/literacy/langserv/languageeservicesbr.pdf>