



Guidance for commissioners: Interpreting and Translation Services in Primary Care

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• Legal position
• Principles for high quality interpreting and translation services
• Commissioning and contracting considerations.

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Guidance Note: Commissioning Interpreting and Translation Services in Primary Care

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This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact the Primary Care Commissioning Team:

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Executive Summary

This guidance aims to support local commissioners of primary care services when commissioning translation¹ or interpreting² services, or reviewing existing services. It was initially written with primary medical care services (GP surgeries) in mind but commissioners may find the contents applicable to other settings, such as other primary care settings or hospital sites.

It highlights principles of best practices commissioners should consider when commissioning services for NHS patients and carers, specifically:

- Quality considerations ('principles')
- Legal position
- Commissioning and contracting considerations.

As and when commissioned contracts come up for renewal, this guidance will help commissioners see gaps in existing provision so that they can consider how best to address them to drive improvements in services.

Interpreters provide a service for patients, carers and clinicians to help them understand each other when they do not speak the same language. Not being able to communicate well with health professionals can impact on health outcomes, increase the frequency of missed appointments, the effectiveness of consultations and patient experience.

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

Equality of access to health services is highlighted within several documents including:

- European Convention for the Protection of Human Rights and Fundamental Freedoms 1950
- United Nations Convention on the Rights of the Child 1989
- Human Rights Act 1998
- United Nations Convention on the Rights of Persons with Disabilities 2005
- Equality Act 2010 (NHS England has responded to the specific equality duties in this Act)
- The NHS Constitution 2012
- Health and Social Care Act 2012
- Social Value Act 2013
- Accessible Information Standard (SCCI1605) 2016.

¹ Translation is where a written source document (for example, a letter) is re-produced in another language. This can involve translating a document from one spoken language to another, such as Spanish in to English or transcribing a document from English in to braille.

² Interpreting is where a conversation or discussion (for example, between a nurse and a patient) is re-produced in another language. This might be from Farsi to English and vice versa. Or, from British Sign Language (BSL) in to English, and vice versa. This may be done face-to-face or using remote methods such as telephone interpreting or video or visual relay interpreting.

1 Principles for high quality interpreting and translation services

The principles below were developed as part of a project led by NHS England's Primary Care Commissioning Team prior to the development and publication of the Accessible Information Standard. They were published in draft format on the NHS England website in 2015. Further details on the people and organisations involved in developing these are available on the [NHS England website](#).

The 8 principles can be used by commissioners to help agree priorities and ambitions for improvements in local translation and interpreting services.

Principle 1: Access to services

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

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 needs³. Patients should not be asked to pay for interpreting services or to provide their own interpreter
2. Patients already have the option to use online systems to book primary care appointments. Primary care providers should look at how systems can be adapted to meet the needs of patients who require language support (e.g. providing BSL video explanations) and indicating the need for an interpreter to be booked
3. When an interpreter is required, additional time will be needed for the consultation (typically double that of a regular appointment)
4. 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 in time for them to book appropriate support.⁴ This should record specific requirements such as those detailed in [Principle 4](#), to ensure the correct service is booked
5. When supporting children with interpreting service, every effort should be made to respect the rights of the child (any person under the age of 18 years and especially those under 16 years of age) and support them in ensuring that interpreting services are provided to them under the principles of Gillick competency
6. The rights of the child to receive healthcare services independently of parental control or decision making must be considered and respected and every effort should be made to empower the child to have an independent consultation if requested. Further guidance on Gillick can be found on the [NSPCC website](#)⁵
7. Where the patient has an identified carer (i.e. someone who provides regular, unpaid care and support (defined by [ISB 1580: End of Life Care Co-ordination: Core Content](#)) then the carer should be able to access language support to

³ 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

⁴ The processes outlined in the NHS England Accessible Information Standard are explained on the [NHS England Accessible Information Standard web page](#).

⁵ The full address for further guidance on Gillick is: <https://www.nspcc.org.uk/preventing-abuse/child-protection-system/legal-definition-child-rights-law/gillick-competency-fraser-guidelines/>

understand the discussion between the medical practitioner and patient, with the patient's consent.

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 book them when required

1. Where an interpreter is required the primary care provider is responsible for ensuring one is booked
2. It is good practice for the primary care provider to confirm to the patient, in advance of the appointment, the name and gender of the interpreter (if known) that has been booked
3. Interpreters must be registered with an appropriate regulator (see [Annex 1](#)), and should be experienced and familiar with medical and health-related terminology
4. All staff within primary care services should be offered training to raise awareness of the role of interpreting, the positive impact on patients and clinicians of high quality interpreting, and appropriate types of interpreting for specific situations. This training should include contact details of the organisation providing interpreting and translation services, how to book appointments and how to make complaints or provide feedback.

Principle 3: Timeliness of Access

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

1. Primary care providers should use appropriate formats and languages to raise awareness that interpreters are available. Commissioners should include this as a contractual requirement for interpreting service providers
2. Patients should not be disadvantaged by waiting unnecessarily longer for appointments to access primary care services because an interpreter is required though it is recognised that access to interpreting is affected by availability of suitable interpreters
3. On registration with a primary care service (or subsequently if their needs change), patients requiring language support should be made aware of the different types of interpreting available to them (e.g. face-to-face, telephone, video remote interpreting / video relay services)
4. Staff within GP practices should ensure that patients with specific language or communication needs are called to their appointment by practice staff in a way which eliminates the opportunity for appointments to be missed (for example directly approaching a d/Deaf patient in the waiting area when the appointment is called, instead of using a public address (PA) system).

Principle 4: Personalised Approach

Patients should expect a personalised approach to their language and communication requirements recognising that “one size does not fit all”

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 indicated clearly in their patient record. This should include:

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- Language requirements, language preferences and communication needs
- Preference regarding gender of interpreter (if they wish to express one)
- Cultural identity where this is relevant to the provision of interpreting

Where patients have requested specific support to meet their needs, this will need to be recorded by the organisation. As such, it may be sensitive personal data and the organisations would need to handle it appropriately (see the [information governance section](#)).

2. Special circumstances 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)
3. Good practice indicates that where a patient requires continuity of care, systems are in place to enable them to access the same interpreter where this is practicable
4. Interpreters should complete their assignment and role to the satisfaction of the patient and the healthcare professional and to the standards set out by their professional body
5. Commissioners should consider how the service can support patients so that ideally the whole episode of care is facilitated, (for example booking future appointments at the reception desk immediately after the appointment)⁶
6. Patients should always be offered a registered interpreter. Reliance on family, friends or unqualified interpreters is strongly discouraged and would not be considered good practice. For details of recommended qualifications please see [Annex 2](#)
7. If a patient expressly desires a family member or friend to act as their 'interpreter', the patient should give informed consent in their own language, sought from them independently of the family member/ friend. The consent must be noted in the patient's record
8. The use of anyone under the age of 16 for interpretation is not acceptable in any circumstance other than when immediate and necessary treatment is required. This must be an exceptional occurrence as safeguarding and competency are serious concerns (refer to Gillick competency guidance outlined in [Principle 1](#))
9. 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 trained and used as interpreters must be covered by indemnity insurance (where clinical staff are bilingual they should use their professional judgement to decide whether they are able to competently communicate with the patient).

From the Accessible Information Standard Implementation Guidance:

Wherever possible, requests from individuals for a preferred gender, for a particular professional and / or for the same professional to provide support to an individual during a course of treatment, should be met. This will support continuity of care and is likely to improve the experience of the patient, service user, carer or parent.

⁶ Interpreters do not provide advocacy. This is an entirely different role which is not covered within the remit of these principles.

Such continuity is likely to be particularly important where an individual is undergoing particularly invasive, intensive or sensitive procedures / courses of treatment, including care relating to pregnancy, maternity or sexual health, radio- and chemotherapy, end of life care and when accessing mental health services. Such preferences should be clearly recorded in an individual's notes⁷.

Organisations should also consider the use of interpreters with additional skills, knowledge or experience in relevant terminologies and / or care settings. For example, a Mental Health Trust may wish to stipulate in relevant contracts / include in their policy that only interpreters with experience in mental health settings should be used, either generally or in particular circumstances. All services may wish to consider the stipulation of knowledge / proficiency in medical / care / social care terminology as part of contracts / policies.

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

1. Interpreters must be registered with an appropriate regulator, be suitably qualified and should have the skills and training to work in health care settings
2. Interpreters must have undergone appropriate checks and clearance in line with Disclosure and Barring Service guidelines
3. Interpreters should be trained annually in safeguarding both children and adults. Any interaction requires the interpreters to be trained to an advanced level. Interpreting agencies are responsible for ensuring that staff and contractors have access to this training and development free-of-charge. All safeguarding training must be evidenced on request and be completed prior to any patient contact.
4. All Interpreters should be made aware of the Mental Capacity Legislation and how to support a person to make informed decisions
5. Interpreters should be aware of the safeguarding children and adults reporting procedures for the organisation. They must comply to the statutory duties to refer and concerns to the relevant agencies as per the organisation's procedures
6. An annual Information Governance (IG) course or the current recommended training standard by NHS Digital or the Information Governance Alliance⁸ should be undertaken
7. Interpreting agencies are responsible for ensuring that staff and contractors have access to this training and development free-of-charge
8. To safeguard and maintain the confidentiality of personal data, the interpreting agency should find a way to meet all information governance requirements when providing interpreting staff information about assignments. A secure online access system may be preferable
9. All interpreters are responsible for ensuring that any interaction is conducted in a secure environment and cannot be overheard or interrupted
10. Interpreters should introduce themselves to all parties at the start of their assignment and explain the purpose of the role (the Interpreter's Declaration)
11. The interpreter is present only to facilitate communication during the appointment. They should not be asked to undertake additional/ ancillary duties

⁷ Where organisations need to share data, they need to be aware of where 'free text' would not routinely be shared and ensure that any preferences are communicated appropriately.

⁸ This could be done through the IG Training Tool provided by NHS Digital or another training tool which meets the standard set by NHS Digital.

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during the appointment (e.g. those which may be delivered by a carer or advocate). There should not be physical contact or support with intimate or clinical procedures and any such procedures should not be performed in view of the interpreter

12. Interpreters are present to interpret for everyone in that appointment including the patient, parents or carers, any representative / chaperone and healthcare professionals
13. Any conflict of interest or issues that may arise within the interaction must be declared to the lead healthcare worker supporting the patient
14. Any actions identified by healthcare professionals that are deemed unsafe, of a safeguarding concern or a breach of confidentiality should be reported to the interpreting agency and where relevant registering body
15. Interpreters should be aware of the Whistleblowing procedures and how to alert agencies to any concerns regarding clinical conduct and unsafe practices
16. Where a safeguarding concern is raised about a registered interpreter, the interpreter should self-declare the concern. The healthcare organisation also has a duty to make a declaration to the registration body.

Principle 6: Compliments, Comments, Concerns and Complaints

Patients and clinicians should be able to express their views about the quality of the interpreting service they have received, in their first or preferred language and formats (written, spoken, signed etc.)

1. Easy-to-follow procedures which maintain confidentiality should be in place to enable positive and negative feedback about the interpreting service. The feedback procedure should be available in appropriate languages and formats including written, spoken and BSL signed video
2. Any response to patients' comments should be in a language they understand. Patients should be able to give feedback directly to the interpreting service. To do this patients will need to know the interpreter's full name, be made aware of who is the provider agency and/ or details of the registering body
3. Commissioners should ensure a system is in place to enable patients and clinical staff to feed back 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, and how to direct patients to this process⁹
4. Interpreting agencies should collate and publish data on feedback and outcomes annually in a service satisfaction report. The service satisfaction report should be made available to commissioners, primary care providers and patients on their website
5. Monitoring of themes and trends should be undertaken to understand if an individual or agency poses a risk to patient and their families.

⁹ The NRCPD has an online complaints procedure relating to the range of interpreters on their register.

Principle 7: Translation of documents

Documents which help professionals provide effective health care or that supports patients to manage their own heath should be available in appropriate formats when needed

1. Documents which are usually available free to patients within practices which may help them to take more control of their health and wellbeing should be available on request, in community languages or alternative formats (e.g. braille) at no additional charge to the patient (practices may wish to engage directly with organisations that provide such literature). Organisations are not required¹⁰ to have ‘stocks’ of information in different community languages and formats (e.g. braille) in anticipation of requests. However, organisations should have an identified process for obtaining information in alternative formats (including those which are not able to be produced in-house) if needed by a patients. Such processes should ensure minimum delay in receipt of accessible information by the patient. Good practice would be for organisations to have a limited number of the most commonly used patient-facing documents / information readily available (i.e. ‘in stock’) in the most commonly required alternative formats
2. Documents translated for the benefit of patients must be translated by competent and appropriately trained translators and not by practice staff
3. Patients should be able to request a translation of their summary care record into their preferred language and format (including easy read, Braille and other accessible formats) at no cost to themselves over and above the standard cost of accessing their patient record. See the [Accessible Information Standard](#) (SCCI1605) for further information
4. Translation of documents can include reading information to the patient in the language required by them – known as sight translation. This also applies to BSL
5. 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 as soon as possible where there is an identified clinical need. The documents should be included in the patient record in both languages where this is deemed necessary
6. Where patients have an identified need for language or communication support, consideration should be given to the best way to contact them. For some people, a letter in English will not be an effective way to communicate. Alternatives could include: text messages; ‘phone calls; or translated / transcribed letters
7. Automated on-line translating systems or services such as “Google-translate” should be avoided as there is no assurance of the quality of the translations.

Principle 8: Quality Assurance and Continuous Improvement

The interpreting service should be systematically monitored as part of commissioning and contract management procedures and users should be engaged to support quality assurance and continuous improvement and to ensure it remains high quality and relevant to local needs

1. Clear lines of accountability must be in place between the commissioner, the agency, the interpreter and healthcare professionals using the service. It must be clear who the commissioner is, who the providing agency is, who the clients /

¹⁰ As described in the Accessible Information Standard [Notes of Clarification](#)

- recipients of the service are and a clear trail of which service has been provided and when. Any data shared will need to be done so in line with NHS information governance protocols (see [Information Governance](#) section)
2. Once commissioned, the service should be subject to regular performance monitoring against the service specification to ensure that it continues to meet patient needs. This may include for example, checks to ensure that interpreters are suitably qualified and registered, review of vetting and barring, review of safeguarding training, appointments are being kept, governance is effective, costs are being monitored and the level of compliments, comments, concerns and complaints recorded. Regular audits should be carried out to support service improvement. Monitoring of themes and trends should be undertaken to understand if an individual or agency poses a risk to patient and their families
 3. Data on service satisfaction should be fed into a continuous improvement plan (CIP) developed by the interpreting service agency. The CIP should be developed with, and made available to patients, commissioners and primary care providers; and should support quality assurance of the service and compliance with these principles
 4. Information governance, confidentiality 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 1](#)
 5. Monitoring of information governance and governance issues must be undertaken monthly and action taken where concerns are raised.

2 Commissioning and contracting considerations

1.1.1 Assessing needs and reviewing current service provision

- Consider the specific language needs of the population (for both BSL and community languages) using:
 - Locally available data including data collected as part of the Accessible Information Standard
 - NHS England data set combining ONS Census data with Local Super Output Area (LSOA) data (available separately for commissioners by e-mailing the [Primary Care Commissioning Team](#))
- Consider the [legal position](#) and whether this is being met by current service provision
- Consider the financial position. The cost of any services commissioned or recommissioned would need to be met from within existing allocations.
- Consider how communication difficulties can prevent people accessing services and how this can be overcome (for example [Sick of It](#) published by [SignHealth](#)).

1.1.2 Deciding priorities

- Demography may have changed since services were first commissioned
- Health inequalities are the driver to considering priorities for groups of patients who require interpreting services
- Consider the range of health services to be covered and ensure that any commissioning plans cover these and avoid disadvantaging specific patient groups
- Consider the organisation's current policy on translation of documents to support people with an impairment (e.g. learning disability, blindness) or who

speak community languages (for example, translation of foreign medical documents).

1.1.3 Designing services

- Commissioners may find it helpful to separate community languages from BSL / braille and address each separately as the [legal position](#) for the two differs
- Consider cost-effective and efficient ways to provide services (for example telephone interpreting or app-based support (noting that these must meet commissioners' governance, quality and procurement guidelines if purchased on behalf of the NHS)
- Consider what support is in place or needs to be in place to support d/Deaf or deafblind people, referring to the [Accessible Information Standard](#) as necessary.

1.1.4 Shaping structure of supply

- Consider commissioning options. The [Crown Commercial Service](#) has a procurement framework. Commissioners could review this to see if it meets their needs or whether alternative arrangements are preferable. Contact NHS England's Commercial Team for guidance and support on the procurement of interpreting and translation services to ensure adherence to NHS England's Standing Financial Instructions (nhsengland.commercial@nhs.net)
- Commissioning with neighbouring organisations may be preferable if it reduces transaction and administrative costs and represents best value.

1.1.5 Managing performance

- Data monitoring should include measurements that support future service planning. You may find it useful to refer back to current contract monitoring records to prioritise data monitoring requirements¹¹:
 - Number of appointments provided broken down by type including:
 - Language provided (broken down by community language and BSL)
 - Type of interpreting provided (face-to-face, telephone, video)
 - Where the service was provided (e.g. GP surgery, pharmacy)
 - Reason for interpreting (e.g. to book appointment, to attend appointment)
 - Patient demographic (e.g. age, gender, language required)
 - Missed appointments and reason (both by interpreter and patient / carer)
 - Feedback from patients broken down by type e.g. compliments, comments, concerns, complaints
 - Themes and trends analysis to review issues and complaints
 - A formal quality assurance review.
- Encouraging ongoing feedback as part of service provision can lead to more timely feedback and enables providers and commissioners to respond quickly when issues arise.

¹¹ Ensure that data collected and shared complies with information governance guidance

2 Legal position

There are different legal obligations concerning provision of support for d/Deaf, blind or deafblind people compared to those who speak a community language. The legal obligations are summarised below.

2.1 Disabled people (i.e. people who are d/Deaf, blind or deafblind)

The Equality Act 2010 places a legal duty on all service providers to take steps or make “reasonable adjustments” in order to avoid putting a disabled person at a substantial disadvantage when compared to a person who is not disabled. Guidance produced by the Equality and Human Rights Commission (EHRC) states that, “Anything which is more than minor or trivial is a substantial disadvantage.” The Act is explicit in including the provision of information in “an accessible format” as a ‘reasonable step’ to be taken.

The [Equality Act 2010](#) places an additional duty on public sector bodies who are subject to the ‘public sector equality duty’ including independent contractors working in a primary care setting. This requires such bodies to have due regard to alleviate disadvantage experienced by people who share a protected characteristic, or to meet their particular needs, by making reasonable adjustments.

In addition, the '[Accessible Information Standard](#)' (which came into full force from 1st August 2016) sets out specific requirements for all NHS providers with regards to the provision of accessible information and communication support for people with a disability, impairment or sensory loss (including people who are d/Deaf, blind or deafblind). The AIS makes it clear that NHS providers including primary care contractors, must identify, record, flag, share and meet individuals' information and communication needs, and in so, doing, address known inequalities. Commissioners of NHS care are also required to support compliance with the AIS by organisations from which they commission services.

2.2 People who do not speak English

Whilst not being able to speak English is not a ‘protected characteristic’ defined under the Equality Act 2010, section 13G of the [National Health Service Act 2006](#) (“NHS Act”) states that NHS England, ‘in the exercise of its functions, must have regard to the need to reduce inequalities between patients with respect to:

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

Annex 1: Information Governance

The interpreting service agency and individual interpreters will be required to comply with information governance requirements. They must 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.

1. Where patient data is to be shared electronically the interpreting service will be required to have and maintain an N3 network connection (the national network for the NHS), to enable 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.
2. All persons acting as interpreters must complete annual Information Governance (IG) Training, compliant with NHS Information Governance standards.
3. Interpreting service agencies must find a way to enable staff to find out details of assignments in a way which meets all information governance requirements. Where interpreters or translators need access to confidential information, such as the patient's needs, there must be an appropriate way of accessing and managing these data. For example this could be a secure online portal for interpreting staff to access their appointments and the information they need to support the patient effectively.
4. Parties handling personal data must comply with data protection legislation: the General Data Protection Regulation (GDPR) and Data Protection Act (DPA) 2018. The following principles must be applied to the management of patient information.
 - Be used lawfully; any sharing of personal data by the controller must have a contract in place which sets out clearly the legal basis for processing of personal data and the responsibilities each party has in relation to the data and its protection. A data sharing contract forming part of the wider supplier contract would look to ensure the following areas are addressed:
 - That personal data is used fairly in a way that the patient would reasonably expect and that they have been informed about prior to its use
 - That personal data is kept longer than necessary- a retention period should be applied within the contract
 - That personal data is used for the purpose intended, and specified by the controller, with the minimum necessary used to achieve that purpose
 - That personal data is accurate (subject to best endeavours of the contractor)
 - That personal data is kept securely and disposed of securely when no longer required - copies of secure destruction should be provided to the controller
 - That personal data is not processed outside of the European Economic Area (EEA). Any proposed processing outside of the EEA should be reviewed with the controller and written permission given before any processing of personal data outside the EEA is undertaken

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- That personal data is processed in accordance with the patient's rights. With data subjects informed about how to exercise their rights.
5. In order to comply with data protection legislation, patients must be provided with a Fair Processing Notice. This means that they should be provided with information regarding the service and how any data sharing will be facilitated :
- Who the data controller is for their data
 - The contact details of the controller's Data Protection Officer (DPO)
 - The purposes for processing the data including the legal basis
 - With whom their data may be shared and why
 - How to exercise their rights under the data protection legislation (i.e. right of access)
 - Outline how long the information will be retained
 - How to contact the Information Commissioner's Office (ICO- the ICO is the UK's independent body set up to uphold information rights) in the event of a complaint.
- Please note that the needs of patients using translation services will need to be considered and material that is accessible provided.
6. Contracted agencies will be required to report annually to their commissioner(s) in line with the current expectations set out in:
- Their contract
 - By standards set by NHS Digital or the Information Governance Alliance
 - By the Information Commissioners' Office.
7. Identifiable data should only be shared with the commissioner when appropriate and there is a lawful basis to do so, which includes the patient being aware of that flow of data.
8. Where the interpretation service is acting as data processor, the contract will outline how they will support the data controller(s) in answering Data Subject Rights Requests (i.e. right of access) from patients. Where the contractor is a data controller in their own right, they are responsible for meeting these data protection obligations in their own right.

Annex 2 - Qualifications and Regulators

Interpreting is a specific skill which requires expertise and training. The qualifications below recognise this. At the present time there are limited numbers of suitably qualified interpreters for both BSL and spoken languages.

1. Qualifications and Regulators for Interpreters for Deaf People

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 (The National Registers of Communication Professionals working with Deaf and Deafblind People) registration requirements. Those working in health and social care settings should have sufficient knowledge of medical terminology in order to communicate information effectively.

Registration with NRCPD confirms interpreters hold suitable qualifications, 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.

2. Qualifications and Regulators for Interpreters for Spoken Languages

Spoken language interpreters should be registered with the National Register of Public Service Interpreters (NRPSI) and hold a Diploma in Public Sector Interpreting (Health).

Where an interpreter does not hold a DPSI (Health) it may be acceptable to use an interpreter who either:

- Is a native speaker in English and another language who also has a minimum of NVQ level 3 in interpreting, or,
- In addition to their own native language has ILETS level 7.5 (English) and also has a minimum of NVQ level 3 in interpreting.

These interpreters should also have training in medical terminology in order to communicate information effectively.

3. 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
- A recognised post-graduate qualification in translation.