Health and Social Care Board

Equality, Good Relations and Human Rights SCREENING TEMPLATE

See Guidance Notes for further information on the 'why' 'what' 'when', and 'who' in relation screening, for background information on the relevant legislation and for help in answering the questions on this template (follow the links).

(1) INFORMATION ABOUT THE POLICY OR DECISION

1.1 Title of policy or decision

Review of the Northern Ireland Health and Social Care Interpreting Service and Language Translation Services for black and minority ethnic groups.

(The screening covers the options identified, outcomes of the Review together with the recommendations and the preferred new model of service.)

1.2 Description of policy or decision

- **what is it trying to achieve? (aims and objectives)**
- **how will this be achieved? (key elements)**
- **what are the key constraints? (for example financial, legislative or other)**

The aim is to conduct a review of the current arrangements and effectiveness of interpreting and translation services within Health and Social Care in Northern Ireland. This includes the NI Health and Social Care Interpreting Service (NIHSCIS), other interpreting provision and language translation services and the assessment of need for face to face and telephone interpreting, language translation, and the analysis of service delivery and funding arrangements.
A proviso of this review is that it excludes sign language interpreting for deaf people. The rationale being that review of sign language interpreting is being undertaken by a separate exercise as part of the implementation of the Physical and Sensory Disability Strategy 2012/2015.
The key elements of the review include an examination of need and the identification of options for delivering a future service which is equitable, value for money and which provides equality of opportunity.

The process includes the comprehensive analysis of service user experience, the process mapping of the services and the development of a detailed service level agreement for future provision.
Key constraints and issues include the increasing pressure to deliver an effective service within existing resources, the inconsistent usage across the system, an over reliance on face to face interpreting and confusion over the contracting and charging arrangements.

1.3 Main stakeholders affected (internal and external)

For example staff, actual or potential service users, other public sector organisations, voluntary and community groups, trade unions or professional organisations or private sector organisations or others

The key stakeholders include;

- The members of minority ethnic communities in Northern Ireland who do not speak English as a first or competent second language;
- The wide range of health and social care service providers and independent contractors who provide services to ethnic minority patients and clients;
- The wide range of voluntary and community organisations who represent people in minority ethnic groups;
- The NIHSCIS team within Belfast Trust and the 381 interpreters;
- The range of telephone interpreting providers and the translation providers;
- Health and Social Care Board, DHSSPSNI, Business Services Organisation, Public Health Agency and Patient and Client Council;
- Staff representative bodies.

1.4 Other policies or decisions with a bearing on this policy or decision

- **what are they?**
- **who owns them?**

Human Rights Act 1998
Race Relations legislation 1997
Section 75 of the NI Act 1998
Race Relations Strategy OFMDFM 2005-2010

(2) CONSIDERATION OF EQUALITY AND GOOD RELATIONS ISSUES AND EVIDENCE USED

2.1 Data Gathering

What information did you use to inform this equality screening? For example : previous consultations, statistics, research, Equality Impact Assessments (EQIAs), complaints. Provide details of how you involved stakeholders, views of colleagues, service users, staff side or other stakeholders.

Information has been sourced from the NIHSCIS data base, the Trusts' and other equality managers, Belfast Trust Finance Department, and HSCB Finance Department.

Desk research has been undertaken to forecast demographic change and to benchmark practice elsewhere. Process mapping workshops took place in February 2012 involving Trust, HSCB and NIHSCIS staff and Business Services Organisation staff.

Focus groups involving health and social care professionals, independent primary care contractors, Patient Client Council, individual clients of the services and the voluntary and community representatives of minority ethnic groups.

As part of this review a questionnaire was administered to Health and Social Care independent contractors. This was supplemented with phone calls to selected Health and Social Care professionals based in the Trusts. The key findings of the questionnaire indicated:

- While there is a general level of awareness of the Regional Interpreting Service, this is not universal or comprehensive.
- There is a lack of understanding of the charging and contracting arrangements and a lack of clarity on who pays for which element of the service.
- Awareness is lacking on when it is appropriate to use which element of the service and the role of additional providers.
- The need for and use of the service is mixed, but when used, users were mostly content.
- How need is defined is unclear, as is the `density` of need; definitions or benchmarks could help.

- The use of family and friends seems to be a continuing practice and for some professionals this was presented as normal practice.

- Language interpreting needs should be considered at the time of client or patient registration with Health and Social Care NI and flagged in the electronic patient record in the same way as religion or other data sets are captured.

- There is strong support for more regional guidance and clear protocols that would provide clarity and advice (and that could be shared across Health and Social Care, Patients and Clients, providers and other partners).

During the review, patients and clients were invited to engage in focus groups. One focus group was with Polish speaking patients and clients, one for Portuguese speakers and the third, Chinese speakers. No Portuguese patients and clients attended their focus group, 10 Polish participants attended a focus group on 23rd May 2012 and 6 Chinese participants attended a focus group on 10th July 2012. Interpreting was provided at the focus groups to facilitate engagement.

Positive comments made by participants included:

- Recognition that the service was provided.

- The interpreters were reported to be very helpful and helped the patient or client's confidence to access the service.

- The interpreter helped the patient or client understand the Health and Social Care system.

- Where interpreter consistency had been ensured, this was found to be extremely valuable. This raised expectation of the level of service the patients and clients were expecting to receive.

Negative experiences reported by participants included:

- Poor customer service from GP reception staff. This included examples of receptionists refusing patients and clients access to interpreting services.

- Patients and clients told to sort their own interpreter out.

- Referring professional did not consider additional time required for interpreter, for example, GP booked interpreter for consultation but then sent patient for bloods etc, the interpreter had to leave due to

other bookings and the patient reported confusion as they did not understand the procedure.

- Those who were able to speak English, found difficulty understanding medical terminology and as a consequence are more likely to seek face to face interpreting.
- Patients and clients did not know how to complain about service they had received from Health and Social Care professionals and organisations.

It was noted that the Chinese group suggested bespoke English language education programmes delivered to patients, clients and users to help them understand medical terminology.

Statistical reports including the NI Census of Population 2011 and NISRA (Northern Ireland Statistical Research Association (2010) Migration statistics for NI (2009) have been used.

http://www.nisra.gov.uk/archive/demography/population/migration/Migration%20report%202009.pdf

BHDU (Belfast Health Development Unit) (2011). Barriers to health: migrant health and wellbeing in Belfast. http://www.belfasttrust.hscni.net/pdf/Migrant-Health-Strategy.pdf

2.2 Quantitative Data

Who is affected by the policy or decision? Please provide a statistical profile. Note if policy affects both staff and service users, please provide profile for both.

<table>
<tr><th>Category</th><th>What is the makeup of the affected group? (%) Are there any issue or problems? For example, a lower uptake that needs to be addressed or greater involvement of a particular group?</th></tr>
<tr><td>Gender</td><td>Data on the utilisation of the current NIHSSCIS in respect of gender is limited. The gender of service users is only recorded if relevant to the booking.
The gender breakdown of the 381 interpreters currently on the register is 80% female 20% male.</td></tr>
<tr><td>Age</td><td>Census 2011
The tables below shows the potential users of interpreting and translations services by age.
<table>
<tr><th></th><th>All usual residents aged 3 and over</th><th>Polish</th><th>Lithuanian</th><th>Irish (Gaelic)</th><th>Portuguese</th><th>Slovak</th><th>Chinese</th><th>Tagalog /Filipino</th><th>Latvian</th><th>Russian</th><th>Malayalam</th><th>Hungarian</th><th>Other</th></tr>
<tr><td>All usual residents aged 3 and over</td><td>1,735,711</td><td>17,731</td><td>6,250</td><td>4,164</td><td>2,293</td><td>2,257</td><td>2,214</td><td>1,895</td><td>1,273</td><td>1,191</td><td>1,174</td><td>1,008</td><td>13,090</td></tr>
<tr><td>3 to 11</td><td>205,970</td><td>2,456</td><td>826</td><td>859</td><td>285</td><td>183</td><td>101</td><td>231</td><td>169</td><td>131</td><td>245</td><td>86</td><td>998</td></tr>
<tr><td>12 to 15</td><td>98,201</td><td>711</td><td>228</td><td>393</td><td>120</td><td>56</td><td>69</td><td>122</td><td>51</td><td>26</td><td>40</td><td>29</td><td>378</td></tr>
<tr><td>16 to 24</td><td>227,634</td><td>1,993</td><td>1,205</td><td>760</td><td>243</td><td>352</td><td>496</td><td>147</td><td>246</td><td>121</td><td>46</td><td>126</td><td>1,379</td></tr>
<tr><td>25 to 34</td><td>243,938</td><td>8,105</td><td>2,256</td><td>555</td><td>676</td><td>1,013</td><td>478</td><td>346</td><td>448</td><td>445</td><td>298</td><td>423</td><td>4,337</td></tr>
<tr><td>35 to 44</td><td>254,108</td><td>2,855</td><td>941</td><td>522</td><td>544</td><td>394</td><td>420</td><td>844</td><td>186</td><td>250</td><td>405</td><td>238</td><td>3,193</td></tr>
<tr><td>45 to 54</td><td>248,578</td><td>1,183</td><td>607</td><td>536</td><td>283</td><td>210</td><td>357</td><td>159</td><td>132</td><td>156</td><td>105</td><td>91</td><td>1,579</td></tr>
<tr><td>55 to 64</td><td>193,562</td><td>372</td><td>160</td><td>251</td><td>110</td><td>47</td><td>190</td><td>42</td><td>36</td><td>51</td><td>32</td><td>12</td><td>685</td></tr>
<tr><td>65 to 74</td><td>145,600</td><td>42</td><td>17</td><td>163</td><td>25</td><td>2</td><td>69</td><td>4</td><td>4</td><td>8</td><td>3</td><td>3</td><td>334</td></tr>
<tr><td>75 to 84</td><td>86,724</td><td>9</td><td>9</td><td>98</td><td>5</td><td>0</td><td>30</td><td>0</td><td>1</td><td>2</td><td>0</td><td>0</td><td>170</td></tr>
<tr><td>85 +r</td><td>31,396</td><td>5</td><td>1</td><td>27</td><td>2</td><td>0</td><td>4</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>37</td></tr>
</table></td></tr>
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	English	age profile English (in %)	Other than English	age profile Other than English (in %)
All usual residents aged 3 and over	**1,681,171**		54,540	
3 to 11	199,400	11.86	6,570	12.05
12 to 15	95,978	5.71	2,223	4.08
16 to 24	220,520	13.12	7,114	13.04
25 to 34	224,558	13.36	19,380	35.53
35 to 44	243,316	14.47	10,792	19.79
45 to 54	243,180	14.46	5,398	9.90
55 to 64	191,574	11.40	1,988	3.65
65 to 74	144,926	8.62	674	1.24
75 to 84	86,400	5.14	324	0.59
85 +	31,319	1.86	77	0.14

Births by country of birth of mother and country of birth of father.
During the period 2001-2010, the percentage of live births to non-UK born mothers has risen steadily across all parts of NI. The rate more than doubled in Belfast and the Southern HSCT area and is above the NI average. Two areas reported very high rates: in Dungannon, over one in four births (28.1%) and Fermanagh about one in five births (19.6%) were to non-UK born mothers (please note, figures include ROI-born mothers).
Source: NISRA (2011); http://www.nisra.gov.uk/demography/default.asp98.htm

The table below shows the age profile of those who received a service from the Regional

Interpreting Service between June 2011 and June 2012 :

Age Range	% of Total Requests	Actual Number
0-18	19.5%	14,752
19-30	22.7%	17,172
31-45	31.6%	23,906
45-60	20.7%	15,659
60+	5.5%	4,160
Total	100%	75,649

Religion

In the 2011 Census, 6198 people who were recorded as being from the Indian ethnic group of whom 32.8% were recorded as Catholic, 10.4% were Protestant and other Christian, 42.6% were other religions, 7.8% no religion and 6.3% not stated.

A total of 6303 people were recorded as Chinese, 4.7% of whom were Catholic, 9.9% Protestant and other Christian, 5.9% other religions, 73.9% no religion and 5.5% not stated. Of the 4998 people in the other Asian ethnic group, 51.4% were Catholic, 14.5% were Protestant and other Christian, 21.9% were other religions, 7.5% were no religion and 4.8% were not stated. (Source: 2011 Census, NISRA Table DC2247NI – Ethnic Group by Religion www.ninis2.nisra.gov.uk)

Political Opinion

No information

Marital Status

Limited information is available in relation to marital status that would have a bearing on this particular review.

Dependent Status

Limited information on carers data

Disability

The 2011 Census table below shows long-term health problems by ethnicity.

Day-to-day activities…	**All usual residents**	Asian						Black				Mixed	Other
		Total	Chinese	Indian	Pakistani	Bangladeshi	Other Asian	**Total**	Caribbean	African	Other		

All usual residents	**1,810,863**	**19,130**	**6,303**	**6,198**	**1,091**	**540**	**4,998**	**3,616**	**372**	**2,345**	**899**	**6,014**	**2,353**
limited a lot	**215,232**	**531**	206	166	63	23	73	**121**	17	65	39	219	169
limited a little	**159,414**	**696**	248	204	65	37	142	**132**	18	78	36	245	153
not limited	**1,436,217**	**17,903**	5,849	5,828	963	480	4,783	**3,363**	337	2,202	824	5,550	2,031
Aged 0 to 15	**379,323**	**4,825**	**1,182**	**1,744**	**310**	**185**	**1,404**	**908**	**34**	**591**	**283**	**3,295**	**502**
limited a lot	**8,719**	**53**	14	13	5	9	12	**6**	0	4	2	77	6
limited a little	**11,305**	**78**	9	26	6	10	27	**12**	1	9	2	91	11
not limited	**359,299**	**4,694**	1,159	1,705	299	166	1,365	**890**	33	578	279	3,127	485
Aged 16 to 44	**725,680**	**10,908**	**3,609**	**3,473**	**567**	**294**	**2,965**	**2,243**	**250**	**1,460**	**533**	**2,272**	**1,295**
limited a lot	**37,617**	**149**	55	39	18	7	30	**62**	4	38	20	67	55
limited a little	**35,686**	**232**	61	74	21	15	61	**81**	8	49	24	101	51
not limited	**652,377**	**10,527**	3,493	3,360	528	272	2,874	**2,100**	238	1,373	489	2,104	1,189
Aged 45 to 64	**442,140**	**2,818**	**1,270**	**747**	**168**	**52**	**581**	**419**	**80**	**269**	**70**	**383**	**428**
limited a lot	**73,934**	**172**	81	42	23	4	22	**40**	11	17	12	57	62
limited a little	**50,151**	**243**	108	57	26	8	44	**28**	8	16	4	35	55
not limited	**318,055**	**2,403**	1,081	648	119	40	515	**351**	61	236	54	291	311
Aged 65 and over	**263,720**	**579**	**242**	**234**	**46**	**9**	**48**	**46**	**8**	**25**	**13**	**64**	**128**
limited a lot	**94,962**	**157**	56	72	17	3	9	**13**	2	6	5	18	46
limited a little	**62,272**	**143**	70	47	12	4	10	**11**	1	4	6	18	36
not limited	**106,486**	**279**	116	115	17	2	29	**22**	5	15	2	28	46

The table below shows the potential users of interpreting and translations services by long-term health problem (Census 2011).

	Total	**Day-to-day activities limited a lot**	**In %**	**Day-to-day activities limited a little**	**In %**	**Day-to-day activities not limited**	**In %**
All usual residents aged 3 and over	**1,735,711**	**214,393**	**12.35**	**158,585**	**9.14**	**1,362,733**	**78.51**
Main language is English	**1,681,171**	**212,476**	**12.64**	**156,493**	**9.31**	**1,312,202**	**78.05**

Total: Main language is not English	**54,540**	**1,917**	**3.51**	**2,092**	**3.84**	**50,531**	**92.65**
Main language is not English: Can speak English very well	20,260	671	3.31	728	3.59	18,861	93.09
Main language is not English: Can speak English well	19,811	449	2.27	634	3.20	18,728	94.53
Main language is not English: Cannot speak English well	11,802	416	3.52	563	4.77	10,823	91.70
Main language is not English: Cannot speak English	2,667	381	14.29	167	6.26	2,119	79.45

Table : Proficiency in English by long-term health problem (based on NISRA Census 2011)

The data demonstrates that amongst those whose main language is not English the share of individuals who experience limitations to their day-to-day activities is much lower than amongst those whose main language is English. Nearly 93% of them experience no limitations versus 78% of the latter. At the same time amongst the very small group of people who cannot speak any English, a higher share experience a lot of limitations to their day-to-day activities (14.29% vs. 12.64% amongst those whose main language is English).

Ethnicity	Since the time of the 2001 Census, Northern Ireland has seen a marked change in its ethnic diversity. On Census Day 2011, 1.8 per cent (32,400) of the resident population of Northern Ireland belonged to minority ethnic groups, more than double the proportion in 2001 (0.8 per cent). The main minority ethnic groups were Chinese (6,300 people), Indian (6,200), Mixed (6,000) and Other Asian (5,000), each accounting for around 0.3 per cent of the resident population. Irish Travellers comprised 0.1 per cent of the population.

Compared with 2001, the minority ethnic count rose from 14,300 to 32,400. Gains were recorded for all groups with the exception of Irish Travellers, whose numbers fell from 1,700 in 2011 to 1,300 in 2011.

Minority Ethnic Group	**Census 2001**		**Census 2011**		**Difference 2001 - 2011**
Ethnic Group	**Count**	**Per cent**	**Count**	**Per cent**	**Count**
Total residents	1,685,267		1,810,863		
White	1,670,988	99.2	1,778,449	98.2	107,461
Chinese	4,145	0.2	6,303	0.4	2,158
Indian	1,567	0.1	6,198	0.3	4,631
Mixed	3,319	0.2	6,014	0.3	2,695
Other Asian	194	0	4,998	0.3	4,804
Other	1,290	0.1	2,353	0.1	1,063
Black African	494	0	2,345	0.1	1,851
Irish Traveller	1,710	0.1	1,301	0.1	- 409
Pakistani	666	0	1,091	0.1	425
Black Other	387	0	899	0.1	512
Bangladeshi	252	0	540	0	288
Black Caribbean	255	0	372	0	117
Total ethnic	**14,279**		**32,414**		**18,135**

pop					

Source: NISRA, Table KS06 (2003); KS201 (2012)

Belfast (3.6 per cent), Castlereagh (2.9 per cent), Dungannon (2.5 per cent) and Craigavon (2.1 per cent) had the highest proportions of residents from minority ethnic groups.

Those residents born outside Northern Ireland in March 2011 accounted for 11 per cent (202,000) of the proportion, compared with 9 per cent (151,000) in April 2001. This change was largely a consequence of inward migration by people born in countries which have joined the European Union since 2004.

The Census 2011 figures revealed that language (spoken by those aged 3 and over was as follows.

English – 96.86% (1, 681, 210)

Polish – 1.02%(17, 704)

Lithuanian – 0.36% (6, 249)

Irish (Gaelic) – 0.24% (4, 166)

Portuguese – 0.13% (2, 256)

Slovak – 0.13% (2, 256)

Chinese – 0.13% (2, 256)

Tagalog/Filipino – 0.11% (1, 909)

Latvian – 0.07% (1, 215)

Russian – 0.07% (1, 215)

Hungarian – 0.06% (1, 041)

Other – 0.75% (13, 018)

Between 2004 and 2009 NI experienced significant in-migration. This reflected the European Enlargement. The first phase collectively refers to the A 8 Accession countries (Czech Republic, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia and Estonia).

More recently the wave of A 2 Accession countries includes Romania and Bulgaria.

In comparison with A8 Accession Countries migration from A2 countries , Romania and Bulgaria, has been relatively modest due to restrictions to work placed on A2 citizens by the UK Government. (Migration in Northern Ireland : a demographic profile – Northern Ireland Assembly Research Paper June 2011)

Black and Minority Ethnic groups are non-homogenous, reflecting a highly diverse range of cultures and languages. The Chinese, Indian and Pakistani communities are the largest and longer established ethnic groups. New migrants have been mainly adults of working age from Eastern Europe, particularly Poland and Lithuania, but also from Portugal and the Philippines. Areas with the largest density of ME population are Dungannon, Craigavon, Belfast, Armagh, and Newry and Mourne.

The table below shows the demand for interpreting in the range of languages during the period April 2010 – March 2012

Language	**No. of Requests**	**% of Total Requests**
Polish	40,004	34.6
Lithuanian	22,659	19.6
Portuguese	11,605	10.0
Chinese-Mandarin	7,761	6.7
Slovak	5,322	4.6
Chinese-Cantonese	5,201	4.5
Tetum	4,235	3.7

	Russian	4,176	3.6	
	Latvian	3,526	3.1	
	Romanian	2,506	2.2	
	Hungarian	2,481	2.1	
	Arabic	1,528	1.3	
	Bulgarian	812	0.7	
	Chinese-Hakka	710	0.6	
	Czech	609	0.5	
	Bengali	369	0.3	
	Somali	301	0.3	
	Spanish	212	0.2	
	Farsi	208	0.2	
	Punjabi	198	0.2	
Sexual Orientation	There is no evidence to suggest that the profile of sexual orientation of the affected group would differ materially from that of the population as a whole (ie 5-7% gay/lesbian/bisexual)			

2.3 Qualitative Data

What are the different needs, experiences and priorities of each of the categories in relation to this policy or decision and what equality issues emerge from this? Note if policy affects both staff and service users, please discuss issues for both.

Category	***Needs and Experiences***
Gender	English proficiency varies by age, gender, country of origin, education, and social class. Indian and African communities tend to have better levels of English proficiency. Women in the home are

	disadvantaged in learning English which is further compounded by fewer minority ethnic women accessing employment (NICEM, 2007). Migrant men's better proficiency in English can have implications for a woman's health particularly when her partner interprets for her. This becomes particularly problematic in cases of domestic violence and abuse, and in gynaecological, obstetric and sexual health settings (Jarman, 2009; NICEM, 2011). The interpreters' gender breakdown is 80% female and 20% male.
Age	In some cases children interpret for their parents and may therefore miss school. Although children acting as interpreters raise issues of confidentiality and appropriateness, many migrants do not see it as unethical (Jarman, 2009). In addition many children feel undue responsibility for interpreting for their parents, and medical interpreting adds one more level of stress to the relationship. This can in role reversal whereby the child is responsible for processing information and providing help and support to the parent or other adult. The review recommends that as part of implementation clear guidance is produced aimed at mitigating this concern.
Religion	
Political Opinion	The assessment revealed little detail of relevance in the context of political opinion. Professional interpreting requires interpreters to be impartial and objective. This requires that interpreters do not let any personal beliefs including political opinions influence the interpreting session. However in some areas it needs to be recognised that there may be very deep-rooted cultural, religious, political or personal tensions between the interpreter and the patient or client requiring the interpreting person that could potentially impact on the service. Such issues reinforce the importance of having in place clear code of practice and ethics as is the case with the Northern Ireland Heath and Social Care Interpreting Services (NIHSCIS).

Marital Status	Limited information is available in relation to marital status that would have a bearing on this particular review. However some overlapping issues in the context of gender and dependants need to be taken into account. In the assessment under “dependants” reference is made to the drawbacks of using family relatives in interpreting situations. This may impact on some cultures more than others particularly where there is higher proficiency of English amongst migrant males when compared with women. This becomes particularly problematic in cases of domestic violence and abuse, and in gynaecological, obstetric and sexual health settings.
Dependant Status	Evidence in the review suggested use of family as interpreters at Accident and Emergency rather than using telephone interpreting. Like in the general population of carers a number of challenges exist but these are coupled with additional issues in terms of stigma, cultural barriers, legal issues and in the context of interpreting and translation issues language and literacy barriers. Interpreting a medical condition correctly is essential for the proper diagnosis and treatment of a patient consequently the use of family members in interpreting is discouraged. There are a number of reasons for discouraging family relatives undertaking interpreting these include: medical understanding: lack of impartiality and stress on relationships. The development of clear guidance as part of the implementation of the new service model is expected to address this problem and support the appropriate use of interpreting and translation services. The new model of provision will facilitate understanding and use of the services by Health and Social Care staff.
Disability	Services need to be developed in a fully inclusive manner in order to ensure the complex needs of different stakeholders can be fully and equally met. Disabled people and non-disabled black people frequently experience discrimination but black and minority ethnic disabled people experiencing discrimination often remain unclear whether they are being discriminated against on the grounds of

	colour, race, culture or disability. In order to meet the needs of black and minority ethnic disabled people, information providers will need to increase their awareness of the complex equality issues affecting their service users. Other studies highlight needs such as: • difficulty in accessing appropriate and culturally sensitive information from organisations • the failure of mainstream authorities/services to produce and distribute specifically-targeted communications • the failure of service providers to plan for the costs of providing translation and interpreting services or alternative formats Physical, mental health and learning disabilities in adults and children are all key issues for people from black and minority ethnic groups not least because double and multiple discrimination is a complex subject.
Ethnicity	The review highlighted the barriers faced by many people from black and minority ethnic groups in accessing services and also the risks to the organsiation in relation to governance and statutory requirements if interpreting services are not in place. The review recommendations are aimed at improving the efficiency and effectiveness of providing language and translation services. The review did not consider bi lingual issues. Evidence exists which suggests that migrants can find it difficult to communicate to health professionals via an interpreter, particularly around mental health issues (NICEM, 2011). In a similar vein, calls were made for developing capacity within the Minority Ethnic community to have bilingual staff as “the language barrier is not easily overcome in the sensitive area of support work, through the use of interpreters” (McAliskey et al., 2005). This may be an issue that proposed Regional Advisory Group could address when the new model

	of service is implemented, though this is not specifically recommended in the review. The outcomes which are high level and intended as a broad framework will require a more detailed implementation plan.
Sexual Orientation	The experience of people affected by more than one form of equality discrimination is known as multiple discrimination. There may be particular and additional sensitivities and barriers facing black and minority ethnic individuals who are gay, lesbian or bisexual accessing health and social care services. Research has shown that: • compared with white gay men, African-Caribbean men are twice as likely to be living with diagnosed HIV, South Asian men are less likely; • black and minority ethnic people who are lesbian, gay or bisexual are less likely than white lesbian, gay or bisexual people to have considered suicide, possibly due to cultural and religious taboos; • black and minority ethnic domestic violence services are mainly targeted at meeting the needs of heterosexual women; and, • black and minority ethnic people who are lesbian, gay or bisexual are even more likely to be a victim of homophobic violence than white people who are lesbian, gay or bisexual. It is important that interpreters are aware of these and have received sexual orientation training.

Staff in the NIHSCIS

The NIHSCIS is based at Graham House, in Knockbracken Healthcare Park and operates under the Belfast HSC Trust's Health and Social Inequalities Team providing a regional service to all of the 6 Trusts, including NI Ambulance Service Trust, and the Health and Social Care Board in Northern Ireland.

The core team consists of 6 staff members

- NIHSCIS Manager
- NIHSCIS Administrative Coordinator
- Permanent Band 2 Operators

2.4 Impact of Recommendations

This section builds on the quantitative and qualitative data and issues outlined in Sections 2.2 and 2.3

The recommendations made as an outcome of this review have been considered for equality implications for staff and service users.

The following table identifies the recommendation, its implications and the equality implications. The Section 75 groups or individuals have been identified in bold type.

Recommendation	Implications	Impacts
Appropriate action to re-profile the usage to achieve a more appropriate balance of face to face interpreting and telephone interpreting. This should include the appropriate use of various forms of interpreting by HSC professionals	A business model to be developed which delivers a re-profiling of usage from a ratio of 93:7 to potentially 50:50 interpreting by 2016 at an indicative cost of £2.50 million(rounded up from the £2.36 million estimated cost of the rebalanced service) Requires robust and strong communication of available services and management of requests to ensure that clients' needs continue to be met with the provision of an appropriate response.	**Positive: all ethnic groups requiring language** support as this will result in a more appropriate response based on their needs. Greater equality of access by all service users across **ethnic groups** to all health and social care sectors including GP and dental services, and community pharmacy. The review has estimated that the number of primary care interactions requiring support is approximately 210,000 and in secondary and territory care it is estimated to be 140,000. This recommendation has

	Funding for all the interpreting services delivered by the Regional Interpreting Service, (face to face and telephone) to be met by the HSCB	the intent of reducing current differentials across Northern Ireland. **Potential negative: all ethnic groups requiring language support** in that there may be a perception that they are losing a service or getting a different service or less of a service than previously if the provision of telephone interpreting is increased. **Mitigation:** clear guidance will be produced for staff to inform of most appropriate forms of interpreting in various situations. This will include guidance on how decisions for each form of support need to be based on a needs assessment. This will include guidance on the types of complex situations where telephone interpreting should never be considered including those where there are other issues to be considered under the equality categories such as **disability - mental health issues, children and young people such as child protection or case conferences** or other complex medical needs. A communications strategy will be

		developed to inform staff and service user and carers. This will include the use of appropriate formats **Potential negative:** All interpreters, of whom there are 381, may experience a reduced opportunity for interpreting and consequently a loss of income. The differential may be felt more by those interpreters undertaking interpreting in the most frequently used languages. These are identified as **Polish, Lithuanian, Portuguese, Chinese Mandarin, Slovak, Chinese Cantonese, Tetum, Russian, Latvian and Romanian** **Mitigation:** The timeline for this change is incremental rather than immediate to allow interpreters to sell their skills in other sectors as these are freelance interpreters.
Clear guidance should be developed to ensure appropriate use of written translation services by HSC Professionals		**Positive: all ethnic groups** as it should lead to greater consistency in the responses to the needs for translation service
Interpreting and written translation	Change of provider from the Belfast	**Positive:** Whilst this is an

services should be delivered on the basis of a regional shared service provided by the Business Services Organisation	Trust to the Business Services Organisation. This allows the service to be managed independently from provider organisations but remains as mainstream health and social care provision To facilitate this happening an Implementation Strategy needs to be developed for the transfer of the service. This strategy will need to consider equality issues as well as the associated operational and human resources issues	operational issue it is anticipated that this change will have a positive impact on service users across **all ethnic groups requiring language support**. It provides opportunity to combine strategically the procurement of interpreting and translation service in a more joined up business planning model. **Potential negative** It has to be recognised that in any change in management arrangements there are likely to be impacts on staff particularly in a period of transition. The current staff includes a Service Manager (Band 7), Office Manager (Band 4), and 4 Operators at Band 2. The Business Service Organisation operates under the same Human Resources rules of employment, redeployment and staff transfers. TUPE rules apply for the protection of staff. It will remain the responsibility of the Business Service Organisation and the Belfast Trust to deal with the impacts on staff in a sensitive manner to minimise staff concerns

		and distress as far as is possible. Open and clear communications to staff are required to communicate the review outcomes and any potential implications. At this stage it is too early to make any determination on any future location. If a decision is made to move this service from its current location this decision will need to be screened further taking into account any particular staff needs in relation to, for example, those with **dependants or additional caring responsibilities, those with a disability or particular access needs.** In early discussions with the Business Services Organisation the Health and Social Care Board has raised the issue of the need for cognisance to be taken of staffing issues.
All face to face and telephone interpreting should be funded centrally and be accessible to all Health and Social Care organisations as well as GPs,	Greater fairness and equity across all of Northern Ireland Eliminates current differentials that exist geographically.	**Positive impact** for **all ethnic groups requiring language support** via GP and Dental Practices and community pharmacists**.**

dental practitioners and community pharmacists.		This will impact positively where demographic evidence indicates higher demands in particular geographical areas where **migrants** choose to settle as a result of work opportunities.
Regional advisory group, reporting to the Health and Social Care Board, to be established to oversee the development and delivery of interpreting and translation services including governance. This group should include patient and client representation.	A strengthening of structures to set priorities and oversee performance in relation to interpreting services. Contribute towards an examination of unmet need. Quality assurance opportunities for written translations. Reinforcement of the need for engagement with service users including those from black and minority ethnic groups including migrants.	Further work will be required on the composition of this advisory group. **Positive:** its existence should lead to greater account being taken of the legal and governance responsibilities of health and social care organisations towards **all minority ethnic groups** requiring language support. This is particularly important for **migrant workers** from the **A8 Countries, Czech Republic, Estonia, Latvia, Hungary, Lithuania, Poland, Slovakia, Slovenia** which accounted for 64.5% of referrals during 2012-2012 and those more recent **A2 Countries, Bulgaria and Romania,** which accounted for 2.9% of referrals in the same period. Other European and Non-European referrals accounted for 10.2% and 17.7% respectively. Service user involvement in any such advisory group is in keeping with the HSCB's commitments for

		greater personal and public involvement and user involvement
The funded base line should be set at an indicative level of £2.50 million in line with the projected cost of the rebalanced service	Commissioner responsibility in respect of funding.	Funding proposed as an improvement to the service as it now covers all face to face interpreting and is to be accessible to health and social care including GPs, Dentists and community pharmacists
Interpreters should be required to pay an appropriate annual registration fee. The additional income generated should be used to provide additional resource as deemed necessary by the service provider.	A change from the current position whereby all training and support is provided free of charge to interpreters Any income generated will be redirected to providing additional resource for direct service provision and improved administration.	**Positive**: redirection of resources into the service improves service provision for **all ethnic groups requiring language support.** **Potential negative**: Impacts on all **381 interpreters across all minority ethnic groups** currently registered with the service. The rebalancing of the service has the potential to reduce the opportunities of current interpreters to earn a similar income from health and social care to that which they are used to. The extra charge has the risk of a reduction in the number of interpreters making themselves available. If this relates to some of the lesser spoken languages, where there is still a demand for face to face interpreting in languages such

		as **Czech, Bengali, Somali, Spanish, Farsi and Punjabi** there may be a potential risk to the service. **Mitigation:** For the charge of a proportionate registration fee interpreters receive training, accredited qualifications, networking and on-going training and support. This training provides interpreters with greater capacity and consequently increased potential to sell their services to other sectors. The remodelling of the service should be able to accommodate any potential risks of reduction of interpreters across the full scope of language provision The communications strategy will include information on this change, and why it is being introduced and the timescale for its introduction.
Interpreters should be deployed as efficiently as possible through effective resource management and innovative use of technology	Technical changes.	No impacts anticipated.

An interpreting portal should be developed to ensure consistency of coding and to encourage appropriate referrals including out of hours requests	Technical changes.	No impacts anticipated.
Consistent and relevant data sets should be developed to ensure effective performance management, including information on referral source, assignment type and service response.	This element of the service needs to be developed.	In the longer term this should contribute to promotion of equality if ethnic monitoring and other monitoring is built into performance and accountability.

2.5 Multiple Identities

Are there any potential impacts of the policy or decision on people with multiple identities? For example: disabled minority ethnic people; disabled women; young Protestant men; and young lesbians, gay and bisexual people.

Recognition that black and minority ethnic groups and individuals are not a homogeneous group in terms of identities or where they live Northern Ireland

2.6 Based on the equality issues you identified in 2.2 and 2.3, what changes did you make or do you intend to make in relation to the policy or decision in order to promote equality of opportunity?

In developing the policy or decision what did you do or change to address the equality issues you identified?	***What do you intend to do in future to address the equality issues you identified?***
From the outset it was agreed that the review needed to be inclusive of stakeholders in terms of the Review Steering Group, the data collection and the process of engaging with stakeholders to seek their views. In terms of openness and transparency it was agreed to undertake a consultation exercise to share the outcomes of the review. This allows for further involvement of relevant stakeholders and the public.	Production of clear guidance on when to use an interpreter, face to face or telephone. Clear procedures and protocols for payment and resourcing across various constituent HSC stakeholders including statutory, independent and community sectors. Deliver a centrally funded service through one service provider to promote access, fairness and equality. Undertake a programme of awareness raising among Health and Social Care organisations and the minority ethnic population to improve understanding of the services available and promote

	knowledge of how to use them appropriately. Further screening activity to be conducted as the changes are implemented.

2.7 Good Relations

What changes to the policy or decision – if any – or what additional measures would you suggest to ensure that it promotes good relations? (refer to guidance notes for guidance on impact)

Group	*Impact*	*Suggestions*
Religion	It is not anticipated that this policy will impact on good relations.	
Political Opinion	As above	
Ethnicity	As above	

(3) SHOULD THE POLICY OR DECISION BE SUBJECT TO A FULL EQUALITY IMPACT ASSESSMENT?

A full equality impact assessment (EQIA) is usually confined to those policies or decisions considered to have major implications for equality of opportunity.

How would you categorise the impacts of this decision or policy? (refer to guidance notes for guidance on impact)

Please tick:

Major impact	
Minor impact	√
No further impact	

Do you consider that this policy or decision needs to be subjected to a full equality impact assessment?

Please tick:

Yes	
No	√

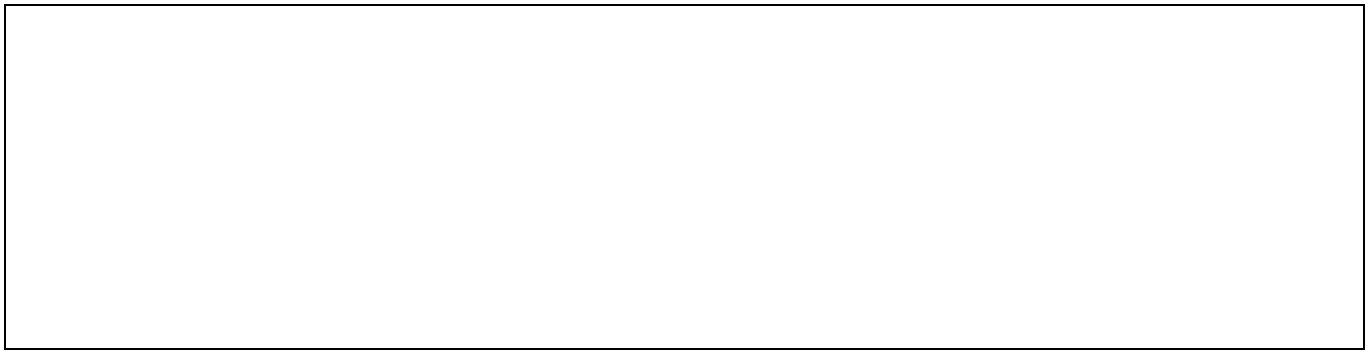
Please give reasons for your decisions.

Undertaking the review of the interpreting and translation service arrangements was an attempt by HSCB to ensure consistency and measure effectiveness of current arrangements including governance and accountability. It was to address current inconsistencies in uptake and understanding of responsibilities on health and social care providers.

The review has been undertaken at a high level. It will require additional work in relation to the implementation of the review's recommendations. In this screening exercise we have identified areas where the review recommendations may have potential impacts. Where possible we have identified further mitigating actions.

Throughout the review regard was given to the equality and human rights duties placed on the HSCB as a commissioner. It is our view that the conduct of the review was inclusive. The public consultation exercise will allow views to be collated on the recommendations including the proposed model of delivery.

It is in the context of any future delivery model where there will be impacts particularly on staff. This screening exercise identifies some potential impacts but it is the view of the HSCB that this is one of the areas that quite clearly needs additional screening to be undertaken by the new service provider. The outcomes of this consultation exercise will also be used to inform any future screening activity in this area or in any of the other areas where suggested changes are recommended.



(4) CONSIDERATION OF DISABILITY DUTIES

4.1 In what ways does the policy or decision encourage disabled people to participate in public life and what else could you do to do so?

How does the policy or decision currently encourage disabled people to participate in public life?	*What else could you do to encourage disabled people to participate in public life?*
It is not anticipated that this policy will impact upon the participation of disabled people in public life.	

4.2 In what ways does the policy or decision promote positive attitudes towards disabled people and what else could you do to do so?

How does the policy or decision currently promote positive attitudes towards disabled people?	*What else could you do to promote positive attitudes towards disabled people?*
It is not anticipated that this policy will impact upon the participation of disabled people in public life.	

(5) CONSIDERATION OF HUMAN RIGHTS

5.1 Does the policy or decision affect anyone's Human Rights? Complete for each of the articles

ARTICLE	Yes/No
Article 2 – Right to life	no
Article 3 – Right to freedom from torture, inhuman or degrading treatment or punishment	no
Article 4 – Right to freedom from slavery, servitude & forced or compulsory labour	no
Article 5 – Right to liberty & security of person	no
Article 6 – Right to a fair & public trial within a reasonable time	no
Article 7 – Right to freedom from retrospective criminal law & no punishment without law	no
Article 8 – Right to respect for private & family life, home and correspondence.	yes
Article 9 – Right to freedom of thought, conscience & religion	yes
Article 10 – Right to freedom of expression	yes
Article 11 – Right to freedom of assembly & association	no
Article 12 – Right to marry & found a family	no
Article 14 – Prohibition of discrimination in the enjoyment of the convention rights	yes
1st protocol Article 1 – Right to a peaceful enjoyment of possessions & protection of property	no
1st protocol Article 2 – Right of access to education	no

If you have answered no to all of the above please move onto to move on to ***Question 6*** *on monitoring*

5.2 If you have answered yes to any of the Articles in 5.1, does the policy or decision interfere with any of these rights? If so, what is the interference and who does it impact upon?

List the Article Number	Interfered with? Yes/No	What is the interference and who does it impact upon?	Is it legal?* Yes/No
8	Positive		
9	Positive		
10	Positive		
14	Positive		

** It is important to speak to your line manager on this and if necessary seek legal opinion to clarify this*

5.3 Outline any actions which could be taken to promote or raise awareness of human rights or to ensure compliance with the legislation in relation to the policy or decision.

On the premise that black and minority ethnic individuals' access to services is enhanced through the provision of accessible information and language support the intention of undertaking this review was to ensure that such a service was adequately funded. The review explored the current arrangements and effectiveness of interpreting and translation services within Health and Social Care in Northern Ireland. The HSCB's intention was to ensure that language and translation provision services are fair, equitable and responsive. This helps to

ensure that people's rights are enhanced. The review makes a number of recommendations to strengthen the service and ensure that there are clear lines of responsibility and accountability that also comply with governance regulations. The consultation exercise is intended to promote further openness and transparency. Further work will be required once the implementation plan is put in place including additional screening for equality and human rights issues.

(6) MONITORING

6.1 What data will you collect in the future in order to monitor the effect of the policy or decision on any of the categories (for equality of opportunity and good relations, disability duties and human rights?

Equality & Good Relations	Disability Duties	Human Rights
Performance monitoring data will be collected which will inform the Regional Advisory group on details about the use of the service such as age, gender, and language need characteristics of users. Any gaps in provision, quality and other areas of performance relating to service response time, geographical coverage and new and emerging language need will be identified. Utilisation data by languages requested and types of materials translated will also help identify need and gaps.		

Approved Lead Officer: Dean Sullivan

Position: Director of Commissioning

Date: 28th June 2013

Policy/Decision Screened by:	Anne Hillis in collaboration with Review Steering Group

Please note that having completed the screening you will need to ensure that a consultation on the outcome of screening is undertaken, in line with Equality Commission guidance.

Please forward completed schedule to: Equality Unit , Business Services Organisation
Email: equality.unit@hscni.net
Telephone 028 90535531