



Public Health
England

Protecting and improving the nation's health

Stakeholder consultation

Language and communication needs assessment

PHE West Midlands

About Public Health England

Public Health England exists to protect and improve the nation’s health and wellbeing and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Anna Blennerhassett, Karen Saunders
For queries relating to this document, please contact: karen.saunders@phe.gov.uk
© Crown copyright 2020

You may re-use this information (excluding logos) free of charge in any format or medium, under the terms of the Open Government Licence v2.0. To view this licence, visit [OGL](https://www.nationalarchives.gov.uk/ogp/) or email psi@nationalarchives.gsi.gov.uk. Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned. Any enquiries regarding this publication should be sent to [insert email address].

Published August 2020
PHE publications
gateway number: GW-1483

PHE supports the UN
Sustainable Development Goals



Contents

About Public Health England	2
Executive summary	4
Need for language and communications service	5
Developing a high quality, credible and useful project	6
Methods	6
Case study one	10
Interview one	12
Interview two	13
Interview three	15
Interview four	16
Interview five	17
Interview six	18
Interview seven	20
Interview eight	21

Glossary

Inclusion health	A service, research, and policy agenda that aims to prevent and redress health and social inequities among the most vulnerable and excluded populations.
Health protection team	<p>Health protection teams provide support to health professionals in the UK, including:</p> <ul style="list-style-type: none"> • local disease surveillance • alert systems • investigating and managing health protection incidents • national and local action plans for infectious diseases <p>They are located in each PHE region and local centre.</p>
Consultant in Communicable Disease Control (CCDC)	A consultant within PHE who is responsible for the surveillance, prevention, and control of communicable disease and noncommunicable environmental exposures.
HPZone	Electronic case management and surveillance system used by PHE health protection teams
Clinical Commissioning Group (CCG)	They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.
Commissioning Support Unit (CSU)	Commissioning Support Units provide Clinical Commissioning Groups with external support, specialist skills and knowledge to support them in their role as commissioners.
English for speakers of other languages (ESOL)	English learning provided for new residents in an English-speaking country.
Flag4 records	Reflect the number of individuals that register with a General Practitioner (GP) in England and Wales and whose previous address was outside the UK and who have spent more than three months abroad.

Executive summary

This is a stakeholder consultation that was used to inform the language and communication service needs assessment conducted by PHE West Midlands. The review presents findings from interviews conducted in September 2019. It outlines the need for a language and communication service to assist PHE health protection teams, and wider public health services. The interviews guided the focus of the language and service needs assessment that followed.

This report should be viewed in conjunction with the final Language and Communication Service Needs Assessment, West Midlands data pack for language and communication service needs assessment and the rapid evidence review on interpreting interventions in public health.

Main points:

Need for language and communications service

Interviews and evidence from the PHE National and West Midlands Health Protection teams demonstrated a normative and comparative need for an interpreting service that can be accessed by the WM Health Protection team.

- During the measles outbreak in the West Midlands in 2018-19, the PHE Health Protection outbreak response was challenged by language barriers. This issue was raised at a national level, and senior management agreed that a sustainable solution was required.
- PHE WM Health Protection team stated that there is a need for access to an interpreting service to respond to the need of the West Midlands population and provide a health protection response that has a high quality and efficiency.
- The national PHE Health Protection team submitted findings from their snapshot survey of all regional PHE HPT. The survey found that 4 of 9 regional centres commissioned a language and communications service. Aligning with

the vision of “One PHE” it would be desirable for all centres to have access to a language and communications service.

- It is important to note that although the PHE Health Protection team identified a need for the service, other teams within PHE WM such as the Health and Wellbeing Team, and Healthcare Public Health team do not require a service for direct use by internal staff.

Developing a high quality, credible and useful project

PHE team leads provided their ideas for shaping the language and communications service needs assessment. External partners provided learning from their own experiences in researching, designing and delivering new and innovative language and communications services.

Methods

- The PHE Migrant Health Lead suggested that the needs assessment explores existing issues around access, quality and finance of services used by PHE. She highlighted that the PHE Migrant Health Guide provides evidence on standards for interpreting in healthcare and public health.

Population

- NHSE/I advised that the needs assessment should carefully consider the specific communication needs of the West Midlands population. This includes people who do not speak English, and people who are d/Deaf, blind or deaf/blind for example. IRiS advised that the impact of intersectionality on the population, especially ethnicity, class and gender is described.
- IRiS emphasised the point that communication is more than language alone. In research in migrant health in the West Midlands, IRiS evidenced the importance of cultural health capital for both healthcare professional and patient, and also cultural humility for healthcare professionals.

Output

- The National PHE HPT suggested that one output from the language and communications service needs assessment should be an options appraisal including a service commissioned and managed centrally as one option.
- PHE WM HPT expressed interest in the hypothesis that a locally commissioned service could be better quality than a nationally commissioned service. Benefits of a local service could be a stronger professional relationship between interpreters and staff, also development of expertise amongst interpreters about language and disease profile of the population.
- The NHS Commissioning Principles for high quality language and interpretation services chose not to recommend either local or national interpreting service as different providers had different preferences based on existing ways of working.
- Sandwell and West Birmingham CCG are at the forefront of designing and delivering an innovative “integrated language and communications service”. It’s person-centred design was based on exploring the wider determinants of healthcare literacy. The novel part is in encouraging the traditional interpreting service to become part of the healthcare economy, forming links with health-related community groups, and working with them to identify social prescribing opportunities, for example. It has 3 pillars including access, developing independence and quality and safety.
- Provision of a service is likely to be one of the recommendations from the service needs assessment. However, interviewees advised that monitoring quality of a service is made a priority. The West Midlands Anti-slavery Network stated that key components of quality are: timeliness, access and professional standards.

Acknowledgements

This stakeholder consultation was conducted by public health professionals in the Health and Wellbeing Team, PHE West Midlands. We would like to thank all those who participated in the interviews and shared their experience of language and communications services.

- Deputy Director, Health Protection, PHE
- Deputy Director, Health Protection, PHE West Midlands
- Deputy Director, Health and Wellbeing Team, PHE West Midlands
- Health Protection Team, PHE West Midlands
- Migrant Health Lead, PHE
- Lead for translation and interpreting, NHSE/I
- Commissioning and Partnership Development Managers, Sandwell and West Birmingham CCG
- Director of Institute of Research into Superdiversity, University of Birmingham
- Executive Director and Development Manager, West Midlands Anti-slavery Network

Methods

Initially, stakeholder mapping was conducted by the PHE WM Health and Wellbeing Team. Mapping identified teams, organisations and networks internal and external to PHE, who work with communities with a significant number of people who don't speak English as a first language. The stakeholders were invited to have a face-to-face or telephone meeting and asked for their opinions on the 2 points below:

- Perspective on what will be considered a credible, high quality and useful project
- Facilitating quality data collection

PHE internal stakeholders were also asked for:

- Perspective on finance for an interpreting and translation service

The interviews and case studies are reported below.

Case study 1

National Management Team, PHE visit to PHE West Midlands 21/6/19

Deputy Chief Executive and Chief Operating Officer

A presentation was given by a CCDC on the measles outbreak in West Midlands over 9 months in 2017-2018. The presentation highlighted the challenges in communicating with people who didn't speak English as part of the outbreak response. The Health Protection Team in the West Midlands used connections with voluntary organisations to access translation and interpretation services. It was proposed that a PHE commissioned interpreting service could provide a sustainable solution to the problem. It could improve the quality of care provided by the HPT when managing all types of enquiries.

Following this presentation, the service gap was raised as a safeguarding issue by a Health Protection Nurse and Safeguarding lead for PHE.

In response the PHE national team stated that a project should explore what the most effective, efficient and affordable approach should be for PHE. It was deemed a "One PHE" issue covering all parts of the organisation, and the output should be a paper reported to the Resourcing and Prioritisation Group, a group that monitors organisational development. This resulted in a snapshot email survey from the Deputy Director for Health Protection, to all regional Health Protection teams.

It asked two main questions:

1. Have you accessed translations services in the last 12 months to support the work of the HPT?
2. If yes, what service did you use?

The results of the survey are detailed in *Appendix 1*. In summary the survey found that 4 of 9 regional centres commissioned a service. The other 5, including PHE West Midlands, don't have a service and mentioned accessing NHS commissioned services, PHE staff or family or friends of the individual they want to communicate with. The survey reported that on occasions

where PHE centres set up ad-hoc or “one-off” sessions with an interpreter it was very expensive.

Interview one

Health Protection, PHE

Deputy Director of Health Protection, PHE Colindale

Perspective on developing a high quality, credible and useful project

The Deputy Director was content with the project proposal and added that if a problem exists in the West Midlands, that might also be the case in other centres. In her opinion it would be useful to consider the national picture in some way, even though the original project may focus only on the West Midlands due to time and resource constraints. This project will be a good starting point and can be used to indicate possible need for similar projects in other regions. In relation to national actions following the survey, the Deputy Director stated that they had not yet decided on further plans for this piece of work. She suggested that if an output from the project is an options appraisal of an interpreting service, that a national service is considered. This would be a centrally managed and commissioned service that each centre could access.

Perspective on finance for an language and communication service

Finance will come from a national budget line if a national service is recommended, with the budget given to a chosen team to manage and commission the service. Alternatively, a local service might be commissioned from the regional non-pay budget.

Facilitating quality data collection

To collect quantitative data on interpreting service use an invoice analysis over the past 11 months was included in the report “Language and translation services in PHE Centres and Regions”. This provides detail on the number of calls, call duration, cost per call and the languages used. No activity data was available on regions that don’t commission a service.

Interview two

Health protection Team, PHE West Midlands

Deputy Director Health Protection, PHE WM

Perspective on developing a high quality, credible and useful project

The challenge for the WM Health Protection Team is the service gap. The HPT currently use informal language support as there is no dedicated service for the centre. However, this leads to possible compromise in quality and efficiency. Methods that have been used to communicate include borrowing the service from the NHS if they're involved, using contacts in Local Authority, using PHE staff who speak a second language, or friends and family of the individual.

Using the 2017-18 measles outbreak as an example this highlighted a number of challenges with sharing information on infection prevention and control, and contact tracing. During the outbreak the WM team planned to use the Southwest centres' service Prestige, however it was costly and the HPT instead used services attached to local voluntary organisations at no cost. The communication barrier is potentially a safeguarding issue. Partner organisations who might use or need access to an interpreting service include the NHS, environmental health and public health teams in local authorities.

The language and communications service needs assessment is much needed along with the national work noted above and that interpretation support should be prioritised. On the topic of a local or national service, the initial feeling is that a local service for WM PHE rather than extension of an existing contract from another Centre was preferred. A local contract would be responsive to superdiversity, allow staff to build professional relationships with interpreters, and interpreters could build expertise on the main public health and communicable disease priorities arising in the WMs. A local service would better reflect the languages spoken in the area.

Perspective on finance for a language and communication service

There is no existing budget line in WM centre for interpretation and translation services. It would have to come from the health protection budget, but not sure if money is available for this. If the service cost is over £50,000 the contract will have to go out to tender. One possibility that has been mentioned is extension of the London contract.

Facilitating quality data collection

Based on anecdotes it is estimated that the WM centre requires the service twice a month. However, there was a limited number of responses to the email survey. Responses came from the CCDC involved in the measles outbreak, the lead for TB management, the lead for safeguarding, and a health protection nurse working mainly in the Acute Response Centre (ARC). Currently, no data is collected by the WM centre on times a service is required, demographic profile of the individual requiring the service, or language required.

Suggestions for data to use in the service needs assessment include using a survey or qualitative methods to collect evidence for case studies. At the time of writing data collection on HPZone by labelling cases or situation where a language need is identified is beginning. This will be supported by a short data collection form related to the case or situation selected. Volunteers from the HPT have been asked to fill in short case studies on memorable times when an interpreter would have facilitated the health protection response.

Interview three

Inclusion Health Team, PHE

Consultant Epidemiologist, Migrant Health Lead, PHE

Perspective on developing a high quality, credible and useful project

The main recommendation from the migrant health team was to explore what the main issues are especially around access, quality and finance of interpretation and translation services used by PHE.

Facilitating quality data collection

The Migrant Health Guide¹ written by the Migrant Health team has a chapter on language interpretation. The chapter outlines the professional and ethical duty of doctors and healthcare professionals to meet the language and communication needs of all patients. It states that communication difficulties can be a barrier to good quality of care. It recommends the use of professional interpreters over family or friends, especially children. Secondly, it provides links to resources for interpretation and translation that can be accessed as well as examples of best practice learning materials, all for healthcare professionals.

Interview four

Health and Wellbeing Team, PHE WM

Deputy Director for Health and Wellbeing, PHE WM

Perspective on developing a high quality, credible and useful project

The Health and Wellbeing team are not frontline, therefore don't have a need for direct interpretation between their staff and members of the public. However, there are interpretation and translation challenges for specific areas, for example, sexual health, prisons and drugs and alcohol services. In terms of health improvement messages provided to the public, it is important to have access for all. This also needs to encompass health literacy levels and may be accomplished by using pictorial and easy-to-read materials.

LA suggested that the project begins with providing data on language across the West Midlands, then focus on interpretation and translation needs within PHE. This would involve exploring PHE direct delivery functions.

Interview five

NHS England and NHS Improvement

Senior Programme Lead, Lead for Translation and Interpreting

Perspective on developing a high quality, credible and useful project

In December 2019, the NHS Commissioning Principles² for high quality language and interpretation services were published. The principles focus on quality of the service and how to commission a service. One of the drivers for the project was that commissioners found existing guideline documents to be more aspirational than pragmatic. The principles are aimed mainly at GP services, and occasionally dental services and optometry. As a public sector organisation, NHSE/I wanted to have a consistent approach.

In terms of using the principles, providers are at different stages across the country. NHSE/I decided not to recommend a national service. The guideline development process led to the discovery that different areas had different preferences for the service location. Some preferred small, local interpretation and translation organisations who they had strong relationships with, whilst others prefer national-level organisations.

There is no planned evaluation of the commissioning principles, due to lack of capacity. However, the Equalities team plan to test assumptions made around using bilingual staff to assist with interpreting, and examples of good practice in potentially controversial areas. Many providers are in the process of recommissioning interpreting services. Anecdotally the NHSE/I is aware of areas where a service is available but its use is variable. One project taking place to improve use is informing GP receptionists about how to access interpreting services. NHSE/I also decided that interpreting is more of a priority than translation. Issues with changing information, standardising organisation communications, and keeping information up-to-date can make the quality of translated materials difficult to maintain. NHSE/I advised that it is important to consider the population who may need communication support due to a disability, impairment or sensory loss.

Interview six

Sandwell and West Birmingham Clinical Commissioning Group (CCG) West Midlands *Commissioning and Partnerships Development Managers, Strategic Commissioning and Redesign Team*

Perspective on developing a high quality, credible and useful project

Sandwell and West Birmingham CCG are procuring (September 2019) an “integrated language and communication service” for Sandwell and West Birmingham³. They shared the business case and service specification. The service aims to meet current and future demand for interpreting, enable patients and staff to overcome communication barriers, and build a place-based language and communication system that encourages collaborative working and patient-centred care. It was developed working with representatives from interpreting service providers, Midlands and Lancashire CSU, local authority, and the EU Migration Network (EMN).

Key to the development process was a stakeholder engagement event which asked “What are the wider determinants of healthcare literacy?” Beyond language, barriers to access included policies such as health charging, and variation in its implementation by healthcare workers, lack of trust and fear of authorities, as well as cultural differences, and difficulties in understanding how to navigate the NHS. Ideas for solutions included involving the whole healthcare economy, to create a holistic delivery model which considers wider determinants of health and wellbeing. In addition to interpreting the service should explain the NHS system and the rights and responsibilities of the individual, have a personalized approach to build trust between organisations and individuals.

The three themes the service specification focuses on are access, developing independence, and quality and safety. The CCG and their partners have come up with a creative and innovative service specification that clearly outlines actions on the social determinants of health. Actions include partnerships between the service and community organisations, raising awareness about self-care opportunities such as coaching, social prescribing, and others that help with integration such as English for speakers of other languages (ESOL). A summary of the business case will be detailed in the HNA to showcase examples of best practice.

The CCG really stressed the importance of long-term planning and having a vision of where we would like to be. This could be achieved by building on community assets by providing tools for people to learn to speak English, through ESOL and ESOL for health programmes.

The service will be commissioned using block contracts rather than payment by session. It is hoped that this method will motivate providers to deliver an innovative and creative service. A market engagement event will be held as part of the procurement process in September. It will invite both potential and existing interpreting service providers, and the Sandwell Consortium, a group that supports third sector organisations to work together and bid for grants to support local services. It hopes to encourage all parties to jointly bid for the contract.

Service evaluation will monitor quality, innovation, productivity and prevention measures. Quality will be measured by improved patient experience and patient activation (PAM), productivity by number of fulfilled interpretations per month (>95%), prevention by referrals to ESOL (with a target of 80% patient cohort referred) and course completion rate of 75%. The innovation measure is under progress but will look to measure the digital component of the service and how it impacts on patient activation.

Facilitating quality data collection

Sandwell CCG have used ONS Flag4 GP registrations⁴ by local authority data to explore the numbers of international in-migrants who have recently registered with NHS GPs, by gender. This has been mapped against all the services for new arrivals in the LA area. Flag4 data can also be used to look at the most common languages other than English spoken.

Interview seven

Institute for Research into Superdiversity (IRIS), University of Birmingham

Director of IRIS

IRIS is a centre for academic study in the field of migration and superdiversity. Recent publications from IRIS include “Adaptation of the health services to diversity”⁵, “Messaging in the Midlands: exploring digital literacy repertoires in a superdiverse region”⁶, and “Coping with language differences in a super-diverse context”⁷.

Perspective on developing a high quality, credible and useful project

The main message from IRIS was that focusing on interpretation alone is not enough. Communication is more than language alone. Cultural health capital is defined as a collection of cultural skills, attitudes, and behaviours and interactional styles that are valued, leveraged and exchanged by both patients and providers during clinical interactions⁸. IRIS recommended that the project also think about intersectionality, the influence of race, class and gender upon communication in accessing healthcare. For example, IRIS research has shown that that women are more open and driven to communicate than men.

IRIS also touched upon fear of institutions, how people can be afraid of the process of accessing healthcare. This could stem from community anecdotes, or experiences with interpreters who act in a judgmental way. Cultural humility⁹ is a tool for service providers to use to learn about other cultures in relation to their own beliefs and cultural identities. It is an ongoing process that providers can engage with when thinking about relationships with service users, colleagues, and communities. It aims to improve self-awareness of the providers’ own beliefs and their understanding of other cultures.

Interview eight

West Midlands Anti-Slavery Network

Executive Director and Development Manager

West Midlands Anti-Slavery Network is a network of agencies tackling modern slavery in the West Midlands and beyond.¹⁰ Nationally, in 2017, potential victims of modern slavery were reported to originate from 116 countries. The most common country of origin reported for adult potential victims was Albania (19%) and for those exploited as children was the UK (32%).¹¹

Perspective on developing a high quality, credible and useful project

The network shared key stories from their members' experience of interpreting. The National Referral Mechanism (NRM) is a framework for identifying victims of human trafficking and ensuring they receive appropriate protection and support.¹¹ Big Word is the service subcontracted by the Salvation Army to deliver the NRM. In Birmingham the NRM is lacking interpreters and cost has been cited as one of the factors contributing to this. The services experience delays in accessing interpreters, for certain languages it takes days to set up an appointment. Sometimes even if the correct language is accessed, different dialects used by the interpreter and the survivor can be a barrier. Another issue for services is understanding the different levels of security clearance each service has for their employees. This can have consequences for victims of trafficking who need to be protected from attempts to re-traffic them. Related to security, safeguarding issues have been reported. These range from interpreters acting in culturally inappropriate ways, or not maintaining professional boundaries and asking survivors for their personal contact details. However, WMASN noted that a benefit of a national interpreting service is that requests can be made for interpreters based on their gender, religion and other sociodemographic factors.

Accessing healthcare can be one part of the NRM for survivors of modern slavery. In these cases, the WM Antislavery Network have noted problems arising when healthcare professionals try to use or don't use interpreting services. At times when a survivor is seen by the crisis team in an emergency department, they may experience long waiting times as the healthcare professional organises interpreting. Incidents have been noted where a GP will prescribe a medication with instructions in English only. As a result, survivors have taken too

much or too little medication. This issue has also been noted in pharmacies. A survivor might nod in response to a question, but a healthcare professional has not taken the time to investigate if the survivor fully understands information on the prescription provided.

Facilitating quality data collection

WMASN highlighted relevant policy documents that state the requirement for survivors of human trafficking to be offered interpretation and translation services. These are detailed in brief below:

Council of Europe Convention on Action against Trafficking in Human Beings (2012)

Article 12 Assistance to victims

1. Each Party shall adopt such legislative or other measures as may be necessary to assist victims in their physical, psychological and social recovery. Such assistance shall include at least:
 - b. translation and interpretation services, when appropriate¹²

The Slavery and Trafficking Survivor Care Standards. The Human Trafficking Foundation (2018)

Care standard 1.6 Working with interpreters (p35, 36)

“It is crucial that the use of an in-person interpreter is routinely offered in all cases where English is not their (a survivors) first language.”¹³

References

1. PHE Health Protection. Migrant Health Guide. Accessed online 14/10/19. URL: <https://www.gov.uk/guidance/language-interpretation-migrant-health-guide>
2. NHS England. Guidance for commissioners. Interpreting and translation services in primary care. September 2018. Accessed online 14/10/19. URL: <https://www.england.nhs.uk/wp-content/uploads/2018/09/guidance-for-commissioners-interpreting-and-translation-services-in-primary-care.pdf>
3. Sandwell and West Birmingham CCG. Integrated Language and Communications Service – A business case. September 2019. Available on request.
4. Office for National Statistics. Flag4 GP Registrations by local authority. March 2013. Accessed online 14/10/2019. URL: <https://data.gov.uk/dataset/7a8ffa53-8f81-4439-a53e-13d53bf9d387/flag-4-gp-registrations-by-local-authority>
5. Phillimore J. with Klaas, F., Padilla, B., Hernández-Plaza, S. and Rodrigues, V. (2016) 'Adaptation of Health Services to Diversity: An overview of approaches'. IRiS Working Paper Series; 2016.
6. Tagg C, Asprey E. Messaging in the Midlands: Exploring digital literacy repertoires in a superdiverse region. IRiS Working Paper Series; 2017.
7. Wessendorf, S., 2015. 'All the people speak bad English': Coping with language differences in a super-diverse context.
8. Dubbin LA, Chang JS, Shim JK. Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine*. 2013 Sep 1;93:113-20.
9. Yeager KA, Bauer-Wu S. Cultural humility: Essential foundation for clinical researchers. *Applied Nursing Research*. 2013 Nov 1;26(4):251-6.
URL: <https://www.sciencedirect.com/science/article/pii/S0897189713000669>
10. West Midlands Antislavery Network website. Accessed online 14/10/19. URL: <https://www.westmidlandsantislavery.org/>
11. National Crime Agency. National Referral Mechanism Statistics. Q1 2019 Jan-March. Accessed online 14/10/19. URL: <https://nationalcrimeagency.gov.uk/who-we-are/publications/291-modern-slavery-and-human-trafficking-national-referral-mechanism-statistics-january-to-march-2019/file>
12. Council of Europe Convention on Action Against Trafficking in Human Beings. (2012) Article 12 Assistance to victims.
URL: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/236093/8414.pdf
13. The Slavery and Trafficking Survivor Care Standards. The Human Trafficking Foundation (2018). Care standard 1.6 Working with interpreters (p35, 36). Accessed

online 14/10/19. URL:<https://www.antislaverycommissioner.co.uk/media/1235/slavery-and-trafficking-survivor-care-standards.pdf>

Appendix 1

Language and Translation Services in Centres & Regions
 PHE National Health Protection Team
 September 2019

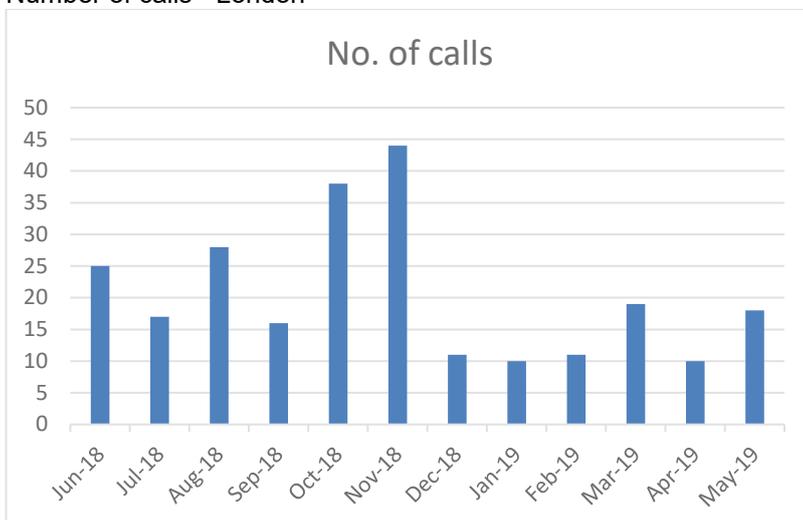
This is a brief description of the current use of language and translation services within Centres & Regions in PHE. It does not cover any use of services by colleagues in NIS or CRCE. Translation services have been used previously at a national level to produce leaflets and information in languages other than English.

Of the nine PHE Centres, only four currently have a contracted service with a provider of language and translation services. PHE North West and PHE South East have contracts with The Big Word, PHE South West use Prestige Network and London uses Language Line. The other centres rely on a combination of using NHS contracted services, using their own staff and using family/friends of the person to whom they wish to speak. On occasions when they have had to use a translation service as a “one-off” it has been very expensive. These centres without a service indicated that they would use a service if it were to be made available.

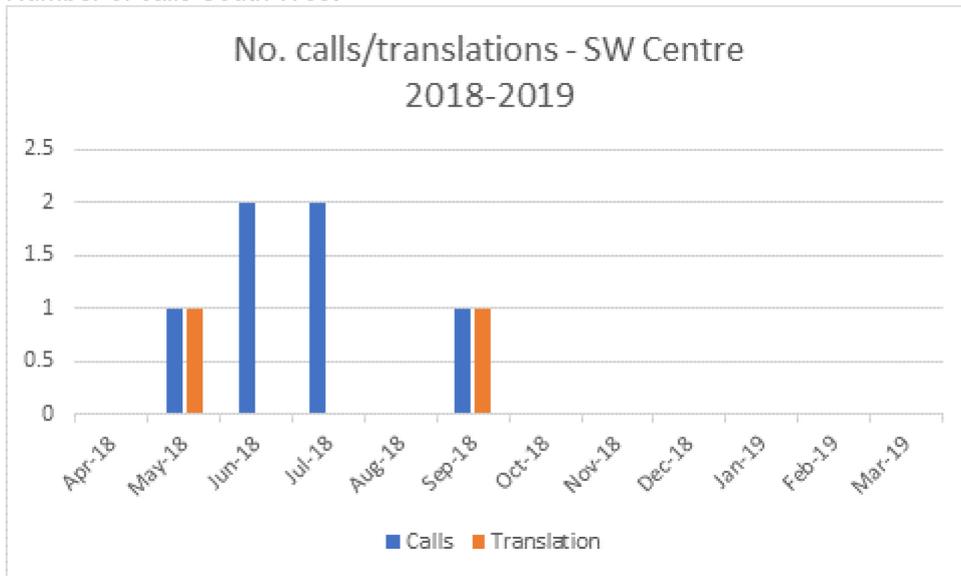
PHE Centre	Translation service used
North West	The Big Word
North East	No service
Yorkshire & Humber	No service
West Midlands	No service
East Midlands	No service
East of England	No service
South West	Prestige Network
South East	The Big Word
London	Language Line

The frequency of use of the translation service varies considerably between the centres, reflecting the diversity of their resident populations.

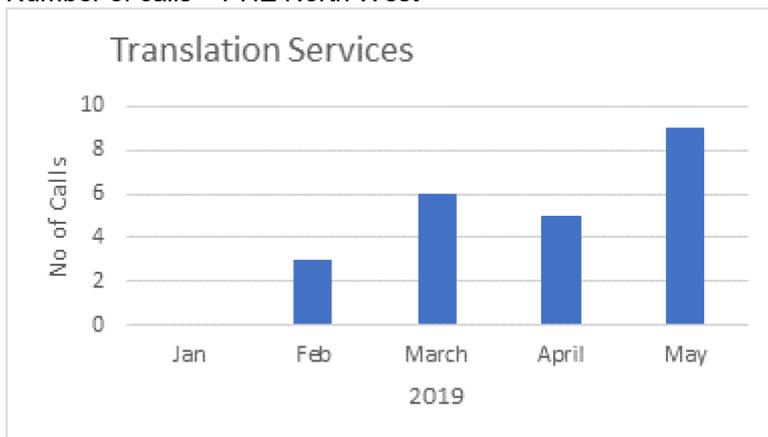
Number of calls - London



Number of calls South West



Number of calls – PHE North West



PHE South East were not able to extract the data on their usage of The Big Word.

Information on the costs of The Big Word and Prestige Network were not available. Language Line provides a three-way dialogue between non-English speaker, PHE staff and interpreter for £1.20 per minute. Analysis of the data from one HPT in London showed 158 calls over an 11 month period totalling 2,475 minutes and total cost of £3,594. Call lengths varied enormously but the average price per call works out at £22.70. Translation was into 23 languages (Albanian, Amharic, Bengali, Bulgarian, Cantonese, Farsi, Hebrew, Italian, Hungarian, Japanese, Lithuanian, Polish, Portuguese, Romanian, Russian, Spanish, Sylheti, Somali, Tamil, Turkish, Tygrinya, Urdu, Yiddish).

Appendix 2

The provision of language and interpretation support services across local areas in the West Midlands.

Authors: Zaheera Teladia, Karen Saunders PHE West Midlands

March 2019

Introduction

The report aims to better understand the provision of language and interpretation support services for migrants across local areas in the West Midlands. To achieve this, 8 qualitative interviews were conducted with key stakeholders from Local Authority Birmingham, screening and immunisation teams in PHE, health visitors, charities (namely Gypsy, Roma, Traveller community) and CCGs.

Firstly, this report will provide some background information on translation services across the West Midlands and the rationale for providing the local picture of translation services in the West Midlands. It will then present some key migrant data in the West Midlands before moving onto presenting key findings from the interviews.

Background and rationale

The UK is currently experiencing an influx of migrants from all over the world. Migrants are a heterogeneous group; diverse across a wide range of variables including faith, immigration status, class and education, within and between ethnic groups. Research shows¹ that some migrants clearly require interpreters in primary care and an absence of them can cause major barriers to the quality of health care. Similarly, The Institute for Research into Superdiversity² conducted some research which revealed that migrants felt the lack of adequate interpreting services was likely to result in misdiagnosis of health problems and consequently a poor experience of NHS care.

Evidence shows that the lack of good provision of translation services means many patients resort to using friends, community organisation and family members, who in many instances are children¹. The cultural or social values can also often be interrelated with the quality of translation services. For example, a study exploring the perspectives of healthcare professionals providing care to migrants¹ showed that translators have the tendency to filter what the patient says due to cultural understandings of what is deemed 'appropriate' to discuss. There were instances when interpreters spoke a completely different dialect to the patient which affected the quality of the service. 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. Without patients appropriately understanding the treatment offered to them, they are unable to give informed consent to treatment.

The above illustrates that language is pertinent in the context of reducing barriers, ensuring safety with diagnosis, prescription and prevention in health care. Although majority of the

¹ Lindenmeyer A, Redwood S, Griffith L, Teladia Z, Phillimore J. Experiences of primary care professionals providing healthcare to recently arrived migrants: a qualitative study. *BMJ open*. 2016 Sep 1;6(9):e012561.

² Health across borders [Internet]. 1st ed. Birmingham; [cited 2 March 2017]. Available from: <http://www.birmingham.ac.uk/schools/social-policy/departments/social-policy-social-work/news-and-events/2016/09/migrants-experiences-of-health-and-healthcare.aspx>

research points to primary care and secondary care, PHE have also recognised their need to better understand how this support is accessed, to identify what is happening with other stakeholders such as NHSE and local areas. This will enable the identification of good practice, improve responses, share models of provision, work effectively and mitigate any potential risks. The need for this project was recognised by the Health Protection Team following the recent measles outbreak. Healthcare professionals at PHE had trouble communicating with and advising some migrant groups who had contracting measles and were at risk to others. The absence of a clear mechanism to communicate with such groups and the lack of clear guidelines around reputable translation/ interpreting service that could be used delayed an immediate and efficient response.

The picture of the service delivery and the interpretation and translation services and quality is patchy. Interpretation and translations services do not only apply to people whose first language is not English, but also, to those who have a sensory impairment or disability. Whilst all are of equal importance, the purpose of this report will focus on interpretation and translations for those whose first language is not English.

Definitions and terminology³

This section will provide definitions related to migration as they are often use interchangeably, although there are clear distinctions between them.

Migrant- Someone who moves somewhere else for a significant period and either moves internally (within a country) or crosses borders (becoming an 'international migrant').

Refugee- People fleeing armed conflicts or prosecution

Asylum seeker- Someone who claims to be a refugee but whose claim hasn't been evaluated. Section 4 asylum seekers are those who have had an initial application refused and who have put in further submissions or an appeal and meet certain criteria laid down by the Home Office. Section 95 asylum seekers are those who are making an initial application and meet destitution criteria.

Long-term migrant- A long-term international migrant, is someone who does not change his or her usual residence for a period of at least a year. ONS long term migration estimates are based only on: people who come to the UK and who do not immediately apply for a national insurance number (such as students) and those who come to the UK to work and stay for a period of 12 months or more

Short-term migrant- A person who moves to a country other than that of his or her usual residence for a period of at least three months but less than a year (12 months)

Usual resident- Anyone who, on Census day, was in the UK and had stayed or intended to stay in the UK for a period of 12 months or more or had a permanent UK address and was outside the UK and intended to be outside the UK for less than 12 months.

Policy and guidance

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

- The NHS Constitution
- Equality Act 2010
- Public Sector Equality Duty 2011
- Health and Social Care Act 2012
- Human Rights Act (1998)

³ https://www.lfphwm.org.uk/library/search-results/doc_download/960-migrant-health-in-the-west-midlands-data-pack

- European Convention for the Protection of Human Rights and Fundamental Freedoms (1950)
- United Nations Convention on the Rights of the Child (1989)
- UN Convention on the Rights of Persons with Disabilities 2005
- Social Value Act 2013

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 protected characteristic. Similarly the General Medical Council guidance states that healthcare professionals must ensure wherever practical, arrangements are made to meet the patient's language and communication needs.

Public Health England's Health Guide includes general advice and guidance for healthcare practitioners on the health needs of migrant patients. They advise that a professional interpreter should be offered as they help foster trust with the patient and deemed it inappropriate to use children as interpreters for migrants. The guide raises awareness of why interpreting is important and to use an interpreting service correctly in a health setting. It is available in English, Arabic, Bengali, Chinese and Somali. The advice states that NHS 111 can provide an interpreter covering a wide range of languages for those using the health care service.

NHSE have undertaken an array of work including setting out principles which are need for a safe, high quality interpreting and translation service in health care. They suggest that the services it commissions makes reasonable adjustments to the way services are provided to take care of the needs of those who do not speak English. The principles are outlined below:

- 1) PRINCIPLE 1: Access to services-Patients must be able to access primary care services in a way that ensures their language and communication needs do not prevent them receiving the same quality of healthcare as others.
- 2) PRINCIPLE 2: Booking of Interpreters- Staff working in primary care provider services should be aware of how to book interpreters across all languages including BSL and to book them when needed.
- 3) PRINCIPLE 3: Timeliness of Access Patients requiring an interpreter should not be disadvantaged in terms of the timeliness of their access.
- 4) PRINCIPLE 4: Personalised Approach Patients can expect a personalised approach to their language and communication requirements recognising that "one size does not fit all".
- 5) 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.
- 6) PRINCIPLE 6: Compliments, Comments, Concerns and Complaints Patients and clinicians should be able to express their satisfaction with the interpreting service in their first or preferred language and formats (written, spoken, signed etc.) as appropriate
- 7) PRINCIPLE 7: Translation of documents Patients and healthcare professionals should have timely access to appropriately and effectively communicated documentation that will enable and support their healthcare.
- 8) PRINCIPLE 8: Quality Assurance and Continuous Improvement The interpreting service should be subject to systematic monitoring for quality assurance and to

support continuous improvement to ensure it remains of a high quality and relevant to local needs.

Migrant Data

The Migrant Health in the West Midlands report by Public Health England (2017)⁴ provides the changing and growing profile of the West Midlands migrant population which allows an informed understanding of the diverse population and associated health needs. This understanding is essential for planning interpreting and translation services. Some of the key points from the report are outlined below

- The overall West Midlands population grew by around 8% between 2005 and 2014 and during the same period, the non-UK born population grew by 54%
- The population of the West Midlands could reach 6.3 million by 2030, with a migrant population in excess of 1 million, accounting for 15%-20%
- The general health profile of the West Midlands is worse than for England, with significantly lower life expectancy and higher levels of deprivation
- The reason for people migrating to the UK is also changing with the majority now related to a definite job or formal education
- The largest number of immigrants come from the Middle East, but the picture varies between the different local authorities
- In 2015 majority of West Midlands, local authorities, most applications were from citizens of Romania, Poland and Bulgaria.

Key findings from qualitative interviews

This section will provide the key themes that emerged from the eight interviews that were conducted with key stake holders from Local Authority Birmingham, screening and immunisation teams in PHE, health visitors, charities (namely Roma gypsy travelling community) and CCGs. The two major themes that emerged were the following: Firstly- existing translation services/material. Subthemes included: formal use of interpreters and informal usage of interpreters.

Secondly- barriers and enablers to translation. Subthemes included: social dimensions to translation, varying dialects and language needs, availability of translators, contracts and commissioning of translation services and conducting a needs assessment.

Existing translation services/ material

Formal use of interpreters

The formal use of interpreters was mentioned across a range of stakeholders. The health visiting manager stated the Birmingham Children Healthcare worked with a Birmingham based translation and interpreting agency called word360 to provide translation services for their service users. There is also an existing budget in place to cover the interpreting and booking costs.

The health visiting manager and the interviewee from Local Authority stated that various leaflets have been translated into a range of languages for the benefit of patients who cannot understand English. However, there was consensus that there remained a gap in the availability of translation services and healthcare material in an array of languages. For example, the interviewee from Local Authority stated the Public Health Team in the West Midlands tend to put out most information in English despite the presence of individuals in the community who cannot understand English.

⁴ https://www.lfphwm.org.uk/library/search-results/doc_download/960-migrant-health-in-the-west-midlands-data-pack

Informal usage of interpreters

Given the lack of existing contracts or the availability of translation services in some organisations, some participants spoke about the informal use of interpreters. Participants from the Local Authority and the Health visiting manager highlighted the use of internal staff who are bilingual or volunteers from the community to provide translation. The Health Visiting manager expressed the challenges of family members acting as interpreters as this was perceived to restrict the patients from speaking openly about their condition.

Barriers and enablers to translation

Social/ cultural dimension to translation

Participants felt there was a general deficiency in the quality of translation services across the West Midlands. A common theme for interviewees was the cultural, religious and social barriers to effective translation. There were examples presented of interpreters filtering conversations, “putting their own slant” on translation or feeling uncomfortable with translating sensitive topics. For instance, conversations around contraception or smear testing were deemed inappropriate by some interpreters due to cultural understandings and thus were reluctant to discuss the importance in detail. However, participants also stated there was no formal training available for translators and interpreters to become culturally competent when delivering the translation service. It was believed the lack of communication between service user and translator can consequently create a lack of trust and frustration on both sides.

Varying dialects

Participants stated that even when language services were in place with interpreters, the quality of the service and the ability to interpret correctly was heavily dependent on the interpreter’s dialect, together with being from the same type of ethnic group. For example, interviewees cited the interchangeability between Romansh and Romanian and interpreters often mistaking one for the other. Others described the deep-rooted tensions between specific ethnic groups that originated from previous places of residence that still affect the interaction between patient and translator.

Varying language needs

Participants highlighted the challenges of communicating important messages to communities with varying health literacy levels and language needs. It was noted that assumptions should not be made that a person can read if they can speak a certain language. Participants cited that for patients with low literacy levels or patients who are illiterate the use of pictorial messages could potentially be helpful in communicating important information in a simple and understandable way. For example, the participant from regional comms at PHE stated that pictorial health posters with very few words are often displayed at public services including schools, GP surgeries and dentists.

Availability of translators

The availability of competent translators who meet the needs of individuals was deemed challenging by some interviewees. This often resulted in the delay of appointments which was believed to be detrimental for people with terminal illnesses.

Contracts and commissioning of translation services

Participants were generally divided in their viewpoints around the lack of formal commissioning of translation services at Public Health England. Despite the limited contact with service users, some held the viewpoint that Public Health England should have a formal process in place given the challenges faced during the measles outbreak. Conversely, others felt that the commissioning of language service is not best placed with Public Health

England as they simply do not possess the budget. Whilst others felt that the responsibility of translating health information was with local authorities.

Suggestions were put forward to have a shared translation services across different services; whereby Public Health England draw up a memorandum of understanding (MOU) between CCGs, hospitals and GPs. Some participants believed the new care models and existing STPs could be the vehicle for joint translation service.

Conducting a needs assessment

Participants stated the importance of conducting a needs assessment and researching the population demographics to identify what kind of translation services are required to support delivery function.

Key recommendations

- Conduct a needs assessment across organisations to identify how often there is a need for translation services to support delivery function. Do services like health protection, epidemiology services require language support?
- Greater clarity on the protocol for commissioning language or services or where the responsibility lies. Explore the feasibility of a local arrangement or drawing up a memorandum of Understanding document between CCGs, hospitals and GPs.
- Identify health literacy levels of the community and the varying degrees of language needs
- Share translation services with other healthcare systems including primary care, secondary care and CCGs. The STPs or new integrated care models might be serve as the vehicle this joint service.