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Γιατροί του Κόσμου DOKTERS VAN DE WERELD MÉDICOS DO MUNDO MÉDICOS DEL MUNDO 世界の医療団 ÄRZTE DER
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Right to interpreting and translation services

Contents

This briefing provides an overview of the evidence and literature relating to the provision of interpretation and translation services in the NHS. It outlines the evidence base which highlights the benefits of providing communication support for people who may experience language barriers when accessing and utilising primary care services, particularly those seeking sanctuary in the UK. It then discusses the legal position of the NHS and the responsibilities and duties set out in guidance that shape the current policy landscape.

Definitions

Translation refers to the conversion of written communications from one language into another. Interpretation refers to the conversion of spoken or signed communications from one language into another. This may be done face-to-face or through remote methods such as telephone and video interpreting or video relay interpreting. Access to an interpreter may require pre-booking (as is typically the case with face-to-face interpreting) or it may be ‘on demand’ and require no prior scheduling (as is commonly the case with telephone interpreting). People who find it difficult to communicate in written and/or spoken English due to disability and/or limited English language proficiency may benefit from interpretation and translation support when using healthcare services.

Need for interpretation and translation services

According to census data, among people who do not use English as their main language, 17.1% report not being able to speak it very well, while 3.1% report not being able to speak it at all (1). The number of people who may benefit from interpretation and translation support may actually be much higher than this, because even people who are conversationally fluent in English may struggle to understand health-related communications (2). The vast majority of people seeking sanctuary in the UK come from countries where English is not used as a main language and are therefore likely to have limited proficiency in English. Steep cuts to funding for English for Speakers of Other Languages (ESOL) course provision has led to fewer people being eligible for state-funded English language teaching and longer waiting lists, exacerbating language barriers (3). People who are not able to understand written or spoken communications in English may find it difficult to engage with healthcare services, leading to poorer health access, experience and/or outcomes.

Existing evidence highlights that language barriers are a major obstacle to accessing primary care for asylum seekers and refugees (4). 15% of people who received support from Doctors of the World UK between 2016 and 2020 reported facing language barriers when accessing the NHS (5).

Language barriers may prevent people from accessing primary care in the following ways:

- People may not be able to navigate the practice's registration procedures and policies – for example, finding a suitably located GP practice to register with and completing the GP registration paperwork.
- They may struggle to explain their circumstances and advocate for themselves when asked by practice staff to provide supporting documentation or other additional information to assist with registration, leading to a higher chance of registration being refused or not completed.
- Once they have registered, people may find it difficult to initiate contact with their GP and request to be seen by a healthcare practitioner. They may also not be able to communicate their needs and preferences to practice staff when booking and managing appointments, increasing the likelihood of appointments being made/changed in error or missed.
- Practice staff may find it harder to signpost people to sources of support or assist with access. For example, people who are on low incomes are eligible to apply for an HC2 certificate to help with health costs but many people who are seeking asylum are not aware of it or may not be able to complete the HC1 form to apply for it themselves.

According to research, language barriers can lead to communication difficulties at all points of a person's healthcare journey, leading to problems such as missed and incorrect diagnoses, medication errors and complications, and delays in treatment – adversely affecting patient experience and outcomes (6-10). Language barriers can also make it more difficult for health professionals to obtain informed consent from patients for treatment (11-12). Census data shows that people who are not proficient in English have a poorer patient experience and are likelier to be in poor health compared to people who are proficient in English, particularly as they get older, highlighting the long-term impacts of language barriers on health (13). Working with interpreters and translators can enable better communication between healthcare providers and the populations they serve, ensuring that services are able to take steps to address health inequalities and provide safe, effective, and personalised care for everyone in the community (14-16).

People who experience language barriers may resort to using friends and family members to support with communication, particularly where there is a lack of NHS-provided interpreters and translators (17). Migrants Organise's *Good Practice Guide to Interpreting* recommends the use of formal language interpreters who are professionally trained and qualified to work in health-related settings over informal sources of support such as friends and family members, particularly children under the age of 16. This is because friends and family members may not be sufficiently competent in both languages and may not understand medical jargon, increasing the risk of interpreting errors occurring. Interpreting in health-related contexts requires specialist expertise, as many medical terms lack direct or straightforward equivalents in other languages. Factors such as embarrassment, shame, and stigma may prevent full disclosure of symptoms and open discussion of sensitive health issues if in the presence of a person who is known to the patient. This 'filtering' can also potentially lead to signs of abuse, neglect, and other safeguarding concerns being missed. Friends and family members are not healthcare professionals and do not have to follow any codes of conduct or standards of practice, putting patient privacy and confidentiality at risk. Moreover, the pressure of facilitating communication can add to the stress and strain of supporting a close relation through health difficulties, rather than allowing them to have a supportive role during appointments.

Rights and entitlements

The NHS Constitution states that "you have the right to be involved in planning and making decisions about your health [...] and to be given information and support to enable you to do this" (18).
General Medical Council guidance states that doctors "must give patients the information they want or need to know in a way they can understand" and "make sure that arrangements are made, wherever possible, to meet patients' language and communication needs" (19). Similar references to supporting people who experience language barriers can be found in codes of conduct and standards of behaviour for other healthcare professions (20).

The Equality Act 2010 ('Equality Act') requires all providers of goods and services to make "reasonable adjustments" for disabled people to ensure they are not being substantially disadvantaged (21). The Act specifically mentions providing information in an accessible format as a reasonable adjustment. Interpreting and translating are therefore likely to be legal requirements for health services as part of their obligation under the Equality Act to make reasonable adjustments.
The Equality Act places an additional duty (known as the 'Public Sector Equality Duty') on the NHS and other organisations that carry out public functions to "advance equality of opportunity between people who share a protected characteristic and those who do not," including by taking steps to meet the specific needs of people with protected characteristics (22) – traits and beliefs that are legally protected from discrimination, harassment, or victimisation.

Because lack of proficiency in English is not a 'protected characteristic' as defined by the Equality Act, providers of NHS care are not legally required to make reasonable adjustments for it. However, Section 13G of the NHS Act 2006 (as amended by the Health and Social Care Act 2012 and Health and Care Act 2022) places specific legal duties on NHS organisations to seriously consider the need to reduce health inequalities in terms of access, experience, and/or outcomes when making decisions and exercising their functions (23).

Vulnerable migrants and refugees are a recognised cohort within the target population defined by CORE20PLUS5, NHS England's approach to reducing health inequalities (24). This means that where language barriers are an obstacle to equitable access, excellent experience, and optimal outcomes, steps should be taken to mitigate them. The Care and Quality Commission (CQC), which regulates health and social care in England, advises that: "A [GP] practice should be aware of the needs of the people on their patient list. This includes their language requirements. If they serve a large number of people whose first language is not English they should plan services appropriately” (25).

While there are different legal obligations concerning provision of support for people who have a disability and/or sensory loss compared to those who are not proficient in English, these needs are not mutually exclusive. D/deaf migrants and asylum seekers, for example, may not be able to communicate in both (spoken and written) English and in British Sign Language, doubly excluding them from health services (26).

Commissioning and contracting responsibilities – guidance on best practice

Interpretation and translation services are commissioned locally by Integrated Care Boards (ICBs) as part of their broader responsibility for planning and managing primary care services. Rather than prescribing a ‘one size fits all’ approach, NHS England’s *Guidance for commissioners: Interpreting and translation services in primary care* sets out eight key principles of best practice for ICBs to consider when commissioning interpretation and translation services, as outlined below (27):

- **Access to services:** Patients who require communication support should not be prevented from receiving the same quality of healthcare as others. Interpretation and translation should be provided for free. Additional time should be allocated to consultations where an interpreter is present (typically double that of a regular appointment).
- **Booking of interpreters:** Where an interpreter is required, the primary care provider is responsible for ensuring one is booked.
- **Timeliness of access:** Patients should not be disadvantaged by waiting unnecessarily longer for appointments to access primary care services because an interpreter is required.
- **Personalised approach:** Patients should be asked about their communication needs and this should be indicated clearly in their record and shared with other services when the patient is referred on (including both language and dialect). This should include preferences regarding the gender and political or cultural background of the interpreter, where relevant. For example, it may not be appropriate to use an interpreter who is from an ethnic group that has been involved in violence in the patient’s country of origin. To facilitate continuity of care, systems should be in place to enable access to the same interpreter. Use of informal interpreters such as friends and family members should be strongly discouraged but where this expressly preferred, the patient should give informed consent in their own language, and this must be noted in their record.
- **Professionalism and safeguarding:** Interpreters must be registered with an appropriate regulator and be suitably trained in safeguarding policies and procedures.
- **Compliments, comments, concerns, and complaints:** Patients and clinicians should be able to express their views about the quality of the interpreting service they have received, in their preferred language and formats. Interpreting agencies should collate and publish data on feedback and outcomes annually.
- **Translation of documents:** Documents which help professionals provide effective health care or that supports patients to manage their own heath should be made available in appropriate formats. Translation of documents must be done by competent

and appropriately trained translators. Where patients have an identified need for communication support, consideration should be given to the best way to contact them – for some people, a letter in English will not be an effective way to communicate. Automated translating tools such as Google Translate should be avoided as there is no assurance of the quality of the translations.

- **Quality assurance and quality improvement:** Services should be systematically monitored as part of routine commissioning and contract management procedures and users should be engaged to ensure they are high quality and relevant to local needs (28). To assist with this, the guidance sets out commissioning and contracting considerations, suggesting best practice for each stage of the cycle.

These core recommendations are supported by guidance found in Public Health England's *Migrant health guide* (29) and the British Medical Association's *Refugee and asylum seeker patient health toolkit* (30).

Commissioning and contracting responsibilities – challenges

While the Accessible Information Standard sets out specific requirements that commissioners must follow as part of their legal duties to ensure that the communication needs of people who have a disability and/or sensory loss are being met by existing service provision, no similar standard exists with regards to people who are not proficient in English. It is up to each ICB to consider the NHS England guidance and decide which arrangements would be most appropriate for their local area.

There is no dedicated funding to support with the commissioning of interpretation and translation services. As the guidance states: "The cost of any services commissioned [...] would need to be met from within existing allocations," even though the level of need is not distributed across England evenly. While fewer than 2% of people surveyed as part of the 2011 Census could not speak English well or at all, this figure rose to 9% in the London Borough of Newham and 8% in the London Boroughs of Brent and Tower Hamlets (13). When considering the costs of service provision, commissioners also need to factor in the allocation of additional time for appointments where an interpreter is required, which can reduce overall capacity. The guidance advises commissioners to consider "cost-effective and efficient ways to provide services (for example telephone interpreting or app-based support)," even though these may not be suitable for everyone: "specific circumstances may mean it is more appropriate for a patient to always have a face-to-face interpreter."

This has led to significant variations across localities in terms of service provision, with certain groups not being 'reached' by services and finding it more difficult to access help which is suited to their specific circumstances and needs. Recent research by the London Borough of Hounslow found that access to the NHS among asylum seekers living in hotel contingency accommodation was limited by a lack of interpreters and a lack of signal to use phones for translations or to call an interpreter (31). Other issues highlighted by existing evidence include interpreters and patients not being familiar with the same dialects of the language, interpreters not being trained in cultural sensitivity and trauma-informed practice, and interpreters not turning up to scheduled appointments (32). Many people are also not aware of what support is available to them or are deterred from seeking support because they do not want to be seen as a 'burden' on the system, highlighting gaps in knowledge and trust (33).

Recommendations for primary care providers

- Be familiar with local arrangements commissioned by the local Integrated Care Board. Ensure all of the relevant languages in the practice area are available.
- Ensure access to interpreters at both reception, consultation and for booking appointments or any other communication with the practice.
- Ensure a process is in place for recording patient communication preferences at the point of registration, including language and dialect, (use language identification cards) and for automatic pre-booking of interpreters for appointments
- Inform patients of their right to free interpreting services, provide translated resources and promote the option to use an interpreter. Consider visual aids and simple language in patient materials to make them more accessible to non-native speakers or those with limited literacy
- Provide training for staff on how to work with interpreters, best practice in communicating with patients and the importance of using professional interpreters rather than friends or family at all communication points
- Ensure all staff are aware of how to access interpreters at both reception and during consultation

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