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Using interpreters when accessing health and adult social care

In July 2010 Newcastle LINK commissioned eight research projects to consider a number of health and social care issues that had been notified to the LINK as issues. This report is one of those research projects. All of the final reports were presented to the LINK Executive Board on 18 January 2011 and it was agreed that they should be sent to the appropriate service providers and/or commissioners of services to request a response. This was done on 22 February 2011 and the responses were received by the 23 March 2011.

Publication of the reports on the LINK website was delayed until after the local government elections in May 2011.

Joint executive summary of the reports produced by Riverside Community Health Project and Newcastle Health and Race Equality Forum on some people's views and experiences of interpreting support in health and social care consultations.

Please note: the full reports containing their specific recommendations are set out after this joint executive summary

Newcastle Local Involvement Network invited Riverside Community Health Project and Newcastle Health and Race Equality Forum (HAREF) to explore views and experiences of interpreter support in the context of an increasingly diverse population in the city, in terms of ethnicity and first language. People move here from other countries to study, to find employment, to join families, and to seek asylum.

Riverside Community Health Project and HAREF workers met to plan work across communities, and to produce questions to start off group discussions.

The group discussions organised by HAREF encompassed 43 people in total, 28 women and 15 men. The ages of the women ranged from early 20s to late 70s, and the ages of the men from middle 20s to early 70s.

People took part from both established and emerging Black and minority ethnic (BME) communities, and participants described their cultural backgrounds as Bangladeshi, Chinese, Pakistani, African (participants from Eritrea, the Democratic Republic of Congo, Cameroon and Libya) Afghani, Indian and Iranian. Their first languages are: Punjabi, Dari, Yoruba, Farsi, French, Cantonese, Lingala, Tigrinya, Urdu, Hindi, Arabic, Mirpuri and Bengali. Some of the people who took part have lived in Newcastle for many years and have a high level of fluency in English as a second or third spoken language. Two people have worked as interpreters. Others are at the beginning of the process of learning English, having recently arrived in the UK. Bilingual workers facilitated group discussions as appropriate.

Riverside conducted six focus groups with people who speak the following languages: Czech, Slovak, Dari, Pashto, and Polish. Each group was attended by between three and seven people. Numbers and mix of languages spoken in groups varied from one group to another depending on the time and availability of participants and interpreters. Groups were quite diverse; some were women only groups and the others were mixed groups. Where the groups were women only this was mainly because of cultural reasons. Most of the men tend to go to work while the women stay at home, which means that more women than men were available to participate in the research. The age of participants varied, with the eldest being 63 and they youngest 23.

The Riverside Community Health Project report to Newcastle LINK

What are the issues that people face in using interpreters when accessing health/adult care services?

What is the issue?

Riverside Community Health Project was commissioned by Newcastle LINK to explore the experiences of service users on using interpreters when accessing health/adult care services in Newcastle upon Tyne. These services include GPs, dentists and hospitals.

Riverside works in the west end of Newcastle to improve the health and wellbeing of individuals and communities. Undertaking this piece of work for Newcastle LINK is useful in informing Riverside's work in supporting the communities it serves, i.e. the findings from this report will also influence work with and behalf of communities to bring about change in policy and service delivery in response to need.

Riverside undertook this work through consultation with its existing service users, in particular, users of its 'Migrant Families and Inclusion Project', and made contact with other groups and individuals as appropriate.

How did you know this was an issue - where did it come from?

The issue was identified by Newcastle LINK as an issue that needed some exploration. Riverside was commissioned to undertake the research. Prior to the issue being identified by LINK, Riverside had already been informed by some of its users that they had concern about the availability of interpreters. Additionally, Riverside has been part of a pilot project to test out a toolkit to measure well-being, working closely with an organisation in South Tyneside, and some people raised the issue of lack of access to appropriate interpreters, as negatively affecting their wellbeing.

Who was involved in collecting people's views? Whose views have you collected and how did you do it?

Prior to starting this research project Riverside had discussions with the Health and Race Equalities Forum (HAREF) which was also conducting research on the same question. We agreed that because health and social care covers such a wide range of issues that we should focus on GPs, dentists, and hospitals, as these are the areas that many people are concerned with, and where they often need interpreters.

In practice, many of the participants wanted to talk about their experiences of using interpreters when accessing the home office for their immigration issues. We kept the research more focused by encouraging participants to focus on health, as in services delivered by, or for the National Health Service (NHS). Although it should be noted that difficulties with interpreters to access essential services, such as advice on immigration, can cause considerable anxiety and be detrimental to mental health. (Any recommendations on improving interpreting services could be shared with other such agencies).

Riverside works with a number of migrant groups who were approached to recruit participants. Most of the focus groups were conducted in the Carnegie Building (Riverside's base), offering a safe venue where people are used to attending. Additionally, it was beneficial in that the participants already knew and trusted the staff who undertook the research. Three members of Riverside staff undertook the research, all of them are bilingual. This offered some advantages; given that the research was about interpreting services it was beneficial to undertake some of the research without the need for third party translation. As the languages spoken by two of the staff involved are

Czech and Slovak it was possible not to use interpreters in the focus groups with members of the Czech/Roma community. When interpreters were used they were from a Community Interest Company (CIC) called Northern Revive, which is a trading arm of North England Refugee Service.

We conducted six focus groups as planned in the proposal. Riverside agreed with HAREF which groups they should target, so as to avoid duplication of languages. Riverside then facilitated focus groups with people who spoke in the following languages: Czech, Slovak, Dari, Pashto, and Polish. All of the groups were attended by between three and seven people. Numbers and mix of languages spoken in groups varied from one group to another depending on the time and availability of participants and interpreters.

Groups were quite diverse, some were women only groups, and the others were mixed groups.

Where the groups were women only this was mainly because of cultural reasons; most of the men tend to go to work while the women stay at home; which means that more women than men were available to participate in the research.

The age of participants varied, with the eldest being 63 and the youngest 23. The origin of most participants was outside of the UK and most had lived in Newcastle for less than five years. All of the participants were registered with GPs in the west end of Newcastle, and the majority of them had not attended a hospital in the last five years.

To enable participants to feel comfortable we took cultural issues into consideration, splitting groups where necessary. So, for the Afghan community we split men and women, and Dari and Pashto speakers. We hosted two groups with people who spoke the Pashto language. One group was for women and one for men.

The Afghan and Roma Community Associations that are supported by the Riverside Migrant Project brought together participants for focus groups. The Polish focus group participants were individuals that use Riverside Toy Library.

Who does the issue affect and how are they affected?

The use of interpreters is essential for those who do not have English as a first language. The effectiveness and efficiency of services provided by health professionals can be influenced by the quality of the interpreting provided to support communication with patients. The findings of this research show that

the use of interpreters can have both positive and negative effects. Below is a summary of issues identified by different groups:

Czech Roma community

This group speaks the Czech language, and are mostly economic migrants. The Czech Roma community has a long history of discrimination which has resulted in some mistrust of those in authority. The Roma community were in the past travellers and although this has changed many of them move house frequently. This could be relevant to an issue that was highlighted in the focus group i.e. some people reported that they get no communication from their GP. Their assumption being that their GP doesn't write to them as they cannot speak English. After a lengthy discussion, where we agreed that GPs have a duty to communicate appropriately with patients, it was agreed that the patient has a duty to keep their GP updated with their current address.

This group also expressed satisfaction with certain interpreters; although they mentioned names they did not know which agency employed those individuals. The participants appreciate the services they get from interpreters, as they feel that without the interpreters they would not be able to communicate effectively.

Slovak Roma community

This group has a similar history to the group above and they also appreciate the service they get from interpreters. The group was facilitated by a member of Riverside staff who had previously worked as an interpreter for some of the focus group participants. On reflection we wondered if this may have influenced the views that participants expressed. There were only positive comments about interpreters i.e. supporting their communication in a professional manner.

However, they did highlight a difficulty around booking appointments at the doctors or dentists, as at that point they don't have an interpreter. They also said that interpreters are not easily available and they often had to delay appointments until one was available.

The only issue they brought was the difficulties they experienced in booking appointments, as at that point they do not have access to any interpreters. The other issue raised was the delay in getting the appointment, as interpreters were not easily available. Because of this some people use their children as interpreters for minor, less serious issues.

Afghan Pashto and Dari women's group

These two focus groups had a total of twelve women participating aged between 30 and 55 years. The group is linked to the Afghan Community

Association. Two interpreters, who spoke two different languages, were used for this focus group. However, we requested a Dari interpreter from Afghanistan but the company gave us an Iranian Dari interpreter, who could not communicate with some of the participants. We stopped the focus group and rescheduled it for a later date so that we could get an interpreter with the right dialect.

Participants indicated that when using interpreting services at a GP appointment they often get interpreters who do not have the correct dialect. They did not realise that they had a right to stop the consultation and request an interpreter with the right dialect. It was suggested that the health professional should try and check out whether the patient and the interpreter can communicate effectively. The difficulties that could arise through poor communication in these situations are considerable and ways to address this should be explored further.

These groups had mixed ideas on whether it is important to have interpreters of the same gender i.e. women interpreters. After some debate they agreed that it is good practice to have same sex, interpreters and health practitioners supporting them.

They also highlighted the importance of having a clear explanation in their own language on how to take the medication prescribed to them. They also noted that the interpreters' services ended in the surgery and not in the pharmacy. They had noticed that some interpreters actively avoided supporting them at the pharmacy, even when it is within the same building as the GP surgery.

However, participants in both focus groups appreciate the interpreting services they receive.

Afghan Pashto-speaking men

The men who attended this focus group are part of the Afghan Community Association. They requested a same gender focus group i.e. men only. However, they were happy to have a woman focus group facilitator as long as she was not Afghan. They explained this anomaly by saying that they can mix with non-Afghan women as they are not part of their culture.

Six men participated in the focus group, aged between 21 and 49 years. They all appreciated the availability of interpreters when they attend appointments at their GP surgery. Some said that their lives were made better by having an interpreter who knew how to explain things they wanted health professionals to understand in English.

They do not want female interpreters for any appointment, regardless of the issue, because of their culture. They specifically mentioned the inappropriateness of female interpreters when they are discussing what they called 'men's issues'. However, they do not mind what gender the medical staff that they consult with are.

This group also expressed some concern that some health professionals rely too much on body language; they felt that there was an assumption that all body language is the same across the globe. They see this assumption as problematic, in that people from different places use and interpret body language differently. The example they gave which they think is common is when asked by the health professional 'Do you understand' and the patient nods their head, it is assumed that they do understand. This is not necessarily what the nod means, and the patient may not understand.

Overall they group acknowledged the good quality of interpreters they get and how professional they were. Some individuals went on to say that it is vital that when services are losing staff due to spending cuts by the government, interpreters should be getting a wage increase, as they are an important bridge between professionals and patients.

Polish-speaking women

This group is not an established group at Riverside but was comprised of women who access other services within our centre. Three women aged between 20 and 30 took part in this research. One acted as an interpreter as she spoke both languages fluently. As with all the participants in this research their views were based on their own experiences, and are personal to them.

The women explained that they prefer to attempt speaking in English (even though for two of them their English is not easily understood) with practitioners, rather than use interpreters. They explained that there is a lack of trust of interpreters within their community.

They indicated that they fear that interpreters may break confidentiality and said that gossip can spread as far as Poland. They are fearful of becoming a 'laughing stock' and would rather attempt to speak English, even given all the limitations this poses for them, than use an interpreter. This may account for the high take up of English courses at Newcastle College by members of the Polish community.

They are happy with services offered to them by health practitioners. They also mentioned a surgery in Benwell that has a Polish doctor and that that most people from the Polish community are registered with this surgery. We found out that the availability of such a doctor made it easy for this community

to access GP services without any language difficulties. None of the participants had attended a hospital.

Are there things that are being done well?

- All the groups are satisfied with the services and the level of support they are getting from their GPs and other health services, and acknowledge the importance of the interpreter's role. A few said 'I would die if interpreters were not available' and that they would not be able to function well.
- Most participants said they noticed how the interpreters remained professional throughout the interviews. This gave them confidence to specifically request particular interpreters when they revisit their service provider.
- Appointments generally run to time because interpreters are used. Participants said they feel 'relieved' and 'convinced that they have explained everything to the health professional, and have received quality advice and attention; as the interpreters made everything clear and simple'.
- The way the interpreters dress in a professional manner was seen as being assuring. Most participants agreed that they judged people by the way they dress, and that dressing professionally gave them confidence in the interpreters ability
- There are some surgeries that are employing bilingual frontline staff. That made it easy for some clients to walk in and get an appointment. There was a consensus that it would be good to have more bilingual staff if resources are available.

Recommendations

Three things that came out clearly as need to be improved are:

- More support is needed when collecting medication from the pharmacy. When the pharmacist explains how medication is to be used they generally assume that the patient understands English. Some people had made mistakes with medication and they said that it is people who do not have children who can read the instructions to them who are most at risk. However, the appropriateness of giving this responsibility to children could be questioned.

- Participants prefer to use the same interpreter each time they visited the clinic because that limits the number of people who have confidential information about them. There was a suggestion that health centres could have bilingual staff to assist with communication while booking appointments.
- Participants suggested that the gender of the interpreter be considered for all appointments as this makes everyone comfortable to open up to professionals about their health. This issue was shared across the board, even amongst the mixed groups. Although some participants made it clear that if it is about saving their lives they would not be bothered who interprets for them. This was considered as good practice where possible.

The origin of most participants was outside of the UK, and most had lived in Newcastle for less than five years. All of the participants were registered with GPs in the west end of Newcastle and the majority of them had not attended a hospital in the last five years.

The two reports produced by Riverside Community Health Project and HAREF present the findings from which the following list of joint recommendations has been produced:

1. Consistent quality standards for interpreter recruitment, training and continuing professional development: "Training is everything."
2. Training for professionals in booking and working with telephone and face to face interpreters.
3. Professionals (reception staff and health and social care practitioners) to:
 - Check with individuals, including those who appear confident in speaking English as a second language, whether they need interpreting support.
 - Discourage provision of language support by family members, to avoid potential mis-interpreting and mis-diagnosis, and conflict of interest.
 - Share their decision about choice of telephone or face to face interpreting with service users.
 - Check which dialect is needed when making an interpreter booking.
 - Check availability of a preferred interpreter, with choice of gender (according to user preference and/or situation) when making a booking.
4. Strategic discussion about availability of professional interpreter support in pharmacies when people collect medication, so that everyone is able to access information about exactly how to take their medication.

5. Service providers to stay in touch with BME communities, via community groups and community development workers, for information sharing and for the development of services in partnership with users. The following information gaps were highlighted:
 - Information about developments in the provision of interpreting support e.g. 24 hour availability of telephone interpreting for routine consultations and emergency situations.
 - Information about the flexibility built in to bookings so that face to face interpreters do not have to leave before consultations are complete.

The Health and Race Equality Forum (HAREF) report to Newcastle LINK

Interpreting support in health and social care consultations: Experiences and views of people in some black and minority ethnic communities in Newcastle upon Tyne

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Introduction

Why look at people's experiences and views of interpreting support in health and social care consultations?

There is an increasingly diverse population in Newcastle upon Tyne in terms of ethnicity and first language. People move to the city from other countries to study, find employment and join families, and over 10,000 people have arrived in the North East of England seeking asylum since 1999 (Rodger and Chappel 2008).

'Appropriate and consistent use of interpreting support' was one of the areas for action identified at the Health and Race Equality Forum 2010 conference, when 120 people from Bangladeshi, Pakistani, Filipino, Czech, Indian, Afghani, Slovak, African and Chinese communities came together to discuss the information and support they need to stay as healthy as possible (HAREF 2010a).

A change of provider of interpreting support to a local NHS Trust was also a good point at which to look at people's experiences of using this form of support in health and social care consultations.

How did the Health and Race Equality Forum approach this piece of work?

A literature review produced evidence that professional interpreters are important in supporting some people with a first language other than English to access health and social care services and use them effectively (Tribe and Thompson 2008, Cambridge 2007, Alexander et al 2004). If people have difficulty describing their situations in social care consultations and their symptoms in health consultations, professionals may be unable to respond appropriately (Mind 2010, Bhatia and Wallace 2007). There is therefore a preventative aspect to investment in interpreting support (Joule and Levenson 2008), in relation to not wasting NHS resources e.g. inappropriate medication, and to avoiding illness e.g. the spread of infectious diseases. Rigorous recruitment, induction and training for interpreters, and training for health and social care professionals in general communication skills and how to work with interpreters, are key to the success of encounters in which interpreting support is required (Escott et al 2009, Macfarlane et al 2009, Free et al 2003).

43 people, 28 women and 15 men, took part in seven group discussions, sharing their experiences and views of using interpreting support (see Appendix 1 for the list of questions asked).

The ages of the women ranged from early 20s to late 70s, and the ages of the men from middle 20s to early 70s. People took part from both established and emerging Black and minority ethnic (BME) communities in Newcastle upon Tyne. The participants described their cultural backgrounds as Bangladeshi, Chinese, Pakistani, African (participants from Eritrea, the Democratic Republic of Congo, Cameroon and Libya) Afghani, Indian and Iranian. Their first languages are: Punjabi, Dari, Yoruba, Farsi, French, Cantonese, Lingala, Tigrinya, Urdu, Hindi, Arabic, Mirpuri and Bengali. Three of the seven group discussions involved people who share the same first language. Some of the people who took part have lived in Newcastle for many years and have a high level of fluency in English as a second or third spoken language. Two people have worked as interpreters. Others are at the beginning of the process of learning English, having recently arrived in the UK. HAREF workers facilitated group discussions with bilingual colleagues as appropriate.

Five group discussions took place in venues familiar to participants, including a community centre and a mosque, and two took place in the meeting room at Newcastle Healthy City. Each group was given a fruit basket as a gesture of thanks for their time. People did not know in advance that they would receive this.

Participants' discussion focussed almost exclusively on health consultations and the report reflects this. There was reference to a weekly drop-in social care surgery at which interpreting support is provided. The surgery is regularly over-subscribed with people queuing outside the building from 7am. This illustrates the importance of interpreting support for some people who need social care, and the themes discussed in the findings section of the report below are relevant across health and social care consultations.

Representatives of four services providing interpreting support to Newcastle residents were interviewed and asked for details of their recruitment and training programmes, information which is often difficult to find at a local level (Macfarlane et al 2009).

Recommendations

- Consistent quality standards for interpreter recruitment, training and continuing professional development across providers: "Training is everything."
- Training for professionals in booking and working with telephone and face to face interpreters.

- Professionals (reception staff and health and social care practitioners) to check with individuals, including those who appear confident in speaking English as a second language, whether they need interpreting support.
- Professionals to discourage provision of language support by family members, to avoid potential mis-interpreting and mis-diagnosis, and conflict of interest.
- Professionals to share their decision about choice of telephone or face to face interpreting with service users.
- Professionals to check which dialect is needed when making an interpreter booking.
- Professionals to check availability of a preferred interpreter, with choice of gender (according to user preference and/or situation) when making a booking.
- Information about developments in the provision of interpreting support (eg 24 hour availability of telephone interpreting for routine consultations and emergency situations; flexibility built in to bookings to avoid interpreters leaving before consultations are complete) to be circulated to people in Black and minority ethnic communities via community groups and community development workers.
- Service providers to stay in touch with Black and minority ethnic communities, for information sharing as above, and for the development of services in partnership with users.

Findings (quotes from people who took part in the research are in speech marks.)

1. The value of being supported, when necessary, by a professional interpreter

This was a common theme across group discussions. Interpreters were described as a “person who connects the client to the professional”, someone who “fills the gap”, “a handy person for you”.

“Sometimes the doctor doesn’t understand how ill a person is feeling without an interpreter.”

“Sometimes you can’t speak out (in English) even though you know in your head what to say.”

While the majority of people acknowledged the importance and the many advantages of learning English, social isolation and lack of confidence were mentioned as barriers to becoming proficient in spoken English.

Participants who said that they can almost always manage health consultations pointed out that they might still need some language support in consultations in which complex issues are being discussed.

“A lot of people, even young people and even people who have been here a long time, might need an interpreter sometimes.”

“You might need an interpreter for some questions. If you can’t manage these questions, you go ahead and struggle and it doesn’t work, and you have to make another appointment which is a waste, and another trip.”

Several people living with diabetes talked about appreciating interpreting support for annual review appointments, while being able to negotiate routine check-ups.

One woman talked about feeling able to manage most GP health consultations and finding it difficult to ask for interpreting support when she needs it, because the receptionist says “You’ve explained why you need to see the doctor. Your English is very good and you don’t need an interpreter”. While recognising that the receptionist’s motive is to support and encourage her, she said that she feels that this puts her in a difficult position.

“If the receptionist says “You can manage without an interpreter” I feel as though I should. The doctor writes everything on the computer and I worry I might be in the wrong if I haven’t explained something properly. An interpreter should be available until you’re very fluent.”

There was reference to people shifting to their first language if they are experiencing stress or distress and if they develop certain illnesses such as dementia.

One participant, who works as a parent support worker, referred to parents needing interpreting support in discussions with professionals about child protection, to make sure that they understand UK law and the reasons why children might be taken into care.

2. The importance of appropriate use of telephone / face to face interpreting support

Some of the people who took part knew about the possibility of telephone interpreting support. It was highlighted that there are occasions when the presence of a face to face interpreter can be a barrier to communication, for example if someone is talking about their sexual health. Telephone interpreting, with a choice of a female or male interpreter, can be an effective alternative, though context and body language (gestures etc) are inevitably lost.

The general preference was however for a face to face interpreter where appropriate and practically possible.

3. People's level of awareness of professional interpreting support

The majority of people who took part in group discussions knew about the possibility of having professional interpreting support.

"If you need an interpreter you go to the surgery first and tell them that you need an interpreter. You can point to a language and say you have just a bit of English."

Some knew about and valued the option to ask for a particular interpreter, with whom they can build up an ongoing relationship (see Alexander et al 2004). At the same time they understood that a particular person might not always be available. Some knew that they can say "I would like to go ahead (with interpreting support) but I don't feel comfortable with this person".

There was a significant minority of women and men who did not know about the availability of professional interpreting support and who had never been asked if they needed it.

"Older people think "What shall I do?" and "Who can help me?" It's difficult for someone who doesn't speak English to know they have a right to an interpreter."

"The concept of rights is difficult for people who arrive seeking asylum, so they need to be told."

Several women said that they had had their children without professional interpreting support, with language support provided by family members, including daughters, husbands and children.

Some young people in Newcastle who shared their views of health services (Health and Race Equality Forum 2010b), talked about the difficulties they can face if they are asked to interpret for family members in health settings, including being kept from school.

Participants highlighted the potential of circulating information about interpreting support through existing groups and via community development workers.

“There’s a lack of information. That’s why community groups are very important. That can give people confidence and the more that people have confidence to go to their GP, the more they understand their right to an interpreter.”

4. What makes interpreting support work well?

There was generally very positive feedback about the way in which primary care professionals organise interpreting support. Some people said they have experience of being consistently asked whether they need support or not. Several appreciated the skill of some receptionists in primary and secondary care settings, in not making assumptions and checking out support needs.

There was excellent feedback across group discussions about the quality of interpreting support in GP settings. 11 people gave positive examples, with a geographical spread across the city, and people referred to good interaction with interpreters.

“No need to improve GP interpreters as I can’t think of anything to improve.”

There was feedback from one group (in which people shared a community language) about difficulties in relation to interpreting support in hospital settings, for example a perceived lack of understanding of complex medical terms. These difficulties were fed straight back to the NHS Trust and interpreting service provider involved and there was a productive meeting with some community members and a commitment to following up the issues.

Across the groups there was agreement that interpreting support works well when interpreters:

- Are properly qualified, with expertise in both languages (English and the first language of the person they are supporting).
- Have a good working knowledge of medical language. An example was given of a recent situation (outpatient eye clinic) in which things did not work well, with the interpreter unable to interpret ‘pupil’ and ‘white of the eye’.

- Have been well trained, so that they understand their role and the importance of professionalism:

“The standard of the work’s important. A checklist isn’t training and can potentially mean dangerous practice. You need to be skilled and keep on learning.”

“The interpreter needs to explain the parameters of consultations and say that if the person doesn’t want a professional to know something, don’t say it, otherwise it will be interpreted.”

- Have had training on the importance of protecting confidentiality:

“Confidentiality is more important than anything.” In several group discussions there was reference to the issue of close-knit communities and potential lack of confidentiality, and the impact of breaches or perceived breaches of confidentiality (see Kensington, Chelsea and Westminster BME Health Forum 2002).
- Know how the NHS system works.
- Are punctual.
- Have a positive attitude (see Alexander et al 2004).
- Are sensitive to the difficulty some people may experience in saying things in front of an interpreter.
- Are able to interpret in the context of the original language:

“Culture and connections are important, especially working with the NHS, where it’s very important to get it right.”

“Interpreting well involves having understanding of context and culture. In African French there’s the concept of witchcraft in relation to mental health problems. A French-speaking interpreter from France might not be able to interpret appropriately. That’s not interpreting wrongly but it’s not the whole story. People from Africa know what that means spiritually. It can’t be interpreted mechanically.”
- Can work to professional boundaries:

“A woman who’s recently moved to the North-East kept making GP appointments (in the town where she lived before moving to Newcastle) for headache and was not able to use interpreter support because of control by family members. Her GP asked to see her alone with a professional interpreter and she was able to disclose domestic violence. But the interpreter was a man known to the family. The gender wasn’t right for the situation and there was a problem with professional boundary-keeping.”

Interpreting support works well when professionals involved:

- Have good communication skills eg look at and speak to the service user, not the interpreter or family member(s).
- Break down the information they’re giving and do not use jargon.

- Give full explanations of conditions, treatment etc.
- Recognise that everyone is the product of their culture and that cultural backgrounds are interconnected with people's physical and psychological wellbeing.
- Have an open approach to clients:
"There are places in Newcastle where there aren't many people from BME communities and some health professionals give the impression that they're thinking 'Oh my goodness, why don't I have a proper white person where I understand the culture and language etc' and you see that in their face as a client and as an interpreter".

Interpreting support works well when service providers:

- Invest in comprehensive, high quality training and continuing professional development.
- Recognise the potential risk of sub-contracting in terms of compromising quality standards.
- Recognise the political / historical / social contexts of the countries of origin of some people who work as interpreters. For example, people may speak the same language as others from a community / country with whom their country / community is or has been in conflict.

Providers of interpreting support to Newcastle residents

Representatives from four providers took part in interviews. Each was asked to outline how interpreters are recruited to their service, trained and supported in continuing professional development. Each interviewee checked interview notes for accuracy, and was invited to add more detail.

The information provided by the four providers illustrates the point made by Macfarlane et al (2009), that 'provision of trained, professional interpreters is patchy'. The information shows a range of recruitment practice from no face to face contact with applicants during recruitment and induction, to face to face multi-stage interview process. It also shows a broad spectrum of investment in initial training, management and supervision, and continuing professional development.

1. North of England Refugee Service ('Northern Revive' is the new trading arm, providing interpreting support and other services)

Organisational values:

- Commitment to developing high quality provision of interpreting support.
- Commitment to investment in the North East economy through providing high quality employment opportunities for local people: "It's about local communities and local assets".

Organisational developments:

- New provider arm, Northern Revive, for delivery of a high quality interpreting service.
- About to launch a new telephone interpreting service.

Recruitment of interpreters:

- Often via local universities eg language/linguistics graduates.
- Employment agency visa check.

Assessment of suitability for the job:

- In-house verification of qualifications e.g. degree certificate.
- CRB check (paid for by interpreter after 1 year's employment).
- Face to face language test (minimum 80% mark needed).

Training:

- In-house training covers range of issues e.g. confidentiality.
- Some via Medical Foundation for the Care of Victims of Torture and Workers Educational Association.

Employment:

- Successfully recruited interpreters are ranked according to knowledge, ability and level of experience e.g. Class A interpreters work in hospital settings where consultations are likely to be more complex than in primary care.
- Interpreters are self-employed.

Continuing professional development:

- Continuing training in partnership with other locally based providers.

2. thebigword

Organisational values:

- "With over 30 years' experience we are proud to have become one of the world's most trusted interpreting and translation companies. Our experts work closely with our public sector clients to provide tailored face to face interpreting, telephone interpreting and translation solutions in over 234 languages."

Organisational services and developments:

- Telephone and face to face interpreting services, British Sign Language, document translation and alternative formats.

Recruitment of interpreters:

- Information circulated via language service fairs, recruitment fairs in new areas when a contract has been won (eg Newcastle, June 2010), and linguist forums. On-line recruitment via global procurement team website, plus general word of mouth.
- thebigword is committed to employing local interpreters.

Assessment of suitability for the job:

- “To provide fully qualified interpreters as per the terms of the contract set.”
- 2 references from previous employers.
- Enhanced CRB check.

Training / preparation for the role:

- Once registered, the interpreters are inducted into the company and sent their code of conduct.
- Interpreting handbook sent out electronically, with guidelines re what's expected in terms of behaviour and conduct.
- Interpreters sign a confidentiality form binding them to National Secrets Act.

Employment:

- Interpreters are based all over the country. The Service Managers are based in the Leeds (HQ) and London office and the project management team is based in Leeds.
- The team only use interpreters who are based locally to the contract.

Management, supervision and continuing professional development:

- 24/7 hour helpline number.
- thebigword Account Manager has made regular contact with interpreters in the area, both in meetings and over the phone.

Evaluation:

- Evaluation of telephone interpreting is via mystery shopping and follow-up with users.
- Face to face interpreting is evaluated through feedback from professionals and from interpreters themselves. The quality team analyses feedback and gives a response to feedback within 24 hours and investigates issues, if necessary, within 5 days.

How the interpreting support system works:

- Request for booking sent to thebigword via secure on-line portal, and basic information about the person and the type of consultation passed on to the interpreter, who can choose whether or not to accept the booking. If the

booking is for a mental health consultation, a more senior interpreter will be invited to attend.

- The interpreter meets the patient in the waiting area (the booking will be for the appointment time). The interpreter has to arrive 10 minutes before the appointment time. The interpreter introduces herself/himself, gives their name and shows their identification card. The professional leads the consultation. Seats should have been arranged beforehand. The client can request a previously used interpreter. The client can ask for a male or female interpreter for both telephone and face to face interpreting support.
- For both in-and outpatients, professionals assess when they can use telephone interpreting and when face to face, eg face to face when there is a consent issue, safeguarding issue or complex case.

3. Interpreting Translation Line (ITL)

Organisational values:

- Commitment to developing high quality provision: “We work towards a pool of well-trained and confident interpreters”.
- Commitment to providing a positive work environment: “We care for their welfare and encourage continuous improvement through CIPD programmes”.

Organisational developments:

- ITL is an Edexcel accredited organisation. As part of organisational development ITL provides a teaching and learning programme to enable other organisations to benchmark and measure the written and oral language proficiency of their staff. They administer a language competency testing service.

Recruitment of interpreters:

- Applicants respond to job advertisement or approach ITL because of word of mouth recommendation. High web presence.
- A Welcome Pack is sent to each interested person, with a list of requirements for the job.

Assessment of suitability for the job

- Face to face assessment of applicants’ speaking, writing and reading skills in first language and English, via a language test (Edexcel Centre for Language Proficiency accredited). Applicants perform an interpreting task and are tested on terminology.
- CV: Applicants’ qualifications are checked against a list of criteria, including MA in Interpreting or Translation, Diploma in Public Service Interpreting Level 4, membership of Institute of Linguists.

- Identity is checked via passport, and proof of permission to work in the UK is checked.
- Two references are required, preferably in relation to interpreting or translation work experience.
- If an applicant's qualifications and experience matches the criteria for employment, they are offered in-house face to face training, covering eg how to work to organisational policies.

Training:

- Successful applicants take part in an in-house one to one training programme (approximately half a day, depending on the capability / experience of the person) covering various issues, including confidentiality, attitude to the job and to clients, how to brief a health professional appropriately about cultural issues eg in relation to pregnancy; the importance of punctuality; what to do if running late; health and safety issues.
- Applicants have to role-play interpreting in a complex situation eg around a vulnerable adult or a child. They are then given small pilot assignments eg a routine appointment for immunisation. The professional has to give feedback on time-sheet: "We can't let them go before they do a job perfectly".

Management/supervision/continuing professional development:

- Service Manager texts interpreters to check their safety and punctuality.
- Free access to de-briefing, face to face or by telephone.
- Annual continuing professional development programme. Some sessions are mandatory e.g. mental health awareness, women and pregnancy, families and children's issues.
- Expectation that interpreters will continue to learn new terminology.

Employment:

- Interpreters are employed on a freelance basis.
- Interpreters of major languages that are in high demand are employed full time as ITL employees.

How the interpreting support system works:

- Just before a consultation the interpreter introduces herself / himself to the client and outlines their role ie that they will interpret everything the client and the health professional say, and the content will remain confidential.
- If the assignment is in a custodial environment or in a secure centre they have to undergo rigid training, police vetting and an enhanced CRB

Evaluation:

- ITL receives feedback and assessment sheets completed by judges, doctors, dentists and police officers who use ITL services.
- This is a mandatory requirement for all provision. ITL utilises the feedback sheet for each assignment as a tool for customer relationship management and interpreter training.
- They also utilise feedback as part of positive encouragement.

4. Newcastle Interpreting Service

Organisational values:

- Commitment to employing local people.
- The service looks after interpreters' wellbeing.
- The Development Manager trains professionals to work with interpreters, promoting access. The Development Manager has done this in Newcastle Medical School for more than 10 years and in Northumbria University, Primary Care Trusts, Northumberland Tyne and Wear Trust etc. This raises awareness of why interpreting support is important and provides practical guidance on how to work with interpreters effectively.
- There is input to Newcastle-wide and regional networks and projects.

Organisational developments:

- Website development.
- Streamlining of booking system.
- On-going development of training programmes for new interpreters and existing interpreters.
- On-going training for professionals on 'How to work with Interpreters' e.g. 700 professionals trained during 2008 and 600 professionals trained during 2009.

Recruitment of interpreters:

- If someone wants to be an interpreter, they can access information on the website as a first step. The Development Manager is happy to talk through employment opportunities with people who are interested in applying.
- Applicants are required to fill in an electronic application form.

Assessment of suitability for the job:

- Face to face interview with panel of three people (Operational Manager, Development Manager and another person, who could be the Assistant Operations Manager or an outside professional. All applicants must pass through the interview stage.
- The panel members use the interview to check each applicant's level of understanding of the interpreter role, and to assess their maturity e.g.

capacity to handle sensitive situations. It is also an opportunity to observe an applicant's personality i.e. "Not what people say but how they say it".

- The interview lasts between 45 minutes and an hour. It includes a test of medical terminology in English and applicants need to have a mark of at least 80%. The test is in three parts: one part tests how well they understand terminology relating to the UK healthcare system e.g. 'inpatient' and 'outpatient'; another part tests how well they know how people express themselves in medical settings e.g. "You will be discharged tomorrow" and "You need a referral" and the third part tests knowledge of medical words e.g. what is cardiology or catheter?
- Proficiency in English is observed during the interview as a whole as well as in each of the test areas.
- If people have done well in the interview but not in the test of medical terminology, and they have potential and willingness to learn, the Development Manager gives them material to study and they are given a new test date. If they pass, they then go on to the interpreting test.
- Applicants who do well in the interview and the medical language test go on to the interpreting test. There are five parts to the interpreting test which is facilitated by the Operational Manager, audio-recorded and sent to a national assessor with the same first language as the applicant. The person is asked to say something about themselves in their first language to test fluency. There is then a health setting scenario and a social care setting scenario, with a task to interpret from English into the applicant's language. There is then a more complex scenario with difficult terminology in a medical setting and a social care setting respectively. This test lasts approximately 20 minutes. Some sentences are longer, to test listening and memory skills. Applicants can ask for things to be repeated, though they must be able to demonstrate ability to interpret longer pieces (as will be required in the post). The recording is sent to a qualified linguist (with a Diploma in Public Services Interpreting and experience where possible). There is a standard form for assessor feedback. The assessor marks each section and writes comments and highlights mistakes. Feedback is shared with successful and unsuccessful applicants. Applicants have an opportunity to highlight their own mistakes first, then to look at the comments made by the assessor. If an applicant does not pass this test, the Development Manager will look at their potential again and if they meet the service's requirements they will be given materials to study and will re-sit the test. This is considered to be a crucial though time-consuming process.
- If an applicant passes all three parts of the recruitment process, they are asked for 2 references (not a friend or relation and ideally a tutor or employer). A CRB enhanced check is undertaken by the service, even if the person already has one (in line with Trust policy). The CRB check is an essential part of quality control, as it shows the person is safe to practice.

In line with the Trust's policy the applicant is also required to have a health clearance i.e. to be screened by the PCT Occupational Health Department to make sure they are fit to work.

Training:

- Successful applicants go on a corporate three day induction training, which includes equality and diversity training.
- Before they start working they must do the service induction, which is focussed on the interpreting role. There is an interactive half-day with videos to highlight good and bad practice. There is a case study, reinforcing good practice. There is an operational part to the induction, covering bookings, payment, what to do if they can't make an appointment, reliability, punctuality, confidentiality and role boundary.

Employment:

- If all of the above is satisfactory, the person is given an 8 month contract, within which time they must do training (Introduction to Public Service Interpreting course) run by the service and accredited by Open College Network at Level 3. This is a comprehensive training covering the role of the interpreter; equality and diversity; health and safety; how health and social care works, terminology and concepts e.g. 'maternity care' and 'elderly health'; dealing with sensitive, complex cases including child abuse, breaking bad news, mental health and counselling. There are 14 sessions, including a final assessment which includes interpreting tests (externally assessed) and health knowledge tests (must have 80% in both, as if not achieved they can't get the qualification). Probationary interpreters need to attend at least 12 of the 14 sessions. The classroom performance provides a chance to observe the person out of an interview setting, and to assess their attitude. There is a portfolio as well, with a reflective diary and worksheets with case studies – interpreters have to show how they would handle them. They also have to put together a bilingual glossary. An internal verifier assesses fairness and consistency of the trainer. An external verifier from Open College Network samples some portfolios for consistency and fair practice. People are not recontracted if they don't pass the training programme. Guest speakers are involved in this training programme e.g. community midwife, Medical Director, health visitors, social workers etc.
- People are offered a permanent contract if they successfully complete all of the above.
- Applicants have to be available for a minimum of 16 hours a week for the most popular community languages. This contributes to the continuity of health care as it is more likely to facilitate the same interpreter being available for the same patients for follow-up appointments. There are

different requirements of availability for other languages with very low demand. It is an 'as and when' contract i.e. no guarantee of work.

- Interpreters have the same terms and conditions as other Trust employees i.e. pension contributions, annual increment (Band 5 Agenda for Change) etc.

Continuing professional development:

- There are opportunities for ongoing professional development e.g. fraud awareness; Mental Capacity Act and Safeguarding Children (compulsory); cognitive behavioural therapy (not compulsory and usually good turnout). There is payment for compulsory training.
- Discussion groups with various themes are run for interpreters to share experience and good practice.
- Some people get other jobs using their experience e.g. as community development worker. The knowledge they gain helps them to work in health and social care settings.
- There is ongoing management and support.
- There is a designated line manager who is the Operations Manager of the service, with whom interpreters can speak. Issues are taken seriously and checked with the Trust Medical Director if necessary. There is feedback to the interpreter concerned and critical events may be used in training scenarios. Interpreters can talk face to face as appropriate (given high priority where necessary e.g. if there is an emotional issue, they'll be seen straight away) and counselling can be arranged when needed, free of charge.
- In the service office base there is a room for interpreters, for use at any time e.g. between appointments. The room has computer access and reference materials.
- Monthly newsletter to keep them informed.

Evaluation

- Monitoring form sent to a sample of professionals. Interpreter does not know when monitoring will be.

Working in partnership to promote health, equality and accessibility, the Service Manager:

- Has been working in partnership with Newcastle Advocacy Service to develop the BME Advocacy Service, and is a member of its Advisory Group.
- Was the Chair of the Race Equality Area of Special Action Training Group (Newcastle Health Action Zone). This multi-agency group developed a Race Equality Charter for Newcastle (Race Equality Training Newcastle: Taking the NHS Forward, November 2001).

- Was a member of the regional Delivering Race Equality in Mental Health Group, and was Chair of the Interpreting Sub-Group.
- Worked, from October 2006 to May 2008, with interpreters and mental health professionals to look at the challenge of interpreting in mental health settings. Questionnaires and focus groups were used. Based on the findings, the Newcastle Interpreting Service further developed techniques and skills for interpreters and professionals to be able to work together to facilitate effective communication with mental health patients. The service continues to train mental health professionals on how to work with interpreters. In the last two years, the service has trained 300 mental health professionals.

Appendix 1: Questions for group discussion

1. If you need an interpreter to support you to see a doctor or another health or social care professional, how does that happen?

2. Can you think of a time when interpreting support worked particularly well?
Prompts:

- Can you tell us a bit more about that?
- What made it work well, do you think?
- When and where was that?
- Did the interpreter say which organisation they work for?

3. Has there been a time when you've noticed something about interpreting support that could be improved? Prompts:

- Can you tell us a bit more about that?
- Were you able to feed that back at the time?

4. If you could give a message to health and social care professionals about what interpreting support means to you, what would you say?

5. If you could give a message to people who work as interpreters, what would you say?

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