

Commissioning Framework for Language Support 2011



Commissioning Framework for Language Support

2011

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Increasing globalisation and the importance of migration requires a response to overcome language barriers to care. These guidelines aim to support commissioners in the provision of language support to achieve equity and excellence in health and social care services.

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Executive summary

1. Why this matters – acknowledging the case for change

Migration is an important and permanent feature of population change across the world. With increasingly multicultural societies there is a growing recognition of the need for culturally competent care and migrant inclusive health systems. Failure to provide language support results in poorer health outcomes for patients, compromised delivery of care for practitioners and inefficient services with increased costs. This presents certain **challenges and issues** for commissioners to consider.

Legislation and key policy drivers

Legislation and key policy drivers demand equal access to services and to positive health outcomes for migrants and Black and Minority Ethnic (BME) communities. The values espoused in Equity and Excellence: Liberating the NHS (DH, 2010) are those of fairness and of patient centred services. Language mediation is not only an essential right in a patient centred service but also meets a basic human need and is fundamental to the patient practitioner relationship.

Meeting the QIPP agenda and the financial case for change

An innovative language support strategy will improve the quality and productivity of services and will contribute hugely to the prevention agenda. Provision of interpreting is often perceived as costly and is sometimes limited or not routinely offered to save costs. Whilst a comprehensive cost benefit analysis does not appear to be developed or readily available commissioners must consider the hidden costs of poor language support to patients, practitioners and services.

Commissioners should:

- **Make communication and language support central to the way care is provided**
- **Develop a clear conceptual framework that describes the differing contexts of language support and recognises the complexities of communicating across language and cultures and allows the professional to achieve effective communication**

2. Assessing your local needs and priorities

The commonest cited barrier to any development of a coherent approach to communication support is the lack of clear data regarding ethnicity and language needs for the population. Whilst there is no one agreed source of data for informing a communications support strategy, this cannot be allowed to deter from provision of language support options.

Sources of information and data available

There is a wide range of national and local data already available from differing sources which provides a useful and sufficient basis for service development. Sources include census data, national surveys, national and local administrative data and third sector and provider activity data. This should all contribute to the Joint Strategic Needs Assessment which will be fundamental to identifying level and types of language support needs.

Using the data

Numerical records of ethnicity and languages is insufficient of itself and needs to be taken together and enhanced with the rich and nuanced information available in local BME voluntary sector and community organisations.

Commissioners should:

- **Collect a range of data not only to identify community languages but more specifically to describe language support needs**
- **Collect, collate and interpret data and information in partnership with local communities and third sector agencies**
- **Ensure detailed and quality ethnic and language monitoring in all services, including interpreting and translation services**

3. Identifying suitable service solutions

Service providers' dependence upon patients bringing their own 'interpreter' results in the unethical use of family and friends. Often it is children who are utilised in this role with severe consequences for the child. This approach to language support cannot be allowed to continue.

Models of language support

A coherent strategy of language support should not only utilise **a service provision model of language support** in partnership with the good Public Service Interpreting and Translation (PSI&T) agencies available; but should provide a range of different ways to meet diverse needs which provide more cost effective solutions and ensure a **social inclusion** approach to language support. Reasonable adjustments must always be made and these include for example dual handset phones on reception and conference phones in every consulting/clinical room, plain English/pictorial service information, flexible appointment systems and facilities for drop in service provision etc. Consideration must be given with every service commissioned to bilingual staff, community volunteers, bilingual link and support workers, working with advocacy agencies and joint working across BME agencies.

Commissioners should:

- **Start from the point of view of those who communicate in forms other than spoken or written English and consider multiple communication approaches that will give service users choice and take into account their concerns, experiences, aspirations and lifestyle**
- **Develop commissioning partnerships with community organisations, voluntary sector agencies and interpreting services which are crucial to community needs assessment and decision making regarding language support provision**
- **Create a language support strategy which includes a locally based interpreting and translation service with and for local communities and ensures every service commissioned includes reasonable adjustments and a wide range of options for language support provision**

4. Defining and specifying services based on best practice

A comprehensive strategy across all service provision will enable a broad range of options for language support to be available to all service areas. The ability of such a strategy to deliver a range of options is dependent upon the development of a social inclusion model of language support.

Public Service Interpreting and Translation (PSI&T)

Understanding the roles and methods of working of the interpreter or translator is essential to establishing basic principles and identifying key measures of a good interpreting and translation service. Service specifications should incorporate pathways to employment for interpreters and include training not only for existing interpreters but also for new interpreters and new languages as migration trends change.

A social inclusion model

The options broadly available within the strategy can be specifically defined within each service commissioned and integrated into the service specification, especially within specialist areas such as mental health, health promotion, and screening services.

Commissioners should:

- **Apply the conceptual framework for understanding language needs and the language support strategy to every service developed.**
- **Consider the full range of options that are available for delivering language support.**
- **Decide what outcomes each individual service should deliver and consider how language support options available will support those outcomes for BME communities.**

5. Working with and developing providers

Working with third sector providers

The central and most important resource to the provision of language support is local BME voluntary and community sector organisations. They possess a keen understanding of language and cultural issues and are in a position to identify both needs and solutions: with local communities possessing the language and cultural resources to develop those solutions. The overall aim of any language support strategy should be to create a partnership approach which seeks to coordinate the support provided by a wide range of partner agencies. The localisation agenda and the concept of the 'Big Society' underpin such a strategy. Commissioners therefore need to **map existing services and funding** in partnership with a range of community agencies in order to identify what should be commissioned and how to access alternative providers.

Procurement and contractual approaches

There are elements that need to be addressed beyond the commissioning of individual services where language support needs should be considered. Workforce development could include for example staff training in cooperation with interpreters, cultural competency and in locally required languages; training in local communities for higher level English skills, and the provision of pathways to volunteering and employment in a wide range of roles (including reception/admin staff, health trainers and clinical staff); and the training of interpreters to the level of Diploma in Public Service Interpreting (DPSI) and in specialist clinical areas such as mental health and palliative care. Community participation in the design of care pathways and identification of the language support solution most appropriate to each stage of the care pathway.

Commissioners should:

- **Work in partnership with the education sectors required to develop language skill in local communities, provide training and professional development for interpreters and support health staff training and development**
- **Familiarise all NHS staff with language support options available, sources of**

translated information accessible, the work of other organisations locally and nationally that can help support service users, legislation, guidelines and policies

- **Ensure all services users are aware of the options available to them and empower them to participate in the development and provision of support options and identifying developing needs and new ideas**
- **Work with service providers in health, housing, social care and in the third/voluntary sector to co-ordinate their work together for individual patients and for communities, share the provision of link, support and advocacy workers and collaborate on the provision of interpreting and translation services**

6. Monitoring performance

Monitoring performance of Public Service Interpreting and Translation services can be clearly defined through **key performance indicators**. However, a **social inclusion model** of language support involves monitoring health outcomes across the board and identifying if those patients with limited English proficiency have equity of access to positive health outcomes. Language support monitoring is thus tied intimately to the monitoring of all elements of a service. Service user and community feedback is essential.

Commissioners should:

- **Actively seek feedback from individuals, communities and staff who are all users of language support**
- **Create guidelines and policies with clear standards with means for their monitoring and evaluation**
- **Ensure the employment, training, assessment and deployment of interpreters and translators meets minimum best practice standards to ensure safety, efficacy and quality of interpreting.**
- **Apply robust monitoring systems essential to facilitating cost effective provision of language support**
- **Build in evaluation of commissioning, planning, service development and delivery from the start**

Introduction



“To communicate effectively you must: make sure, wherever practical, that arrangements are made to meet patients’ language and communication needs.”

(GMC, 2006)

The aim of these guidelines is to support commissioners in the development of coherent and robust evidence based language support and interpreting/translation strategies and policies, which can be used to deliver culturally competent service provision.

Migration is an increasingly important feature of population change across the world, so people are crossing national borders to live in countries where they may not be fluent in the national language. In order to embrace diversity, and meet the health needs of people with different explanatory health beliefs and cultural constructions (Tribe and Tunariu, 2009) there is a growing recognition of the need for culturally competent care (Bennett and Keating, 2009) and a migrant inclusive health system. The right to language mediation not only meets a basic human need, but is fundamental to the patient practitioner relationship (Umer et al., 2009) and is an essential element of equal access.

Approaches to communication needs have tended to focus upon access to interpreters and whilst it is true that health and social care services are making increasing use of interpreters and translated information, broader approaches to language support are required with the utilisation of a variety of models of provision. The

overall aim of any strategy should be to create a more joined up approach with overarching financial, strategic or developmental planning taking due consideration of language support services. It is also important to realise that language support services do not operate in a vacuum and their development must take place within the context of strategies for equalities and equity of service.

Equity and Excellence: Liberating the NHS (DH, 2010) firmly sets the grounding for ‘Putting patients and the public first’ (p6) and ‘Focusing on improvement in quality and healthcare outcomes’ (p8). The values espoused centre on fairness for everyone in society, with patient centred approaches where services are designed around patients ‘needs, lifestyles and aspirations’ (p8), and patient involvement that enables *improved outcomes, increased satisfaction*, better understanding of health issues and a resultant improved cost effectiveness (p13). Language support will be key to achieving the changes proposed and ensuring improved patient experience and safety. Without language support patients with limited English proficiency cannot contribute to Patient-Reported Outcome Measures (PROMs) and real time surveys; will not have access to ‘*comprehensive, trustworthy and easy to understand information*’ (p13), will be unable to have meaningful access to their care records and their collective voices will not be ‘*strengthened*’ (p19).

Case Study 1 - Clinical issues with inadequate language support

Difficulties accessing interpreters means that professionals often have to compromise with informal interpreters with the following results:

Consent not properly obtained:

"...her 10 year old son interpreted for me. However, it occurred to me that her son might not understand all the concepts I was explaining and therefore the woman could be signing something that she didn't actually understand."

Sensitivity with using family or people from the local community:

"Mr X was referred to me as having severe psychotic episodes, he did not speak English and his wife interpreted. However, I was aware that there were relationship problems and it was inappropriate for his wife to act as an interpreter but I couldn't get hold of any other interpreter."

There are examples where community members have not registered with a GP and have never accessed primary care services because of lack of knowledge about the way things work in the UK:

"She was 65, lived in a small Norfolk village for 35 years and had never registered with a GP, because she did not understand the "system". If she had seen a GP, she would never have ended at the A&E and nearly died there."

Patients do not know what to expect:

E.g. Portuguese people sitting all morning in a surgery waiting in vain for their appointment as they have not arranged one.

Community members do not understand how the NHS works and visit the A&E department when they have a minor ailment:

"This Portuguese lady turned up at the A&E because her son had not had a poo that day." A&E staff

Community members have less access to prevention programmes than other groups, hence increasing risks of incurring serious illnesses or even death:

E.g.: *A Bengali man used an informal interpreter. He was diabetic and ate something very sweet which resulted in him falling into a coma. His son had not interpreted "otherwise you could die" to his father because in their culture children do not tell their elders what they can and cannot do.*

Patients may overuse diagnostic, specialist services or beds:

E.g. *"I saw this patient again and again for the same issue."*

E.g. *"We were not able to discharge him, because we did not know where to get an interpreter."*

Patients may be misdiagnosed:

E.g. *"I realised that in the past I used to establish my diagnosis based on the few words patients were giving me. With the interpreter, my patients are more relaxed, and are able to give me a fuller picture. On a few occasions with the interpreter, I realised that my diagnosis changed radically as a result of that story."*

Patients may not be able to understand the nature and consequences of medical procedures:

E.g.: *"She was trying to have a baby. Because of the lack of an interpreter staff had not explained to her the consequences of having a hysterectomy"*.

All quotes Gidney (2010) Unpublished document

SECTION 1:

Why This Matters Acknowledging The Case For Change

1. *“...providing interpreting services...is a financially viable method for enhancing delivery of health care to patients with limited English proficiency”*
(Jacobs et al., 2006)

With globalization people are increasingly moving across national borders to live and work (www.statistics.gov.uk). Thus if equity of access to health and social care across those borders is to be supported there is an increasing need for language support (Tribe and Lane, 2009). There is a danger in believing that interpreting needs are a temporary problem that will somehow diminish. Beliefs that immigration figures are falling for whatever reasons; that new migrants are required to learn English and provision of interpreting and translated information somehow hinders this; or that current provision of telephone interpreting is sufficient to meet need, are false and lead to short-termism in thinking and ad hoc forms of provision.

Language diversity

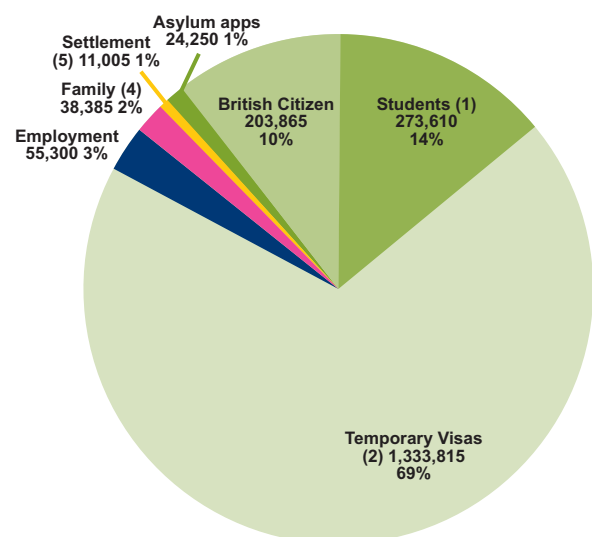
Such short-termism does not reflect the reality of the situation experienced by service users and providers on the ground. Migration, rather than births and deaths, is now the principle component of population change (ICOCO, 2007). At least three million people living in the United Kingdom were born in countries where English is not the national language (National Centre for Languages, 2006). Long term migration, defined as stays over 12 months, has increased from 320,000 in 1997 to 574,000 in 2006 (ICOCO, 2007 p3). The Home Office Statistics for 2009 (Home Office, 2010) show the number of visas issued to people entering the United Kingdom had increased by 2% to 1,996,500 and there were 24,250 asylum applications which involved some 29,845 people.

There are a range of languages in common usage in the UK. British Sign Language was officially recognised as a minority language in the

United Kingdom in March 2003 and is believed to be the preferred language of 50,000 of the total registered 8,945,000 deaf and hard of hearing people in the UK and the ratio of fully-qualified interpreters to sign language users is 1 to 275. (Perez and Wilson, 2006). Also there are 23,000 deaf blind people in the UK. Community languages include those of established BME communities and the 2001 census identifies these as Urdu, Bengali, Punjabi, Chinese (Cantonese), Polish and Italian. It is important to recognise however, that communities are not homogenous and that there are differences in dialect and in cultural expressions within such communities.

National statistics give an important picture regarding the range and numbers of migrants in the UK. Commissioners will however need to know the profile of their own communities and can use national data to identify the types of data that might be important: for example: students numbers would indicate the need for data from Higher Educational Institutions and the identification of local language schools.

Number of visas issued (excluding dependants) 2009



- (1) Tier 4 of the Points Based System
- (2) Visitors, working holiday makers, Tier 5
- (3) Tiers 1 and 2, Highly Skilled Migrant Programme, Work Permit Holders
- (4) Spouse / civil partner actual and proposed
- (5) Indefinite Leave, Certificate of Entitlement

Home Office (2010)

Learning English

New migrants experience specific difficulties in developing English language proficiency and using English to communicate effectively. First accessing courses as requirements for some categories of students, for example new spouses, to meet nationality and residence status as defined by the Home Office, means that they have to wait until they receive settled status for acceptance as a home student before becoming eligible for funding (Home Office, 2003). Also, waiting lists for courses can be long: over 100 people in Ipswich according to one third sector provider (CSV Media, 2010), “There are not enough ESOL classes being delivered to accommodate the growing number of people who require ESOL they are timetabled during the working day, which is not convenient for those migrants working irregular shift patterns during the day” (ISCRE, 2007 p29). Additionally, the majority of classes being provided in Suffolk are for learners working at Entry level 3 or below, meaning that each entry 3 learner would need about 200 guided learning hours to reach the equivalent of GCSE English (SCC ACL, 2010).

Some people experience difficulties in learning languages especially if they are not literate in their own language. Many ESOL courses provide only basic English and do not develop language skills to sufficient degree to be able to communicate in complex situations or where specialist language is used (Home Office, 2003) especially to the level required to communicate to communicate in a clinical context. Also, age, crisis, fear, pain and illness all impede communication in a second language when people will revert to their first language.

“I have been here two years and only been able to go to an English class at The Forum once or twice. Where can my children go when I go to class? Who will take me? I live outside the town and there are no classes there. I can speak in English to buy food but not to explain my problem to the doctor...”

Female Turkish service user (Stallabrass, 2005)

Case Study 2 - Passive and active English capability

MM (over 50), a Polish patient suffering from chronic pain in the right hip area radiating down to his right leg and left hip area. MM is a historian by profession and has worked as a bus driver for a few years in the UK. He was dismissed from work due to his health condition and made an appointment with a GP to seek help with his condition and learn what other work he would be able to do. He also stressed that he was not willing to claim disability benefit. The patient did understand the English language, the problem started when he tried to communicate and express his problems. That is where the interpreter's assistance is indispensable to facilitate the easiness of conversation and eradicate any distortions, misinterpretations and annoyance resulting from lack of proper communication.

What I found is that the passive understanding of English is not as much of a problem as the active production including specialised vocabulary, unfamiliar to the Polish patient. The interpreter added to both patient and GP's feeling of comfort ability and introduced some light humour. Prior to the assignment the patient had spoken to the receptionist and asked for a Polish doctor who was, unfortunately, unavailable on that day. As a result, the patient became anxious and wished to cancel his appointment with an English speaking physician. Only when he learnt that there was an interpreter available, did he calm down and agree to see the doctor on that day.

Contact: Dr. Forsythe-Yorke & Kasia Urbaniak, HSE Norwich kasia.urbaniak@hse.gsi.gov.uk

1.1 Challenges and issues

Case Study 3 – Written communication

The patient is in her 30s and has been with her husband for more than 10 years and has 3 children. She has lived here for 5 years and has 5 years leave to remain - refugee status. Patient speaks some English but cannot really read or write in her own language or English. She comes from a conservative Muslim background. I was surprised when in an advice session she pulled out an envelope from her GP. This contained a prescription with a scrawled handwritten message on the back. Basically stated a swab had tested positive for Chlamydia and she needed to take the prescription once she finished the course of medicine she was on. I honestly thought that there was a mistake but was told by the receptionist that it was correct.

The interpreter and myself then had to try and explain to the patient about the illness using the internet. Obvious implications about her partner etc. Patient stated that she had shown the message to her son who is 10 but he didn't know what it meant. Patient was VERY upset and to try and remedy the situation I arranged an appointment with the GP and an interpreter provided by us. In addition to all the obvious I wondered if the GP would have bothered to talk to patient about her husband being treated.

Contact: Liz Wood, Suffolk Refugee Support Forum lwood@srsf.org.uk

There are a variety of issues caused by the lack of provision of interpreting: poorer health outcomes and vulnerability of patients, poor communication and associated risks for practitioners, inefficient service provision and increased costs for service providers, difficulties disseminating health information, widening health inequalities for commissioners and increasing marginalisation for communities. The following table identifies some of the specific issues and gives sources to explore the details more fully.



Table 1

Issues caused by inadequate language support

Patients

- Use of family, particularly children places stresses upon family dynamics and unacceptable stresses on children under 18
- Unable to make appointments with services (Alexander et al., 2004)
- Unable to access positive health outcomes which leads to lower health status (Dubard and Gizlice 2008; Bischoff 2010)
- Miss out on opportunities to access preventive, diagnostic and therapeutic services delivered through primary care, including vaccination screening services (HPA, 2010)
- Those most in need are less able to access services (Alexander et al., 2004)
- Receive inappropriate medication or do not understand medication requirements (Andrulis et al., 2002)
- Loss of English language proficiency with age (Alexander et al., 2004), crisis or mental health need
- Prefer to use family and friends because they are more culturally aware and sensitive (BMA, 2004)
- Lack of confidence that interpreters provided by services are reliable (Alexander et al., 2004)
- Psychological support received is limited (Gerrish et al., 2004) or less effective (Farooq and Fear, 2003)
- Feel dissatisfied with services and care received (Weech-Maldonado et al., 2003)
- More serious adverse outcomes from medical errors (Divi et al., 2007)
- Poorer understanding of their medical diagnosis and treatment (Flores et al., 2005).
- Women and children subject to abuse and trafficking are not identified or enabled to speak for themselves (Stallabrass, 2009)

Practitioners

- Misunderstandings in 20% of GP consultations (Roberts et al., 2005)
- Late presentation of more ill patients (Johnson, 2007)
- Difficulty in obtaining accurate patient histories, joint patient-provider decision-making on treatment, and supporting self care (Wisnivesky et al., 2009)
- Poor adherence to medication regimens
- Use of family and friends as interpreters compromises confidentiality and reliability
- Error in diagnosis may result in the provision of inappropriate treatment and care (ISCRE, 2007)
- Multiple presentations of the same issue take up time and resources (ISCRE, 2007)
- Increasing dissatisfaction in service provided (Hampers, 2002)
- Lack of training and support to overcome language barriers (Gerrish et al., 2004)
- Lack of understanding of the access, development and use of translated information
- Poor skills in identifying appropriate interpreting and in working with interpreters (Johnson, 2007)

Table 1

Issues caused by inadequate language support

Providers

- Poor standards of care (ISCRE, 2007)
- Missed appointments (Brach et al., 2005)
- Inappropriate use of services by patients creating higher consultation and treatment costs (Hampers et al., 2002; Smedly, 2003)
- Higher rates of communication errors leading to increased likelihood of clinical errors (Flores et al., 2005)
- Governance and legal risks of misdiagnosis and unsafe treatment (Bischoff and Denhaerynck, 2010)
- Legal risks of failing to provide interpreting
- High costs of providing unsupported ad hoc interpreting and translation
- Language difficulties lead to negative judgments and stereotyping and patients are seen as difficult (Roberts et al., 2005)
- Language issues seen as the greatest barrier to health care (BMA, 2004)

Public Health

- Less health promotion advice given on contact with a health professional (Ngo-Metzger et al., 2007)
- Minimal access to relevant information for health protection [e.g. malaria, TB, smoking, obesity]
- Difficulties in disseminating essential information [e.g. swine flu]
- Increasing health inequalities (Messias et al., 2009)
- Less use of preventive care (Ku and Flores, 2005),
- Reduced attendance at routine check-ups (Pearson et al., 2008)
- Less effective health promotion campaigns

Commissioners

- Poor health outcomes (Anderson et al., 2003)
- Inadequate data collection to identify ethnicity and language needs
- Lack of commissioning without robust ethnicity data
- Unequal access to services (Bischoff and Denhaerynck, 2010)
- Non compliance with legal and policy directives
- Increased costs of uncontrolled ad hoc interpreting use
- Lack of skills, capacity and training for staff to work cross culturally and with interpreters
- Limited interpreting and language capacity for some languages and in new migrant communities
- Without ethnicity breakdown there is no way of understanding needs, trends for disease or illness to then be able to inform commissioning of services
- Confusion over language/interpreting issues were consistently identified as barriers to access, for migrants as well as for organisations commissioning and providing services. (HPA2010)

Communities

- Increasing marginalisation (ISCRE, 2007)
- Greater dependence upon voluntary sector services (ISCRE, 2007)
- Greater requirement of support from small and marginalised communities
- Reliance upon a small number of interpreters can reduce trust or create fear regarding confidentiality
- Some interpreters can act as gatekeepers to services minimising or complicating access

1.2 Legislation and key policy drivers

Legislation

The Equality Act 2010

The Equality Act became law in October 2010. It replaces previous legislation (such as the Race Relations Act 1976 and the Disability Discrimination Act 1995) and ensures consistency in what you need to do to make your workplace a fair environment and to comply with the law. The requirement to be pro-active in preventing discrimination is emphasised.

“I sign in Farsi and no-one here can do that. In London I started to learn BSL but there are no classes for me here. I have to communicate through writing things down in Farsi for an interpreter to translate for the doctor”

Iranian service user (Stallabrass, 2005)

The Equality Act covers the same groups that were protected by existing equality legislation – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership and pregnancy and maternity – but extends some protections to groups not previously covered, and also strengthens particular aspects of equality law.

The Disability Discrimination Act 1995 and 2005

All service providers are obliged to provide communication support to people whose preferred language is British Sign Language.

Race Relations (Amendment) Act 2000:

Amends and strengthens the **Race Relations Act (1976)** through which it was made unlawful to discriminate on racial grounds either directly or indirectly. Failure to provide language services where there is a known language need could be construed as indirect discrimination. The Amendment Act places a further enforceable duty on all public authorities, including health authorities, trusts and primary care trusts, to promote equal opportunities and good race relations and to address racial discrimination by their employees (Section 71). Failing to provide

interpreting facilities in relation to service provision, when it is known that there is a language barrier, could be construed as unlawful racial discrimination.

Human Rights Act 1998

Failure to provide language support breaches some of the articles of the **1950 European Convention on Human Rights** explicitly in relation to access to an interpreter when arrested by police or appearing in court, and implicitly, for example the refusal of treatment, of registration with a service, or lack of information because of inadequate language support facilities can be interpreted as a breach of Article 25 *The right to the highest attainable standard of health* (Potts, 2008).

NHS and Community Care Act 1990

Places an explicit responsibility upon commissioning agencies and purchasers of health and social services to carry out a needs assessment and to consult with the local population in order to determine local needs. Gaps and unmet needs in service provision should lead to specific service development.

United Nations Convention of the Rights of the Child 1989

Children have the right to learn and use the language and customs of their families (Article 30); All organisations concerned with children should work towards what is best for each child (Article 3); Children have the right to say what they think should happen when adults are making decisions that affect them, and to have their opinions taken into account (Article 12). In order to meet these requirements language support is essential if the child has limited English proficiency.

Mental Health Act 1983

Explicitly recommends the use of interpreters in the explanatory memoranda and codes of practice.

Key policy drivers

Equity and Excellence: Liberating the NHS 2010

The focus on patient experience, service effectiveness and patient safety, and the underpinning values of equity and fairness require commissioners to consider how they will engage with services users and make service user involvement meaningful. The document makes explicit reference to providing assistance to those who have difficulty accessing information (p15), being responsive to services users' needs lifestyles and aspirations (p8), and supporting people who have a lack of capacity to make choices (p19). Language support will be key to achieving these aims.

Inclusion Health: improving primary care for socially excluded people 2010

The four strategic aims utilised in addressing the complex health needs of some of the most marginalised groups includes: people shaping services, promoting healthy lives, continuously improving quality, and locally led change. Language support is identified as a basic requirement to address access barriers and improve outcome measures.

The Marmot Review 2010

Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010 examined persisting inequalities in health with a social determinants approach. The report identifies a social gradient in health where the lower a person's social position, the worse his or her health. Action focusing on social inequalities and across all the social determinants of health was identified as a key policy objective. The report advocates cross sector partnerships and effective local delivery systems focused on health equity in all policies; participatory decision-making at local level and empowering individuals and local communities.

Towards the Best Together. A Clinical Vision for our NHS, now and for the next decade. NHS East of England 2009

Towards the best, together is the vision for the NHS in the East of England, setting out how health and healthcare services should be improved, now and over the next decade. A

theme highlighted in the document is the lack of information and understanding to enable choice: whether it is knowing which service is most appropriate; choice of hospital; registering with a GP; or access to an NHS dentist. Whilst this applies to all groups of the population, it is particularly relevant to those with learning disabilities and mental health problems and those with limited proficiency in English. The document states: *"The failure of the NHS to provide choice to patients is unacceptable and it can stand in the way of effective and timely treatment"* (p6).

Mrs K has often attended hospital to act as an interpreter for her friend who was admitted to hospital as an emergency yet: 'they don't speak English, but I'm trying to help them. My English is no good. I'm using dictionary all the time, especially for doctors – they use words we don't use in normal life'

Polish woman – age 28 (SCC ACL, 2010)

Guidance on Developing Local Communication Support Services and Strategies 2004

Guidance and recommendations were made to commissioners for the design and delivery of communication support services following research into the use of communication support at a number of NHS sites. Whilst these recommendations are offered as guidance and are not mandatory, when considered in relation to the legislative framework it is clear that a coherent language support strategy is a minimum requirement.

Children Act 2004 and Every Child Matters 2003

Lord Laming's original report into the death of Victoria Climbié (Laming, 2003) ushered in major reforms to children's services through the Every Child Matters agenda, culminating in the Children Act 2004. Language support provision is essential in increasing the focus on supporting families and carers and on the protection of the safety and welfare of children.

Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England 2003

Communication support strategies are clearly fundamental to the achievement of the three key objectives for reforming mental health services identified in this report, including the development of cultural capability in mental health services.

Inquiry into the Death of David ‘Rocky’ Bennett 2003

(Norfolk, Suffolk and Cambridgeshire Strategic Health Authority, 2003). One of the key findings of the Inquiry into the death of this

African–Caribbean man was that institutional racism does exist in the NHS in general and in mental health services specifically. Failure to put in place the structures and processes required to provide appropriate language support can be considered to be institutional racism if it means that an organisation cannot provide adequate services to all its actual and potential patients (Bennett and Keating, 2009).

Acheson Report 1998

Particularly cited the language barrier as a factor in what appeared to be a differential quality of care for patients from minority ethnic groups.

Case Study 4 – Patient understanding of illness

The patient is from Iraq and is 27 years old. He came here in 2002 fleeing the war. He has Perthes disease which is a bone problem affecting the hip joints. If children have it in this country it is normally diagnosed pretty quickly whilst they are young. Treatment is given so that it only becomes a problem in much later life. This did not happen to the patient as he was with his family in the back of a lorry going over the mountains of Northern Iraq fleeing Saddam Hussain. He believed that his illness stemmed from this time because of the journey.

As he gets older the pain has got a lot worse and the patient is now unable to work. The hospital is reluctant to give him a hip replacement because of his age. He claimed ESA but was turned down after a medical at ATOS - the company who do the medical checks for people who say they are too ill to work. The form was then filled in by SRSF but in all fairness if the patient does not know what his illness is then how can a person filling in the form on his behalf be able to give the correct information. The patient then got more and more depressed as SRSF had to appeal the outcome. The GP at this stage did write a letter to the Benefits Agency at Bury St Edmunds but it was not sent to the right department. The GP did give a copy to the patient who by chance showed it to me. I was then prepared for the tribunal hearing which took place in June some 18 months after the original form was filled in. The GP on the panel took one look at my and the GP's letters and awarded ESA.

With an interpreter I had to explain to the patient what Perthes disease was using pictures off the internet. If the patient had understood or even known what his illness entailed then time and money would have been saved for everyone. A clear letter written by the GP some 20 months earlier would have made all the difference. There is a big difference between saying “my hips are painful” and stating “I have Perthes disease”.

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1.3 Meeting the QIPP agenda and the financial case for change

By taking action to ensure communication support for a wide range of different members of the community commissioners can contribute significantly to the Quality, Innovation, Productivity and Prevention agenda for their area.

Table 2

Meeting the QIPP agenda

Quality

- Provision of adequate and appropriate language support services on first and subsequent contact improves the quality of interaction for both the patient and the practitioner. This improves concordance with treatment protocols, increases understanding around service provision and referral processes and helps to ensure that appointments made are attended.
- Tackling health inequality through improved language support for those migrants who are among some of the most vulnerable people with the poorest access to primary care, can improve health outcomes and ensure 'inclusive practice' for all (Department of Health 2010).

Innovation

- A range of communication support strategies within a comprehensive commissioning framework reduces the dependence upon simply finding interpreting provision and increases the flexibility and accessibility of services: for example bilingual staff including reception and admin staff; link workers; services joining together to provide surgeries in a specific language and in-house interpreters.
- Innovation and development of local services to provide jobs for local people can reduce the costs of bringing in trained interpreters from outside the area, enhance a community's economic status and educational opportunities, and improve social cohesion.

Prevention

- Improved availability of translated information enables better understanding of lifestyle issues (e.g. smoking and obesity) and knowledge of the availability and purpose of services. Language support strategies such can increase the use of preventative services and early intervention.
- Dissemination of urgent public information can be assisted where language support strategies and community are already established [e.g. pandemic flu situation and migrant workers].
- The distress and disruption caused to family, and particularly children, will be prevented thus reducing the need for additional services and support in education and children's services and enhancing mechanisms to ensure child protection and welfare [e.g. child carers, children missing from school].
- The risk to patient safety, even to the point of loss of life, can be lessened.

Productivity

- Appropriate, sufficient and flexible communication support will prevent inappropriate use of services as a result of failure to identify needs, flawed diagnosis, missed appointments or over-use of crisis or intensive services as a result of late presentation of needs. Resources for individual agencies would be used more effectively and improve the cost benefit ratio.
- The risk of legal costs resulting from poor communication support (e.g. negligence) would be reduced.



The financial case for change

There are few studies which adequately describe the costs incurred for failing to provide language support (Bischoff and Denhaerynck 2010), and it was not possible to identify any current cost-benefit analysis for the purpose of these guidelines. Assumptions informing the debate include evidence that poor care results in greater costs in the long term, and that costs incurred by providing interpreting are not beneficial or cost effective or result in increased health care consumption thus increasing overall costs.

The use of interpreters has been shown to improve quality of care (Morales et al., 2006; Karliner et al., 2007) and reduce health inequalities (Karliner et al., 2006; Jacobs et al., 2004; Flores, 2005). Access to professional interpreters improves outcomes with better chronic disease management, reduced inpatient episodes and a consequent reduction in health care costs (Graham et al., 2008; Chan et al., 2008; Fernandez et al., 2010). Jacobs et al., (2004) argue that patients using interpreter services incur higher costs with greater utilization of health care (prescriptions, screening, appointments) but that this is offset by a lower number of ineffective referrals, improved illness prevention and reduced hospital admissions. They conclude that providing interpreting services *“is a financially viable method for enhancing delivery of health care to patients with limited English proficiency”* (p869).

More longitudinal research and detailed cost benefit analysis is required in this area to further explore these arguments. However, experience of local service providers has identified areas of cost saving when using interpreting services. And the use of bilingual staff and workers would suggest

further cost savings, though again there is no empirical evidence to support this.

Cost saving - One off ad hoc interpreting, ‘as and when’ most needed, costs the health service provider more per unit than the cost of the same assignment completed as part of a comprehensive service provision through a service level agreement. (Stallabrass, 2005)

Cost saving - The deployment of interpreters locally reduces travel costs and time, which can form the major part of the costs to the health service provider of using face to face interpreting (Gidney, 2010)

Cost saving - Efficient use of interpreting services by trained health staff able to discern the most appropriate type of interpreting from a range of options costs less to the health service provider than untrained use of services (Bischoff and Denhaerynck, 2010).

“When I ask for an interpreter at the hospital I am told that I can’t have one because it is too expensive. But I don’t understand what the doctor is saying to me so I can’t see how that is saving costs because I have come here and ask you to contact the doctor to see what he said and make another appointment. Why don’t they just listen when I say I need an interpreter.”

Polish service user (Stallabrass, 2005)

Cost saving - Patients with limited English proficiency, without interpretation, incur higher charges and longer stays in hospital than other patients, increasing the cost of patient care for NHS Trusts (Jacobs et al., 2004).

Cost saving - Patients with limited English proficiency, without interpreting access, have a higher incidence of adverse events requiring emergency care, increasing the cost of patient care to NHS Trusts (Divi et al., 2007).

Cost saving - "Did Not Attend" costs currently cost the NHS over £400 million per annum. Language support reduces these costs (Bischoff and Denhaerynck, 2010).

Case Study 5 - QIPP Agenda and the INTRAN Partnership

INTRAN (the Partnership) creates solutions needed by public service providers and members of the population with limited English proficiency or who are deaf. The Partnership has grown to 37 partners across the Eastern Region and in 2009/10 recorded nearly 32,000 bookings for interpreters (52% of which are for the NHS alone).

Quality: Barriers to understanding between clinical and support staff and patients are minimised through the use of qualified interpreters, which leads to safe and high quality care. Services are accessible 24/7. The Partnership has a robust quality assurance strategy, monitoring service delivery and satisfaction closely against contractual expectations.

Innovation: Joint funding of a central development team, with specialist knowledge, and the creation of a cross-sector network of champions, have enabled each individual partner to benefit from major economies of scale and of learning. The Partnership has developed a wide range of innovative enablers for its partners to help them promote “reasonable adjustments” to its staff and users. The Partnership continually researches new developments to benefit its partners

Productivity: A cost effective service is delivered by tendering for a service which secures a pool of local interpreters and minimises travel costs. Paying the interpreters a fair rate that is affordable by the public sector means that qualified interpreters work for INTRAN partners for less than if they were freelancing. The Partnership works with its partners to help break down barriers through the active implementation of communication and education strategies, focusing on “how to do things more effectively”. By utilising the Partnership’s statistical analyses and local intelligence, NHS Norfolk identified the potential for considerable savings and quality improvements in healthcare for Thetford residents with limited English proficiency and developed regular clinics with an interpreter.

Prevention: The role of the INTRAN champion in provider organisations is crucial in ensuring that people understand how NHS services work and are able to access PSI&T services when necessary. Empowering staff to use the Partnership’s services at the first point of contact prevents repeat visits or conditions worsening so that patients need more intensive services.

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SECTION 2:

Assessing Local and Priorities

2. Your Needs

Commissioners need to be proactive in the identification of communication needs rather than simply reactive to who walks through the door.

There is general recognition that migration statistics are inadequate at national and particularly at local level. The commonest cited barrier to any development of a coherent approach to communication support is the lack of clear data regarding ethnicity and language needs for the population. There is no one agreed method or source of data for informing a communications support strategy.

However, poor quality ethnicity data should not be allowed to prevent its use in addressing health inequalities and disparities (Aspinall and Jacobson 2007). There is a wide range of data available and although each source has its limitations, taken together and enhanced with other local data it does provide a useful picture on which to base service development.

2.1 Sources of information data available

Census data

National Census

The Census is a 10 yearly national census providing a comprehensive snapshot of ethnicity and migration information. However, it does not collect information on languages and as it is only taken once every ten years (last in 2001) it is simply a snapshot in time and does not reflect new migration or changing patterns of migration. Nor does it reflect the needs of those with insecure immigration status who are unable or unwilling to contribute. The groupings in relation to ethnicity do not necessarily identify accurate ethnicity data. In the census (and many other

surveys), respondents sometimes have difficulty in identifying the appropriate ethnic group from the limited list of categories on offer.

Pupil Level Annual School Census (PLASC)

This annual census of all children in grant maintained schools in the UK includes address, age, ethnicity (not nationality) and mother tongue. This does not capture the children arriving and leaving within the year or pupils as they leave the system but does give an indication of the numbers of languages in an area.

Surveys

International Passenger Survey (IPS)

This survey is important to the collection of national data with over a quarter of a million people interviewed every year and involves a voluntary face to face interview of passengers arriving and leaving the UK.

However, there are limitations to the use of this data particularly at local level. Not all ports of entry are covered and the data is aggregated to produce national migration estimates. It also makes adjustments to take account of the fact that the survey is not conducted at night. The sample size is very small compared to all passenger movements (0.2%) and only around 1% of those sampled are migrants thus it is difficult to draw conclusions particularly for the local level (ICOCO 2007) with the result that there is a tendency to extrapolate figures to give estimates of too many in-migrants into London, and centres of higher concentrations of migrants and too few into some of the other regions. A further issue is that the IPS measures people's intentions, which may or may not accord with final actions, migrants plans are often uncertain and when asked to give a destination respondents tend to give the name of the nearest big city and not their actual destination if known.

Labour Force Survey (LFS)

The Labour Force Survey is a quarterly sample survey of 60,000 households living at private addresses in Great Britain which provides information on the UK labour market that can then be used to develop, manage, evaluate and report on labour market policies. Information on respondents' personal circumstances and their

labour market status is collected during a period of one week or four weeks (depending on the topic). It does include questions on nationality, ethnicity, current and last address, and date of arrival in the UK. Its main drawback is the sample size and the sampling methodology means that data cannot be extrapolated to be representative of any given area.

The Annual Population Survey (APS)

The Office for National Statistics (ONS) has developed annual local area datasets called the Annual Population Survey (APS) household datasets. They allow production of family and household labour market statistics at local level and for small sub-groups of the population across the UK, between the ten-yearly censuses. The APS combines the Labour Force Survey (LFS) and the English, Welsh and Scottish Labour Force Survey boosts. APS household datasets cover the calendar period of January to December for individual years from 2004. There are approximately 170,000 households and 360,000 persons per dataset. Additionally, the WRS scheme will cease completely from May 2011. Thus it is able to provide more robust local area labour market estimates than from the main LFS. Whilst one of the key strengths of the APS is that socio-economic data can be analysed in a wide range of ways at sub-regional level, analysis can become restricted by small sample size and reliability issues, which can have a considerable impact at local area level, and is one of the main limitations of the APS estimates (ONS, 2010).

Administrative data

Administrative data is available as Local Area Migration Indicators on the Office for National Statistics website - www.statistics.gov.uk and allows comparisons to be undertaken within local authority areas.

National Insurance Number (NINo) registration data

These statistics from the Department of Work and Pensions show the number of foreign nationals applying for National Insurance

Numbers, broken down by their country of origin and by local authority of UK residence. It cites the nationality of adults from abroad who have been granted a National Insurance number to allow them to work in Britain. Because a job offer is required in order to apply for a NINo, migrants who do not choose to register for work, and children are not included. Also the local authority coding in this dataset is likely to indicate the area of first settlement in the UK rather than the point of entry to the country. Another major disadvantage is that there is no available corresponding measure of outflow, and thus it is not known if the registered person has moved out of the area.

Worker Registration Scheme (WRS)

The WRS was introduced to regulate access to the labour market of the nationals of the A8 accession countries that joined the EU in 2004. The data provides numbers of A8 nationals who have applied to register to work in the UK (but not self employed). Those who leave employment are not required to de-register from the WRS, so some applicants since May 2004 are likely to have already left the UK. The data is based upon first registration so does not account for moves and changes in occupation. Whilst the scheme may be mandatory, the need to sign up within the first 30 days of starting work and the £90 fee does present a barrier to those in low skilled low paid occupations, so some don't register making the data flawed.

"I went to the doctor to register but they wouldn't use the form I had filled in with your support worker. They gave me more forms, some of them looked the same as the ones you gave me. I didn't understand what I needed to do so I left without registering"

International Student (Stallabrass, 2005)

General Practice 'Flag 4' registrations

A person registering with a GP whose previous address is outside the UK is flagged ('Flag 4') and this information can be used to identify new migration into an area. A separate flag can be

used to identify migrants returning from overseas and re-registering with the NHS. Flag 4 counts are useful to identify persons who arrive to stay for periods of 3 months to under one year, however many people do not register if here for a short time and may delay registering with a GP until they have a medical need. Also the flag is lost when a patient moves within the UK. Currently GPs are incentivised to collect the ethnicity of patients newly registering with them under the Quality and Outcomes Framework.

Higher Education Statistics Agency (HESA)

HESA maintains a register of all students in the UK, recording the total number of international students and all students' arrival and departures. However, until recently this was based upon institution address and not domicile. Students form an important part of migration in the UK

Electoral Register (ER)

A form is sent annually to every household, requesting information regarding household composition in order to identify and register those who are eligible to vote. Flags can now be allocated to the names of those entitled to vote, in theory enabling data to be kept on non voters. However, this register is not specifically designed to track migration and data is incomplete, particularly where temporary residents and others who do not believe they are able to vote do not respond.

Asylum Statistics

The UK Border Agency publishes figures to a local level regarding asylum support accommodation and subsistence payments, Initial Accommodation statistics and 'Section 4' applicants (refused asylum seekers applying for support until removal can be arranged, or whilst fresh claims are pending).

Third Sector and Provider Activity Data

Third sector translation and interpreting agencies (telephone and face to face) are often approached for statistics regarding languages used and number of episodes of interpreting. Whilst this is certainly useful information it does not help to identify languages that are not requested and is dependent upon services being supportive and pro-active in their use of interpreting facilities. Commissioners need to look

beyond the statistics to the rich data language support agencies and other BME Voluntary and Community Sector agencies hold. There are a whole range of agencies working with communities from small community organisations, to outreach services, Race Equality Councils, Racial Harassment initiatives etc. They may choose to collect ethnicity data and whilst coding of ethnicity may vary they are working at the front line with communities and are a rich source of information regarding service needs and gaps, barriers to positive health outcomes, experiences of patients, and issues and concerns within communities.

Service providers in public sector agencies will also have nuanced information regarding BME communities. The monitoring of victims of Hate Crime records ethnicity, nationality and language as well as the sorts of issues and circumstances faced by BME communities. Police forces have growing data concerning BME community issues and are mapping communities through community-led policing. Partnerships amongst public sector agencies are an important source of information.

Other NHS Ethnicity Data

Live Births by Country of Origin

This data records births to mothers who were born outside the UK, and as such is retrospective in nature, thus current migration will be reflected in future birth statistics.

Hospital Episode Statistics (HES)

Acute hospitals are directed by DH to collect the ethnicity of in-patients so every time a patient is admitted to inpatient services, their ethnicity is recorded. However, ethnicity coding is not always consistent, and a patient's recorded ethnicity may change from one admission to the next.

General Practice Data

The Annual GP Patient Survey is commissioned by the Department of Health and run by the NHS Information Centre. These large sample surveys are a rich source of data and include analyses by ethnicity. GPs are also required to collect information regarding the ethnicity and language of all their patients under the Direct Enhanced Service. In this instance subset categories



detailed in Department of Health ethnic data collection guidance can be used to support local understanding.

Mental Health Minimum Dataset (MHMDs)

The dataset contains record level data about the care of adults and older people using secondary mental health services. The dataset records daily clinical and legal interventions for every patient and includes ethnicity data (Care Quality Commission, 2010). The lack of national reporting and feedback to Trusts has probably had an impact on the overall quality of the data collected. There are still concerns with the coverage, completeness and quality of the data.

Health Protection Agency (HPA)

Data on topics such as healthcare associated infections, Infectious Diseases (HPA, 2009)

National Treatment Agency (NTA)

NHS data on drug and substance misuse

Healthcare Commission reports

These reports provide robust evidence regarding how BME people access and experience the NHS. Each year, the Commission undertakes a series of patient-focused surveys collecting data on the age, gender and ethnicity of patients and looking at different aspects of health.

Public Health Observatories (PHOs)

PHOs operate in each Government Office region and collect and analyse a range of health-related data, including ethnicity and other equality data. Each PHO specialises in particular themes, with London PHO leading on BME health and data. The London PHO, in partnership with the NHS Information Centre and the Association of PHOs (APHO) has developed a national collation of a wide range of measures that can be used at a local level to track progress against local priorities for action on health inequalities, some related to ethnicity.

University of Nottingham, School of Community Health Services

Provides a Q Research database derived from the anonymised health records of over nine million patients in the 550 or so GP practices using the EMIS clinical computer system; subject to the quality of ethnicity data from GP practices.

(For a detailed review of data sources see HPA (2010)

<http://www.migranthealthse.co.uk/sites/default/files/report/Migrant%20Health%20Report.pdf>)

Case Study 6 – Data collection

Suffolk County Council (EELGA 2010)

NINo registrations, Worker Registration Scheme data and school census data were used to identify the top 10 nationalities in Suffolk on which to base the sample for the survey. Public Perspectives then undertook 400 quantitative face-to-face interviews with migrants who had been in the county for less than 3 years, plus a further 12 in-depth qualitative interviews across the 7 districts in Suffolk.

The main report summarises the findings from all aspects of the research. Each question in the quantitative survey has been analysed against a set of key demographic and conceptual variables. Commentary is then provided where significant or meaningful findings and differences are identified.

- A small majority of respondents (52%) said that it was easy to access local services. One factor which may affect the ease of accessing local services is the ability to speak English well, with 8% of those who say they can speak English well finding it difficult to access services compared to 23% of those who say they cannot speak English well.
- The main barriers to accessing services are language and not knowing what services are available. Where barriers to accessing local services exist, the most common is language (cited by 26%).
- Suffolk needs to plan and deliver services for migrants with children. 25% of migrants have children. Services such as children's centres, health services and schools need to be future-proofed for their potential impact. A significant proportion of the children (66%) are currently under 5.
- Challenge the accessibility of services – the main factor which eases access to local services is the ability to speak English well. Suffolk needs to test if it is providing information about services in appropriate languages. There is a need to encourage service providers to consult migrants when planning service delivery.
- Suffolk needs to manage the relationship between health services and the migrant population – there is an awareness of and understanding of the health service, but there are instances of misuse, which places a burden on the health service. Need to examine what measures can be put in place to manage their expectations about where and when to access appropriate health services.
- There is scope to improve ESOL provision – only 45% accessing ESOL are satisfied. In addition, poor English language levels are one of the most significant barriers to accessing services. Suffolk is developing the programmes it offers to improve access to and the quality of its ESOL provision as this may positively impact on access to services.

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2.2 Using the data

There have been huge improvements in public health data collection for specific geographical areas and there are general sources of information that taken together can provide a general picture. Existing data can provide sufficient information on which to base a communication support strategy but effective use and interpretation of such data requires specific actions which should be incorporated into any communication support strategy.

Collecting data

Insufficient ethnicity data is taken from within services and this issue should be addressed within a comprehensive communication support strategy, with standards, protocols and methods for coding ethnicity effectively. There is clear (Department of Health (2005) *A practical guide to ethnic monitoring in the NHS and social care*) guidance to the NHS on the categories and codes to use when monitoring the ethnicity, religion, and language proficiency of patients. However, there remains some discussion of the usefulness of this in relation to language as ethnicity/country of birth is not a proxy for language and there are many dialects within countries/ethnic groups. Also, as noted in the DRE framework: *“Even where services are based on high quality needs assessment, the assessment should be re-examined regularly to discover whether changes in the local population require a change in service provisions. This is an issue that particularly affects BME communities”* (3.105).

Language proficiency

It has to be recognised that ethnicity data, including population size and the language spoken does not give information regarding language proficiency. Assessment of the fluency of spoken and written English cannot be effectively determined from ethnicity data in a way meaningful to determining the needs of the population. A larger established population might have large numbers of people with limited written or spoken English but might also have a number of people who could become sufficiently trained as interpreters, bilingual support workers or as staff members. The smaller and less established the population, the less capacity within the community and the greater the dependence upon services to provide formal interpreting.

“Most clients cannot read the appointment letter and are not aware of their appointments. Some clients have consented to have their contact numbers given to our interpreters in order to be reminded of their appointments. We offer this free extra service in order to reduce the rate of non attendance at their appointments. Receiving a telephone call from their interpreters helps immensely and clients feel safe to attend their appointment knowing someone will be there for them”

(Mason, 2010)

Data can be collected regarding not only first language but also proficiency in English. There are a number of ways to do this: self assessment of language proficiency (Karliner et al., 2008); preferred language spoken (Roat, 2005); and language spoken at home (Glimpse, 2009). However, it must be remembered that levels of fluency also change with need: using English as your second language may be acceptable when you need only to communicate about something simple but with mental health issues (Farooq and Fear, 2003), crisis or severe illness (Ayanian et al., 2005) and increasing age (Alexander et al., 2004) fluency can be lost.

The data collected about languages also provides important information about issues of arrivals in the area, perhaps relating to specific health needs, and identifying specific areas of exclusion. A coherent language support strategy can make proper and informed use of such information to guide planning.

Partnership working

Partnership working is essential to not only identify ethnic groups but to link this with patterns of need and offset some of the various limitations inherent in particular data sources (Department of Health, 2010). The Joint Strategic Needs Assessment needs to ensure ethnicity, language and communication issues are incorporated. Local Strategic Partnership involvement is essential in identifying new and emerging issues.

Local Government research and intelligence services are critical to the collation and interpretation of the varieties of data available.

Partnership working with the various BME groups, voluntary and third sector services, employers and other service providers is essential. However, short-term migrants, who arrive here to seek work and are highly mobile, are unlikely to be counted as part of the resident population and appear in any formal statistics. Services on the ground, however, will have contact with this group and understand the needs and impacts and have links into communities.

It has to be remembered that the giving of ethnic data is voluntary and ethnic monitoring still arouses suspicion for some people who see it as a means of further discriminating against them. The reasons for ethnic monitoring should, be clear and analyses and decision making should be transparent. Minority ethnic communities and staff need to be involved in gathering and analysing the data and developing an understanding of its relevance to the issues at hand and in making decisions. Useful guidance may be found in the ODPM's 2004 publication *"Ethnicity monitoring involvement - guidance for partnerships on monitoring involvement"*

Service user comments

Information regarding language support needs for different services can easily be gathered from service users, who often have clear ideas of what will help and suggestions for service improvement (see ISCRE, 2007).

"There is a big Kurdish community here now so why can't the GPs provide a Kurdish clinic with an interpreter there for those who need help with the language and a health support worker to help with the forms. Better still my daughter could work as the receptionist as her English is very good and she could help people make appointments"

Kurdish service user (Stallabrass, 2005)

Surveys and audits

A proper survey of the linguistic communities living in the area served, and their levels of fluency could be conducted to assess languages used, levels of proficiency in English and written proficiency in their first language, gender and age variations, the size of minority language communities, and barriers or ease of access to services. A concurrent audit of service providers will also determine the capacity for language support through bilingual staff, the level of access to services by people with limited proficiency in English and BME communities and experiences of practitioners. Comparisons can then be made to identify whether the current usage of language support accurately reflects the needs of the local population and whether more creative approaches to staffing and service provision are required to move away from dependence upon translation and interpreting as the only language support strategy.

Community Engagement

Local people are often employed as contracted interpreters or in bilingual link worker posts, thus language support could advance opportunities for community engagement for example to set up a steering group of interested individuals to monitor the provision of language support, presenting further occasions for joint working and mutually beneficial communication. Important information may be held by interpreters, bilingual professionals and third sector partner agencies, who are rarely asked to inform colleagues about cultural world views, ideas on health and illness, etc. Whilst recognising that it is always a danger to treat one individual as somehow being a "cultural expert"; given the homogeneity of cultures within any given national or societal group, this would appear to be a rather wasted potential resource that might be better used to help to shape services.

Case Study 7 – Community Engagement

NHS Peterborough ran a 'TB or not TB' awareness project targeting the Pakistani community. We tapped into existing groups and contacts such as children's' centres within the community, women's groups, Imams via Mosques, English Classes and Senior Citizen groups. We consulted the community to find out their knowledge base about TB and what they would like to know and understand.

We used local demographic data, knowledge and experience of our staff having worked in the targeted geographic area and existing networks to enable easy engagement of the communities.

The data supplied from the Health Protection Agency showed high prevalence of TB in the Pakistani community but also some cases in East European communities. Therefore we decided from knowledge we had to target the Pakistani community using bilingual staff from our team to deliver level 1 training in Punjabi to women and senior citizens in particular which was well received. We used pictorial and easy translated information for the TB Alert which worked well. Initial questionnaires were also short and easy as were evaluation forms. Initial master copies of these were translated into Urdu. In addition a couple of sessions were run in Punjabi using the language skills of our staff.

- Engagement and true consultation with the communities is an essential first step
- Communities often give us the solutions to problems if we only care to talk and listen to them

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SECTION 3:

Identifying Suitable Service Solutions

3. The overall aim of any strategy should be to create a more joined up approach which seeks to coordinate the support provided by a wide range of partner providers and community networks and enable the identification of gaps in and solutions for language support provision.

Being able to speak to patients in their own language is a fundamental pre-requisite to professional, clinical practice. The preference for patient and practitioner would be to always provide a patient with limited English proficiency with a practitioner who speaks that patient's own language (McPake and Johnstone, 2002). There is now a growing wealth of research to evidence the benefits of language concordance between patients and providers (i.e. both speak the patient's primary language well) (Ulmer et al., 2009).

3.1 Models of language support

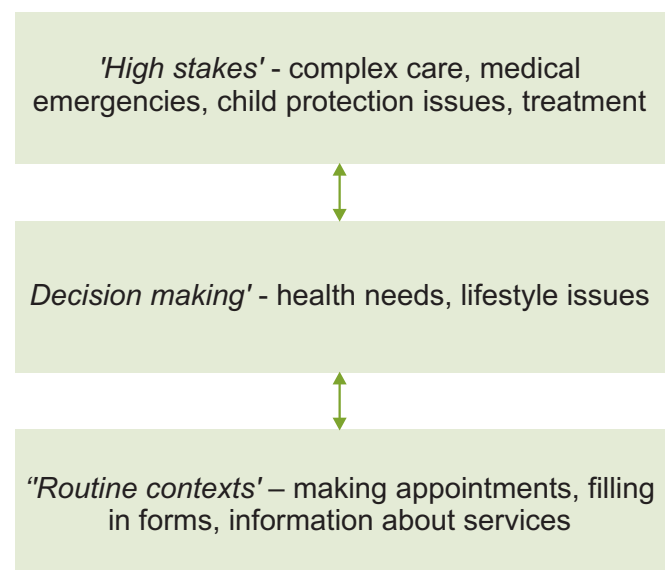
Research finds that where providers and patients are language discordant, some of the disadvantages can be mitigated by having trained interpreters. However not all the disadvantages can be ameliorated in this way and the presence of an interpreter may actually interfere with the consultation and communication (Ngo-Metzger et al., 2007). Whilst it cannot be possible or practicable to always provide a practitioner who speaks the patient's preferred language, this is the goal to which we should aspire.

A coherent strategy with regard to language support should therefore address the provision of language support in many ways, including: bilingual staff in a wide range of roles including clinicians where possible; cultural diversity training; bilingual advocacy, link and support workers; community volunteers; support for ESOL

and interpreter training, and face-to-face, sign language and telephone interpreting; and translated information (inc. Braille). The overall aim of any strategy should be to create a more joined up approach which seeks to coordinate the support provided by a wide range of partner providers and community networks and enable the identification of gaps in and solutions for language support provision.

In the last decade guidance and policy has moved away from a 'service provision model' for addressing language support issues to a more comprehensive 'social inclusion model'. However, this shift in approach is still not reflected in the way communication needs are met in practice (for more detailed discussion see McPake and Johnstone, 2002; Perez and Wilson, 2006). McPake and Johnstone (2002 p56) propose a contextual framework to assist in the important process of decision making around language support options. At one end of their continuum are 'high stake' contexts where the consequences of poor communication could be serious or life threatening. In the middle of the continuum are contexts where people are seeking advice and information to enable them to make decisions. At the other end of the continuum are routine situations. They propose that the provision of language support needs to take into account the context and the implications of failing to provide adequate support.

Fig. 2



3.2 A service provision model of language support

The **service provision model** focuses on addressing language barriers experienced by those with limited English proficiency in public sector services by supplementing existing service structures with additional provision of interpreting and translation. Thus a service user requiring language support is viewed as having additional needs and often seen as a problem, or at least their lack of English as their problem. Responses have traditionally been reactive: illustrated by demands that the patient 'bring their own' at worst; limited access to ad hoc telephone or face to face interpreting as a norm, and at best, co-ordinated efforts to improve access and quality and reduce costs in interpreting provision with inter-agency partnership. Whilst provision of interpreting certainly ameliorates some of the disadvantages of limited communication between service and service user it can also create further problems, particularly in relation to quality, consistency and cost. Failure to address these problems has often hindered the development of language support services.

However, sessional interpreters employed through outside agencies will always be needed as an option for smaller or more newly arrived groups, and in cases where the practitioners and bicultural workers employed are insufficient to meet the needs of users. Understanding the role of the interpreter is fundamental in making

decisions regarding models of language support to be commissioned and in ensuring staff work effectively within the different options provided to ensure quality and cost effectiveness. There are a number of types of service provision identified in this approach and the key to their utility is to combine **all** the available options, as providing only one option [e.g. telephone interpreting] cannot meet all needs, be useful in all situations and be cost effective.

The role of the professional interpreter

Professionally trained interpreters:

- have a fluent command of English and their interpreting language(s),
- are competent in the specialist techniques of interpreting and translation,
- are neutral and independent,
- will only interpret what is said, and everything that is said, and will only interrupt for clarification or repetition,
- maintain confidentiality and are professionally accountable (National Register of Public Service Interpreters),
- have a specialist knowledge of the structure, procedures and terminology of the professional areas in which they work (e.g. health, law),
- have had professional training (Diploma in Public Service Interpreting),
- have an objective understanding of the culture(s) with which they work,
- are equal participants in the exchange,
- are paid for their professional role.

Case Study 8 - Role of the interpreter

RR (over 55), a Polish patient suffering from musculo-skeletal problems, work-related attended Healthcare-Nottingham for the purpose of medical evaluation. The patient was feeling poorly and experienced acute pain in shoulder girdle. The pain radiated toward his chest, hips, arms and both legs. He used a walking stick to support his limbs. The patient was assisted by his teenage daughter, who was there to act as an interpreter, though not in a professional capacity as her language skills were limited. It is important to underline that the assistance of a professional interpreter is crucial in order to avoid miscommunication in a specialised environment (here: medical). The only problem encountered by an interpreter was the manner in which the patient spoke, snippets of information, factual and time-line confusion, disruptions, frequent digressions and sentence overlapping. The interpreter's role was to pick up the relevant information and translate it so that it made sense to the English interlocutor, ask for clarification and then translate the whole content to avoid chopping the sentences and their overlapping. If the interpreter was absent, the communication would be majorly restricted or even non-existent.

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Some interpreters employed by community interpreting services may have a lesser qualification than the DPSI. When engaging an interpreter it is important to understand the level of qualification: simple assignments are appropriate for bilingual interpreters with basic training, whilst longer, more complex and specialised assignments will require a higher level of training.

Service providers sometimes require an interpreter to provide cultural information, explanations of systems and procedures, and advice; whilst service users might expect the interpreter to be acting as advocate on behalf of an ethnic minority individual or community. However, codes of practice and ethics view this as inappropriate for an interpreter, and this is more the role of an advocate or befriender (see Creation of Link Worker, Advocacy and Support Roles).

Face-to-face interpreting

This is when the interpreter is physically present in the room (also known as liaison/dialogue/community or public service interpreting). This usually requires “bilateral” interpreting, where the interpreter is working “in both directions” between two languages. This type of interpreting may be either consecutive or simultaneous, or involve a mixture of the two.

The advantages of this model of interpreting is that it tends to be preferred by both service users and health professionals, it allows other aspects of communication to be identified and responded to, it is easier to manage longer consultations or sensitive or distressing information, and it is possible to maintain continuity by booking the same interpreter for all consultations.

Disadvantages include distance travelled and travelling expenses raising the costs, interpreters for some languages may not be locally available, it might not be possible to access an appropriate interpreter in an emergency situation or at night, and community interpreters might be known by the patient who may then fear breach of confidentiality.

Face-to-face interpreting includes British Sign Language (BSL) and also Lip-speaking, which is used by hard of hearing or deaf people who lip-read and use spoken English as their

communication choice. A professional lip-speaker repeats silently what a speaker says, but with clear speech movements, appropriate gestures and facial expressions and finger-spelling (Perez and Wilson, 2006).

Relay interpreting

This describes a style of interpreting working through two interpreters, where it is not possible to locate a single interpreter with competence in both languages required. This could help facilitate a service for people with special language needs (Perez and Wilson, 2006) for example:

- English < > Farsi (speaking interpreter) /Farsi (hearing and signing)< > Iranian Sign Language
- English < > Turkish/Turkish < > Kurmanji (a local Kurdish language in Turkey).

Telephone interpreting

Telephone interpreting is a system where a health professional can access an interpreter at any time of day or night through locally agreed processes and often a national or international provider. The advantages are the ease of access to an interpreter, the availability of unusual languages, the reduction in costs by not having to pay travel costs, and the ability to use the interpreter for short assignments. The disadvantages are often cited as being the cumbersome nature of the communication, concerns regarding inability to vet the competence and level of training of the interpreter, and the fact that interpreters can be sourced from other countries and may not therefore be aware of UK processes and systems.

IT based systems

Video-interpreting is used more widely in the US and other countries, and has the potential to supersede telephone interpreting, particularly for BSL and other sign languages. Video interpreting would also improve interpreting provision for spoken languages in situations where understanding non verbal cues in communication would be beneficial. A video-conferencing system can be used to provide both audio and video access to an interpreter; and improving video technology available on mobile phones might be a useful means to provide greater flexibility (Perez and Wilson 2006).

“Electronic Note-taking” or Speech-to-Text (STT) (e.g. live television subtitling) allows a verbatim written version of an oral conversation to be produced on a computer screen and is useful to enable people who are hard of hearing or deaf people who use English, to follow what is being said. Machine shorthand systems (Palantype or Stenograph) such as those used in a court of law, can be used by a trained person. Speech-to-Braille is a similar system to “speech to text” for use by Deafblind people.

Other IT based systems to consider include web resources such as the MyUKinfo website (<http://www.myukinfo.com/en/home>), touch screens in GP practices and in other services which can provide translated information and be updated and developed centrally. On line British Sign Language (BSL) interpreting via a webcam link is available to GP practices and hospitals through ‘*Signtranslate*’ (<http://www.signtranslate.com/interpreting.php>). The website also offers a library of 500 common medical questions with yes/no answers in 12 different languages.

Videoconferencing technology is well established in the legal sector and offers a potential solution for provision of qualified interpreting, especially for minority languages. Remote interpreting (RI) would enable access to an interpreter at a distant location, even overseas, over a video link. This would extend access to languages not available locally beyond that of telephone interpreting by providing for the non-verbal aspects of communication in a consultation. However, evidence regarding the viability of this form of interpreting provision, the training needs and technical requirements and supporting policies is awaited (AVIDICUS, 2009).

Translation

Translation refers to the written word. Consideration of translation tends to be neglected as it is more hidden: the presence of a patient requiring immediate care is more palpable (Perez and Wilson, 2006). The Department of Health (2004) document ‘*Better information, better choices, better health*’ raises this need directly with some guidance around such issues as literacy in own language, community based navigators, access to health records, information accreditation, letters to patients etc. However,

further work is required in looking at the information provided and how it can be made more accessible to people with limited proficiency in English.

In general the best way of commissioning translation work is to find a qualified professional (for example from the Institute of translation and interpreting www.iti.org.uk, or the "Find-a Linguist" pages of the Chartered Institute of Linguists www.iol.org.uk where many "unusual" languages are represented).

Informal interpreting

This is where untrained family, friends and community members with a wide range of bilingual skills provide language support in ad hoc circumstances. Whilst the disadvantages are many and best practice statements hold the view that this should never be relied upon, this strategy was found to be used by 70% of service providers in one survey (Turton et al., 2003) and 92% of Scottish Health Authorities (SALSI, 2000) in a survey of services to the deaf.

“They said come back with someone who can translate. The only person in my family who can speak English is my son. How can I talk about these women's things in front of him?”

Female Kurdish service user (Stallabrass, 2005)

The disadvantages include: insufficient language skills such that errors are common; lack of confidentiality; lack of openness in revealing important information or censoring of the information provided, damage to the balance of relationships within the family, particularly with children (Downing and Roat, 2002); impact of school absences for children (McPake and Johnstone, 2002: 35); the risk of non identification of issues such as child abuse (McPake and Johnstone, 2002), domestic violence and trafficking, stress on the informal interpreter (CRE, 1992); and devaluation of formal interpreting services (McPake and Johnstone, 2002).

Providers often see this as the easiest and most cost effective means of ensuring language support (Turton et al., 2003). Service users

themselves, whilst recognising that there are problems and limitations often express a preference for using friends and family because they trust them and feel more understood, both in cultural and personal terms; moreover they may trust them more than a formal interpreter who they see as not on their side (Alexander et al., 2004).

In providing this option as a means for language support for service users, the provider must ensure that staff are fully trained and policies clear in discerning when this is appropriate (e.g. making appointments, routine situations, social settings, immediate urgency) and when not (when a woman is always spoken for by an accompanying male, clinical/psychiatric/social care issues, etc.). A range of other options have to be accessible, advertised and explained, and understood by service users and also by providers. The Joseph Rowntree Foundation (Alexander et al., 2004) advocates that basic interpreting training be provided to family and community members who often find themselves in this role; to improve quality, reduce errors and mitigate stress.

Registers of Bilingual Staff

Staff with language skills and cultural knowledge may already be employed in various roles within an organisation. Some NHS organisations, particularly hospitals have already identified staff within their organisation that can be called upon to interpret. This has advantages in that the staff member is already employed, is more easily available and this strategy would appear efficient and cost effective (Downing and Roat, 2002).

However, there are many drawbacks to this arrangement. Bilingual staff might have insufficient language skills in both languages to provide interpreting for clinical situations, and insufficient interpreting skills or ability to cope with the situations presented (Downing and Roat, 2002). This form of interpreting provision undermines professional interpreting and may cause confusion in terms of roles of the bilingual staff. Additionally there is no continuity with the patient, confidentiality is not necessarily understood, the work of the staff member and the service they provide is disrupted and the person involved in the interpreting can become quite stressed. High turnover rates have been noted

where staff are used in this way (Downing and Roat, 2002), which incurs hidden costs to the organisation.

This strategy does have a potential for development. Screening of staff to identify levels of language proficiency, training in interpreting and allied issues such as confidentiality and child protection, support for debriefing and making up the time lost in the principle role and the commitment of line managers is essential to the quality of the service. Pay differentials for staff required to interpret, having days where they work solely as an interpreter and accredited training make this role worthwhile in terms of professional development and recognition.

Redesign of services to facilitate interpreting

Services are often not provided in a way that easily facilitates working effectively with interpreters. Appointment timings need to allow greater time for communication through an interpreter. Single language surgeries have been used effectively in areas where there are higher numbers of speakers of one particular language. Multi-agency surgeries can provide a solution for reducing interpreting costs for those patients who have a number of statutory and voluntary sector agencies working with them. A caseload of patients can be allocated to one interpreter across agencies or repeat appointments made with the same interpreter in order to develop trust between service providers, patients and the interpreter. All these opportunities require a co-ordinated interagency approach to interpreting provision.

When providing a service consideration needs to be made about the practical aspects of working with interpreters: consulting and treatment rooms with sufficient space to work effectively with an interpreter; dual handset telephones; access to Skype and videoconferencing; telephones in dental treatment rooms; reception areas that allow access to the phone or computer screen for patients at the reception desk, etc.

Patients also need to be made aware that they have a right to language support and the range of options available needs to be clear. Issues of trust are important, particularly with local community interpreters and thus a patient must also be clear that they can refuse a particular interpreter if they have any concerns.

Training of staff

Adequate training of staff is absolutely fundamental to the success of any language support strategy: especially in terms of quality, efficiency and cost effectiveness. Attitudes to interpreting may also need to be addressed with the belief that language support is the problem of the patient being revised to an understanding that language support is the need of the health professional and a role for the service. A range of options for language support is required and thus the ability to discern which option is most appropriate, with clear guidelines, procedures and monitoring to ensure appropriate decisions. Working with the interpreter (face-to-face or

telephone) requires skills in managing the consultation, briefing and debriefing the interpreter, developing a three way relationship in a consultation and being sensitive to the issues and nuances of this skilled interaction.

A comprehensive language support service will address issues of vetting of interpreters, levels of qualification, how costs are to be managed, confidentiality and managing complaints, so that frontline staff can have trust in the quality and reliability of the provision. Services need to also consider their use of language and jargon and how they can more effectively communicate in plain English.

Case Study 9 - Training staff to work with interpreters

Ipswich & Suffolk Council for Racial Equality (ISCRE)

Based on feedback from interpreters and members of the community Translation and Interpreting Project (TIP is a project of the Ipswich and Suffolk Council for Racial Equality) decided to run a Working with Interpreters course. We identified that in some cases individual staff members were fearful of working through an interpreter and this was a barrier. We also know that there is a lack of understanding of just how much the barrier of language impacts on people accessing services. We know too that often, despite policy and need, interpreters are not always provided.

We advertised the course free for local regular customers via our e mail and web site. The response was overwhelming with more than 40 people expressing an interest.

We have developed our course based on local examples in order that delegates could get a real experience. We invited trainee interpreters about to be assessed to support the course in order that they could practice in a local context. It was decided that no more than 15 could be on the course in order that each delegate could get the opportunity to practice. We had a range of service providers including Housing, Health, Education and Hate Crime. 4 languages from 4 different nationalities were represented, which allowed the agencies not only to engage in respect of language but also build links and relationships with local community members. One of the members of the community cooked food from their country for lunch. The session was fully interactive and students were put firmly into the shoes of someone who does not speak or read English.

The local media expressed an interest, and the Community reporter sat in on the session. This led to a piece in the local press, which told a positive, and therefore different, media story about the barrier of language and accessing services.

Feedback is extremely positive from the course and we have since delivered a bespoke one for the Probation service. All agencies who came said it reinforced their understanding of the importance of trained professionals. All enjoyed the direct engagement with local people and learnt more about cultural backgrounds. They also learnt a bit more about ISCRE and feel more confident to ask for advice as the session took place at ISCRE offices. The interpreters who came learnt more about the different types of agencies who attended, and the services they provide, thus building their capacity for living and working in the UK. Well trained staff, providing interpreters at the point of need is about providing efficient services. Getting services right first time is the most efficient way of delivery.

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Training for interpreters

Interpreters and translators should be required to have a minimum level of professional competence to ensure quality of service provision. So that the linguist with no prior training can be supported to provide basic bilingual language support which will eventually lead onto to a DPSI qualification. Professional interpreters can demonstrate core interpreting skills, an understanding of the role of an interpreter, an ability to work within standard procedures for a service and can effectively manage common dilemmas within a code of ethics. In addition, they need specific training before being able to work in certain settings such as in mental health, palliative care etc. A comprehensive language support strategy needs to ensure that those with specialist training are used consistently in those areas.

Interpreters require support from services, health professionals and staff to enable them to develop their expertise and competency in working in a health and social care context. On registration with an agency a new interpreter might shadow other interpreters in certain areas of service provision, or work as part of a team with a mentor or be supervised for a period. Interpreters also require supervision and support to enable them to cope with some of the issues they face and prevent burnout: especially in mental health where some areas have introduced coping techniques and anxiety management to prevent secondary trauma (British Psychological Society, 2007). Interpreters are often required to work in domestic settings when accompanying a health visitor or community nurse for example. Services need to provide support and training for service providers and interpreters in order to maintain safety and apply lone working policies; but consideration is also required regarding the interpreter's role and position in the community and confidentiality issues.

Across all languages, including Deafblind support, there are difficulties in providing training, mentoring and supervision for new interpreters (Perez and Wilson, 2006). A lack of interpreters generally and a lack of skilled staff prevents adequate training and assessment. Often those with the required skills to provide such support would be needed instead to interpret rather than spend time with a trainee. BSL interpreting was



underpinned by a more rigorous framework, incorporating an assessment system, continuous professional development and monitoring. This was largely supported by the professional body (Association of Sign Language Interpreters).

Interpreters cannot necessarily work as translators as this requires an entirely different set of skills. Translators also need to have access to the Internet, both to help with research and to communicate with an agency and need to be able to use word-processing equipment to produce a final professionally-formatted document. Close collaboration with the communications and IT department of the agency commissioning the translation are essential for quality control, coherence and testing. All translated information needs to be checked by a reader group to ensure there are no errors.

Case Study 10 – Interpreter Training

Herts Interpreting and Translation Service (HITS) is based within Community Action Dacorum and benefits from being within an organisation which delivers a wide range of activities to support identified needs within the community. This includes having synergy with other initiatives within the charity, such as the Strategic engagement agenda, training of ESOL and work with the Migration Impact Fund.

HITS was founded in 2001 as a Dacorum Interpreting and Translation Project. Its initial purpose was to recruit and train suitably skilled individuals solely within the Borough of Dacorum. Through funding from Hertfordshire Community Foundation and the Lloyds TSB Charitable Foundation we were able to support our initial training course starting in December 2001 for the Diploma in Public Service in Interpreting (DPSI) qualification.

This initial course included 16 local residents. Since 2001 we have now been responsible for training more than 1,000 individuals from more than a dozen counties. We have also provided training courses for local authorities in Swansea and Cumbria. Our intention is always to recruit people from the local area if possible but as a registered national training centre we are happy to accept applications from anywhere in the United Kingdom.

Since the very outset of our service, our absolute commitment has been to the DPSI qualification. During the past nine years we have entered approximately 300 candidates into the national examinations in the local government, health and law options. During this period we have established ourselves as arguably one of the leading academic services for professional interpreter training in the UK. In both 2007 and 2010 HITS has been awarded the Nuffield Trophy by the Chartered Institute of Linguists as the best DPSI centre of the year. In addition 4 of our candidates were awarded national cups as the leading candidate of the year in their respective options (including both the health and local government options in 2010).

Our future plans include:

- To maintain excellence as a registered exam centre for the DPSI, including expanding the options we offer to include Law
- To ensure a high quality of service which meets the needs of the public sector, in terms of duty and quality of access for residents
- to develop the local communities in which we operate
- to provide students with meaningful preferred qualifications, increased levels of confidence and employment opportunities
- To maintain our strong presence in the geographic areas in which we operate and to expand further afield

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Support for interpreting and translation agencies

Training for interpreters is thus an important issue and commissioners have an opportunity to support local interpreting agencies with developing the capacity to meet the interpreting needs for local statutory and voluntary sector services. Research conducted by Perez and Wilson (2006) in Scotland found that whilst the DPSI or a university postgraduate qualification may be available in certain core languages there were very few training opportunities for interpreters in more unusual languages. More generally, there was a lack of training materials and reference resources for interpreters working in any language in the public sector.

Commissioners might wish to assist language support service providers with training for some minority languages in their area. However, the lack of trainers with the required language skills, the lack of advanced ESOL courses and the difficulty in providing assessment in the interpreter's chosen interpreting language make such assistance complex.

General principles of commissioning outlined by IDeA National Programme for Third Sector Commissioning apply to working with interpreting and translation agencies, who experience many of the same difficulties regarding funding, capacity building and long term planning even if they are paid for the service they provide. Only telephone interpreting agencies seem to have sufficient volume of work to provide training, monitoring and supervision for their staff (Perez and Wilson, 2006). Responsible commissioning needs to take account of the viability of suppliers as part of a long-term relationship. The more mutually beneficial approach to Third Sector Commissioning is described as 'engaged funding' which involves a close collaboration and partnership between commissioners and agencies with a long term strategic view (Unwin, 2004 & 2006).

Case Study 11– Regional Service Provision Model

NHS Norfolk and INTRAN Partnership (the Partnership)

Good Practice example, taken from Equality and Human Rights Commission

NHS Norfolk takes a partnership approach to the provision of interpretation and translation services for the County and has been a key player in developing the Interpretation and Translation service in Norfolk with a partnership between the Trust, the County Council and 30 other agencies across the region. This approach provides economies of scale, an ability to respond quickly to specific needs as well as a speedy barometer of key emerging community issues. The Partnership trains community-based interpreters which provides local employment. This includes regular interpreting sessions at two GP surgeries. The Partnership has been recognised as an example of social cohesion good practice by the Department for Communities and Local Government and it has received two national awards for procurement.

Background/Development of INTRAN for NHS Norfolk

Since 2000 NHS Norfolk (initially the Health Authority) has been a major stakeholder in the Partnership and as such has been able to commission interpretation and translation services for people with limited proficiency in English or who are Deaf or hard of hearing. Being an INTRAN partner enables us to commission interpretation and translation providers who meet our requirements for professional, impartial, confidential and quality standards. The Partnership provides a seamless, high quality service for our patients. It has developed clear standards regarding quality and by pooling resources we are able to drive down costs and commission services that are appropriate to our local population. NHS Norfolk has embedded the Partnership within its equality strands and it is used as evidence that we are meeting our Public Duties regarding accessibility of services and information for our patients. In the year 2009/10 NHS Norfolk recorded 7,300 Partnership bookings, which is the highest number since its inception.

Development of interpreter sessions in two GP practices in Norfolk through INTRAN

The Partnership interpreter sessions have been held at two GP surgeries in Thetford (School Lane and Grove Surgery) since 2004. These started as a three-month project to address the health needs of the Portuguese speaking population. At the time there had been a huge influx of migrant workers into the area and there were problems around patients accessing and understanding the local health services and also a lack of understanding from health professionals as to how to make adjustments for people who could not speak or understand English.

Through the Partnership we were able to book an interpreter for 2 days a week in one surgery and one in the other. The interpreter covers new registrations, immunisations, midwifery, etc. These sessions were advertised widely in Portuguese, and five years on the needs are still there and interpreting services are as important to both the practices and the patients. Whilst initially this has led to an increase in cost to NHS Norfolk, in terms of meeting our duties around access to our services and providing a cost effective service to a very high standard, it has been invaluable.

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3.3 A social inclusion model of language support

A **social inclusion model** focuses upon the right for all to participate fully in social and cultural life whatever their linguistic and communication ability, and adopts alternative approaches that involve changes in the ways services are structured and provided and impacts every area of public life. This requires a shift in thinking from a narrow language perspective to a broader approach to facilitate communication; and a shift in emphasis from the problems to the aspirations of those who do not use conventional English to communicate (McPake and Johnstone, 2002). It also requires a shift in the power relationships between provider and service user: it is no longer the prerogative of the provider to permit (or not) access to interpreting but the choice of the service user to utilise a range of communication support opportunities on offer as preferred.

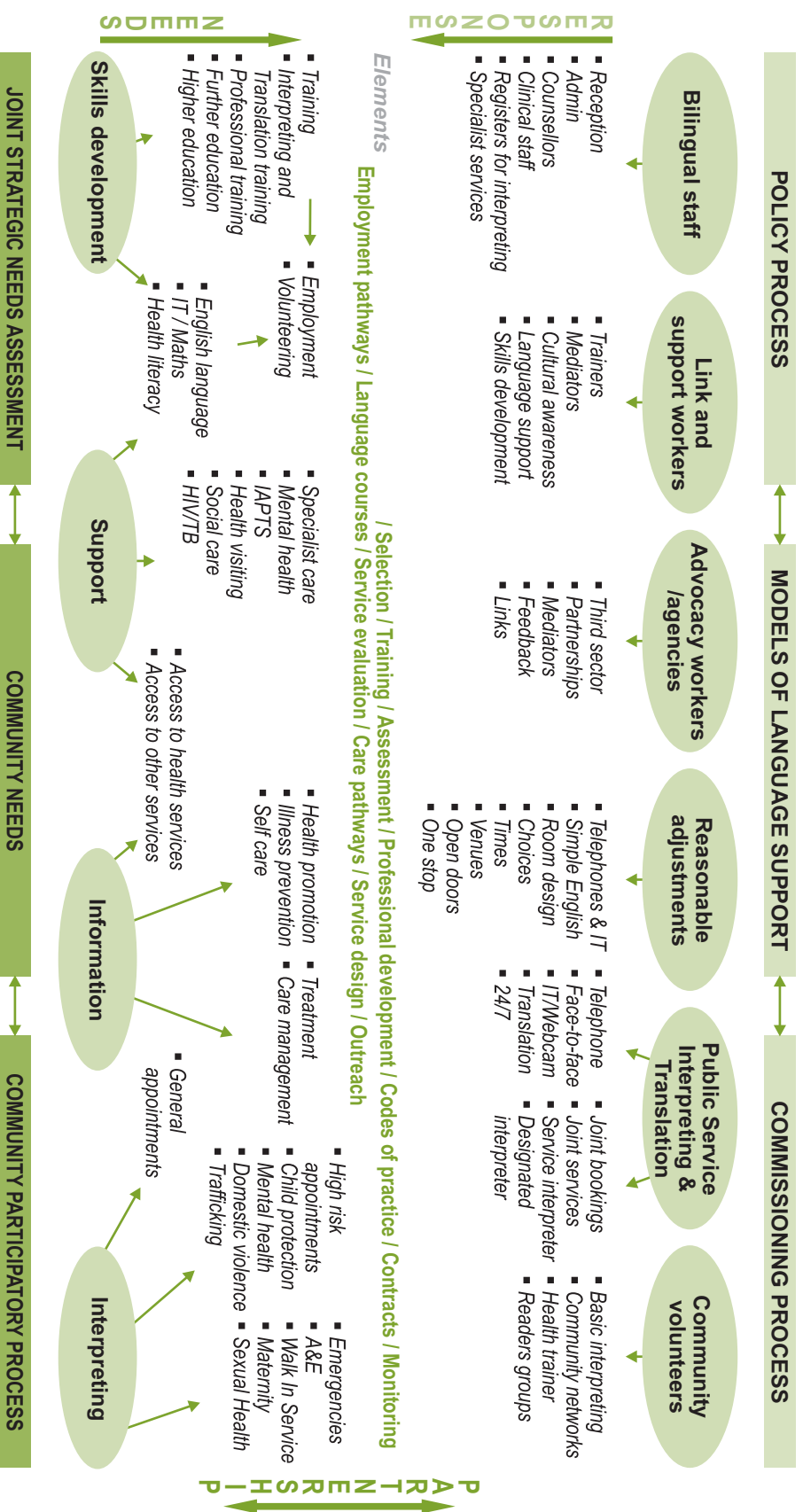
There are a number of models of language support that can be employed (see figure 3), each with its strengths and issues (see table 3). The question is not whether to choose any one model over and above another, but what needs to be put in place to ensure delivery of service outcomes for each and every service and ensure positive health outcomes to meet the needs of BME patients using those services. The commissioning

process needs to work in partnership with community participation processes. Policy and strategy development should be responsive to community needs as described in the Joint Strategic Needs Assessment.

There are elements that require consideration beyond the commissioning of individual services in order to have a comprehensive language support strategy (see figure 3) for example:

- Outreach to communities to identify needs, to facilitate community participation in service design and care pathway development, to identify the most appropriate language support solution and to monitor services;
- Pathways to employment for BME communities that will include training in local communities for higher level English skills, and to provide pathways to volunteering and employment in a wide range of roles (including reception/admin staff, health trainers and clinical staff) and the training of interpreters to the level of Diploma in Public Service Interpreting (DPSI) and in specialist clinical areas such as mental health and palliative care;
- Workforce development could include e.g. staff training in working with interpreters, cultural competency and basic competency in speaking local languages;
- Standards and codes of practice for services, staff, interpreters and agencies providing language support.

Fig. 3





Recruitment of Bilingual Practitioners and Staff

If patients prefer to communicate with a practitioner directly in their own language and if this makes for a better quality of interaction, then the provision of bilingual staff should provide the most appropriate response (30% of Nurses in the NHS are recent migrants Personnel Today, 2006). Yet this can appear a logistically unsustainable task to implement; in areas where there are few bilingual health care practitioners, even for long term communities; where there is a lack of (recognisable) professional qualification and bilingual proficiency in new and emerging communities, and in areas/services where a number of differing languages and dialects are required.

Prioritising of certain areas of work may be helpful in focusing limited resources. In some circumstances it is of particular value to recruit bilingual staff rather than work through interpreters; particularly in mental health, counselling and in sensitive work (e.g. with children, family mediators and with domestic abuse), as familiarity with the work situation and an understanding of the complexity of particular issues goes beyond a simple transfer of information from one language into another (McPake and Johnstone, 2002). In cases where there are many users of a service in a locality with higher numbers of a particular linguistic and cultural group, and few practitioners with appropriate language skills, it would be pragmatic to recruit practitioners specifically to address this need.

The Race Relations Act (1976) does permit the recruitment of staff on the basis of racial or

language skills if the case for doing so is clear. Whilst it might not be easy to recruit someone with specialist or clinical qualifications (e.g. a psychotherapist) particularly from new communities, it is certainly possible to recruit non-clinical staff such as administration and reception staff, who can use their bilingual skills in the course of their job. This might be through direct employment or in partnership with a voluntary sector organisation working with a specific language group or cultural community, where certain service functions (e.g. booking appointments) can be undertaken by the partner agency.

In some geographical areas it is possible for patients to select a General Practice based upon the languages spoken by GPs in that practice. This has been noted traditionally with Asian patients in places such as Bradford or Birmingham (University of Warwick, 2006). Service information provided by the practice often gives the languages spoken by staff, and patients frequently get to hear about the presence of bilingual GPs through community networks. The NHS choices website specifies in some cases what additional languages are spoken in a particular practice.

Access to a GP service by a higher proportion of one language group can have negative impacts upon a practice where only one particular staff member speaks that language; and whilst it is not possible to provide GPs for all languages it is possible to facilitate the development and use of this as a language support strategy. Removing the geographical criteria for registration with GPs and/or provision of GP clinics by practices working in partnership to provide routine services will allow for improved access across a larger geographical locality. Support would be required for practices with Quality and Outcomes Framework exemptions and payment on achievement of additional targets around language; and bilingual staff could be recruited for reception duties. Improved access to support and training for BME doctors could be provided at Deanery level, an action required to address safety issues.

Creation of Link Worker and Support Roles

Issues of consistency and trust are found to be of the utmost importance when patients are asked to evaluate their experience of language support (Alexander et al., 2004). Service providers and practitioners often find that repeated appointments for additional follow up or support are required to explain or reinforce certain information or in supporting therapeutic interventions, complicated with the additional expense of an interpreter. Bilingual link/support workers can be employed to provide this additional contact thus supporting practitioners and services whilst enabling patients to express their needs to service providers. They can act as mediators between professionals and patients, negotiate understandings of cultural issues and provide language support. The development of the link/support worker role is particularly relevant in geographical areas where there are a large number of users requiring language support from a particular community.

Link/support workers will need to be recruited from the local community and may not, especially in the case of newly emerging communities, have had prior work experience in the UK. Their English skills may be limited and difficulties encountered in recording patient notes or communicating medical terminology or health concepts (e.g. management of anxiety) (Downing and Roat, 2002). They may have experiences close to those whom they are supporting which might result in additional stress if they over identify with the patients (e.g. refugees), or they may hold prejudices or ideas which might conflict with other members of their own community: communities are not homogenous or might even not constitute what we might understand to be a 'community'. These issues will require additional close supervision and support, training and professional development opportunities (linked with further education establishments) and formalised accreditation and pathways into employment.

It is important to consider how their work links with the services provided by other organisations and there may be opportunities to work in partnership with a variety of voluntary or statutory sector agencies such that a worker could be jointly employed and carry a caseload of patients accessing multiple services.

Community Volunteers

Recruiting bilingual volunteers from the community, with adequate and appropriate support and role clarity can facilitate service provision. Bilingual volunteers can help make reception and waiting areas more welcoming, they can provide basic immediate interpreting at reception, support patients with directions to services they have been referred to, enhance activities such as providing health promotion displays and assist the service with a variety of administrative and support tasks. Many have specialist areas of expertise or experience that they can offer and in turn hone and develop their skills. Providing volunteer roles enables the development of pathways into employment and enhances links with communities. Bilingual volunteers can have a particular role in working with communities: for example as health trainers, peer educators, health ambassadors and to identify service improvements, support new developments and evaluate provision.

Development of career pathways and routes into employment

As the largest employer in Europe, the NHS has a responsibility to take a lead on equality and diversity, not only meeting the legal requirements to build a diverse workforce, but where possible exceeding them. Linking into national initiatives to create routes into employment for BME community health care professionals is an essential aspect of local workforce planning. Strategies to develop career pathways for bilingual staff into a wide range of areas in the NHS need to be considered at local level and should include support for English language acquisition for newly engaged staff to enhance record keeping and other communication skills.

Much could be achieved by providing routes into work for the 1,199 refugee doctors already in the country (BMA, 2008), through clinical placements in practice, tutorials for IAPTS language and GMC PLAB examinations, and developing the Physician's Assistant role. It costs £25,000 to support a refugee doctor into work in comparison with £200,000 to train a new doctor (NHS Employers, 2009). There are numbers of refugee dentists, psychiatrists, nurses, midwives and allied health professionals, many of whom end up in menial employment instead of using their skills. The Refugee Healthcare Professional

Programme (ROSE, 2010) has experience, information, advice and support for refugees and for employers.

Training of Providers

Communication is more than just a simple transfer of words from one language into another. Staff will require skills in working in a culturally competent manner in order to be able to respond to the diversity of languages, beliefs, behaviours and situations for all BME groups. Improving the communication skills of service providers to help them adapt their style of language use to different contexts will be an important aspect of cultural competency training for staff. Particular attention is required to the development of skills in working with interpreters: not only how to work with an interpreter but also what sort of different interpreting options are available and most appropriate to different situations and needs.

“Someone who worked in a hospital as a hostess...witnessed some nurses asking a patient what he wanted to eat. Due to the fact that he could not speak English and explain what he wanted to eat, they said give him 'cheeses and biscuits or whatever'. As a result, from then on, the patient always said that he wanted cheese and biscuits... as that was the only word in English he had learnt...”

(ISCRE, 2007 p10)

Bilingual skills within a workforce could also be achieved through language training in line with the Knowledge Skills Framework for all NHS staff (McPake and Johnstone, 2002). Whilst it takes time to develop fluency and some staff may be fearful or reluctant to learn languages, it is possible to support the learning of a specific language for such roles as reception duties. This would enable these staff to fulfill their roles more effectively.

Such training can be provided in partnership with interpreters, bilingual staff, advocacy workers and volunteers as well as local community organisations and other local and national providers. Where those individuals providing

language support are enabled to take an active role in service development and feed into planning mechanisms, they can also provide important information and help shape services in more appropriate ways.

Changes in the way services are provided

Commissioners need to understand communication needs in their local area. Pathways can then be designed to ensure providers are able to offer appropriate support at the time any intervention is required. Provision of translated information and of information regarding options for language support is important for the service provider to enable them to deliver a service. Identification of the language needs of those who do not overcome the barriers to access a service requires engagement with communities. However, consideration of ‘consultation fatigue’ and the focus on the need to empower communities requires different approaches. Bilingual staff and volunteers will come from the communities accessing the services and such communities often have qualified people with skills and knowledge that can be nurtured, developed and utilised by health and social care services (McPake and Johnstone, 2002). Neighbourhood renewal, Local Strategic Partnerships and social inclusion partnerships are all tools for more effective community engagement (McPake and Johnstone, 2002 p25).

All services need to consider ways that they work with Black and Minority Ethnic groups and with those who have limited proficiency in English rather than expect that there will be a specialist outreach service just for that group. The so called ‘hard to reach’ groups need to be provided for within mainstream services. New methods of service delivery should be considered: times of service provision to coincide with availability of patients, more local venues for aspects of the service, open door systems rather than appointments, jointly provided one stop services with other agencies etc. Incorporating English language learning into real situations and as part of service provision helps to develop competency and confidence of those with limited English proficiency (e.g. support workers modelling and then encouraging small transactions in English like booking an appointment), ESOL training provision on site and in a variety of contexts (e.g. children’s centres).

Advocacy

Provision of advocacy is the most socially inclusive means of language support involving a distinct change of emphasis. The person providing language support acts as an advocate or patient centred interpreter, shifting roles from one of communicating to the patient the requirements of staff, to communicating to the staff the patient's questions and needs. The advocate or patient-centred interpreter represents the interests of the patient, working with them on an ongoing basis, getting to know their needs and helping them to negotiate services and obtain their entitlements. Many service users see language support not in terms of a professional interpreter with excellent linguistic ability but as someone who can *"argue a case"* (Alexander et al., 2004, p.21), who is understanding and empathic, and who will be proactive on their behalf. Professional interpreters are often perceived to be under orders from the service providers and many service users express dissatisfaction with them until they have seen them on a number of occasions and been able to develop trust.

"I am so grateful to.... (advocacy worker). I have been trying to get them to understand that I am depressed because I keep having miscarriages and I don't understand why, but they just gave me tablets. Now I have the counselling I need and have had tests to find out why."

Female Kurdish service user (Stallabrass, 2005)

Advocacy workers have been shown to improve access to services, enhance control of patients over their own decision making and health related behaviours and improve a sense of well being and health status (Warwick University 2006). Their ability to offer an ongoing relationship with the potential for a very supportive bond to develop is particularly useful with very isolated patients and those with mental health difficulties, and can help address wider issues than are addressed by one particular service area (e.g. networking and skills development).



Service providers often express fear and concern over working with advocates, anticipating a level of criticism and hostility, which in practice is rarely the case. Health advocacy often helps to bridge the differing cultural understandings between practitioners and their patients and services and the community, particularly around health beliefs and behaviours (Warwick University, 2002).

However, it requires that advocates are trained and supported in an ongoing way, so that they can manage the demands of their role and maintain boundaries. Working practices also require a shift in emphasis: briefing advocates to enable them to work effectively with the particular service provider, advocates meeting with the patient prior to the meeting the service provider in order to agree how to approach the service provider and clarify what the patient wishes to achieve; and in situations like psychological therapy, where the relationship between patient and therapist is central, the advocate can be supported to understand the importance of working as part of a three way therapeutic relationship, building trust and allowing for exploration of difficult and challenging areas.

Table 3 Advantages and limitations of language support strategies		
	Advantages	Limitations
Language support Bilingual staff (clinical staff, receptionists)	<ul style="list-style-type: none"> • Preferred by patients and practitioners • Essential in specialist services • Ease and speed of communication • Cultural competency • Employment opportunities for marginalised communities 	<ul style="list-style-type: none"> • Practitioners not available in more unusual languages • Some may have limited English proficiency • Limited availability of specialist practitioners • Cannot cover the whole range of languages in all services
Registers of bilingual staff to act as interpreters	<ul style="list-style-type: none"> • Easily available within the organisation • Professional development opportunities 	<ul style="list-style-type: none"> • Compromises staff members' primary role • Poor continuity of care • Training required to support confidentiality and quality
Link and support workers	<ul style="list-style-type: none"> • Support patients' skills development • Mediators between communities and services • Joint working across agencies • Continuity of care across sectors 	<ul style="list-style-type: none"> • Difficulties for individuals managing boundaries with and expectations of communities
Advocacy workers and agencies	<ul style="list-style-type: none"> • Patient-centred interpreting promoting patients' preferences and control over decision making • Preferred by patients • Improve access to services 	<ul style="list-style-type: none"> • Provider staff can be suspicious of advocacy workers initially
Community volunteers	<ul style="list-style-type: none"> • Basic immediate interpreting • Pathways to employment • Community and cultural knowledge • Outreach (e.g. health trainers) 	<ul style="list-style-type: none"> • Training and support for confidentiality and for managing boundaries and community expectations
Reasonable adjustments	<ul style="list-style-type: none"> • Essential to meet legislative requirements • Facilitates the development of a wide range of language support options 	
Face-to-face interpreting	<ul style="list-style-type: none"> • Preferred over telephone interpreting • Facilitates signing/relay interpreting • Professional, confidential, supports understanding • Locally available 	<ul style="list-style-type: none"> • Some languages not locally available • Travel costs can be prohibitive
Telephone interpreting	<ul style="list-style-type: none"> • Available 24 hours per day • Available in an emergency • Can provide for unusual languages 	<ul style="list-style-type: none"> • Misses non-verbal communication cues • Not cost-effective for contacts over 20 minutes • Cost effective for short simple interpreting (e.g. on reception) • Not suitable for complex, sensitive issues or children

Case study 12 – A socially inclusive model of language support

Suffolk Community Refugee Team was a nurse-led **General Practice** using various language support methods to provide General Medical and Personal Medical Services for asylum seekers, refugees and migrant workers.



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SECTION 4:

Defining and Specifying Services Based on Best Practice

4. Fundamental pre-requisites to successful language support strategies include a joint focus, commitment to provision of language support and good partnership working

Whichever language support options commissioners wish to adopt, certain underlying features and principles of best practice are fundamental to success. Many current primary care and third sector providers are likely to have significant existing experience and expertise and examples of good practice, which can be utilised to shape and define services as they develop.

4.1 Public Service Interpreting and Translation

Underlying features and principles

- Ad-hoc systems are inefficient and are not patient-centred. This leads to fragmented services and/or to service duplication.
- Good practice models help NHS agencies make reasonable adjustments to their services. They will be pro-active at identifying and continually looking at the way they deliver services to help make improvements for patients who cannot communicate fluently in English.
- Good practice models will be patient-focused and will integrate “access”, “patient safety” and “risk management” in their strategies.
- NHS agencies will develop internal systems and procedures to help staff make an efficient, safe and cost-effective use of services. Staff will be given support to achieve these goals.

- Equal Access to Service and Information means that NHS agencies will:
 - Call interpreters and translators when necessary
 - Ensure that those interpreters and translators are competent (DPSI qualified with medical interpreting training, ethics training, and access to mental health, drugs and alcohol, child protection additional training) and CRB-checked
 - Provide an effective service across cultures
 - Interpreters will be accessible over the telephone (immediate access) or on a face-to-face basis (by appointment). Interpreters may be able to interpret consecutively, simultaneously and sight translate.
- NHS agencies may consider operating in partnership with other agencies, including agencies operating in other public sectors, to gain economies of scale and of learning as well as addressing gaps in provision, such as locally.
- NHS agencies will be committed in contributing to the development of locally-based interpreters and be supportive of providers of interpreting training.
- The delivery of best model practice requires a member of staff to act as the central point of contact between the organisation and commissioned suppliers. Communicating with managers and staff and with communities is crucial to the success of the strategy.
- Make language support a corporate issue. Communicate with staff to make sure that:
 - Budgets are secured
 - Staff know about your provision of services, and know how to use services effectively.
 - Controls are in place to monitor good practice and effectiveness.
 - Monitoring and management information are used as intelligence to identify trends, achievements, gaps, and needs for continuing development.
 - If staff decide not to provide interpreters, is central evidence kept of the reasons why it was decided, in some particular instances, not to provide an interpreter, as in the recommendations of the Laming Report 2003.

- Children require special consideration: *“when communicating with a child is necessary for purposes of safeguarding and promoting that child’s welfare, and the first language of that child is not English, an interpreter must be used. In cases where the use of an interpreter is dispensed with, the reasons for doing so must be recorded in the child’s notes/case file.”* (Laming, 2003)

Common practical issues

Common practical issues fall into four areas: the logistics of organising interpreting, the accuracy and professionalism of interpreters, the dynamics of working with interpreters and the use of translation services.

Logistical problems:

Interpreters might arrive late to sessions, cancel at short notice or not appear at all, without any sort of explanation. Whilst this does not occur often it can be very disruptive to service delivery. Sometimes the reverse happens when a face to face interpreter is booked and the patient does not turn up, incurring additional costs. It is often difficult to arrange an interpreter at short notice at the particular time and date available for the worker, or in a crisis situation. There also may be problems when trying to arrange to use the same interpreter for ongoing work with a service user. When GPs do not inform hospitals in their referral letters that the patient needs an interpreter in X language, referral letters may be ignored by the patient causing unintended Did Not Attends.

Booking of interpreters requires consideration of cost effectiveness. Practitioners prefer face to face interpreting and may be reluctant to work with a telephone interpreter even when sufficient and more cost effective. Face to face interpreters may be booked for a whole day in day procedure units, when only required face to face pre-operatively to gain consent and can be contacted by phone post-operatively to confirm and recap on what was said previously. Face to face interpreters are not given priority when appointments are running late. One consequence of this is that the agency incurs higher costs with interpreters waiting for the appointment to commence. Policies need to be implemented and controls put in place to ensure that agencies make a cost-effective use of public resources.

“This lady was pregnant and I told her she was HIV positive, her 17 year old daughter was interpreting. At the end of the consultation as my patient continued to smile at me, I decided to rebook her with an interpreter. Through the interpreter I received the confirmation that her daughter had not informed her mother of her condition, and that the mother had not taken the anti-virals”

(Gidney, 2010)

Patients benefit from a cross-sector partnership approach to translation and interpreting provision as they will receive the same provision from each agency. This results in the continuation of high quality, successful care throughout their experience. Lack of active management implies that some NHS agencies book face to face interpreters in the same place speaking the same language several times a day. A coordinated approach would contribute to facilitating repeat bookings or internal organisation, so that the same interpreter is used throughout the day, hence incurring no travel charges.

Without a structured, well organised system of interpreting and translation there will be confusion regarding which agency should pay for which invoices.

Communities are often unaware of the fact they can access services in their language. As a result, people postpone their contacts with the NHS, with predictable consequences attached. Patients postpone consultations and/or operations as a result of not having interpreters provided. Patients, who do not know otherwise, often bring a friend or family member, or volunteer to interpret. This often leads to omissions, additions and misinterpretations.

Accuracy of Interpreting:

Professional interpreters are trained to provide accurate and reliable interpreting within a clear code of ethics, which is supportive of patient and practitioner. They are skilled in managing some of the difficulties in consultations for example clinical

terminology, embarrassment, anger and bad language.

It is vital for the agency providing the interpreter to ascertain the nature of the appointment in order that the interpreter with the right level of competency is provided. It is important that interpreters are well trained and confident to explain to the provider that they require more time to explain particular issues for example because the word may not exist in their mother language or because of the level of understanding of the patient.

Dynamics of Working with Interpreter:

There is a different dynamic between practitioner and service user when an interpreter is in the room: this takes some adjustment, particularly in the mental health setting or with complex issues and staff require training to be able to manage the consultation effectively. As a result some practitioners might express concerns about the accuracy of interpretation, or both practitioners and services users might be concerned about the standard, capability, confidentiality and professionalism of the interpreter. These issues can be overcome with training of both practitioners and interpreters and good translated information for patients explaining how interpreters are engaged by service providers. Good supervision processes, partnership working and support for interpreting agencies are important if interpreters are to gain skills in working in particular settings such as mental health or palliative care.

Translation:

A clear policy regarding translation is necessary, especially as the costs involved can be high. Sometimes it is not necessary to translate a whole document as only part is required for a particular purpose. On other occasions all that might be required is to read through a short document such as a letter with an interpreter. Translated health information is often available on the World Wide Web or from other agencies; and readers' panels to assess this information can be useful in ensuring the accuracy and appropriateness of the materials to the local situation. Translation should be completed by translators who have specialist training, skills and computer resources for written translation, and documents such as translated leaflets and letters..

Cambridge (2010) advises that the process should include pre-editing in collaboration with both the translator and designated community members so that the original English text represents the level of language, lack of jargon, and general tone that will produce an effective Other Language document and the colour, graphics, style and production are appropriate also. The draft translation can then be tested with the community concerned and if necessary the translator asked to make small edits prior to printing. The price and a reasonable deadline for all this will have been agreed with the translator beforehand, and the parties put in touch with one another

Table 4

Key measures of an effective interpreting and translation service

Suppliers focus

- Provide a speedy response for 24 hour, 7 days a week, 365 days a year
- Include deaf and hard of hearing services
- Access locally-based qualified interpreters
- Support interpreters
- Ensure suitable standards
- Provide meaningful management information
- Accurately monitor and manage information; including invoices
- Implement solid Quality Assurance controls
- Provide good quality Complaints feedback
- Innovate
- Avoid cheap options that would imply that interpreters are paid the minimum wage; a postgraduate professional interpreter should work for remuneration commensurate with their training

Internal focus

- Integrate interpreting and translation services
- Deliver active contract management
- Make patients central to your language support strategy.
- Empower your staff through the active delivery of “awareness-raising” programmes
- Implement a robust Quality Assurance policy
- Monitor usage, performance and efficiency
- Plan realistic budgets
- Create one central point of contact to link your suppliers, senior management, staff and patients
- Evaluate services regularly
- Ensure communication is central to the process of integrating interpreting and translation services
- Consider a variety of opinions: few interpreting and translation agencies can claim to be full experts in all aspects

4.2 A social inclusion model of language support

High Quality Care for All. Inclusion Health: improving primary care for socially excluded people (DH, 2010) details a number of best practice issues when commissioning for and working with third sector agencies and BME or other communities. Many of these guidelines apply to the provision of language support:

• Critical mass

Achieving economies of scale can be challenging, when some language groups have very few people within them in a given area, and sometimes bilingual staff etc just cannot be found. Community interpreting services may also have difficulty in accessing specific languages in a given area with the result that interpreters may have to travel long distances. Partnership working across agencies is essential as an individual may be receiving services from other agencies, and joint meetings could be set up to make effective use of an interpreter. Telephone or audio-visual IT technology would also be of use and staff should be trained to identify and work with these choices effectively.

• Common barriers to accessing services and receiving optimal care

Insufficient language capability is a key barrier to accessing services; however, many such services users may also experience a number of other compounding barriers.

• Local leadership

Commissioning partners, third sector agencies and community champions need to provide strong and clear leadership and commitment.

• Integrated approaches and continuity of care

Ensuring care pathways and language support are integrated and seamless so that support worker or interpreter provision in one area of the care pathway (e.g. primary care/midwifery) is continued into another care pathway or area of provision (e.g. secondary care/delivery suite). The most successful integrated models will emphasise joint delivery and co-location of services to promote integration. There is sometimes confusion amongst staff regarding the rules around patient confidentiality when working across services. The sharing of information within agreed protocols is perfectly possible and it should not act as a barrier.

- **Engaging individual service users and communities**

Good engagement with service users requiring language support is not only a long term undertaking but requires language support strategies and resources and good planning in order to build trust and achieve effective engagement to enable involvement in the design and development of services.

- **Children and Families**

It is important to recognise that children's language needs are often different from those of their parents. Interpreters, bilingual staff and advocacy workers will be required to work in very different ways and will require additional support and training.

- **Physical environment**

Basic considerations such as clear, simple signage (e.g. simple language, use of images, large text etc.), access to telephone interpreting on the front desk, volunteers and advocates in the reception area can make a big difference to reducing the confusion and anxiety felt by people with language support needs, which can sometimes lead to them leaving before their appointment.

- **Partnership working**

Fundamental pre-requisites to successful language support strategies include a joint focus and commitment to provision of language support and good partnership working (between commissioning organisations, between provider organisations, between commissioners and potential providers and between commissioners, communities and providers).

- **Supported workforce/networked services**

Staff involved with provision of language support whether external to an organisation (e.g. interpreter) or employed in the third sector; require support networks, supervision and training.

- **Personalisation**

A language support strategy will comprise many different elements (e.g. telephone and face-to-face interpreting, advocates, bilingual staff etc.) operating across agency and service boundaries. It is important that services are

commissioned and developed in a way which promotes the ability of the service providers to understand the different options for language support available and respond to individual needs. This will require clear protocols, and training and proficiency in integration and co-operation.

4.3 Specialist clinical issues

Mental health

Therapeutic interventions to support people with mental ill health, respond to mental health crises and promote mental well-being rely entirely on communication in its fullest sense. Language barriers will severely impede the provision of such care and will compound other barriers experienced (cultural understandings, stigma etc.). Good language support is essential with interpreters, bilingual staff, advocates etc.) being fully supported and appropriately trained in this specialist area of work. Telephone interpreting is neither appropriate nor cost effective. The establishing of an effective therapeutic relationship cannot progress without trust in the interpreter or advocate by the service user or health professional.

New Horizons: a shared vision for mental health (DH, 2009) promotes strategies for improving population mental health and ensuring the delivery of effective, evidence-based treatments and care in primary care and secondary mental health services. Its approach addresses the needs of people who are socially excluded who are at greater risk of mental ill-health, and supports the basic requirement for language support for those excluded on the grounds of language capability. Equality of access and outcomes for BME groups is identified as a specific action (p25) as is early intervention (p23). Appropriate language support is key to achieving these actions.

Health promotion and screening

To combat the under utilisation of screening services and the failure of some health promotion messages requires not only the provision of clear and appropriate translated information and interpreting at appointments, but also the active involvement of BME voluntary and community organisations with bilingual health trainers, support workers and advocates.

“This lady went to her mammogram appointment with her daughter acting as an interpreter. Her daughter was a British born Chinese and was able to interpret some information but not all. She ended up not having a mammogram check and had a huge argument with her daughter when her daughter explained the metal plate would be chopping her breasts off”
(Chow, 2010)

Speech and Language Therapy

Speech and Language Therapists are skilled at altering their style of communication according to the children’s and parents’/carers’ needs. However, working through an interpreter to support patients (children or adults with for example brain injury) and their carers will require additional support to ensure continuity of interpreter and training for the interpreter in working within this specialism.



Paediatrics / Children’s Services

Children must be given the opportunity to themselves communicate in their own language and practitioners not rely only upon parent / carers interpreting for the child or providing information on behalf of the child. Child protection issues are paramount and experienced interpreters will be essential to any child protection work. Children must also be protected from the consequences of acting as the interpreter for family members.

SECTION 5:

Working with and Developing Providers

5. Commissioning of an interpreting and translation service is much more cost-effective if commissioning is multi-sectoral - involving Health; Social Care; Housing; Police; Job Centre Plus; Education and the Voluntary Sector.

Funding for interpreting services is often perceived and experienced as problematic, and whilst organisations are required to review their practices little guidance is given regarding how to balance priorities, and interpreting services are often abandoned on the basis of cost (McPake and Johnstone, 2002). Arrangements thus often remain ad hoc and therefore more costly, thus reinforcing the perception of the insurmountable costs. This in part is due to an undervaluing of the role of the interpreter and failure to understand the complexity of the skills involved; but it is also the result of a failure to adopt the more inclusive options of language support available.

5.1 Working with third sector providers

The development of a comprehensive, socially inclusive language support strategy is dependent upon the third sector. Where commissioners find service users difficult to engage with, especially if particularly marginalized or suspicious of statutory agencies, third sector agencies and community organisations can provide in-reach and engagement. Local communities will provide the linguistic expertise to supply interpreters to meet that community's specific language needs (languages, dialects, cultural groups). Bilingual staff (administrative, auxiliary and clinical) will need to be recruited from local communities. Local agencies hold the knowledge and data that commissioners require in order to identify the appropriate commissioning strategies. Third sector agencies also have access to funding streams that support an inclusive approach, and are part of wider organizations, offering a 'one-stop' service approach.

Commissioners often find engagement with the third sector difficult when provider agencies are small, staffed with volunteers, are specific to certain groups within communities and have little ability for long term strategic planning. Third sector agencies themselves find procurement practices are not flexible enough to meet their particular needs and many report NHS procurement processes to be over complicated. They have limited capacity to complete bids to the standard required and in competition with national companies. Their existing funding is often short term and from multiple sources with specific outcomes expected from that funding stream. Often third sector providers are completely excluded in the initial research and design stages of procurement (DH, 2010)

However, it is through third sector agencies that many community interpreting services are provided. Even those agencies offering BSL and are 85% not for profit, are often charitable agencies dependent upon donations, and any central funding received is inadequate to meet costs and is often cut year on year (Perez and Wilson, 2006). Yet they provide services that statutory bodies should themselves be providing to meet service user needs and legal requirements. Central government, statutory bodies and local government need to recognise that provision of language support for BSL and minority languages is a legitimate and necessary cost.

5.2 Procurement and contractual approaches

Contractual frameworks options need to incorporate multi-agency provision and multi-agency commissioning. A range of agencies will be required to provide different elements of a language support strategy and multiple agencies will need to have access to the various options available. Thus procurement and contracting must be flexible and sustainable as lead contracting arrangements will involve multiple funding streams, and a variety of differing contractual arrangements.

A long term commitment to socially inclusive language support is essential; particularly when considering work-force development options and capacity development for providers. Capacity

Case Study 13 – Local Multi-Agency Partnership

Translation and Interpreting Project (TIP) (ISCRE)

TIP works closely with multi-agency partners in order to facilitate services needed by public service providers and service users who are not fluent in English language. It is particularly important in mental health cases as patients tend to fall back on their mother tongues when they are mentally unwell.

Mrs. Z who was 50 years old had been suffering from mental illness for a long time. Her family did not recognize her illness and did not seek medical help for some time. Mrs. Z was lucky to be saved by a passer-by who witnessed her walking into the sea and called the police. Mrs. Z suffered from Schizophrenia; she demonstrated severe symptoms which included serious self harm while she was being treated in a mental health hospital.

With the help of her interpreter, doctors were able to properly assess her mental status. After year-long treatment, she was well enough to be discharged. Her children, however, cannot look after their mum at home due to their work commitments. She was offered a place in a residential mental health care home in order to build a positive and meaningful future for herself. Her care was the responsibility of *Suffolk Mental Health Partnership Trust, Suffolk County Council and NHS Suffolk*.

TIP provided the same interpreter for each visit. This was seen as important by the mental health specialists who wanted continuity to help build trust between the interpreter and the patient in the patient's best interests. Additionally this continuity was helpful for the agencies. Because of the impact of the patient's illness on her needs, the residential home requested a flexible 24/7 telephone interpreting service provided by the same interpreter. Through its track record of building strong relationships and flexibility with its interpreters TIP was able to provide all the services requested by the service providers.

Over the 3 years the agencies and TIP have been involved with the patient, she has done very well building a more positive future for herself.

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building in the third sector is fundamental to developing language support services as the expertise required rests within the communities themselves; this means a commitment to pick up long term funding where both commissioning and service provision can be responsive to changing needs over time.

'Design and build'

The NHS procurement hub can itself be very costly and time consuming and the timing of commissioning rounds might not correspond with the timing of applications for some of the short term, ad hoc funding sources available to third sector agencies (Comic Relief, Lottery etc). A flexible 'design and build' approach is essential (DH, 2010). This may have a number of features and advantages including:

- services designed around users needs;
- potential users, or communities of users,

- involved in service development at all stages and a panel of local expertise can be created to guide broader communication strategies;
- it supports the localization agenda allowing small local agencies a better chance to compete in the tendering processes as it is from these that the people with the language expertise have to be drawn;
- contractual arrangements commission for 'capacity' rather than units of activity;
- support is provided for agencies to do long term strategic planning rather than short-termism based on insecure year by year funding;
- services can be more flexible and innovative and accessibility criteria for service users are broadened;
- data can be collected to inform future commissioning and service development. (DH 2010).

‘The Compact’

The Compact (DH, 2007) is an agreement between the Government and the voluntary and community sector in England which provides a framework and guiding principles for effective partnership. It commits Government bodies to working towards longer term funding arrangements with third sector organisations, 3 years being the accepted period with options to extend where appropriate.

Partnership approaches

Bringing third sector and statutory services together in partnerships to collaborate in the provision of jointly-provided areas of service such as advocacy workers or in the provision of co-located, integrated and one-stop services.

Commissioning around ‘Touch points’

Commissioners will need to identify and understand key service ‘touch points’ (DH, 2010), where service users actually present to access services. This might be through inappropriate presentations at A&E for non emergency needs or it might be appropriate use of a walk-in centre. Understanding why service users present to services where and how they do, will enable commissioners to develop improved patient pathways. More importantly, ‘touch points’ offer an opportunity to target language support interventions. With inappropriate presentations in A&E for example, quick access to telephone interpreters might help facilitate quicker

throughput and ensure provision of health information to redirect subsequent contacts more appropriately along with the opportunity to refer to a bilingual support service to provide ongoing health information and support. Additional services could be built around a walk in centre to provide a wider range of health interventions, reciprocal arrangements between health and other services or a point of access for language support options.

Reasonable adjustments to existing or mainstream services

Commissioners might wish to consider incentivizing mainstream services to work with service users requiring language support or to make reasonable adjustments. The DDA defines discrimination in a number of ways and outlines four specific types of discrimination: direct discrimination, failure to make reasonable adjustment, disability-related discrimination and victimisation. It is unlawful for service providers to treat someone less favourably because of their disability, and this requires them to make “reasonable adjustments” to service provision. A service does not have to be impossible to use before a service provider has to make changes: they also have to make changes when it is unreasonably difficult. Service providers should be thinking ahead and continually looking at the way they provide services, the physical features of their premises and services, and how they can make improvements for disabled people.

Table 5

Reasonable adjustments for language support

All audiences	<ul style="list-style-type: none"> • Use of plain English • Information easy to read and simple • Inform of different methods of provision • Be aware of cultural differences • Make reasonable adjustments • Staff aware of duties and have the practical know-how on how to behave, how to write, communicate, present displays, avoid certain typefaces, etc... and larger font. • Staff guidelines – with training to make the guidelines more meaningful
Deaf people and hard of hearing, deaf blind.	<ul style="list-style-type: none"> • BSL interpreters • Lip speakers • Hearing loops • Minicom • Speech to text for hard of hearing. (transcription of the word onto a screen) • Languages include BSL, Makaton, deaf manual, deaf blind manual and more • Typetalk (funded by BT) to communicate with hearing people and vice-versa, through the operator translating the spoken word and text • Support for people with learning disabilities to arrange their bookings • Internet signers to explain services are provided and how to access them and what users' rights are
Non English speakers	<ul style="list-style-type: none"> • Foreign Language Interpreters • Translators • Sight translating or verbal interpretation of documents • Pictures and symbols
Blind and visually-impaired	<ul style="list-style-type: none"> • Large Print • Braille • Audio cassettes
Older people	<ul style="list-style-type: none"> • Look at visual impairment, mobility impairment and hearing impairment • Or learning disability
Learning disabilities	<ul style="list-style-type: none"> • Plain English, short sentences, large print, use pictures-photos, information on audio tapes, write in symbols (Rebus) - using symbols to support words and 'Easy-read' format
Speech impairment	<ul style="list-style-type: none"> • Text phones • Typetalk (funded by BT) to communicate with hearing people and vice-versa, through the operator translating the spoken word and text

Collaborative commissioning approaches

Commissioners might find that service users access services across a number of area boundaries or a wide range of different areas of provision. Thus the needs of their particular area might be better served by a specialist service incorporating a range of language support models. Commissioning of an interpreting and translation service is much more cost effective if commissioning is multi-sectoral, involving health, social care, housing, police, Job Centre Plus, education and the voluntary sector.

Workforce development

Most community interpreting service providers recruit self employed freelance interpreters. Workforce development initiatives need to work towards long term sustainability and retention of an interpreting workforce by offering support for professional development and training and career options (e.g. specialist interpreters employed in mental health services). Mainstream services should be supported to recruit bilingual staff and this might mean commissioning English language training and writing skills support for those staff in partnership with education facilities.

5.3 Mapping existing services and funding

With a wide range of options available in the social inclusion model the best service solution will depend upon a number of factors, including

existing service provision, changing needs and funding streams available. The most effective approaches to mapping services and identifying funding are those which collaborate closely with existing service providers, service users and local communities. Inclusive approaches such as advocates, bilingual staff etc opens up a wider range of funding opportunities to address language support needs imaginatively. Partners in commissioning and provision of language support can agree funding streams to support contracts from many different sources.

Funding sources might be local, short term, through European initiatives, or central government.

- The Department of Health (DH, 2009) has issued guidance for commissioners on the use of grants in place of commercial contracting
- NHS can use General Medical Services (GMS), various Personal Medical Services (PMS) options and Enhanced Service Agreements to integrate language support options within GP practices, Dental Surgeries and community services;
- Education: colleges and universities have access to funding to support training of interpreters, training of bilingual staff in administration or professional roles such as counseling and for research (including local bursaries).
- Home Office funding streams for dispersal need to include support for local costs of interpreting for NHS services.

Case Study 14 – Occupational health and safety

Ipswich & Suffolk Council for Racial Equality (ISCRE)

A Lithuanian female in her 40's who had been in the UK 5 years, sending money home to support her teenage son who lived with her parents. Spoke very little English, working 12 hour shifts 6 days a week. She experienced an accident at work, which left her unable to return to work. The employer did not offer letters in her own language about her continued absence from work. She was not in the Union and did not appear to understand the role of a Union.

On arrival at ISCRE offices with her paperwork she was living in a hostel, along with drug users and alcohol users. We engaged an interpreter immediately. She was apparently receiving a small amount of benefit, very stressed and really confused about her work status - she thought she had been sacked. The injury to her arm was apparent, despite it being about 6 months old. Review of the paperwork showed that she was being asked to attend Occupational Health by the employer for an assessment with a view to terminating her contract. In addition she had paperwork that indicated she had sought legal advice about her injury at work. There was no evidence of any interpreter and a letter from the law firm suggested she would be unlikely to win a Personal Injury claim. Reviewing the paperwork regarding the injury the investigation felt unsatisfactory. This was not however her priority.

Additionally she was experiencing other health problems and again she did not appear to have any correspondence on this in any language other than English. She was due to have a procedure at the hospital and was really fearful and unsure what it would entail. This was what had prompted her to come to us. We called the hospital who agreed to ensure an interpreter was present at the pre operation appointment. We wrote to the GP and Hospital to determine whether interpreters had been used on all occasions, describing her complete lack of understanding of what was going to happen to her. We rang the work place to ensure that that Occupational Health met with her with an interpreter. They refused to commission a professional and agreed to use a work colleague who spoke some English.

Because of her subsequent hospital procedure she felt unwell enough to pursue any complaint against the employer or the law firm. Eventually we lost contact with her as she was towards the end living in poor conditions and leading a chaotic lifestyle but understand she returned to Lithuania.

This shows the human costs of not embedding the removal of the barrier of language every time it is required. There are additional costs too:

- The potentially dangerous work environment has not been addressed
- The loss of income led this woman into an environment that she became influenced by, that exacerbated her health problems
- The discriminatory impact of accessing justice for a potential Personal Injury claim
- The costs associated with organisations like ISCRE who paid for interpreters in order to understand her issues and to be able to offer her the right support and guidance
- The fear of not fully understanding what your GP or Consultant is telling you

Contact: Jane Basham, ISCRE jane@iscre.org.uk

SECTION 6:

Monitoring Performance

6. ...with language support provision actually emanating from the community which it serves it as a fundamental prerequisite to have meaningful community participation at all levels.

In specifying what type of services to include in a communication support strategy, commissioners will need to assure themselves that not only the range of services provided is appropriate, but that this is supported by a rigorous evidence base. Good evidence is not easily available for a new area of service development so it is important that commissioners are clear regarding the outcomes required in each service area and standards to be achieved.

6.1 Key performance indicators

Service provision for translation and interpreting

The commissioning of an interpreting and translation service will require consideration of the following service performance indicators, management and monitoring.

Table 6

Service level agreement / tender specification headings

1. Background and history
2. Scope of the service
3. Telephone, BSL and Lipspeaking, face-to-face foreign language interpreting, written translations
4. Service availability
5. Special requests
6. Additional services: Braille, audio translations, large script, etc.
7. Customer service support
8. Booking processes
9. Management information
10. Selection and development of interpreters

11. Training
12. Publicity materials
13. Quality control
14. Complaints
15. Disaster recovery
16. Upsurge or variations of demand
17. Research for development
18. Confidentiality and code of conduct
19. Referees
20. Partnership working
21. Payment and cost of service

Service Provision Standards for interpreting provision

Call Centre

- Call centre to be staffed 24 hours per day/7 days per week/365 days per year
- [99%] of all calls answered within [20] seconds
- [1%] of all calls answered within [60] seconds

Bookings filled

- [99%] of all requests booked

Speed of response

- [90%] of all emergencies – interpreters arrive within [1] hour (need for local service development)
- [90%] of all emergencies – interpreters arrive within [5] hours

Cost control – ability to reduce mileage costs

- [x%] of all standard language face to face interpreters travel [x] miles (depends upon local situation)
- Ability to recruit and train interpreters to meet local gaps in provision
- Look at usage statistics:
- Cannot provide interpreter/language/unmet need
- Had to provide interpreters from further distance

Quality of services delivered

- Each booking needs to show language qualification/level of training of interpreter used
- Translators must have a qualification in translation (not interpretation)
- 100% compliance with quality standards agreed in the SLA
- Ability to provide interpreters trained in particularly complex areas of the NHS e.g.

Mental Health, Drugs and Alcohol. Expert staff can train locally-based interpreters in areas of expertise. In Mental Health, interpreters must be fully confident in simultaneous interpreting (which is tested in the DPSI qualification).

- Customer satisfaction feedback
- Complaints/incident resolution
- Identifying when “complaints of the same nature” reoccur and review
- Review training and CPD targets with suppliers at each review meeting for face to face interpreters

Management Information

- 100% timeliness of submission of monitoring and management information
- 100% accuracy and completeness of management and monitoring information
- 100% accuracy of ID codes
- 100% accuracy of invoices (and ability to check and verify: must be audit-trackable).

Customer satisfaction

- Staff surveys
- Service user surveys
- % of complaints/total bookings and resolution satisfaction

Additional services and innovation

- Depending upon contracts, suppliers may be offering added-value services. In order to implement them, a guarantee of value is required to ensure efficiency.

Co-ordination and management is a key issue where there are multiple commissioning partners, commissioning services from a range of providers, in order to provide interpreting and translation to a number of services. Partner organisations will save a considerable amount of time and money if a coordinating/management body is utilised to manage the complexities of delivery, ensure the success, efficiency and cost effectiveness of provision.

A managing/coordinating body:

- Tenders and reviews performance with partners on an ongoing basis
- Produces SLAs and Partnership Agreements and pays for legal consultation fees as and when necessary through a pooled partnership budget
- Reviews contracts quarterly on behalf of all its partners

- Provides written annual reports and ensures standardized and consistent reporting from all providers/suppliers
- Communicates with providers/suppliers as and when necessary to ensure best value, consistency and quality
- Develops champions in service providers to support staff in each service and link with the management team/coordinating body
- Trains staff in local situations, booking systems, working with interpreters, choosing between different options of language support
- Monitors on a yearly basis:
 - Service delivery – usage, contract compliance, top languages per area/service, gaps in provision, average unit costs
 - Recruitment and training of interpreters
 - Quality assurance and quality control
 - Feedback received from staff, interpreters and users, yearly reviews of customer satisfaction
 - Areas for improvement
 - Current and future development work and targets

Services need to be managed. The most complex and potentially more expensive services will be face to face. As part of commissioning guidelines, these performance indicators solely concern the monitoring of performance of commissioned suppliers.

These do not measure:

- the ability of the NHS’s organisation to meet patient’s safety through PSI&T services
- internal efficiency – staff making an effective use of services

It is however important to point out that not only suppliers but staff themselves contribute to the effectiveness of the delivery of the contracts.

Partnership working

Good partnership working provides for more than basic monitoring for data collection or managing of processes. A range of patient issues and needs can be identified (e.g. not being able to access a particular service), shifts and changes within communities can be responded to (e.g. sudden ‘removals’ of asylum seekers or increasing numbers of family joining individuals in a particular community), tensions and misunderstandings can quickly be addressed (e.g. confidentiality and trust) and community cohesion issues highlighted (e.g. increasing homelessness).

Case Study 15 – Partnership Working

INTRAN Partnership

A group of 9 NHS agencies* meet to benchmark and monitor internal performance, share experiences of good practice and prevent duplication. All partner agencies access services through a regional commissioning framework and expect therefore, to receive the same level of quality services. Each agency appoints a PSI&T champion that acts as the critical link between the organisation, staff and patients. The champions rely on extensive analyses of quantitative and qualitative data to identify developmental needs and to inform future decision-making. In-depth analyses are provided centrally prior to meetings taking place.

Working in partnership helps problem-solve, increase the in-depth knowledge of individual champions (who are themselves responsible for justifying the needs for such services on behalf of their organisation), gain good ideas, increase NHS staff efficiency, reduce the amount of wasted staff time when communicating with non-English speakers and sometimes to share costs. Partnership working has:

- identified gaps in efficiencies, higher usage needs and solutions for addressing them
- shared good practice and has therefore been able to improve services
- researched situations where face-to-face interpreting is essential and situations where telephone interpreting could be used more extensively
- developed common guidelines and systems on the effective use of PSI&T services
- regularly reviewed the effectiveness of “access points”. For example, acute and mental health trusts have worked constructively with primary care agencies to improve patient access and remove barriers at primary care level. This could be something as simple as a surgery informing a hospital of a patient’s need for an interpreter
- set up controls to make sure that all PSI&T services meet the audit trail requirements
- created a library of translated resources at NHS Norfolk to share with partners without cost
- identified awareness raising needs by comparing high users to non-users
- enabled discussions to be held when usage is significant in some departments in one hospital and not in others
- in instances where acute trust hospitals see patients that could have been looked after at primary care level, the NHS Norfolk champion consulted the surgeries in question to raise their awareness of the need for them to access PSI&T services to help reduce preventable demands for secondary services
- in order to save costs, held discussions relating to the value and required mechanisms in high usage areas of booking an interpreter regularly. Two partners have implemented regular clinics with interpreters where patients report a high level of satisfaction for the clinical care they receive

* Members of the sub-group include:

- James Paget University Hospitals NHS Foundation Trust
- NHS Great Yarmouth and Waveney
- NHS Norfolk
- Norfolk Community Health and Care (about to join the group)
- Norfolk Drugs and Alcohol Agency
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk and Waveney Mental Healthcare NHS Trust
- Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
- West Suffolk Hospital NHS Trust

Contact: The NHS group by emailing INTRAN@norfolk.gov.uk, or David Hewer, NHS INTRAN Chair, at the same email address

6.2 Service inclusion model evaluation

It is of vital importance that a process of evaluation of language support services is instituted and takes place on an ongoing basis. There are often difficulties reported with regard to the credibility and trust between ethnic minority service users and service providers. Evaluation and monitoring can play an important part in addressing such difficulties. Community involvement in monitoring and evaluating service provision is a useful means to increase confidence in the services being provided. Furthermore, with language support provision deriving from the community itself, it is a fundamental pre-requisite to have meaningful community participation at all levels. Despite this, it is often the case that there are few systems and procedures for quality assurance of language support, and monitoring take-up, user satisfaction and operational efficiency are poorly addressed.

Monitoring of services would depend largely upon the type of service being provided (primary care, community services etc) and upon the form of language support offered (bilingual staff, link workers etc). For mainstream services commissioners might wish to align some measures to the reasonable adjustments they wish service providers to make. *‘Design and build’ approaches to service quality and outcomes, and development and improvement require ‘risk sharing agreements’* (DH, 2009) as opposed to target setting and enforcement. This would involve ongoing monitoring, service user and community consultation via a steering group and periodic external evaluation by an independent

agent with expertise in the fields of equal access and language service provision. Such independent evaluation should generate recommendations for service improvement.

“Using photos in this way was fun and really showed me that I am not alone as other refugees have the same problems and experiences.”

16 year old Afghan service user (Stallabrass, 2005)

Service user feedback

Each agency will have its own internal ways of seeking user feedback. It is important to point out that:

- New ways of approaching service user feedback are required for those with limited English proficiency
- Suppliers will not seek to retrieve feedback from service users. For example, if a feedback card was completed and given to the interpreter, the likelihood of hearing about anything negative would be nil.
- Agencies could produce simple user questionnaires translated in top languages.
- Agencies could be pro-active at promoting the PALS service to their patients.
- Agencies could have regular surveys, by looking at statistics and identifying regular staff users who have contact with the same patients. In such case, they could target their efforts through that member of staff.
- Agencies could produce simple information leaflets
- Mystery shopping exercises
- Focus groups

Table 7

Quick Feedback from Service User

Did the interpreter:	Yes	No
Arrive on time?		
Dress appropriately?		
Behave impartially?		
Show professionalism?		
Meet your requirement?		
Comment:		

**Thank you for your time!
Translation and Interpreting Project (ISCRE)**

Staff feedback:

Staff are also users of the service and thus it is essential to act upon their feedback:

- Website facility – to communicate with staff-users and invite them to complete the quantitative/qualitative survey on the staff website, in order to monitor quantitatively satisfaction for each commissioned agency and to receive comments and good ideas in the qualitative section
- Suppliers can contact a sample of staff users every month and results can be sent to the champion
- Targeting staff users through IT surveys, like 'surveymonkey'
- The champion can support staff who seem to make ineffective use of the services (if bills higher than should be)

6.3 Reporting performance

In order to coordinate a number of commissioning partners, different providers for different areas of service and the number of service providers using language support careful consideration will be required regarding:

- The creation of champions within these areas to support staff and service users and provide information and experience from the ground level to commissioners;
- Designation of a named lead within commissioning partners;
- The most useful and influential place to report to in order to continue the development of language support provision;
- Reference to equality and diversity monitoring;
- Responses to exception reporting, incidents and complaints and
- Which particular information and data to collect.

Case Study 16 - Monitoring

NHS Peterborough

The NHS has a key Access Target and a statutory duty under the equalities legislation to ensure NHS services are accessible in compliance with race, gender and disability in particular. Provision of interpretation and translation for patients accessing primary and community services (including face to face for non verbal communications) has been provided by NHS Peterborough for the last 15 years. This has been managed through a central budget for interpretation whilst translation of information has been paid for by individual service areas.

Over the last 4 years the need has grown with the increase of diversity in Peterborough and influx of asylum seekers, refugees and new arrivals in the city. Our population has grown from 153,000 to 164,000 currently, with over 100 languages spoken in the city. Approximately 5 years ago our budget was exceeding £300,000. Our users have been Primary Care (all GP surgeries, Dentists, Opticians and Pharmacies), the Walk-In Centre, and Peterborough Community Services. In addition we provide for a Counselling Service with Primary Care referrals, community midwifery services at GP surgeries and Children's Centres. All hospital based services are paid for by the hospital contract.

Following for the first time a tender process for interpretation and achieving a joint 3 year contract with NHS Peterborough and Peterborough City Council, the usage was monitored closely for the following elements: quarterly trends of usage for both face to face and telephone interpreting, broken down by each GP practice or service area e.g. health visiting etc.; location of interpreters, number of bookings per month and on costs, length of time face to face interpreters were used etc. Variations in use were found and poor use of face to face for short lengths of time which proved to be costly.

Following robust monitoring an executive decision was taken to achieve efficiency in use and in cost with an understanding of and commitment to interpreting service provision. Explicit criteria were developed to aid decision making between face to face and telephone interpreting in primary care with detailed monitoring of face to face use. Through these criteria savings of approximately 50% were achieved (06/07 £305K reduced 08/09 to £153K and 09/10 to £121.5K). HSP also supported service areas with one off payment to install telephone lines in dental consultation rooms, provided hands free loud speaking telephone handsets and training in how to use telephone interpretation in a variety of ways and settings and information packs.

Important features included:

- Good relationships with providers of interpretation services and their cooperation
- Good relationships and communications with service users
- Top level understanding of the service and support
- Robust monitoring systems both from providers of service and commissioner perspective for reporting purposes and responding to Freedom of Information requests
- Adapting the service to suit the provider and using ID codes split by each service area, GP practice etc to enable robust monitoring

Ensuring interpretation and translation policies are in place as point of reference. (NHSP policies are pending review until the current tender process is over)

Contact: Geeta Pankhania NHS Peterborough Geeta.pankhania@peterboroughpct.nhs.uk

SECTION 7:

7. Recommendations

Acknowledging the case for change

- Make communication and language support central to the way care is provided
- Develop a clear conceptual framework that describes the differing contexts of language support and recognises the complexities of communicating across language and cultures and allows the professional to achieve effective communication

Assessing your local needs and priorities

- Collect a range of data not only to identify community languages but more specifically to describe language support needs
- Collect, collate and interpret data and information in partnership with local communities and third sector agencies
- Ensure detailed and quality ethnic and language monitoring in all services, including interpreting and translation services

Identifying suitable service solutions

- Start from the point of view of those who communicate in forms other than spoken or written English and consider multiple communication approaches that will give service users choice and take into account their concerns, experiences, aspirations and lifestyle
- Develop commissioning partnerships with community organisations, voluntary sector agencies and interpreting services which are crucial to community needs assessment and decision making regarding language support provision
- Create a language support strategy which includes a locally based interpreting and translation service with and for local communities and ensures every service commissioned includes reasonable adjustments and a wide range of options for language support provision

Defining and specifying services based on best practice

- Apply the conceptual framework for understanding language needs and the

language support strategy to every service developed.

- Consider the full range of options that are available for delivering language support.
- Decide what outcomes each individual service should deliver and consider how language support options available will support those outcomes for BME communities.

Working with and developing providers

- Work in partnership with the education sectors required to develop language skill in local communities, provide training and professional development for interpreters and support health staff training and development
- Familiarise all NHS staff with language support options available, sources of translated information accessible, the work of other organisations locally and nationally that can help support service users, legislation, guidelines and policies
- Ensure all services users are aware of the options available to them and empower them to participate in the development and provision of support options and identifying developing needs and new ideas
- Work with service providers in health, housing, social care and in the third/voluntary sector to co-ordinate their work together for individual patients and for communities, share the provision of link, support and advocacy workers and collaborate on the provision of interpreting and translation services

Monitoring performance

- Actively seek feedback from individuals, communities and staff who are all users of language support
- Create guidelines and policies with clear standards with means for their monitoring and evaluation
- Ensure the employment, training, assessment and deployment of interpreters and translators meets minimum best practice standards to ensure safety, efficacy and quality of interpreting.
- Apply robust monitoring systems essential to facilitating cost effective provision of language support
- Build in evaluation of commissioning, planning, service development and delivery from the start

Glossary

ACL	Adult & Community Learning (Suffolk County Council)
APS	Annual Population Survey
BME	Black and Minority Ethnic
BSL	British Sign Language
CINTRA	Cambridge Interpreting and Translation
CRB	Criminal Records Bureau
CSV	Community Service Volunteers
DCSF	Department for Children, Schools and Families now Department for Education
DDA	Disability Discrimination Act
DH	Department of Health
DPS	Diploma in Public Service Interpreting
DRE	Delivering Race Equality
EELGA	East of England Local Government Association
ER	Electoral Register
ESA	Employment and Support Allowance
ESOL	English for Speakers of Other Languages
FOI	Freedom of Information (requests)
PLAB	Professional and Linguistic Assessments Board (for medical practitioners)
HES	Hospital Episode Statistics
HESA	Higher Education Statistics Agency
HITS	Herts Interpreting and Translation Service
HPA	Health Protection Agency
HSA	Health & Safety Executive
IAPTS	Improving Access to Psychological Therapies Services
ICOCO	Institute of Community Cohesion
INTRAN	Multi-agency partnership providing language support services throughout the Eastern Region
IPS	International Passenger Survey
ISCRE	Ipswich & Suffolk Council for Racial Equality
LFS	Labour Force Survey
MECAN	Minority Ethnic Community Action Network
MHMDS	Mental Health Minimum Dataset
Nis	National Indicators
NINo	National Insurance Number (Registration Data)
NRPSI	National Register of Public Service Interpreters
NTA	National Treatment Agency
ODPM	Office of the Deputy Prime Minister
ONS	Office for National Statistics
PALs	Patient Advice & Liaison Services
PHOs	Public Health Observatories
PLASC	Pupil Level Annual School Census
PROMs	Patient-Reported Outcome Measures
PSI&T	Public Service Interpretation & Translation
QIPP	Quality, Innovation, Productivity & Prevention
SRSF	Suffolk Refugee Support Forum
TIP	Translating & Interpreting Project (Ipswich & Suffolk Council for Racial Equality)
WRS	Worker Registration Scheme

Appendix 1

Regional and national resources

Policy Guidance, Research and Support

The Scottish Translation, Interpreting and Communication Forum

The Forum aims to promote good practice in the use of interpreting, translating and communication support to people whose first language is not English. It also aims to develop high professional standards in the use, management and delivery of interpreting and communication support in Scotland. <http://www.stics.org.uk/>

Training and Education

Working with Interpreters

CINTRA Ltd

8 Wellington Mews
Wellington Street
Cambridge
CB1 1HW
Contact:

Mrs Jill Wilkinson
01223 346 873
jill.wilkinson@cintra.org.uk
www.cintra.org.uk

Herts Interpreting and Translation Service

48 High Street
Hemel Hempstead
Herts
HP1 3AF
Contact:

Mr Ian McKenzie
01442 867 212
interpreting@communityactiondacorum.org.uk
www.hertsinterpreting.org

INTRAN Partnership

INTRAN is a multi agency public sector partnership providing language support services throughout the Eastern Region.
<http://www.intran.org/cms>

Practical guidelines:

- Cost effectiveness
<http://www.intran.org/cms/BestPractice/CostEffectiveness.html>
- Using interpreters wisely
<http://www.intran.org/cms/StaffSupport/UsingInterpretersWisely.html>
- Using translators wisely
<http://www.intran.org/cms/StaffSupport/UsingTranslatorsWisely.html>

Refugee Council

Refugee Council provides training for service providers who work with refugees and migrant communities and for the communities themselves and Refugee Community Organisations.
<http://www.refugeecouncil.org.uk/>

Translation and Interpreting Project (ISCRE)

TIP provides training for service providers who work with interpreters, to support best practice when using interpreters in Suffolk and a wider geographical area if requested.

Contact:

Annie Chow
Project Manager
annie@iscre.org.uk
<http://www.iscre.org.uk/Translation%20&%20Interpreting%20Project.asp?nid=189&pid=185>

Training of Interpreters

Diploma in Public Service Interpreting – course providers and examination centres in the East of England

Barnfield College

York Street Campus
Luton
LU2 0EZ
Contact:
Mr David Farrer
0158 256 9850
david.farrer@barnfield.ac.uk
www.barnfield.ac.uk

CINTRA Ltd

8 Wellington Mews
Wellington Street
Cambridge
CB1 1HW
Contact:
Mrs Jill Wilkinson
01223 346 873
jill.wilkinson@cintra.org.uk
www.cintra.org.uk
Law/Health/Local Government

Herts Interpreting and Translation Service

48 High Street
Hemel Hempstead
Herts
HP1 3AF
Contact:
Mr Ian McKenzie
01442 867 212
interpreting@communityactiondacorum.org.uk
www.hertsinterpreting.org
Health/Local Government (Part-time course)

Language Solutions GY

124 King Street
Great Yarmouth
Norfolk
NR30 2PQ
Contact:
Costa Ricardo
01493 855 666
solutionsgy@hotmail.co.uk

University of Bedfordshire

Bedford Campus
Polehill Avenue
Bedford
MK41 9EA
Contact:
Ms Laure Scott
01234 793 083
laura.scott@beds.ac.uk
www.beds.ac.uk
Health

Chartered Institute of Linguists

Website with further information on the Diploma in
Public Service Interpreting:
http://www.iol.org.uk/qualifications/exams_dpsi.asp

Interpreting and Translation Services**CINTRA (Cambridge Interpreting and Translation)**

Cintra provides interpreting and translation services to public and private sector partners in the UK. CINTRA specialise in providing highly trained, qualified and security vetted interpreters (in person or by telephone) 24 hours a day, every day of the year.

8 Wellington Mews, Wellington Street, Cambridge
CB1 1HW

Telephone: 01223 346870
Fax: 01223 309923
General email cintra@cintra.org.uk
Bookings email booking@cintra.org.uk
Website: <http://www.cintra.org.uk>

Herts Interpreting and Translation Service (HITS)

HITS provide language support services (telephone and face-to-face interpreting, translation, audio recordings and language assessments) for Health Trusts, Local Authorities, non-statutory sector organisations, commercial and private partners throughout Hertfordshire, Buckinghamshire, Milton Keynes, Oxfordshire and beyond.

48 High Street, Hemel Hempstead, Herts HP1
3AF

Telephone: 01442 867212 (24 hours a day -
seven days a week)
0845 4500273 (during office hours)
Fax: 01442 239775

E-mail:
interpreting@communityactiondacorum.org.uk
Website:
<http://www.hertsinterpreting.org/index.html>

INTRAN Partnership

INTRAN is a multi agency public sector partnership providing language support services throughout the Eastern Region.
<http://www.intran.org/cms>

National Register of Public Service Interpreters (NRPSI)

NRPSI provides public service organisations, and agencies that they may work through, with a register of professional, qualified and quality assured interpreters.

The Register lists interpreters who have satisfied entry criteria in terms of qualifications and experience, and are subject to a Code of Professional Conduct.

This is a public access register, available at no cost to users. To access, please go to:
<http://www.nrpsi.co.uk>

On Line Sign language Interpreting SignTranslate GP and SignTranslate Hospital

Websites to allow access to BSL interpreting via webcam link and a talking signing medical phrasebook of some 500 commonly used phrases in a medical consultation. This facility is also offered for 12 foreign languages including: Arabic, French, Gujarati, Korean, Polish, Portuguese, Punjabi, Somali, Spanish, Turkish and Urdu.
<http://www.signtranslate.com/programs.php?page=programs>

Translation and Interpreting Project (TIP)

A community-led flexible service within the Ipswich and Suffolk Council for Racial Equality (ISCRE), TIP provides interpreting and translation services to the public, private and voluntary sector in Suffolk and across the UK. This includes access to BSL signers.

ISCRE, 46a St Matthew's Street, Ipswich IP1 3EP
Tel: 01473 408111/400082
Bookings email: tip@iscre.org.uk
Website: www.iscre.org.uk

Helplines

More details can be found on

<http://helplines.community.officelive.com/default.aspx>

Arthritis Care

0808 800 4050
Monday – Friday 10am – 4pm
Interpreting Service
<http://www.arthritiscare.org.uk/PublicationsandResources/Someonetotalkto/Helpline/Aboutthehelpline>

Alzheimer Society Helpline

0845 300 0336
Monday – Friday 8.30am – 6.30pm
Interpreting Service
<http://www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200273>

Asthma UK Adviceline

08457 010203
Monday to Friday 9am -5pm
Interpreting service
http://www.asthma.org.uk/how_we_help/adviceline/

Autism Helpline

0845 070 4004
Monday to Friday 10am-4pm
Interpreting service
http://www.escis.org.uk/Entry/View/The_National_Autistic_Society_Autism_Helpline/20690

Diabetes UK Careline:

0845 120 2960
Interpreting service
http://www.diabetes.org.uk/How_we_help/Careline/

Epilepsy

0808 800 2200
Monday to Friday 10am-4pm (6pm on a Thursday)
Interpreting service
<http://www.epilepsy.org.uk/services/freephone.html>

Family Planning Association

0845 122 8690
Monday to Friday 9am to 6pm
<http://www.fpa.org.uk/Helpandadvice/FPAhelplines>

McMillan & Cancerbackup

0808 800 1234

Monday to Friday 9am-8pm

Over 100 languages, ask nurse for an interpreter

Also has helplines in a number of languages:

Arabic 0808 800 0130

Bengali 0808 800 0131

Chinese 0808 800 0132

French 0808 800 0133

Greek 0808 800 0134

Gujarati 0808 800 0135

Hindi 0808 800 0136

Polish 0808 800 0137

Punjabi 0808 800 0138

Turkish 0808 800 0139

Urdu 0808 800 0140

Vietnamese 0808 800 0141

<http://www.macmillan.org.uk/HowWeCanHelp/TalkToUs/Talktous.aspx>

Meningitis Research Foundation

0808 800 3344

24hr helpline

Interpreting service

<http://www.meningitis.org/helping-you/freefone-24-hour-helpline>

Saneline

Every day 365 days per year 6am – 11pm

<http://www.sane.org.uk/News/View/205>

Smoking

NHS Asian Tobacco helpline:

Urdu 0800 169 0881

Punjabi 0800 169 0882

Hindi 0800 169 0883

Guajarati 0800 169 0884

Bengali 0800 169 0885

Tuesday 1pm-9pm

Asian Quitline:

Bengali 0800 00 22 44 Monday 1pm-9pm

Guajarati 0800 00 22 55 Tuesday 1pm-9pm

Hindi 0800 00 22 66 Wednesday 1pm-9pm

Punjabi 0800 00 22 77 Thursday 1pm-9pm

Urdu 0800 00 22 88 Sunday 1pm-9pm

Turkish/Kurdish

0800 00 22 99 Thursday & Sunday 1pm-9pm

<http://smokefree.nhs.uk/questions/south-asian-tobacco-use/>

Appendix 2

Local BME and Community Agencies

Below is a list of projects working with asylum seekers, refugees and/or migrant workers. The information is being shared as a sign of good practice. Should you wish to find out more information about any of the projects, please contact them directly.

The projects are listed under their relevant county or unitary council base:

Bedford and Central Bedfordshire

(area covered by Bedfordshire New Migration Partnership)

Bedford Refugee and Asylum Seeker Support (BRASS) offers practical advice to refugees and asylum seekers (not counselling). Address: 27b Tavistock Street, Bedford MK40 2RB, Tel: 01234 211381, Email: info@brass27b.org, Website: <http://www.brassbedford.org.uk>

BME Voice Bedford makes a contribution to empowering local BME community members to become active citizens, influencing local decision-making, with more representation, participation and consultation for the delivery of accessible services. Contact: Jasmin Nessa, jasmin.nessa@hotmail.com

The Learning Partnership works with migrant workers through the Transqual project and the Train to Gain ESOL Project. Address: 1 Sunbeam Road, Woburn Road Industrial Estate, Kempston, Bedfordshire MK42 7BZ, Tel: 01234 857637, Email: info@learning-partnership.co.uk. Website: www.learningincommunities.co.uk

Polish British Integration Centre (PBIC) aims to support vulnerable migrants to attend culture awareness courses with embedded ESOL. Address: Bradgate Road, Bedford, MK40 3DE. Tel: 01234 358100. Email: info@pbic.co.uk This e-mail address is being protected from spambots. You need JavaScript enabled to view it

Cambridgeshire (area covered by the Cambridgeshire Migrant Workers & Asylum Seekers and Refugees Network and by the Fenland Diversity Forum)

Cambridge Refugee and Migrant Support is a project run by the Cambridge Ethnic Community Forum providing a first point of contact for asylum seekers, refugees and migrant workers in Cambridge City. The project offers advice and support with a range of issues and free counselling services and English language tuition. Address: 62-64 Victoria Road, Cambridge, CB4 3DU, Tel: 01223 315877 Website: <http://www.cecf.co.uk/crms.html>

The East of England Polish Community Organisation is a voluntary group that provides information and support to the Polish community in Cambridge and the surrounding areas. Services include a "one-stop-shop" in Dom Polonia providing assistance with filling forms, translating documents; information on self-employment, employment rights, education issues and benefits. Address: 231 Chesterton Road, Cambridge, CB4 1AS, Tel: 07914 49 33 52, Email: marta.maj@eepco.co.uk, Website: <http://eepco.co.uk>

The Ferry Project works with the housing company Luminus Group to provide housing and skills training for single homeless people. Address: 16 - 24 Mill Close, Wisbech Tel: 01945 461106 (Female), Tel: 01945 589905 (Male), SOFA Project: 01945 467596.

Fenland CAB Migrant Workers Project supports migrant workers in rural areas. Drop-in sessions in Portuguese. Address: 12 Church Mews, Wisbech, Cambs, PE13 1HL. Tel: 01945 464367. Email: bureau@fenlandcab.cabnet.org.uk

The Rosmini Centre provides guidance and support for newly arriving and established migrant workers, offering help with translation, form filling, and family learning opportunities. Address: Rosmini Centre Community Development Manager, 69 Queens Road, Wisbech, Cambs, PE13 2PH Tel: 01945 474422, Email: rcw_manager@btconnect.com

Essex (area covered by Essex Multi Agency Forum)

Integration Support Services (ISS) is a non-profit making charity for ethnic minorities, refugees, migrants and other isolated communities, based in Harlow. Its purpose is to make a positive contribution to the communities in which it works and serve to improve the life of both immigrant

communities and the indigenous population through education, support services and welfare support. Address: 2 Wych Elm, Harlow, Essex, CM20 1QP, Tel: 01279 639442; Website: <http://www.integrationsupportservices.org.uk/index.php>

REVI (Real and Enthusiastic Voice of Integration) aims to improve the quality of life of people of all ages from migrant communities, to facilitate integration, promote understanding and reduce isolation in the UK and abroad, and enable migrant communities to maintain their own cultures and heritage. Address: Braintree District Council, Causeway House, Bocking End, Braintree, CM7 9HB, Tel: 07976 071722, Email: anna.szwagiel@braintree.gov.uk, Website: <http://revirevi.co.uk/index.html>

TACMEP (Tending and Colchester Minority Ethnic Partnership) supports Black and Minority Ethnic (BME) people who live in the Colchester and Tending areas. Address: Winsley's House, High Street, Colchester, Essex, CO1 1UG, Tel: 01206 769789 and 01206 50047, Email: info@tacmep.org.uk, Website: <http://www.tacmep.org.uk>

Hertfordshire (area covered by Hertfordshire Migrant Workers Multi Agency Forum)

Community Action Dacorum is a local umbrella organisation which provides a circle of support to voluntary organisations and community groups, as well as delivering a number of services that support identified community need. The CAD has managed the "Meeting the Information and Economic Needs of Migrants" (MINEM) project. Address: 48 High Street, Hemel Hempstead, Herts, HP1 3AF. Tel: 01442 253935. Website: <http://www.dacorumcvs.org.uk/>

Polish Community in St. Albans is based around the Polish Saturday school. The communities from Welwyn and Hatfield are going to join an education project for children from different parts of the county. Contacts: Chair of the Polish Community: Ula Bowdler, Email: u.bowdler@ntlworld.com; Head of the Polish Saturday School: Iza Fraser, Email: izafraser@gmail.com

Portuguese Community in Bishop's Stortford
Contact: Betty Silva
brunecaspeed1975@msn.com

Stevenage Polish Association runs drop-in sessions twice a month in Stevenage Fire Station and ESOL classes in cooperation with North Hertfordshire College, Contact: Malgorzata Poczatek, E-mail: gosia_lolo@yahoo.com, Website: www.spa.socjum.pl

Welwyn Hatfield Ethnic Minority Group (WHEMG) Contact: Moreen Pascal, WHEMG Strategic Manager, whemgroup@yahoo.co.uk

Welwyn Hatfield Polish Forum runs ESOL classes, organises meetings with guest speakers and is planning to open Polish Saturday School and Mother and Toddler Group. Contacts: Michal Siewniak, michal_siewniak@yahoo.com; Ola Goral, olagoral@wp.pl

Luton (area covered by Luton New Migration Partnership)

Bedfordshire African Community Centre (BACC) aims to empower, support and assist individuals and minority groups from the African continent including asylum seekers, migrant workers and refugees living in Luton and Bedford areas. Address: The Basement, Aldwyck House, Upper George Street, Luton, Beds, LU1 2RB. Telephone: 01582 484807. Email: bacc.office@virgin.net, info@africancentre.org.uk, Website: www.africancentre.org.uk/

Centre for All Families Positive Health (CAFPH) is a specific service that is peer-led and all efforts are made to involve people living with HIV/AIDS, including asylum seekers and refugees, in the development and improvement of services at all levels. Address: 11-15 Park Street West, Luton L1 3BE, Tel: 01582 726 061, Website: www.cafph.org/

British Red Cross The work undertaken by the Red Cross in this area includes providing support to refugees and asylum seekers. Bedfordshire Area Office, 232 Dunstable Road, Luton, Tel: 01582 589080, Website: www.redcross.org.uk

Luton Training & Mentoring (LTM) aims to look at providing free customised mentoring support to NEET (Not in Education, Employment or Training) young people aged 14-19 and vulnerable adults throughout Luton and Bedfordshire with the help of qualified, trained and experienced mentors. Address: Luton Training & Mentoring, Community Enterprise &

Resource Centre, The Moakes, Luton, LU3 3QB, Tel: 01582 848488, Email: anj@lutonmentor.com website: www.lutonmentor.com/

Norfolk (area covered by Norwich Asylum Seeker and Refugee Forum, Norfolk Migrant Workers Forum, West Norfolk Diversity Forum, Great Yarmouth GYROS Multi-Agency Forum)

Amigos - the project acts as a liaison between the local churches and migrant communities so that they may have their needs met and integrate in the local society; it focuses on the Breckland area. Email: Jorge Damesceno, amigos_uk@hotmail.co.uk

Asylum Voice (Norwich) is a meeting group which engages with community members with the aim of representing the voice of asylum seekers and refugees within the Norwich Asylum Seeker and Refugee Forum. Its objectives are to promote local and regional policy based on well-informed asylum issues and to produce knowledgeable, skilful and confident community representatives. Address: c/o Red Cross Refugee Resource Centre, 44-46 St. Augustine's Street, Norwich, NR3 3AD, Tel: 01603 623041, Email: pmjobarteh@redcross.org.uk

City of Refuge/New Writing Partnership - this community programme offers projects for young people, competitions, a library project and various training and workshop opportunities. Address: 14 Princes Street, Norwich, NR3 1AE, Tel: 01603 877177, Email: info@newwritingpartnership.org.uk, Website: www.newwritingpartnership.org.uk

Community Connections (Great Yarmouth) is a community development and empowerment organisation working across the boroughs of Great Yarmouth and Waveney. Communities are supported through a whole range of services and projects. Address: Electra House, 32 Southtown Road, Great Yarmouth, NR31 0DU. Tel: 01493 656372, Email: info@communityconnections.org.uk, Website: <http://www.communityconnections.org.uk>

Great Yarmouth International Association (GYIA) aims to bring together the different Black Minority groups of Great Yarmouth and promote good relations within the wider community through social and cultural events. Address: 52a, Deneside, Great Yarmouth, NR30 2HL. Tel: 01493 851598, Email: gyia1@btconnect.com

Great Yarmouth Portuguese

Association/Herois del Mar - one of the group's key roles is to encourage Portuguese community members to pursue education and training and to improve their English. The "Boca em Boca" newsletter also provides information and help with access to advice and services. Address: c/o Café Arroz dos, 31 King Street, Great Yarmouth.

GYROS (Great Yarmouth Refugee Outreach & Support) provides settlement and integration services to newcomers to the UK and is the main point of contact in Great Yarmouth for asylum seekers, refugees and migrant workers needing advice, information or support. Address: 52A Deneside, Great Yarmouth NR30 2HL, Tel. 0149 3745260, Email: enquiries@gyros.org.uk, Website: www.gyros.org.uk

Kings Lynn Area Resettlement Support (KLARS) provides advice and information for migrant workers, asylum seekers and refugees. There are four drop-in sessions every week, where newcomers can get information in English, Portuguese, Russian, Polish and Lithuanian. Address: The Granaries, 21 Nelson Street, Kings Lynn PE30 5DY, Tel: 07916 201729 or 07727957815, Email: postmaster@klarskl.org.uk, Website: <http://www.klarskl.org.uk/>

META@Keystone - META drop-in is a face-to-face information and support service staffed by migrant workers to help mobile communities settle down quickly and effectively. META staff provide support in 7 languages. The META hotline is a telephone service providing information to migrant workers in the Eastern region. Address: Keystone Development Trust, The Limes, 32 Bridge Street, Thetford, Norfolk IP24 3AG, Tel: 01842 754 639, Email: enquiries@keystonetrust.org.uk, Website: <http://www.keystonetrust.org.uk/META/>

Mid-Norfolk Association (MNA) - projects include "Portuguese school for all", ESOL classes and youth club activities. Contact: adchoca@yahoo.co.uk

NEAD (Norfolk Education & Action for Development): NEAD is a development education centre working across the eastern region. NEAD promotes awareness and action on local and global justice and equality issues including community cohesion, migration and diversity. The World Voices programme trains and

guides local people with backgrounds in other countries to share their culture in schools
Address: Charing Cross Centre, 17-19 St John Maddermarket, Norwich, NR2 1DN. Tel: 01603 610993, Email: info@nead.org.uk, Website: www.nead.org.uk

New Routes Integration Project provided services to asylum seekers, refugees and other ethnic minorities and runs a variety of projects which reflect the diversity of its clients. Address: 48 St Augustine's Street, Norwich NR3 3AD, Tel: 01603 632816, Email: newroutes@tiscali.co.uk, Website: http://www.interfacelearning.org.uk/new_routes.html

NORCAS Great Yarmouth confidential clinical service offers information, advice, assessment, needle exchange, counselling and support for anyone who has an alcohol or drug problem or is concerned about a relative, friend or colleague. NORCAS also offers counselling services for gambling clients. Some bilingual support is available to Portuguese speakers. Address: 59 North Quay, Great Yarmouth, NR30 1JB, Tel: 01493 857249, Email: gt.yarmouth@norcass.org.uk, Website: <http://www.norcass.org.uk/>

Norfolk African Community Association (NACA) aims to foster social cohesion amongst the scattered African persons or groups in Norfolk and thus mitigate any feelings or effects of isolation, social exclusion or racial abuse. Address: 47 Winchester Tower, Vauxhall Street, Norwich, NR2 2SE, Tel: 01603 625470, Email: ashwondi@hotmail.com, Website: <http://www.n-a-c-a.org.uk>

NORFRESA (Norwich French Speakers Association) is a community group for French speaking people, especially refugees from Africa. Address: c/o MENTER, 19 Muspole Street Norwich, NR3 1DJ, Email: gervais@norfresa.org.uk

Norwich International Youth Project - created for young people aged 12 - 19 from non-European Union countries who are currently living in the United Kingdom. The project provides orientation, integration and education. Contact Fairlie Winship, Project Co-ordinator Email: norwichyouth@yahoo.co.uk, Tel: 07825 630941

Norwich Lithuanian Association Address: c/o St Martins Housing Trust, 35 Bishopgate,

Norwich, NR1 4AA, Tel: 01603 667706, Email: noah.gins@stmartinshousing.org.uk

Norwich & Norfolk Racial Equality Council (NNREC) is an independent charity covering the county of Norfolk. It works in partnership with communities, local, regional and national statutory & voluntary bodies to address issues of inequality and discrimination. NNREC provides free advice & information about racial discrimination and harassment, equal opportunities and the promotion of good race relations. Address: North Wing, County Hall, Martineau Lane Norwich NR1 2DH, Tel: 01603 611644, Email: enquiries@nnrec.org.uk, Website: <http://www.nnrec.org.uk/>

Red Cross Refugee Orientation Project offers a drop-in service on Mondays and Fridays where volunteers are able to provide support and help with practical problems. Address: 44-46 St. Augustine's Street, Norwich, NR3 3AD. Tel: 01603 623041, Email: rop@redcross.org.uk

Support and integration of Migrants promoting Legal Equality (SIMPLE) runs drop-in surgeries and cultural activities for migrant newcomers in the Breckland area and produces the "Gossip" newspaper. Contact: carla_a_barreto@hotmail.com

Voluntary Norfolk in Great Yarmouth supports the development of a programme linking local residents, including migrant workers, into training, volunteering and employment pathways. Address: The Neighbourhood Centre, 143 King Street, Great Yarmouth, Norfolk NR30 2PQ, Tel: 01493 845925, Email: simon.oleary@nvs.org.uk, Website: <http://www.nvs-gy.org.uk/>

West Norfolk Chinese Association aims to increase the visibility of the migrant Chinese community and to promote cultural activities. Address: 38 Reffley Lane, Kings Lynn PE30 3EQ.

Peterborough (area covered by Peterborough Multi-Agency Forum)

African Caribbean Forum provides support to elderly Caribbean people and activities for young people. Address: Millennium Centre, Dickens Street, PE1 5DG, Tel: 01733 562663.

Bissau-Guinean Association c/o New Link Tel: 01733 864305, Email: newlink@peterborough.gov.uk

British Red Cross Refugee Services coordinates services for asylum seekers and refugees living in the East of England. Address: Brassey Close, Peterborough, PE1 2AZ, Tel: 01733 557472, Email: AHewett@redcross.org.uk

Czech and Slovak Community Organisation c/o New Link Tel: 01733 864305, Email: newlink@peterborough.gov.uk

Ethiopian and Eritrean Community Association c/o New Link Tel: 01733 864305, Email: newlink@peterborough.gov.uk

Lithuanian Community Association c/o New Link Tel: 01733 864305, Email: newlink@peterborough.gov.uk

New Link is Peterborough City Council's asylum and migration service. It aims at creating a new model for managing new arrivals in the UK. Individual projects have been established in Peterborough to achieve this aim. Address: Operations Directorate, Bayard Place, Broadway, Peterborough PE1 1HZ, Tel: 01733 864305, Email: newlink@peterborough.gov.uk, Website: http://www.peterborough.gov.uk/community_information.aspx

Peterborough Portuguese Association facilitates ESOL classes in Peterborough. Address: 128 Gladstone Street, Peterborough, PE1 2BL, Email: PPAssociation@hotmail.com

Peterborough African Community Organisation (PACO) was set up as a means of tackling isolation. PACO addresses this issue by facilitating contact between people with common origins who came to settle in Peterborough. Address: c/o New Link Tel: 01733 864305, Website: <http://www.pacouk.org/>

Peterborough Community Group Forum aims to increase discussion and information exchange and to provide a more effective voice for community groups, organisations and associations in the wider community. Address: c/o New Link Tel: 01733 864305, Email: newlink@peterborough.gov.uk

Peterborough Women's Centre focuses on raising awareness of women's issues, rights, education and personal development, and also promotes interagency links. Courses offered include ESOL, ESOL for ICT, and there is a pilot group for refugee women. Address: 69-71 Broadway, Peterborough, PE1 1SY, Tel: 01733 311564 or 311568, Email: pboro.womens.centre@btclick.com, Website: <http://www.peterboroughwomenscentre.org.uk/>

Poor African Refugee Community Association (PARCA) aims to work towards the full integration of refugees and asylum seekers. Projects and activities cover provision of general information and advice, signposting and referral services, help with training and job search. Address: Unity Hall, Northfield Road, Peterborough, PE1 3QH, Tel: 01733 310091, Email: ukparca@yahoo.co.uk info@poor-refugee.org, Website: <http://www.poor-refugee.org/>

Somali Community of Peterborough offers advice and support for the Somali community in Peterborough and signposts for housing and education services. Address: c/o New Link Tel: 01733 864305, Email: info@scopeuk.org, Website: <http://scopeuk.org/>

Suffolk (area covered by Suffolk Forum for Refugees, Asylum Seekers and Migrants)

Anglo- Chinese Cultural Exchange promotes Chinese and British cultures and exchanges details and learning about everyday lives of the two groups. It is hoped that by engaging in the exchange of cultures and arts, understanding between the two groups will grow and strengthen. Address: C/o Ipswich Community Radio, CSV Media Clubhouse, Ipswich, IP1 1RS, Tel: 01473 225312/078 67614349

Bangladeshi Support Centre provides information, help and support in a culturally sensitive environment; advances the education of individuals and the community as a whole; empowers the individual and community and provides various types of education & recreational training, workshops, and activities for people from the Black and Minority Ethnic background. Address: Bangladeshi Support Centre, Ipswich, IP1 3BE, Tel: 01473 400081 Email: mojlum.khan@bscentre.org.uk, Website: www.bscentre.org.uk

The Basis Project is an England-wide service giving one-to-one support to refugee community organisations (RCOs) to help them manage, develop and sustain their organisation. The contact person for the East of England is Shpetim Alimeta, Tel: 01473 297 912, Email: shpetim.alimeta@refugeecouncil.org.uk

British Red Cross - the work undertaken by the Red Cross in this area includes providing support to refugees and asylum seekers from their centre in Chevallier Street. Address: 15 Chevallier St, Ipswich, IP1 2PF, Tel: 01473 219260, Website: www.redcross.org.uk

CSV Media The Clubhouse in Ipswich is a large digital multimedia centre with music and community art facilities. Amongst CSV's activities is work with Millennium Volunteers, the hosting of Ipswich Community Radio and provision of information, and advice and guidance sessions. Address: The Point, 120 Princes Street, Ipswich, IP1 1RS, Tel: 01473 418014, Email: ipswichmch@csv.org.uk, Website: <http://www.csv.org.uk/Get+Trained/Media+Training/Media+Clubhouse+Ipswich.htm>

Ipswich and Suffolk Council for Racial Equality (ISCRE) provides information, advice and support of a non-financial nature to individuals and families who have experienced, or are experiencing, racial discrimination/harassment or race-related difficulties. They also provide training to service providers. Address: 46A St Matthew's Street, Ipswich IP11TE, Tel: 01473 408111, Website: www.onesuffolk.co.uk/ipswichandsuffolkcouncilforracialequality/

Ipswich Suffolk Indian Association Address: PO Box 757 Ipswich, IP1 9ND Tel: 0844 8844824, Email: info@isia.org.uk, Website: www.onesuffolk.co.uk/isia

JIMAS (Jamait Ihyaa Minhaaj Al-Sunnah) Address: PO Box 24, Ipswich, IP3 8ED Tel: 01473 251578, Email: mail@jimas.org

Karibu African Women's Support Group gives information and advice to their members, provides help and support and signposts to other service providers and also runs different activities for children. Address: 2nd Floor, 1 Cornhill, Ipswich, IP1 1DD, Tel: 01473 289330; 07757 660 833, Email: karibu_wsg@yahoo.co.uk, Website: www.karibuawsg.org

Lowestoft International Support Group is a small organisation run by volunteers, which supports refugees through providing free English classes and a help and information service from their office. Address: 15 Surrey Street, Lowestoft, NR32 1LJ, Tel: 01502 501444, Email: lowestoftlsg@yahoo.co.uk

The Refugee Council - the East of England Asylum and Refugee Integration Service, based in Ipswich, helps asylum seekers and refugees in Suffolk, Norfolk, Essex, Cambridge, Bedfordshire, and Hertfordshire. Address: c/o ICVS 1 Cornhill, Ipswich IP1 1DD, Tel: 01473 297900 National Own Line Telephone Advice Service (OLTAS) 0808 808 2255, Website: www.refugeecouncil.org.uk

Suffolk Refugee Support Forum runs a drop-in advice and advocacy service for anyone to receive free advice and support on a broad range of subjects from housing and employment to how to make friends and learn English. Address: 38 St. Matthews Street, Ipswich IP1 3EP, Tel: 01473 400785, Email: refugeesupport@ukonline.co.uk

Suffolk Inter Faith Resource (SIFRE) was established in 1994 by a group of people representing the faiths and cultures of the residents of Ipswich and Suffolk. Their intent is to promote understanding between people of different faiths. Address: Long Street Building, University Campus Suffolk, Rope Walk, Ipswich IP4 1LT, Tel: 01473 343661, Email: aa@sifre.org.uk, Website: <http://www.sifre.org.uk/>

The Ipswich Polish Club provides advice in legal and community matters, financial and employment support and all general matters. Address: 57 St Margaret's Street, Ipswich, IP4 2AX, Email: secretary@theipswichpolishclub.co.uk, Website: <http://www.theipswichpolishclub.co.uk/facilities.htm>

Waveney Ethnic Minority Project (WEMP) is a voice for Waveney's BME population and was formed in recognition of the emergence of a more diverse Waveney community. Contact: Douglas Mhizha-Shayanewako, Tel: 07785 383670, Email: w.e.m.p-diverse@hotmail.com

Appendix 3

EQUALITY IMPACT ASSESSMENT: Commissioning framework for language support guidelines

Name of project/policy/strategy (hereafter referred to as "initiative"):

To produce commissioning guidelines for language support services

Provide a brief summary (bullet points) of the aims of the initiative and main activities: The aim of these guidelines is to support commissioners in the development of coherent and robust evidence based language support and interpreting / translation strategies and policies, which can be used to deliver culturally competent service provision.

Project/Policy Manager: Simon How

Date: 1/12/10

This stage establishes whether a proposed initiative will have an impact from an equality perspective on any particular group of people or community – i.e. on the grounds of race (incl. religion/faith), gender (incl. sexual orientation), age, disability, or whether it is "equality neutral" (i.e. have no effect either positive or negative). In the case of gender, consider whether men and women are affected differently.

Q 1. Who will benefit from this initiative? Is there likely to be a positive impact on specific groups/communities (whether or not they are the intended beneficiaries), and if so, how? Or is it clear at this stage that it will be equality "neutral"? i.e. will have no particular effect on any group.

The main group to benefit from this initiative are community members whose first language is not English and who would have found communicating with their healthcare profession in English a challenge. The expected benefits to this particular group are to overcome the challenges detailed in Appendix 1.

However by easing some of the pressure on local services it is expected that there will be a small positive impact on the community as a whole, in addition to an increase in community cohesion. In this way the initiative is expected to have a positive impact on equality.

Q 2. Is there likely to be an adverse impact on one or more minority/under-represented or community groups as a result of this initiative? If so, who may be affected and why? Or is it clear at this stage that it will be equality "neutral"?

There is not expected to be an adverse impact to other groups as a result of this initiative

Q 3. Is the impact of the initiative – whether positive or negative - significant enough to warrant a more detailed assessment If not, will there be monitoring and review to assess the impact over a period time? Briefly (bullet points) give reasons for your answer and any steps you are taking to address particular issues, including any consultation with staff or external groups/agencies.

A detailed assessment is not required as negative impacts are not expected. However those implementing guidelines at a local level are encouraged to monitor and assess both the expected benefits and any adverse impacts not foreseen.

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