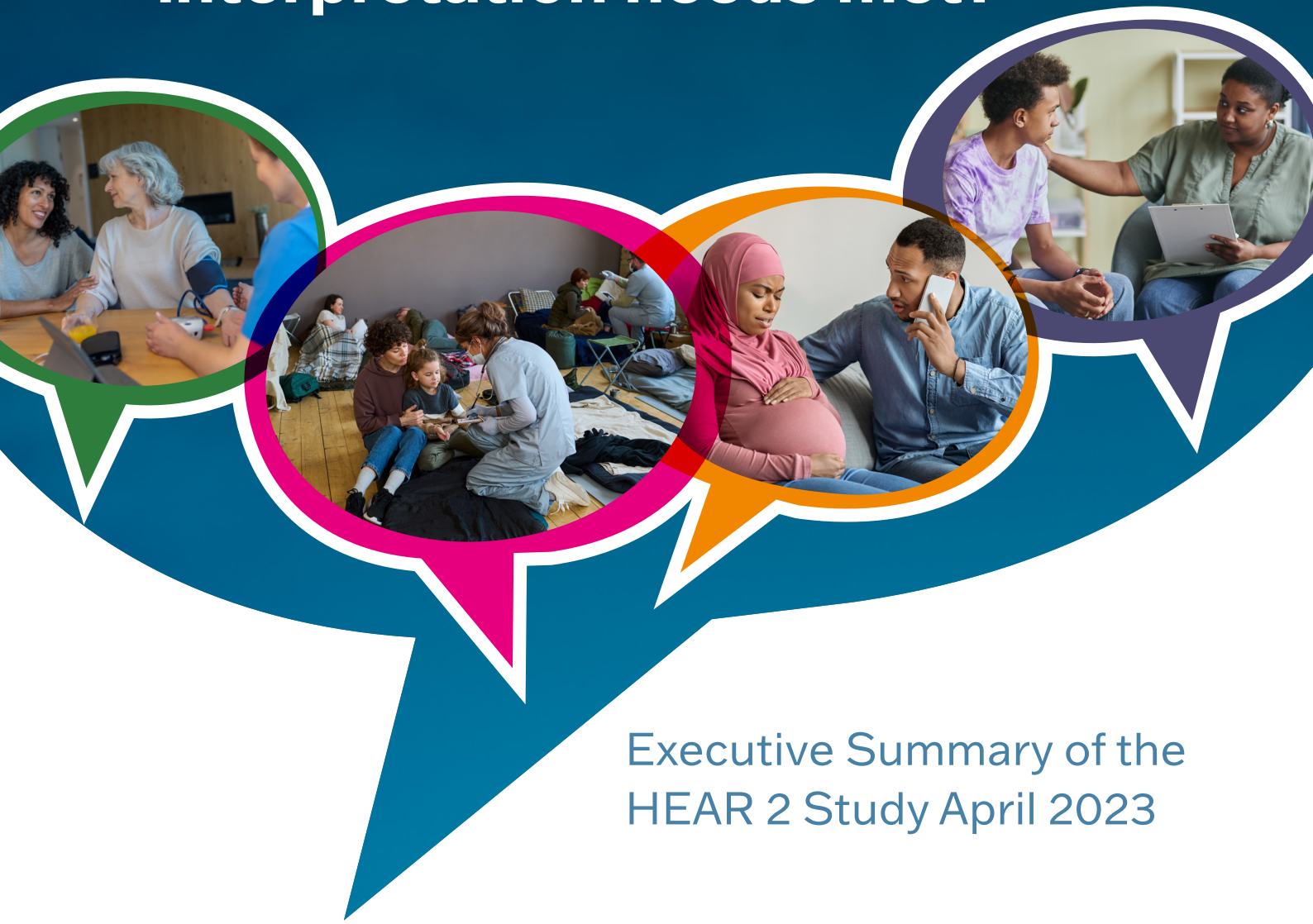
Health Experiences of Asylum Seekers and Refugees in Wales: How well are interpretation needs met?



Executive Summary of the HEAR 2 Study April 2023

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"I put my whole life in his hands... since I have no English"

Asylum seeker talking about her NHS Interpreter

"...a voice for the voiceless"

Asylum seeker talking about interpretation services in health

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Executive Summary

Context

People seeking asylum and people with refugee status using NHS healthcare in the UK are entitled to interpretation services to meet their communication needs and fully articulate their health concerns. The 2019 HEAR (Health Experiences of Asylum Seekers and Refugees in Wales) study highlighted the need to improve interpretation in the NHS in Wales as a priority.

Communication is central to patient-clinician encounters. Clinicians need to be able to take medical history to guide diagnosis, explain prevention or treatments, and address any concerns of patients or carers. International literature indicates that the presence of professional interpreters can improve the quality and appropriateness of care, for example reducing unnecessary and potentially harmful examinations, treatments and hospitalisations, improving preventive measures, shortening hospital stays and decreasing the need for re-admissions. Communication problems can increase missed appointments, affect diagnosis, decrease effectiveness of consultations, harm patient experience and affect health outcomes. Policy guidance and standards on NHS Interpretation have been developed for NHS England and Scotland, but do not yet exist for Wales.

Quality and effectiveness of interpretation services in health and care are under-researched but exploratory studies have found that appropriate interpretation services are not consistently offered or provided in a timely manner. Informal interpretation provided by family members or friends has been found inadequate or inappropriate, especially for sensitive consultations such as mental health, pregnancy, sexual health and conditions requiring consent such as surgery.

Aims and methods

HEAR2 was a collaborative study with two aims: to investigate demand, experiences, and quality of interpretation services in primary and emergency care in Wales; and to assess the feasibility of a comprehensive evaluation of interpretation services in these settings across the UK, including a description of currently commissioned interpretation services. We worked with key stakeholders to develop a logic model describing effective interpretation services and the impact they may have. We trained people seeking sanctuary in research methods as peer-researchers. We conducted a survey of asylum seekers and refugees, comparing three methods of study recruitment; through trained peer-researchers identifying participants, community organisations cascading an internet link, or through a postal approach to those who had used NHS services in five participating sites in Wales. We also conducted semi- structured interviews with asylum seekers and refugees who had responded to the survey and with healthcare professionals and professional interpreters, to gain understanding of different perspectives of using interpretation services. We carried out a four-nation UK survey of NHS commissioners of healthcare interpretation services and a matrix-based assessment of interpretation service quality with health care professionals in the five participating sites. We also investigated the feasibility of collecting the data which would be required to undertake a full health economic evaluation and a comprehensive evaluation of interpretation service provision in primary and emergency care across the UK.

Public and Patient Involvement

Public and patient involvement (PPI) improved the study design, recruitment materials and data collection tools, including accuracy of translated documents for this research. A Participatory Patient Advisory Group (PAG) comprised of people with lived experience of the asylum system supported us throughout the study. The use of peer-researchers and third sector groups enabled outreach to those whose views may not have otherwise been captured and provided key insights. Peer-researchers assisted in helping asylum seekers and refugees complete questionnaires and participate in interviews. The peer-researchers completed ‘Safeguarding Children Level 2’ training through Virtual College in collaboration with our third sector partners. Additional training was provided on how routine health data is collected by the NHS and used in research in line with secure governance processes and patient consent.

Two PPI representatives were recruited to the Study Reference Management Group to ensure independent oversight.

Main findings and implications

Of 384 respondents, 142 (37.0%) had used a professional telephone or face to face interpreter provided by the NHS during a healthcare contact or visit. Awareness of their right to a professional interpreter for NHS contacts was highest amongst refugees 79.8%, but lower among those with asylum seeker status 68.8%, and lowest amongst those who asylum application had been refused 44.4%, despite the latter group having been in Wales the longest. In general, participants reported positive experiences of using a professional interpreter provided by the NHS during a planned visit, though some participants reported not often having a choice in choosing the gender or dialect of their interpreter and were not offered the same interpreter for subsequent health visits/contacts. Users of NHS 111 were most likely to have reported delays due to attempts to access an interpreter.

We found that the three methods for contacting respondents reached different populations in terms of demography, language and health status. It is therefore important to choose the survey method carefully as it will shape the population reached. NHS identified participants had poorer self-reported health and quality of life measures than those identified through the wider population methods (peer-researcher and community links approach). These two groups reported similar measures, which were lower than the general population of Wales.

Interviews confirmed the first point of contact with healthcare services can present a real challenge to people in need of interpretation. Overall satisfaction of patients was relatively high, but interpretation services offered are not always appropriate or specific in terms of dialect, gender or culture, with some examples of poor experiences where interpreters could not understand, were distracted, late or not able to fully translate. Professional interpreters were seen as hugely varied in terms of training and experience. However, trust in professional interpreters to maintain patient confidentiality was high due to trust in NHS processes. Overall, when used, health providers were happy with the quality of interpretation services, in terms of professionalism and courtesy but assessing accuracy was difficult. They felt access processes, for telephone interpretation, could be streamlined, and there were challenges to accessing interpretation as needed in pressured emergency settings.

It was evident that the specialist asylum seeker health service was well practiced in using interpreters and was able to offer patients longer appointments, which is not always possible in mainstream services. Mainstream service clinicians expressed more need for awareness of patient entitlements and training in interpretation service processes. They experienced more pressures on consultation time making using interpreters more challenging.

The self-reported assessment against a matrix of quality criteria showed that only two of the five NHS sites involved met at least 60% of quality criteria in relation to interpretation services, with one service only meeting 12.2%.

The availability of routine NHS data around interpretation needs and provision was variable across the five sites, but where present, enabled data linkage. The inconsistencies of coding of language needs, need for interpretation service and asylum status in mainstream NHS services creates challenges for researchers in this field.

Our UK Commissioners survey revealed differences within and between countries. Service planning based on language need and feedback loops into the commissioning cycle were not universal. Responses were received for all four nations. Few commissioners gathered data on use of interpretation services by asylum seekers or refugees. England had most evaluated feedback from patients, Scotland had most evaluated feedback from interpreters and Northern Ireland had most evaluated feedback from health professionals. Challenges to interpretation delivery included: accessing appropriate languages/dialects especially during emergency calls/appointments, increased demand compared to supply, lack of face to face interpreters for remote areas, concern over quality of service, patients and professionals being unaware of interpretation entitlements, prioritisation of competing urgent needs and budgetary constraints. Our survey showed short-term annual contracts with interpretation service providers were more common in Wales.

Progression criteria for a full health economic and comprehensive evaluation of interpretation service provision in primary and emergency care across the UK were met. Therefore, it is feasible to conduct a future UK-wide study.

Recommendations

The recommendations resulting from this research are relevant to various stakeholders including policy makers, the NHS (including service planners, commissioners and health care practitioners), interpretation service providers, local government, the Home Office, voluntary sector partners and future researchers.

Summary

The HEAR 2 study will guide policy recommendations for the commissioning and delivery of interpretation services in Wales, benefiting patients, the public, and the NHS. Improvements in the quality and safety of healthcare are potential benefits of providing care appropriately in the preferred language of patients in primary and emergency care. This can reduce adverse events, unnecessary healthcare contacts, and improve physical and mental health. This research has wider implications for all who need or provide NHS healthcare through interpretation services.

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