Translation and interpreting services in maternity and neonatal care

Sands & Tommy's Policy Unit
Working together to save babies' lives

Sands & Tommy's Joint Policy Unit briefing paper

Key messages

- Reports and reviews have highlighted issues with the use and quality of interpreting and translation services in maternity care, contributing to poor outcomes and avoidable harm.
- Existing guidance states that professional interpreting services must always be available when needed, and that family members should not be used in place of a professional interpreter.
- There is poor documentation of interpreting need, and inadequate response to requests for interpretation.
- Where interpreting and translation services are available, they are not used consistently. Barriers to this include limited appointment time and poor quality of services.
- Lack of high-quality interpreting services are also impacting personalisation of care and choice, and women and birthing people's ability to give informed consent to treatment and procedures.

Definitions

This document refers to both interpretation and translation:

Translation deciphers meaning of the written word from one language to another.

Interpretation conveys meaning of the spoken word from one language to another

Background

In 2022, 30.3% of all live births in England and Wales were to non-UK-born mothers[1], an increase of 11.7% from the 2003 rate of 18.6%[1]. In London, 58% of all live births were to women born outside the UK[2].

The latest ONS data[3] on language found that, out of the 5.1 million people who did not report speaking English as their main language, 43.9% (2.3 million) could speak English very well, 35.8% (1.8 million) could speak English well, 17.1% (880,000) could not speak English well, and 3.1% (161,000) could not

1 The Sands & Tommy's Joint Policy Unit is committed to inclusivity and ensuring that everyone feels heard and seen. To recognise transgender and non-binary gestational parents, we refer to women and birthing people throughout this report. However, when referencing research, we will mirror the language used in the underlying study to avoid introducing inaccuracies.

speak English at all. If this proportion were the same for the birthing population, this would equate to around 37,000 live births[2] where the mother did not speak English well or at all.

However, it is unclear how many pregnant women and birthing people require an interpreter or translation service, as there does not seem to be data reflecting this. One study based on Freedom of Information requests to 37 Trusts found that between 1 and 25% of births at the Trusts (average 9%) required interpreter support,and that these women received an average of three interpreter sessions across their pregnancy, birth and postnatal journey[4].

Recent reports have highlighted issues with non-English speaking women and birthing people being able to access equitable maternity care, with inconsistent use of interpreters and translation services, and cases where this has contributed to poor outcomes.

Current guidance for health services providing translation and interpretation services

There is some existing guidance setting out standards for provision and use of translation and interpreting services in maternity care.

NICE guidance on routine antenatal care

- Ensure that reliable interpreting services are available when needed, including British Sign Language. Interpreters should be independent of the woman rather than using a family member or friend.
- There was evidence that women who needed to use interpreters found the service to be unreliable and inconsistent, so the committee made a specific recommendation highlighting that interpreters should always be available when needed (including, for example, at scan appointments) and that they should be independent of the woman and not, for example, a family member or a friend.
- The recommendation on the use of interpreters is not new but is not well implemented in all units, so may involve a change in practice.

NICE guidance on pregnancy and complex social factors

- To allow sufficient time for interpretation, commissioners and those responsible for the organisation of local antenatal services should offer flexibility in the number and length of antenatal appointments when interpreting services are used, over and above the appointments outlined in national guidance.
- Provide the woman with an interpreter (who may be a link worker or advocate and should not be a member of the woman's family, her legal guardian or her partner) who can communicate with her in her preferred language.
- When giving spoken information, ask the woman about her understanding of what she has been told to ensure she has understood it correctly.

Office for Health Improvement and Disparities – Language interpreting and translation: migrant health guide

2 20.2% (total percentage who reported that they could not speak English well or at all) of 183,309 live births to non-UK-born mothers equals 37,028.

This guide is written in the context of migrant health but is relevant for all translation and interpreting needs:

- General Medical Council guidance states that all possible efforts must be made to ensure effective communication with patients. This includes arrangements to meet patients' communication needs in languages other than English.
- NHS England and NHS Scotland guidance stipulate that a professional interpreter should always be offered, rather than using family or friends to interpret. Working with professional interpreters will:
    - ensure accuracy and impartiality of interpreting
    - minimise legal risk of misinterpretation of important clinical information
    - minimise safeguarding risk
    - allow family members and friends to attend appointments and support the patient (emotionally and with decision-making) without the added pressure of needing to interpret
    - foster trust with the patient.
- When translating documents, automated online translating systems or services such as Google Translate should be avoided in healthcare settings as there is no assurance of the quality of the translations.
- Record a patient's language and interpreting needs in their healthcare record. Pass on this information when referring them to other health professionals.
- Since interpreted communication requires the delivery of messages at least twice (once in the original language, and once in the converted language), plan for the interpreted session to take around double the length of time as a session without an interpreter.

Summary: requirements on health services from current guidance

- Guidance states that professional interpreting services must always be available when needed.
- Family members, and particularly children, should not be used in place of a professional interpreter.
- Automated online translating systems or services such as Google Translate should also be avoided.
- Services should allow sufficient time for interpretation (around double the length of an appointment without an interpreter) and offer flexibility in the number and length of appointments when interpreting services are used.

Issues highlighted regarding the provision and use of translation and interpreting services

Interpreting and translation services not being used

The Healthcare Safety Investigation Branch (HSIB - now the Maternity and Newborn Safety Investigation, or MNSI) 2020 summary of maternity themes report[5] analysed completed maternity investigations since the programme started in 2018. Cultural considerations emerged as a key theme which included translation and interpreting services. Investigations found that although interpreting services are available, they may not be utilised by staff at the relevant time. They found that there is often an assumption that if the mother can speak 'good English' she understands all aspects of the

discussion around her care, leading to a disconnect ‘between what she has been told and what she understands’.

The CQC’s 2022/23 state of healthcare and adult social care report found issues with staff communicating with women with language needs[6]. In the report, midwives explained that there was a lack of willingness among some colleagues to use interpreting and translation services. This was usually due to it being seen as taking too long, or ‘not worth bothering with’, particularly in situations such as a routine appointment. It was noted that a standard 20-minute appointment is not enough time to allow for translation, so even if an interpreter is used, a person who doesn’t speak English ‘may still not get care of the same standard’.

The Sands Listening Project highlighted a case where a mother of Pakistani ethnicity was seen at three different hospitals when trying to access a scan following bleeding at 12 weeks[7]. During this time she was not offered a professional interpreter, with staff relying on her husband to explain to her what was happening. She later requested to see her notes and was upset to see that the written record did not agree with what she had understood to be happening at the time.

There are also issues around consistency during the care pathway. Out of the 15 women who did not speak English whose case was reviewed by the MBRRACE panel, none received interpreting services throughout the care pathway[8].

Family members or staff being used in place of a professional interpreter

Despite guidance stating that family members should not be used in place of a professional interpreter, reports have found that this continues to occur. HSIB’s summary of maternity themes found that family members or staff who speak the relevant language were used as interpreters, resulting in potential misunderstandings.

The MBRRACE confidential enquiries into Black and Asian baby deaths also found inappropriate use of family members and healthcare professionals as interpreters.

It has been reported that sometimes women themselves request that a family member is used rather than a professional interpreter. A qualitative study with pregnant women with language barriers on their experiences with interpreting services in England found that ‘most of the women preferred a family or friend to interpret for them as they could trust them’[9]. When this was not possible, they discussed not having a choice in the interpreter they get, for example a female interpreter when discussing intimate details, or a face-to-face service. When using professional interpreters, some women worried about confidentiality[10].

It is important to consider the impact on family members being used as interpreters, particularly children. Healthwatch held interviews with patients and staff on language barriers and health inequalities in 2022. All four family members who took part in their research said they preferred not to act as ‘interpreters’[11]. This was due to various reasons, including feeling they have an additional responsibility for their relative's health, and lacking the medical knowledge to provide the proper support.

Quality of interpreting and translation services

It has been highlighted that poor-quality interpreter services impact on women’s ability to ‘seek help, disclose risk factors and communicate effectively with their healthcare providers’[12]. When speaking about their experiences with interpreting services in England, women explained how they felt the accuracy of the interpretation was questionable, with some feeling that words were changed or that the interpreter simply didn’t know their language well enough. This was particularly the case for languages

where there are significant regional differences, for example differences in French from the Ivory Coast and French from the Congo[13]. Overall, these women described a negative experience of interpreting services during their maternity care, either through a lack of access, or poor-quality interpreting.

The NHS Race and Health Observatory's report also found that high quality interpreters were not being provided in mental healthcare, in GP surgeries and at various points along the maternal health care pathway[14].

As well as being off-putting to services users, poor-quality services can lead to healthcare professionals not wanting to use them, as they may also question the accuracy of the interpretation. It is not clear what the standard qualifications are for a professional interpreter when working with women and birthing people in maternity and neonatal services. The Office for Health Improvement and Disparities migrant health guide states that professional interpreters will have different levels of qualifications and experiences in their respective languages. It also says that not all are trained to work in healthcare settings and competently use health-related terminology. This lack of clarity around what qualifications a professional interpreter must have can make it challenging to ensure that high-quality services are always available. It can also lead to Trusts opting for cheaper options such as companies that do not use registered professional interpreters.

Impact of these issues in translation and interpreting services on care

Poor interpreting and translation services linked to poorer outcomes

Issues with interpretation and communication have been linked to poorer outcomes. The BBC wrote a Freedom of Information (FOI) request to HSIB[15], asking them to review all investigations from 2018-2022 that involved cases of babies dying or being diagnosed with a severe brain injury in the first seven days of life. The FOI found that 80 cases out of 2,607 included references to interpretation or communication problems due to language difficulties, which it therefore considered to be a contributing factor in the death or brain injury.

Many of the legal experts interviewed in the Birthrights inquiry into racial injustice in maternity care referred to the poor translation services playing 'a significant part in negligent care'[16]. The case reviews in the MBRRACE confidential enquiries into Black and Asian baby deaths identified significant or major language issues, which were probably or almost certainly relevant to the outcome, for five Asian women, three Black women and two White women[17].

HSIB reviewed the findings of maternity investigations into intrapartum stillbirths referred between 1 April and 30 June 2020 (the first peak of the Covid-19 pandemic in England). They found that, of the 37 cases of stillbirths identified, 16 women and pregnant people (43%) did not have English as their first language[18]. The review highlighted 'variable adherence to guidance' on use of interpreting services, with 22% of cases involving families whose first language was not English highlighting a lack of access to interpreters. In half of these cases, it was possible that 'this affected the care received'.

Data suggests that non-English speaking women and birthing people are also at higher risk of maternal death. Of the 241 women who died from direct and indirect causes during or up to 42 days after the end of their pregnancy in 2019-21, 12 (5%) could not speak English[19].

Language barriers affecting personalisation of care and choice, and informed consent

Personalisation of care and choice has been identified as key to improving the safety of maternity services. The Royal College of Obstetricians & Gynaecologists (RCOG) have stated that translation and interpreting services are essential to providing 'safe, consensual and personalised care' for women who don't speak English, and that healthcare professionals rely on these services being available to

ensure women are ‘able to make informed choices about their care’, and ‘can give informed consent to treatment and procedures’[20]. Informed consent requires the woman or birthing person to be well informed about any ‘proposed treatment or intervention’, including the risks and alternatives[21].

The MBRRACE confidential enquires noted that a lack of independent interpreting services may have impacted upon ‘women's ability to make informed choices about their care’[22].

The Birthrights inquiry[23] found many examples of women with limited or no English who did not have access to an interpreter or adequate translation services. This led them to having procedures where ‘they were not clear of the risks or benefits, or even why they were having it at all’. The report also included a case where a woman was told that hiring an interpreter was ‘too expensive at a rate of £50 an hour’, and therefore was ‘a waste of public money’.

As a large meta-ethnographic study on language challenges in midwifery care stated, ‘language barriers could, in the worst case, lead to violations and perceived forced consent in emergency situations’[24]. This is due to women not fully understanding information being provided to them, which could have serious consequences.

More generally, research has highlighted that patients with language barriers who access general healthcare services are ‘less likely to actively participate in their care, do not share their concerns, ask fewer questions and are less verbally dominant than patients belonging to the majority population’[25].

Summary: Issues highlighted in previous research and reports and impact on care

- Issues with interpreting and translation services in maternity and neonatal settings are consistently identified across numerous reports and are resulting in avoidable harm.
- Too-often inappropriate steps are taken to translate or interpret, which run counter to nationally agreed standards. This includes the use of family members or healthcare professionals as interpreters.
- There is poor documentation of interpreting need, and inadequate response to requests for interpretation.
- Where translation and interpreting services are available, they are not always used by healthcare professionals.
- Lack of high-quality interpreting services are impacting personalisation of care and choice, and women and birthing people’s ability to give informed consent.
- Limited appointment time, and quality of services, appear to be barriers to the effective use of translation and interpreting services.

What data is available on the provision and use of services?

It is not clear exactly how many pregnant women and birthing people require interpreting and translation services, but one study based on FOI requests to Trusts found that on average, 9% of the births at the Trusts required an interpreter, and that these women received an average of three interpreter sessions during pregnancy, birth and postpartum[26]. Information obtained from the FOI request suggests that documentation of a woman's interpreting need is not complete or consistent across NHS maternity services[27].

One of the challenges in understanding how many pregnant women and birthing people require an interpreter is that there does not appear to be a standard definition for someone that does not speak English, and who therefore requires these services. ONS data separates out the general public into those who can speak English very well, well, not well or not at all, however it is not clear what the numbers of pregnant women or birthing people are in these categories. It is also not clear how English language proficiency is described in a maternity and neonatal healthcare context. There is a large grey area between those who can speak English fluently and those who cannot speak it at all, for example there is reference to women who spoke 'some' or 'conversational' English in an MNSI article on safety factors and effective communications[28]. One of these women, who was not provided with an interpreter due to her being able to speak 'conversational' English, did not understand the medical language used relating to 'contractions' and 'established labour' in the information leaflet that she had been given in English. She came into hospital in extreme pain with an obstructed labour and her baby sustained a brain injury due to lack of oxygen.

Having a standard definition across organisations will help to ensure consistency in identifying women and birthing people with language barriers that require translation and interpreting services.

Availability and provision of services

It is understood that the availability of telephone interpreting services across healthcare means that clinicians should have access to interpreters 24 hours a day[29]. However, it is clear from previous research and reports that despite apparent availability of services, they are not being used. A study carried out across a number of UK general practices found that professional interpreter services including face-to-face interpretation and telephone interpretation were under-utilised[30].

Reasons for this are likely to include those discussed above, including time constraints and quality of services, but it is also important to note that maternity care professionals do not receive training on how to assess English language proficiency. This links to the absence of any standard definition of who requires these services, and means that healthcare professionals may misjudge language needs or rely on a woman's own assessment of whether an interpreter is necessary[31]. There are also differences in documenting language needs in systems that can make it difficult to ensure an interpreter is available. For example, in some NHS Trusts and Boards there is clear documentation when an interpreter is required (such as a 'flag'), in other systems it is less obvious, making it necessary to go back to the record of the initial midwife appointment[32]. Furthermore, some systems don't record language spoken, but country of origin, which is unhelpful if multiple languages are spoken in that country.

When examining the availability of services, it's important to consider the different types of service that may be required in different situations. Whilst face-to-face interpreting is the gold standard in healthcare and should be used whenever possible, it will not be appropriate or possible in all circumstances. For example, Trusts based in rural areas may not always be able to arrange a face-to-face interpreting service for every language required. Telephone and internet connection may also be challenging in rural settings, and therefore offline provisions must be in place in case needed.

There will also be situations that aren't routine and therefore cannot be planned ahead, for example emergency attendances at maternity triage. In these situations, it's vital to ensure that there are appropriate video and telephone interpreting services available. This requires a multi-layered approach to guarantee equal and consistent provision of services.

What policy recommendations have been made?

Current commissioning arrangements

Integrated Care Boards (ICBs) are responsible for ensuring translation and interpreting services are available for patients accessing primary care. To support ICBs, NHS England guidance exists for commissioners on interpreting and translation services in primary care.

Similar guidance does not exist for secondary care, as noted by the MBRRACE confidential enquiries into Black and Asian baby deaths. However, Trust Boards are responsible for ensuring that there is access to a trained interpreting and translation service provided by approved, independent organisations for their services.

Recommendations for improvement

The Health Innovation Network for South London sets out the following recommendations for interpreting services in maternity care:

- Where possible aim for continuity of interpreter to allow trusted relationships to grow
- Care pathways must be amended to include the interpreter as a member of the muti-disciplinary team
- Building on this work South West London Local Maternity and Neonatal System (LMNS) should benchmark interpreting services and ensure there is no unwarranted variation across the system
- Training and guidelines for maternity and neonatal teams should be provided, benchmarking against the Maternity pan-London guidance.
- Development of interpreting services must be coproduced with collaboration between:

a) Women and birthing people
b) Maternity and Neonatal care providers
c) Community assets
d) Maternity and Neonatal Voice Partnerships
e) Maternity core connectors/community engagement practitioners

Other recommendations have also been made, including the following in a Midwives Information & Resource Service (MIDIRS) article exploring how maternity care can be improved for women with limited English[33]:

- Creation of a specialist midwife role, to improve care for women with limited English language proficiency.
- Provide advanced communication skills training for clinicians and staff, including English language proficiency.
- Provide improved interpreter provision, through the development of national guidelines for interpreter training and support, and wider adoption of bilingual health advocates in the NHS.
- To designate language as a protected characteristic, and separate language out as a variable in research.

Considerations for policymakers

This paper has collated and synthesised issues with the use and quality of services, with a focus on interpreting services, that have been highlighted in previous research, reports and reviews.

We want to understand how we can improve the availability, consistency and quality of interpreting and translation services, considering the following:

- Consider establishing a standard definition for women and birthing people who do not speak English and that require translation and interpreting services, to be used across organisations to ensure that they are consistently identified and provided with services.

- How is data and insight on the quality and availability of interpreting services being collected, so that this can been seen nationally?
- How can we ensure an equal level of provision across services? This could include exploring the feasibility of a national service.
- Provide clarity on what qualifications a professional interpreter needs, so that women and birthing people are consistently provided with high-quality translation and interpreting services.
- What national commissioning arrangements are needed to support consistent provision of high-quality interpreting services?
- How can we determine the availability of services in different scenarios, for example in rural settings, routine care, or emergency attendances? It is important to consider the many ways that women and birthing people make contact with services, including for example through telephone triage.

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