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

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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

Acknowledgements

The authors thank all those who participated in the HEAR2 study - public, patients, professionals and especially our peer researchers.

We were supported throughout by Displaced People in Action, the British Red Cross and the Ethnic Youth Support Team.

We thank Rebecca Fogarty for expert advice, Angharad Claydon for administrative support throughout, Kate Ashill for communications support, Michael Ogunibiyi for event logistical support, Sam Baig for assistance on interpretation services, Adam Howls and the Wales Interpretation and Translation Service, together with Elen De Lacey, the R and E team at PHW, and the finance teams at Swansea University and PHW.

We thank Hayley Jenney from Jenney Creative for design and production, and all those who assisted with translation for final publication.

This study was funded by Health and Care Research Wales.

Technical Report of the HEAR2 Health Experiences of Asylum Seekers and Refugees in Wales: How well are interpretation needs met?

April 2023

ISBN: 978-1-83766-156-5

Main Messages

Background: The ability to receive health care in our own language is a requirement for all NHS organisations. A study into Health experiences of Asylum seekers and Refugees in Wales, 2019 (HEAR) revealed concerns around provision of interpretation services in health care. Lack of interpretation services can lead to significant problems with care, such as the wrong diagnosis being made, ineffective treatments being advised, missed appointments, and issues with consent and confidentiality.

Methods:

We conducted the HEAR2 study which involved carrying out surveys and interviews with asylum seekers and refugees in Wales to understand their experiences of using interpretation services. We trained people seeking sanctuary in research methods as peer researchers. We also interviewed health professionals and professional interpreters in Wales and conducted a cross-UK survey of commissioners of interpretation in the NHS.

Results:

There were a number of important findings from this study. These included:

1. Some asylum seekers and refugees faced challenges in accessing interpretation services. The first point of contact can present a real challenge to people in need of interpretation. When received, patients were generally satisfied with professional interpretation during planned visits. There were some concerns around quality of interpretation, lack of choice of gender or dialect of the interpreter.
2. Users of NHS 111 were most likely to have reported they experienced delays due to attempts to access an interpreter.
3. Those with refugee status were more aware of their right to a professional interpreter (79.8%) than those with asylum seeker status (68.8%), particularly those with an unsuccessful asylum application (44.4%).
4. For health professionals, more streamlined processes for accessing interpretation services, additional consultation time and training on working with interpreters would be beneficial.
5. Differences in characteristics of survey respondents, including demographic, language and self-reported quality of life measures, can occur when using different recruitment methods (NHS sites, community links and peer researcher approaches).
6. Coding of asylum status at NHS sites is inconsistent, which presents a challenge for further research in this field.
7. Few commissioners sought feedback on NHS interpretation services from patients.
8. Criteria for a future UK comprehensive evaluation of interpretation service provision in primary and emergency care were met.

Implications:

This study has produced new evidence on meeting the interpretation needs of asylum seekers and refugees with potential benefits in healthcare quality, safety, and physical and mental health outcomes. Results are relevant to wider groups using interpretation. Recommendations have been made for policy makers, the NHS, interpretation service providers and others, with the aim of achieving this. These include the development of commissioning guidance and standards for interpretation in health and care for Wales, simplifying processes to access an interpreter especially for unplanned/urgent care and strengthening ways to feedback on interpretation services from patients and staff. The use of peer researchers in the administration of survey and interview elements of the programme enabled outreach to those who may have been otherwise excluded. The involvement of the third sector throughout the study also proved a strength. HEAR2 has added to the body of evidence in an under-researched field.

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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.

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 in 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.

Contents

Background and Rationale

Provision of interpretation services to support healthcare delivery is a requirement of all NHS health care organisations. However, there is evidence that interpretation needs of asylum seekers and refugees in healthcare are not met adequately [1]. International conflict, most recently in Syria, Afghanistan and Ukraine, and human rights abuses have contributed to the rise in people seeking sanctuary. The main barriers to 'vulnerable migrants' receiving good quality primary care continue to be language and administration barriers [2]. Problems in access include lack of knowledge about what is available (among patients and practitioners); confidence and trust; and time-consuming processes which conflict with the delivery of routine care [1].

Research evidence about need and effectiveness of interpretation is scarce, particularly with first contact services such as primary and emergency care [3,4]. Misunderstandings lead to errors with potential consequences for: safety [5]; compliance; disadvantage, including in the care of patients with mental health problems [6]; and uptake of preventive services [7,8]. Challenges to interpretation include a lack of availability, use of family, friends or other non-professionals as interpreters [9-13] (leading to problems of accuracy and lack of confidentiality) [14], differences in dialect between patients and interpreters [11,15], and interpreters who were unsuitable in age or gender [11]. Communication is central to patient-clinician encounters. Clinicians need to be able to take requisite history to guide diagnoses, explain prevention or treatments, and address any concerns of patients and care-givers. International literature indicates that the presence of professional interpreters can improve quality of care [6], for example reducing unnecessary and potentially harmful examinations, treatments and hospitalisation [16], improved adherence to and use of preventive measures [6, 17], shorter durations of hospitalisation and decreased need for re-admission [18]. Communication problems can affect health outcomes, effectiveness of consultations and patient experience as well as increasing missed appointments [14].

Asylum seekers and refugees are more likely to experience difficulties with mental health and well-being than the local population [19], including higher rates of depression, post-traumatic stress disorder (PTSD) and other anxiety disorders [20, 19, 21], but are less likely to receive support [22]. Evidence shows that interpreters who are trained and qualified provide a better patient experience [23] and can improve the outcome of psychological treatments for asylum seekers and refugees [24].

Policy guidance and standards on NHS interpretation have been developed for NHS England and NHS Scotland [14, 25]. Evidence about ethnic diversity and inequality may be overlooked by commissioners of interpretation and commissioning teams may be unrepresentative of ethnically diverse populations [26].

The interpretation experience of sanctuary seekers in Wales has not been researched previously. This study adds to our understanding of interpretation service delivery in NHS care, from commissioning to service quality and patient and practitioner experience, informing future policy and practice.

Primary Research Questions

1. **What are the experiences of asylum seekers and refugees with language needs when they seek healthcare within primary and emergency healthcare settings in Wales?**

2. **Is it feasible to carry out a UK wide evaluation of interpretation services in these healthcare settings to improve policy and practice?**

Study Aims

1. **To describe use, experience, challenges and quality of service provision for asylum seekers and refugees when accessing interpretation services within primary and emergency health care in Wales.**

2. **To assess whether a full evaluation of effectiveness of interpretation services in primary and emergency healthcare across the UK is feasible, including description of currently commissioned services, and building foundations for future research.**

Study Objectives

To meet aim 1 – describe:

1.1 Scale and nature of interpretation service delivery in primary and emergency health care in Wales.

1.2 Quality of service provision as assessed against known standards.

1.3 Experiences, perceptions and challenges in accessing and using interpretation for asylum seekers, refugees, providers of healthcare and interpretation professionals.

To meet aim 2 – assess:

2.1 Engagement of services in research, whether predetermined progression criteria for full evaluation are met.

2.2 Availability and reliability of data sources about need and provision of interpretation.

2.3 Utility of data collection (survey) methods – comparison of postal survey of patients attending general practice and emergency care; peer-researcher administered questionnaire survey in community settings, and questionnaire survey cascade by specialist third sector organisations (community links).

2.4 Existing models of service provision in health care settings in Wales and across the UK.

2.5 Potential to link study participants to retrieve outcomes and resource use from routine datasets related to primary and emergency healthcare.

2.6 Feasibility of undertaking a health economic study as part of definitive future evaluation: collecting the cost of providing interpretation, the quality of life data (using EQ-5D-5L in different languages) and healthcare resource use.

A matrix of HEAR2 study areas matched to programme objectives can be found in Appendix 2.

Methods by objective

1.1 We recruited five NHS sites: one NHS Ambulance Trust, two General Practices, one Specialist Primary Care Centre and an Emergency Department (ED). A Clinical Research Officer visited sites and searched routine healthcare records to identify adults residing in Wales with an interpretation need. We aimed to collect data on age, gender, presenting complaint/diagnosis/condition, whether an interpreter was offered for the consultation and the medium of interpretation delivery (whether face to face or telephone for example).

1.2a We carried out an on-line stakeholder workshop to develop a logic model for the study. We invited 30 stakeholders from Wales and England, including people with lived experience of the asylum process and professional staff involved in commissioning, planning, and delivering interpretation services in the NHS. Five groups undertook three facilitated discussions. Questions discussed were: 'What is needed to provide an interpretation service?' (Inputs); 'How do you think interpretation services work for asylum seekers and refugees?' (Mechanisms of change); and 'What difference does it make to have an interpretation service?' (Outcomes). Responses were recorded and used to develop our study logic model.

1.2b Indicators from national guidance [14, 25] were used to develop a Quality Assessment Matrix (QAM) (58 questions). We invited the Principal Investigator at each of the study sites to complete it on behalf of their NHS service.

1.3a We developed a cross sectional questionnaire for asylum seekers and refugees based on the research literature, results of the HEAR1 study, the logic model and quality standards. It included questions on demographic and health status; need for interpretation and experiences of this in primary and emergency health care in Wales (Appendix 3). We took three approaches to identifying potential participants:

Route 1. Peer-researcher supported: We recruited peer-researchers who used personal networks to identify individuals eligible to complete the questionnaire. They offered support to help individuals complete paper or online versions. We aimed to recruit a sample of 200 respondents through this route.

Route 2. Community links: We shared a link to the online questionnaire with community organisations for wide cascade to people seeking sanctuary in Wales. Individual respondents completed the questionnaire themselves online, without support from the study team. This was an unplanned addition to our original methods with no target sample size.

Route 3. Patients identified from routine health records at NHS sites were sent postal surveys (from this point onwards referred to as 'postal survey from NHS sites'): A clinical researcher within the team identified eligible patients at NHS sites using routine records. Study researcher support was offered if required. We aimed to send up to 1000 questionnaires, across five NHS sites, however delay in access to sites due to Covid-19 meant that this was not possible.

Paper questionnaires and information sheets were available in English and in ten other languages (Albanian, Amharic, Arabic, Farsi, French, Kurdish Sorani, Spanish, Swahili, Tigrinya, Urdu). All participants were offered a £10 high street voucher for completing the survey. We included all responses that were submitted online or returned by post

over a six-month period (23rd February – 3rd August 2022). For this objective we analysed combined questionnaire responses from routes 1 (peer-researcher) and 2 (community links) only as recruitment was methodologically similar.

1.3b We conducted semi-structured interviews with 14 asylum seekers and refugees. Questionnaire respondents were invited to be interviewed. The interviews were carried out using standard questions via video call by peer-researchers in the participant's preferred language, with questions translated as required. Peer-researchers were supported by study team members in this task. All participants provided consent for the interviews to be recorded, transcribed, and, where necessary, translated. Participants were offered 'thank you' gift vouchers.

In addition, we conducted semi-structured interviews with 14 service providers using standard interview templates. Ten were health care providers, and four were involved in providing professional interpretation services. The healthcare providers worked in a range of settings, some with experience of more than one: specialist primary care service providing short term care for asylum seekers and refugees (n=3); mainstream primary care (n=2); and emergency care settings (n=5). Interpretation services discussed included face to face and telephone provision. Interviews were conducted via video call by members of the study team and were recorded and transcribed in full.

We analysed qualitative data thematically, using a framework derived from the literature. We developed a common analytical framework for use with all interview transcripts. Interview guides can be found in Appendix 4.

2.1 In consultation with the research team and Study Advisory Group we developed progression criteria before data collection, which we used to assess whether a full UK wide evaluation of interpretation services in primary and emergency healthcare is feasible.

2.2 Availability and reliability of data sources about language need and provision of interpretation comprised a subset of 2.5 and so has been dealt with in conjunction with that objective.

2.3 We compared response rates, completeness of data, participant characteristics and self-reported experiences between the three methods of recruitment for the survey (peer-researcher supported, community links, postal survey from NHS sites), analysing using SPSS.

2.4 We conducted a UK wide online cross-sectional survey of NHS commissioners of interpretation services in Spring 2022, to understand existing commissioning and provision of interpretation services for asylum seekers and refugees in primary and emergency health care in the UK (see Appendix 5). We aimed to describe planning, contracting and evaluation of interpretation services, identifying any challenges to delivery. Following a review of the literature, we developed an online questionnaire on the Joint Information Systems Committee (JISC) online surveys platform. We used the NHS Commissioning model [27] as the basis for the questionnaire which was reviewed by commissioners of interpretation services in each UK nation and revised before wider distribution.

The survey was distributed to all Health Boards in Scotland (n=14), Wales, with the addition of the Welsh Ambulance Trust (n=8), Health and Social Care bodies in Northern Ireland (n=5) and Clinical Commissioning Groups (n=144) in England,

with support from relevant networks in each nation. Integrated Care Boards (ICBs) replaced clinical commissioning groups (CCGs) in NHS England from July 2022, so follow up questionnaires were also sent to the 42 ICBs. This led to responses in England coming from a mixture of CCG's and ICB Regions/ICB's. Respondents were offered telephone completion with a researcher if preferred.

Responses were analysed in SPSS. Free text responses were initially coded and organised into key themes by one researcher, verified by a separate member of the research team to support consistency and reliability in the interpretation of the data. Detailed rules for handling of responses during this period of NHS reorganisation were drawn up (see Appendix 5).

2.5 As part of this study we sought to identify:

- what NHS codes were available in primary and secondary care to capture asylum status, language and interpretation use
- what processes are in place for their use
- whether codes are routinely applied and whether linkage fields are available.

We did this through quantitative data collection, discussions at five NHS sites and with partners based in Data Science, Swansea University.

2.6 The HEAR 2 project aimed to investigate the feasibility of collecting data required to undertake a full health economic evaluation within a future study of effectiveness, including feasibility of:

1. collecting resource use data and unit costs associated with intervention implementation and
2. retrieval of utility data required for a potential cost-utility analysis;
3. consideration of a health economic evaluation framework for a potential future study.

Retrieval of data resource from routine data sets was also highly relevant (2.5). A full formal health economic evaluation was not undertaken as part of this study. The analysis focused on the feasibility of data collection, including assessment of the number of completed data items required for health economic evaluation, percentage of missing data and description of health-related quality of life scores. The feasibility of collecting data required for the evaluation of the implementation cost (e.g. number of interpretation sessions provided, duration of interpretation sessions (in minutes), cost/pay band of interpreters, etc.) was established by reviewing survey data and discussions with the study team. The feasibility of collecting health-related quality of life data using the EQ-5D-5L questionnaire and visual analogue scale (VAS) [28] which were administered to participants which were part of the HEAR2 survey element was assessed through description of the number and percentage of complete responses that could be analysed without imputation. A preliminary descriptive analysis of EQ-5D-5L scores was undertaken to review differences between people with different immigration status and differences in methods of survey delivery (peer-researcher supported, community links, postal survey from NHS sites).

Patient and Public Involvement

Patient and public involvement (PPI) was central to our study design from the outset. We built on the work of the first HEAR study looking at the experience and access to health care by sanctuary seekers in Wales. Our research team included two lay members with lived experience who were involved in the HEAR1 study as advisors and peer-researchers They advised on design of the HEAR2 study and then became active members of the Research Management Group. We set up a Public Advisory Group (PAG) of 7 members and recruited 12 peer-researchers who participated in data collection. For detail on PPI advisors, PAG members and peer-researchers by area please see Appendix 6. The PPI and peer-researchers spoke a total of 12 languages (Albanian, Arabic, Bantu, Berber, English, Farsi, French, Kurdish Sorani, Lingala, Russian, Spanish and Tamil). The peer-researchers and PPI members met before survey recruitment phase and online three times during training and data collection. Training included questionnaire completion. Those who would be conducting face to face interviews were given guidance and supervision. The peer-researchers completed 'Safeguarding Children Level 2' training through Virtual College. 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.

PPI and peer-researchers were involved in;

- Advising on questionnaire design and accuracy of translated versions
- Advising on ethical aspects including recruitment and consent during the Covid-19 pandemic.
- Revising participant-facing materials
- Participating in data collection

Results by objective

1.1 We included data on 147 individuals across four sites who were identified as having needed or used interpretation services: 101 from Site A, 3 from Site C, 11 from Site D and 32 from Site E. We were not able to collect data from Site B as research permissions were not granted within the study period. The median age was 35 years overall, with those attending the specialist service and ED being younger than those attending primary care (Median). Asylum seeker/refugee status was only reliably available at the specialist service, where 94.1% of patients' status was recorded. Females comprised 55.8% of patients. See Table 1 and 2 in Appendix 7.

Table 3: Asylum status

Site	Number of patients	Asylum Seeker	Refugee	Missing/Not known/ Not recorded
Site A	101	47 (46.5%)	48 (47.5%)	6 (5.9%)
Site C	3	0 (0.0%)	0 (0.0%)	3 (100.0%)
Site D	11	1 (9.1%)	1 (9.1%)	9 (81.8%)
Site E	32	7 (21.9%)	2 (6.3%)	23 (71.9%)
Total	147	55 (37.4%)	51 (34.7%)	41 (27.9%)

Amongst non-specialised secondary and primary care sites, levels of 'asylum status not recorded' were 71.9%, 81.8% and 100.0%.

Service Contacts

There were 222 healthcare contacts recorded for 147 individuals across the four sites. Interpretation provider was not recorded for 68.9% of contacts, but the most frequently recorded provider was family/friends/other. Language Line and Big Word were the interpretation service providers recorded. Reason for contact was not recorded for 75.7% of contacts, and where available was mostly related to physical problems, with some mental health conditions recorded. See Table 4 and 5 in Appendix 7.

Table 6: Contacts with specified interpretation provider

Site	Big Word	Language Line	Family/ Friend	Missing/NR/ NK	Total contacts
Site A	9	5	10	99	123
Site C	0	3	0	0	3
Site D	0	7	7	0	14
Site E	0	0	28	54	82
Total	9	15	45	153	222

Two sites had complete recording of interpretation provider, but one had recorded this in 34.1% of cases and one only in 19.5%.

1.2a We developed a logic model including components, mechanisms, outcomes and context and finalised it through discussions with providers and those with lived experience in an online stakeholder event (see Figure A).

1.2b All five sites completed the Quality Assessment Matrix. In terms of criteria met, there was considerable variation between sites, although no site met all 41 quality criteria. Site A and Site C reported most criteria met (26 criteria, 63.4%) while Site B reported the least (5 criteria, 12.2%) (see Table 7 in Appendix 8).

Table 8 in Appendix 8 shows that many criteria were reported as 'Met' or 'Partially met' by at least one site. Two criteria were reported as 'Met' by all five sites which were 'Committed to equality of access' and 'Interpreter is only present to facilitate communication.' Three of the five sites reported that 'Interpretation need delays access'. No site reported 'Access to training on how to work with interpreters' and there was no evidence that 'Feedback loop with interpretation service provider,' 'Name and gender of interpreter shared with patient prior to appointment' or 'Processes followed when patient refuses an interpreter' were met for any site. Only 1 of the 5 sites met 'Continuity of interpreter throughout patient journey assessed,' and 'Debrief with interpreter following assignment.' Encouragingly, 4/5 (80%) sites reported that the interpreter 'Explains role to both parties at the outset.' The same proportion of sites reported 'Feedback sought and welcomed' as 'Not Met.' Just two sites met 60% of the quality assessment matrix criteria.

Table 9: Quality, competence and professionalism of interpreters: combined results from sites

Criteria	Met	Partially Met	Not Met	No Evidence
Good interpersonal skills	1	2	2	0
Awareness of the cultures of the languages they interpret in	3	0	2	0
Understands context of Welsh healthcare system	1	2	2	0
Knowledge of medical terminology	2	1	1	1
All parties treated with dignity and respect	3	1	1	0
Professional at all times	3	1	1	0
Explains role to both parties at the outset	4	0	1	0
Interprets original message and asks for clarification when required	2	2	1	0
First-person interpreting used	2	1	2	0
Feedback sought and welcomed	1	0	4	0

1.3a In this section we report combined findings from the questionnaires completed through the peer-researcher supported and community links survey routes. A comparison of response rates, completeness of data, respondent characteristics and experiences between the three methodological approaches is reported below, against objective 2.3.

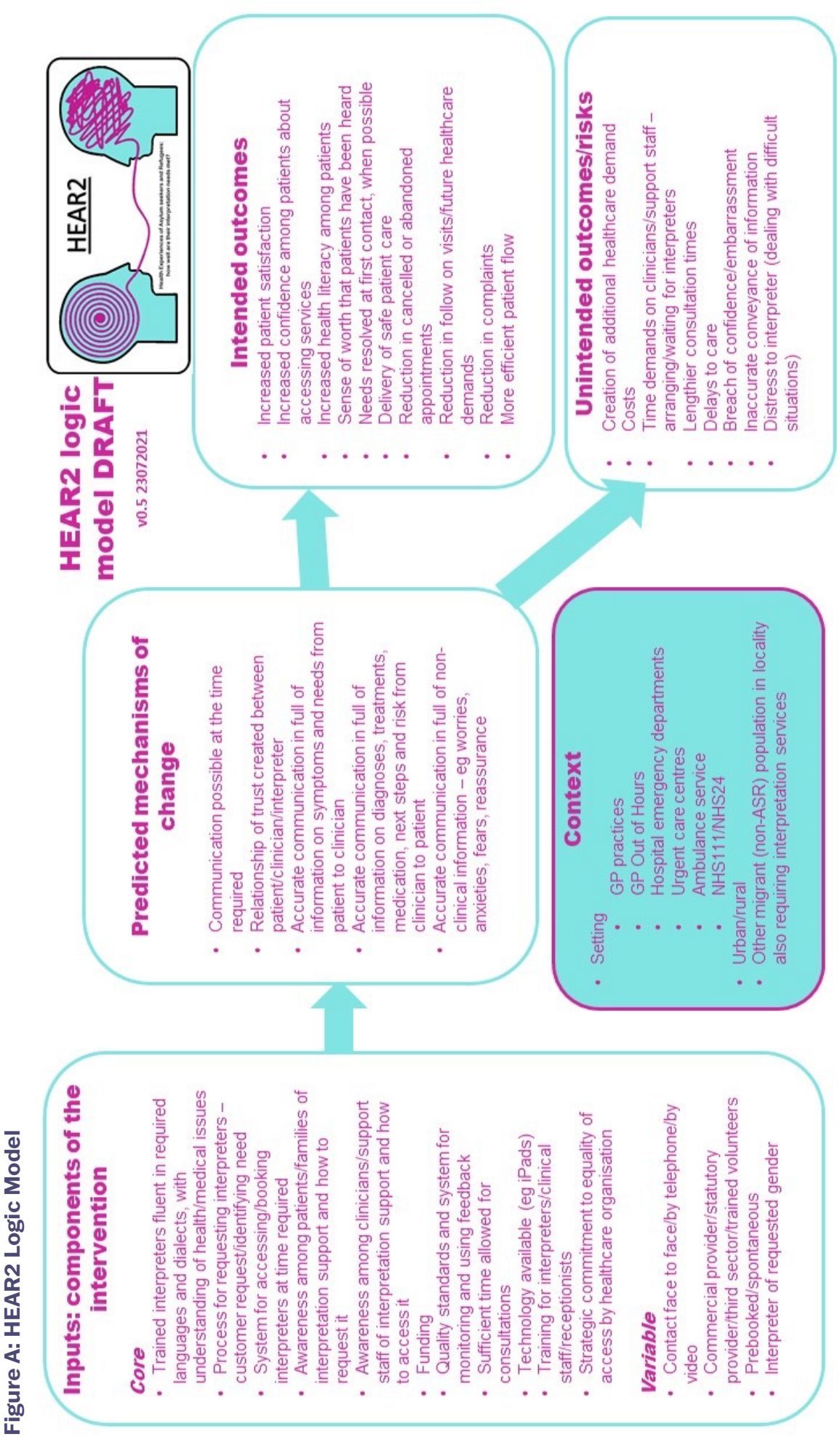


Figure A: HEAR2 Logic Model

Demography of participants

Gender (383 valid responses): 137 (35.7%) **male**, 246 (64.1%) **female**, 1 (0.3%) unstated.

Age in years (377 valid responses): 80 (20.8%) **18-30**, 261 (68.0%) **31-50**, 34 (8.9%) 51-65, 2 (0.5%) aged 66 and over, 7 (1.8%) unstated.

Most respondents (326, 84.9%) reported their **marital status** as either being single (143, 37.2%) or married (183, 47.7%). For responses to other categories see Graph 1 in Appendix 9.

Asylum status: Of those who provided a response (n=382), 50.5% of participants had refugee status, 36.4% had asylum seeker (Section 95) status, and 4.7% were asylum seekers whose application was refused. The remaining participants had different categorisations or were unknown.

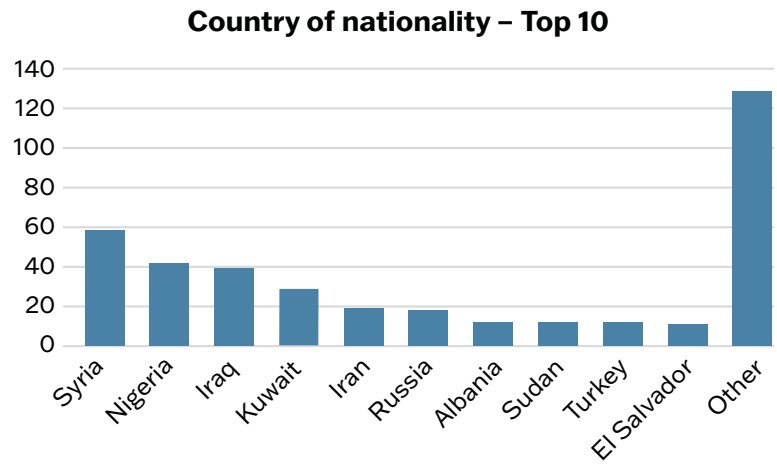
Length of time in the UK: 33 (8.6%) **less than 1 year**, 29 (7.6%) **1 to less than 2 years**, 160 (41.7%) **2 to less than 5 years**, 94 (24.5%) **5 to less than 10 years**, 59 (15.4%) **10 or more years** and 9 (2.3%) unstated.

The cross tabulation of **length of time in UK against asylum status** in Table 10, Appendix 9 illustrates that 28.3% of asylum seekers (all categories) had been living in the UK for less than two years compared to 8.3% of refugees. However, 48.7% of refugees had been living in the UK for more than five years, compared to 23.3% of asylum seekers (all categories). This shows that as could be expected a higher proportion of asylum seekers had a shorter duration of living in the UK.

We asked **'Do you consider yourself to have a long-term illness or disability (a physical or mental health problem that prevents you from doing activities?'** 62/384 (16.1% overall) respondents reported 'yes'. Just 58 of these respondents described their illness or disability, 43 (74.1%) as physical health conditions, 11(19.0%) as mental health conditions and 4 (6.9%) as combined physical and mental health conditions.

A range of nationalities was reported by participants as shown in Graph 2.

Graph 2: Responses to 'What is your nationality?'



'Other' includes countries such as Ghana, Namibia, Sri Lanka, Bangladesh and Democratic Republic of Congo. 'Other' also includes 'Missing' responses, n=5.

The top 8 responses to the question **'Which language do you feel most comfortable speaking in everyday life?'** were: Arabic (102, 26.6%), English (92, 24.0%), Kurdish (37, 9.6%), Russian (19, 4.9%), Spanish (13, 3.4%), Albanian (12, 3.1%), Turkish (10, 2.6%) and Persian/Farsi (9, 2.3%). For more information see Table 11, Appendix 9.

In a cross tabulation of current situation against **level of reading** (English), there is little difference between level of reading (English) for respondents who have refugee status and those who are asylum seekers. Similarly, in a cross tabulation of current situation against **level of speaking** (English) there is little difference between having refugee or asylum seeker status and level of speaking (English) (See Tables 12 and 13 in Appendix 9).

Experiences:

When asked if participants *knew that the NHS should provide you with an interpreter if you need help with talking to a doctor, nurse, or receptionist*, although those with refugee status were more likely to know this (79.8%), more than half of those with asylum seeker status (66.0%) did also. However, there was a significant difference (p=0.046 using a Likelihood Ratio Test) in knowing that the NHS should provide an interpreter between those with failed asylum claims - Section 4, and application has been refused - (8/18, 44.4%), and other asylum seekers - Section 95, section not known - (97/141, 68.7%). (See Table 14, Appendix 9).

222 (57.8%) respondents reported that they had *used interpretation* for a healthcare contact or visit. This could be any type of interpretation, not necessarily provided by a professional interpreter. Reasons provided for not having used interpretation for a healthcare contact or visit included: 'Not needed,' 'Did not know they could have an interpreter,' 'Did not know who to ask/how to get,' 'Felt unable to ask (embarrassed/uncomfortable),' and 'Used other methods (family/google translate).'

268 (69.8%) respondents had ***contacted their GP*** in the last year. Of the 266 respondents who provided valid responses to the next question, 113 reported that it was 'Very easy' or 'Easy' to talk to the GP themselves during their most recent contact or visit. In contrast, 93 (34.9%) respondents stated that it was 'Very difficult' or 'Somewhat difficult.' For comparison with other health settings see Graphs 3-9, Appendix 9.

Of those respondents who had contacted their GP in the last year, 101 (37.7%) reported that they had used an interpreter. 95 participants provided further information about how the interpretation was provided with the most common answers being 'Telephone interpreter' (37, 39.0%), 'Friend/family member' (21, 22.1%), and 'NHS interpreter (not otherwise specified)' (20, 21.1%) (See Graph 10, Appendix 9). 88 participants provided information about who arranged the interpreter for them. Over half (46, 52.3%) reported that interpretation had been arranged by 'GP/GP practice staff.' Other answers included: 'NHS (not otherwise specified)' (11, 12.5%), 'Friend/family member' (9, 10.2%), and 'Self' (9, 10.2%) (See Graph 11, Appendix 9). Of 140 valid responses, 49 (35.0%) respondents stated that the interpreter had to be arranged before their contact or visit to the GP (See Table 15, Appendix 9). The majority of participants (90, 64.3%) did not believe that using an interpreter caused any delay in their care or treatment, however 14 (10.0%) did think so. Participants who explained the reason for the delay reported the cancellation/late arrival of interpreter (n=2), poor quality of interpretation (n=1), and the time taken to obtain an interpreter (n=5).

202 (52.6%) respondents had **contacted other people (e.g. receptionist, nurse, midwife) at their GP surgery** in the last year. Of the 199 respondents who provided valid responses to the next question, 66 (33.2%) respondents stated that it was 'Very difficult' or 'Somewhat difficult' to talk to other people during their most recent contact or visit. (See Graph 4, Appendix 9). For further primary care survey details see Appendix 10.

Just 66 (17.2%) respondents had **contacted an Out of Hours GP** in the last year. Of the 62 respondents who provided valid responses to the next question, 17 (27.4%) respondents stated that it was 'Very difficult' or 'Somewhat difficult' to talk to the Out of Hours GP themselves during their most recent contact (See Graph 5, Appendix 9). For more details about this service see Appendix 11.

Only 85 (22.1%) respondents had **called the 999 emergency ambulance service** in the last year. 31 (36.9%) stated that it was either 'Very difficult,' or 'Somewhat difficult' to talk to the 999 advisor on the telephone (of 84 valid responses) (See Graph 6, Appendix 9). For more details about this healthcare setting see Appendix 12.

Only 52 (13.5%) respondents had been **treated by an emergency ambulance paramedic** in the last year. 11 (22.4%) stated that it was either 'Very difficult,' or 'Somewhat difficult' to talk to the paramedic themself (of 49 valid responses) (See Graph 7, Appendix 9). For more details about this healthcare setting see Appendix 13.

100 (26.0%) respondents had **attended the hospital Accident and Emergency (A&E) department** in the last year with 32 (33.3%) participants reporting that it was either 'Very difficult' or 'Somewhat difficult' to talk to the A&E doctor, nurse or receptionist themselves (of 96 valid responses) (See Graph 8, Appendix 9). Of those respondents who had attended the hospital A&E department in the last year, 28 (28.0%) reported that they had used an interpreter. 27 participants provided information about who or how the interpretation was provided with the two most common answers being 'Friend/family member' (6, 22.2%) and 'Telephone interpreter' (6, 22.2%). 20 participants provided information about who arranged the interpreter for them. The most common answer was 'Hospital (not otherwise specified)' (30.0%). Other responses included 'GP/GP practice staff' (3, 15.0%), 'NHS (not otherwise specified)' (3, 15.0%) and 'Self' (2, 10.0%). Of 38 valid responses, 12 (31.6%) respondents stated that the interpreter had to be arranged before they spoke to the A&E doctor, nurse or receptionist. However, 17 (44.7%) respondents reported that the interpreter did not have to be arranged beforehand. When

asked if using an interpreter caused any delay in their care or treatment, 40 participants provided a valid answer. Most participants (25, 62.5%) stated 'No'. For those participants who had experienced a delay in their care or treatment the reason given was 'Time taken to obtain interpreter.' Please see Appendix 14 for full details.

See Appendix 15 for findings relating to contact with NHS 111. Users of this service were more likely to report delays due to needing to access interpretation.

Some 7.8% of participants used family / friends for informal interpretation for their GP, 5.9% for emergency ambulance and 6.0% for A&E.

Experience of using an interpreter

Of the 142 (37.0%) participants who answered 'Yes' to having used a professional telephone or face to face interpreter provided by the NHS during a healthcare contact or visit:

Choice in choosing interpreter (141 valid responses):
43 (30.5%) = Yes, 81 (57.4%) = No, 17 (12.1%) = Sometimes

Interpreter explained role (140 valid responses):
109 (77.9%) = Yes, 14 (10.0%) = No, 17 (12.1%) = Sometimes

Interpreter explained they would not be judgemental (140 valid responses):
83 (59.3%) = Yes, 42 (30.0%) = No, 15 (10.7%) = Sometimes

Interpreter explained they will interpret exactly what is said and information will be kept private (141 valid responses):
103 (73.0%) = Yes, 23 (16.3%) = No, 15 (10.6%) = Sometimes

Interpreter spoke the language participant was most comfortable in using (140 valid responses):
116 (82.9%) = Yes, 8 (5.7%) = No, 16 (11.4%) = Sometimes

Interpreter correctly explained participant's health problem (139 valid responses):
104 (74.8%) = Yes, 8 (5.8%) = No, 27 (19.4%) = Sometimes

Interpreter made it easier for participant to talk about their health problem (141 valid responses):
112 (79.4%) = Yes, 9 (6.4%) = No, 20 (14.2%) = Sometimes

Participant offered the same interpreter for each health visit or contact (141 valid responses):
19 (13.5%) = Yes, 101 (71.6%) = No, 21 (14.9%) = Sometimes

Overall interpretation experience (140 valid responses):
22 (15.7%) = Excellent, 53 (37.9%) = Very Good, 59 (42.1%) = Good, 6 (4.3%) = Poor

Participants had similar experiences of using a professional interpreter in healthcare regardless of whether it was provided through a statutory organisation or a third sector organisation.

53.9% participants reported that they had help completing the questionnaire, 41.9% agreed for their answers to be linked to their health information in a different study in the future, and 28.6% were interested in participating in an interview (Appendix 16).

Analysis of free text responses to the questionnaire provided a total of 313 statements reporting their views on professional interpretation services. Much the biggest group of statements (178) were generally positive. 88 statements described some kind of problem associated with interpretation services. The biggest group of these (51) were concerns about the quality of services, such as a perceived lack of empathy from interpreters or the interpreter's English not being of a high enough standard. 32 statements were about problems with accessing interpretation services, such as a lack of knowledge about entitlement or problems making needs known to a receptionist. See Appendix 17.

1.3b

Asylum seeker and refugee respondents' use of interpretation in healthcare encounters varied greatly, from a single use to ten or more times. Two had no experience of using interpreters at all, with one stating that she avoided using an interpreter as she wanted to practise her English. We developed key themes:

- **The need for interpretation services is not a simple yes/no choice**. Respondents conveyed that the need for an interpreter can vary according to the details of the consultation, with an interpreter being needed for more complex issues: '*There are very specific questions and I didn't understand her (healthcare professional), and then she offered me an interpreter, and I answered yes.' 92600651*

- **The first point of contact can present a challenge to people in need of interpretation.** While one respondent was comfortable with texting the doctor's receptionist to request an interpreter, for many respondents with no English, the process of making an appointment with a clinician and requesting an interpreter was a challenging one: *'It's not easy, imagine yourself [at] the reception in GP, you may want to get an appointment, but as you don't understand English, there's no way they can do that to help you. So it is mandatory that if we go there, they have to get us an interpreter.' 90744214*
  Some respondents described using their children to help make doctor's appointments.

- **Sometimes those who might benefit from interpretation are missing out.** Some respondents described using workarounds which are not always satisfactory, such as phoning a friend to interpret, or trying to communicate in sign language and pictures:*'When the dentist told me something, he drew a lot, and I still didn't understand.' 95050462*

- **Satisfaction was generally high.** On balance, respondents were generally pleased with interpretation services and when provided, found them useful: '*this wonderful service.'* 9075543

- **Interpretation services need to be sensitive to preferences about the gender of interpreters.** Three of the female respondents discussed their concerns about using a male interpreter, particularly if the consultation concerned sensitive issues relating to women's health: *'When the interpreter was a young man, I was shy and was not telling everything. When the interpreter was a woman, I was telling her more about myself, gynaecology related things that I was shy to tell to men.' 90755343*

- **Interpretation services need to be specific in responding to language requirements.** Respondents needed to convey to providers not just which language was required, but also, in some cases, **which dialect**. One respondent reported that sometimes a language was offered that, while broadly understandable, was not their native tongue:*'They had interpreter, but Persian and… and other language, but it's not for Dari, er, my own language… And for Iranian interpreters or Persian interpreters they can't say the Dari words, you know what I mean?' 90997822*
- **Trust was hugely important in the delivery of interpretation services**. Respondents generally had trust that their information would be kept confidential, and that the words were being accurately translated – though they had no way of checking if this were so: *'I put my whole life in his hands as I do not know English.' 93389127*

Interviews with ***service providers/interpreters*** revealed the following key themes with the first two mapping directly onto findings from the interviews with asylum seekers and refugees:

- **The need for interpretation services is not a simple yes/no choice**. It will vary according to the patient's condition/presenting complaint, and the degree of trust or rapport between clinician and patient. It may also change over time:*'Sometimes they say no to a translator previously, but they want one if the clinician is different, if they haven't got that, that rapport with the clinician.' A1*
  Some patients may need interpretation but prefer to have family or friends provide it.
- **The first point of contact can present a challenge to people in need of interpretation.** Patients who need support with interpretation need to make their needs known at the first point of contact, which would most commonly be on the phone. Patients might delay contact or try to find their own workaround, such as asking a neighbour to call. GP receptionists have a key role, and might exercise judgement about needs:*'It very much probably depends on who is at the desk, who takes the call, and their assessment of whether an interpreter is needed just by how they converse with the patient. So it's variable.' D1*
- **Telephone interpretation services provide a readily accessible and valued resource for most healthcare encounters.** Face to face interpretation has particular value for complex pre-planned care and when continuity is valued.
- **Access processes, in particular for 'on demand' telephone interpretation, could be streamlined**. Clinicians describing frustration at having to give an access code then repeat their details in full every time. Particular challenges were reported in the ED, where – in the context of a hectic workload and restructuring of the layout – they often struggled to find the telephone or the number for accessing the telephone interpretation service.
- **Specialist providers incorporate interpretation much more smoothly into their daily workload than do other healthcare providers**. Specialist primary care providers described how their open access approach to appointments was flexible enough to readily accommodate interpretation, needed in the majority of appointments. By contrast, in mainstream primary care, using interpreters had an impact on the operation of the practice, even if an interpreter was promptly available:*'It's time consuming so we allow two appointments, so that means, so there's less appointments because that person's taking double the time.' E1*

- **Sometimes trade-offs and compromises needed to be made, especially in emergency settings.** This was driven both by the operational demands resulting from significant pressures, and by concern about individual patient risk, judged, in the ambulance setting, by the call handler:*'I would make the overall decision on whether to get an interpreter because it would depend on the situation, and how time critical it is. …… I would have to decide whether to do the call in potentially broken English …, or to put them on hold and wait for an interpreter.' B2*
- **On the whole, health providers were happy with the quality of interpretation services, in terms of professionalism and courtesy**. In terms of accuracy they were generally confident, though they have limited ability to check. They could see the value of support for patients:*'I'd say 75% [of interpreters] are really good.' E1 'Once we have the interpreter, the level of care they get is better because we know they're definitely going to understand all the instructions.' B2*
- **Professional interpreters were seen as hugely varied in terms of training and experience.** While it was evident that some had specialist qualifications in healthcare interpretation, there was a concern some were potentially unqualified 'community interpreters' eg in recently prioritised languages such as Ukrainian. Interpreters may want to achieve qualifications, but the cost of this is borne by the interpreter, so can be a barrier.
- **Waiting times for telephone interpreters were described as variable (up to 30 minutes, dependent on language) and unpredictable.** Since telephone interpretation was generally set up on the spot by the clinician, the longer waits had significant impact on the clinical encounter: *'Sometimes the wait can be a very long time. That's one of the downsides. So you can wait up to 12 to 15 minutes for an interpreter on the phone, so you'll be sat there and the appointment's gone. And so it places a huge amount of stress on the clinician using interpreters.' A1*

2.1

Table 16: Study progression criteria

Progression Criteria	Red	Amber	Standard Met
80% sign up of sites	≤59%	60 - 79%	≥80%
Reach at least 60% of the target sample size in at least one of the cohorts of the ASR survey	≤39%	40 - 59%	≥60%
At least 80% of sites to return Quality Assurance Matrix	≤59%	60 - 79%	≥80%
Achieve stakeholder interviews with at least 60% of the target sample size	≤39%	40 - 59%	≥60%
Ability to retrieve the number of patients to whom interpretation was provided in at least 60% of sites	≤39%	40 - 59%	≥60%*

*This criterion was met but involved accessing Language Line invoices that indicated 'interpretation provided' and/or searching patient routine records for language need. We hand sifted for interpretation provided at all participating sites. The specialist site with good records accounted for 68.7% of patients. Caveats and limitations are described in the discussion.

2.2 The availability and reliability of routine (NHS) data sources about need and provision of interpretation is outlined above and in section 2.5.

2.3 Overall response results for the three different methodological approaches are presented in Table 17, Appendix 18. For the community links approach 98.6% of questionnaires were completed on-line and for peer researcher supported 78.2% were completed online. All questionnaires completed through the postal survey from NHS sites route were completed on paper. Due to the nature of how we recruited respondents in the different methodological approaches (see above), a response rate was only available for the postal survey from NHS sites approach: 38.1%.

There were demographic and health status differences between respondents using the different methodological approaches (Table 18). The postal survey from NHS sites approach had similar proportions of male and female respondents, whereas for both other approaches, there was a greater proportion of females (see 1.3a results). There was also variation in the proportions of refugees and asylum seekers, with refugees predominating in the postal survey from NHS sites (62.2%) and peer-researcher approach (55.3%), whereas in the community links approach, there were similar proportions of refugee and asylum seeker respondents (all categories combined).

There were marked differences in country of nationality of respondents using the three different approaches. In the postal survey from NHS sites approach, the greatest proportion of respondents were from Asia (48.9% from Afghanistan) and the Middle East (26.7%). For the community links approach, the Middle East was the highest category (43.5%), then Western Africa (22.0%), and for the peer-researcher supported route, this was the Middle East (36.5%) and Europe (21.2%).

There were also differences in how long respondents had lived in the UK and in the proportions of respondents who answered that they had a long-term disability or illness. Using the postal survey from NHS sites approach, more than half of all respondents reported both that they had been the UK for less than 1 year (55.6%) and that they had a long-term illness or disability (53.3%), greater proportions than with the other two methodological approaches.

Table 18: comparison of self-reported demographics and health status of respondents by methodological approach

		Methodological approach		
		Peer-researcher supported	Community links	Postal survey from NHS sites
	Topic of question	Number (%) of total	Number (%) of total	Number (%) of total
Age category (years)	18-30	24 (14.1%)	56 (26.2%)	9 (20.0%)
	31-50	118 (69.4%)	143 (66.8%)	21 (46.7%)
	51-65	21 (12.4%)	13 (6.1%)	12 (26.7%)
	66+	1 (0.6%)	1 (0.5 %)	1 (2.2%)
	Missing	6 (3.5%)	1 (0.5%)	2 (4.4%)
Gender	Male	67 (39.4%)	70 (32.7%)	22 (48.9%)
	Female	102 (60.0%)	144 (67.3%)	21 (46.7%)
	Missing	1 (0.6%)	0 (0%)	2 (4.4%)
Long-term illness or disability	Yes	33 (19.4%)	29 (13.6%)	24 (53.3%)
	No	132 (77.6%)	176 (82.2%)	21 (46.7%)
	Missing	5 (2.9%)	9 (4.2%)	0 (0%)
Current immigration status	Refugee	94 (55.3%)	99 (46.3%)	28 (62.2%)
	Asylum seeker Section 95	51 (30.0%)	88 (41.1%)	9 (20.0%)
	Asylum seeker Section 4	4 (2.4%)	7 (3.3%)	3 (6.7%)
	Asylum seeker whose application has been refused	5 (2.9%)	2 (0.9%)	1 (2.2%)
	Asylum seeker section not known	0 (0%)	2 (0.9%)	1 (2.2%)
	Don't know	7 (4.1%)	11 (5.1%)	2 (4.4%)
	Other	7 (4.1%)	5 (2.3%)	0 (0%)
	Missing	2 (1.2%)	0 (0%)	1 (2.2%)
Country of nationality, by region	Asia	20 (11.8%)	18 (8.4 %)	22 (48.9%)
	Percentage of this total from Afghanistan	**10%**	**16.7%**	**100%**
	Central America	7 (4.1%)	7 (3.3%)	4 (8.9%)
	Europe	36 (21.2%)	15 (7.0%)	3 (6.7%)
	Middle East	62 (36.5%)	93 (43.5%)	12 (26.7%)
	Central Africa	9 (5.3%)	4 (1.9%)	0 (0%)
	Eastern Africa	10 (5.9%)	8 (3.7%)	2 (4.4%)
	Northern Africa	5 (2.9%)	11 (5.1%)	1 (2.2%)
	Southern Africa	5 (2.9%)	8 (3.7%)	0 (0%)
	Western Africa	14 (8.2%)	47 (22.0%)	0 (0%)
	Missing	2 (1.2%)	3 (1.4%)	1 (2.2%)
Length of time living in UK	Less than 1 year	6 (3.5%)	27 (12.6%)	25 (55.6%)
	1 to less than 2 years	7 (4.1%)	22 (10.3%)	7 (15.6%)
	2 to less than 5 years	84 (49.4%)	76 (35.5%)	5 (11.1%)
	5 to less than 10 years	40 (23.5%)	54 (25.2%)	5 (11.1%)
	10 or more years	29 (17.1%)	30 (14.0%)	2 (4.4%)
	Missing	4 (2.4%)	5 (2.3%)	1 (2.2%)
Total number of questionnaires		**170**	**214**	**45**

There were also differences in self-reported English language abilities, when analysed by methodological approach (Table 19, Appendix 18). Respondents identified through the postal survey from NHS sites reported lower abilities in English than with the other two routes: 51.1% reported that they 'cannot read English', compared with 7.6% for peer-researcher and 10.7% for community links approaches. Similarly, 46.7% reported that they 'cannot speak English', compared with 9.4% for peer-researcher and 7.9% for community links approaches; and 84.4% reported that they 'cannot hold a conversation in English with a health professional', compared with 33.5% for peer-researcher and 7.5% for community links.

Across the three approaches, the languages that respondents most frequently identified that they were 'most comfortable speaking' were similar. The community links and peer-researcher supported approaches were particularly closely aligned, with Arabic, English and Kurdish as the three most frequently reported languages. However, in contrast, English was not one of the most frequently reported languages using the postal survey from NHS sites approach (Dari, Arabic, Kurdish). (See Table 19, Appendix 18)

In examining self-reported experience of using interpretation services (Table 20, Appendix 18), a high proportion of respondents across all three approaches reported knowing that the NHS should provide them with an interpreter. This was highest using the postal survey from NHS sites approach (93.3%), as expected given that receiving interpretation had been used to search for these participants. There was variation in terms of respondents' reported experience of using NHS provided interpretation services, however, overall, responses were generally very positive regardless of methodological approach used (Table 20, Appendix 18).

EQ-5D-5L scores were similar amongst those who had refugee and asylum seeker status but were lower than that of the general UK population. Mean scores were: 0.728 (Refugees), 0.744 (Asylum seekers), 0.821 (Other), and 0.803 (Don't know) (See Table 21, Appendix 18). Comparing the mean EQ-5D-5L results as part of the preliminary analysis found no difference in health-related quality of life/ utility scores between respondents who had completed the survey through the peer-researcher and community links routes (Table 22). However, significant and substantive differences were observed between both these routes and those contacted by postal questionnaire from NHS sites (mean difference: -0.370 and -0.407; $p<0.001$; see Table 22). This suggests that participants who completed postal questionnaires through NHS sites reported worse health.

Table 22: Comparison of differences of health-related quality of life/utility scores based on survey delivery method

EQ-5D-5L				95% Confidence interval	
		Mean difference	p-value	Lower	Upper
Peer researcher	Community links	-0.036	0.441	-0.106	0.033
	Postal	0.370*	<0.001	0.258	0.483
Community links	Peer-researcher	0.036	0.441	-0.034	0.106
	Postal	0.407*	<0.001	0.296	0.517
Postal	Peer-researcher	-0.370*	<0.001	-0.483	-0.258
	Community links	-0.407*	<0.001	-0.517	-0.296
Visual Analogue Scale (VAS)					
Peer-researcher	Community links	-10.677*	<0.001	-16.61	-4.74
	Postal	16.697*	<0.001	7.18	26.21
Community links	Peer-researcher	10.677*	<0.001	4.74	16.61
	Postal	27.374*	<0.001	18.04	36.71
Postal	Peer-researcher	-16.697*	<0.001	-26.21	-7.18
	Community links	-27.374*	<0.001	-36.71	-18.04

VAS scores suggest that those who responded through the community links route assessed their own health slightly (and statistically significantly) more highly than those included through the peer-researcher route. Again, participants who were contacted by postal questionnaire assessed their own health as much lower than both other groups (Table 22).

No significant differences between responses by immigration status (refugee, asylum seeker, other, don't know) were found (Table 23, Appendix 18).

2.4 Commissioner Survey responses (n=44) were obtained from all UK nations. Response rates were 6/8 (75%) for Wales, 7/14 (50%) for Scotland and 3/5 (60%) for Northern Ireland. Response rate could not be calculated for England due to changes in denominator mid-survey. To accommodate the organisational and functional change to the CCGs in England, rules were applied to the dataset regarding CCG and ICB responses, to ensure there was minimal duplication and accurate geographical area assignment of response. It became clear that the data from England could only describe primary care and out of hours primary care given the CCG/ICB remit. Given the delays caused by NHS re-organisation and not having a comprehensive sampling frame for Acute Trust emergency services, a line was drawn on data collection, and thus information for England represents the views and experiences of Commissioners of Primary Care (including out of hours/ emergency primary care) only. A small number of Trusts responded having had the questionnaire shared with them. These questionnaires were therefore set aside and not analysed for this current study. For numbers excluded by rule applied see Appendix 5.

Table 24 in Appendix 19 shows **Availability of Interpretation Services** in primary care were reported as 24 hours 7 days a week in all sites in Wales, Scotland and Northern Ireland with 16 sites in England (57%) affirming this also for primary care.

With regards to **information for planning,** when asked, "Does your organisation know **how many people** using primary care, emergency care, and urgent care in your area have **made use of interpretation** service(s) in the financial year April 2020 - 2021?" All sites in Northern Ireland, 85.7% in Scotland 66.7% in Wales and 64.3% in England responded that they did.

Few commissioners gathered data on **use of interpretation services by asylum seekers or refugees** (33.3% respondents in Wales, 28.6% in England and Scotland and none in Northern Ireland).

Generally low proportions of respondents reported that they undertook functions listed in commissioning guidance, as shown in Table 25, although proportions were higher for training of healthcare staff and promotion to the public of interpretation services in Scotland, Wales and Northern Ireland. Evaluation of feedback from patients and interpreters was reported by a minority of responders but more reported feedback evaluation from healthcare practitioners.

Table 25: Service commissioning: functions reported
(For full table of results please see Appendix 19)

		Where are you based?			
		England n=28	Scotland n=7	Wales n=6	Northern Ireland n=3
Audited language needs for your population	Yes	14 (50.0%)	2 (28.6%)	1 (16.7%)	1 (33.3%)
Provided training for health practitioners in primary care, emergency care, and urgent care on the use of interpretation service(s)	Yes	12 (42.9%)	6 (85.7%)	5 (83.3%)	3 (100.0%)
Promoted interpretation services to the local population	Yes	14 (50.0%)	6 (85.7%)	5 (83.3%)	2 (66.7%)
Evaluated feedback by patients on interpretation service(s)	Yes	15 (53.6%)	1 (14.3%)	2 (33.3%)	0 (0.0%)
Evaluated feedback by interpreters on interpretation service(s)	Yes	6 (21.4%)	2 (28.6%)	1 (16.7%)	0 (0.0%)
Evaluated feedback by health and social care professionals on interpretation service(s)	Yes	14 (50.0%)	4 (57.1%)	3 (50.0%)	2 (66.7%)

All commissioners from each country expected demand for interpretation services by primary and emergency care services to increase or remain static in the next financial year, except for one respondent in England who felt it would reduce (Table 26, Appendix 19). Respondents from England tended to place longer contracts with interpretation providers of 3 years and over, Wales respondents placed the shortest contracts of 1 year, with Scotland and Northern Ireland respondents tending to place contracts of between 1 and 3 years (Table 27, Appendix 19).

Challenges to interpretation delivery included:

"Lack of interpreters for remote regions, increased demand compared to supply of interpreters, availability of specific languages including some language availability reduction since Brexit, insufficient face to face interpretation available, concern over quality of service, patients being unaware of their entitlements, healthcare professionals being unaware of patients entitlement to interpretation, prioritisation of competing urgent needs, budgetary constraints, lack of acknowledgement of interpreters as professionals and accessing appropriate languages during emergency calls/appointments."

"A primary challenge is that most of our services are accessed by telephone and the caller must be able to navigate making that call first before speaking to an operator to request a translator."

"Main challenge is ensuring our thousands of staff & primary care who we don't employ understand how to access interpretation services and to understand that this is a right under the Equality Act and not optional."

2.5 Identification and potential to link study participants to other routine datasets

we found there was no standard method for identifying patients who had requested or received interpretation services, or whether they were asylum seekers or refugees. Search strategies had to be tailored to individual sites. All sites except the ED kept electronic notes, albeit on different record management systems. The ED kept written notes scanned to the service portal, with a computerised database of patient attendances. Staff members at all research sites noted that data relevant to the study may not be recorded or coded.

Table 29: Routine health data location, method data collection

Site	Record management system	Method of data collection
A	Vision	Since all attendees were asylum seekers/ refugees, select diary view to search all routine appointments meeting study inclusion criteria
B	Oracle, CAD (Computer Aided Dispatch), ePCR (Electronic Patient Clinical Record), WDS (Welsh Demographic Service)	Use interpretation service invoices to identify incident numbers of patients receiving interpretation services. Incident numbers then used to access ePCR
C	Patient Management System (PMS), local patient record database*	Search diary of emergency attendances for patients matching information from interpretation service invoices and study inclusion criteria
D	Vision	Use record management search functions to exclude the READ code 'English as first language'. Search remaining health appointments for inclusion criteria
E	EMIS	Use record management search functions to exclude the READ code 'English as first language'. Search remaining health appointments for inclusion criteria

** This site also used WCCIS and Paris systems but were not included in the study, as not required.*

It was possible to identify people with interpretation needs or use at each site, although at two sites this required accessing invoices and manually linking back to individual patients. It was only possible to reliably identify asylum seekers / refugees at the one specialist primary care service site. We did not find any other reliable sources of records related to asylum seekers and refugees that were available within these healthcare settings. For patients identified as having needed or used interpretation, we were able to access full identifying information required for data linkage (NHS number, name, address, date of birth) to other datasets including Patient Episode Database Wales (PEDW), ONS.

2.6 Overall, a full health economic evaluation as part of a future trial investigating interpretation needs of asylum seekers and refugees is deemed feasible. However, some methodological considerations may need to be undertaken to resolve potential challenges.

1. Feasibility of implementation cost data collection. Implementation cost collection was deemed feasible in Wales, but potentially challenging, considering that interpreters are utilised on a self-employed basis by the Wales Interpretation and Translation Service (WITS). The following considerations may support the feasibility of intervention implementation cost collection in a future trial:

- Number of interpretation sessions provided was not collected and would need to be added to the data of those identified through NHS care
- The feasibility of reviewing interpretation invoices or arranging discussions with interpreters would need to be considered to collect data on duration of interpretation sessions, average pay bands and travel time
- The feasibility of arranging discussions with healthcare professionals would need to be considered to collect data on time required for arranging interpretation services, and administration time required

2. Feasibility of health-related quality of life/utility data collection. The EQ-5D-5L questions and VAS were well completed for all survey methods (Table 26) and all participant groups based on immigration status (Table 27). There was considerable variation in each group, with highest variation in the NHS identified group (postal questionnaire) (Table 26).

Table 30: Percentage of complete responses and missing data and mean health-related quality of life/utility scores based on survey delivery method (SD=standard deviation).

	Peer-researcher supported	Community links	Postal survey from NHS sites
EQ-5D-5L			
Complete responses	162 (95.3%)	204 (95.3%)	44 (97.8%)
Missing	8 (4.7%)	10 (4.7%)	1 (2.2%)
Mean score (SD)	0.762 (0.280)	0.798 (0.253)	0.391 (0.399)
Visual Analogue Scale (VAS)			
Complete responses	159 (93.5%)	192 (89.7%)	43 (95.6%)
Missing	11 (6.5%)	22 (10.3%)	2 (4.4%)
Mean score (SD)	64.60 (24.85)	75.28 (22.14)	47.91 (24.53)

Interpretation and Discussion

Summary of the main findings and implications:

The study provided new evidence on interpretation service use in primary and emergency healthcare in Wales and the quality of interpretation provision, including perspectives from asylum seekers, refugees, and healthcare providers. It also tested the feasibility of a full UK evaluation in which we met the progression criteria, tested different survey methods, gained knowledge of current commissioning, and described the availability of routine NHS data on interpretation need and provision.

The main findings of the study against each of the objectives described in the methods were:

1.1 Asylum seeker/refugee status was only reliably available at the specialist service, where 94.1% of patients' status was recorded. The interpretation provider was not recorded for most of the contacts, but the most frequently recorded provider was family/friends/other. Reason for contact was not recorded for most contacts, and where available was mostly related to physical problems, with some mental health conditions recorded.

1.2 The **Quality Assessment Matrix** showed variability in many aspects of service provision, with only two sites meeting 60% of the quality assessment criteria. Improvements were needed in training healthcare providers to work with interpreters and developing processes if a patient refuses an interpreter. Joint working is urgently needed between NHS Wales and the interpretation provider service, including assessing the need for continuity of interpreter and establishing feedback loops. The specialist model of service enabled more patients to be seen efficiently but involved longer appointments, while time pressures on mainstream services were considerable.

1.3 The **survey with asylum seekers and refugees** shows that they often did not have a choice in the gender or dialect of their interpreter and were not offered the same interpreter for subsequent health visits. While most participants reported positive experiences using a professional interpreter provided by the NHS during a planned visit, a third experienced issues with quality and experiences varied by service provider sector. Users of NHS 111 reported the most delays in accessing an interpreter.

1.4 In **interviews** with **sanctuary seekers** the need for interpretation was found to be complex, with some not needing or preferring not to have it, while others reported challenges in accessing NHS care, particularly in unplanned situations. Patients generally reported high levels of satisfaction with interpretation services, but there were instances where the service was not tailored to their specific needs. Patients also faced difficulties in knowing how to ask for interpretation at first contact, while **healthcare practitioners** believed access to interpretation services could be streamlined, especially in emergency settings. Professional interpreters were perceived as having varied levels of training and experience. Overall, trust in professional interpreters to maintain patient confidentiality was high, linked to high trust in NHS confidentiality processes.

2.1 **Progression criteria** were met however with some caveats, including needing to access Language Line invoices that indicated 'interpretation provided' and/or searching patient routine records for language need.

2.2 **Availability and reliability of data sources** about language need and provision of interpretation comprised a subset of 2.5 and so has been dealt with in conjunction with that objective.

2.3 The **recruitment methods** for asylum seekers and refugees yielded different sub-groups with differences in demographics, language, quality of life, and health among respondents. Survey methods accessing respondents through NHS settings or records recruited a different population who had poorer self-reported quality of life measures compared to wider population methods. Researchers need to tailor recruitment approaches to their research questions and target population. Peer-researcher and community links approaches yielded more respondents compared to those identified through NHS sites. However the response rate using the postal survey from NHS sites approach was relatively high (and higher than we expected) when compared to similar questionnaire-based studies [29, 30].

2.4 A UK **Commissioners survey** found variable commissioning practices within and between countries. Commissioning guidance for interpretation services exists in England and Scotland, but not in Wales. In England 50% respondents had audited language needs for their population, compared to 33.3% for Northern Ireland, 28.6% for Scotland and 16.7% for Wales. Training for health professionals in the use of interpreters was high in Northern Ireland, Scotland and Wales and moderate in England. England had evaluated feedback from patients on interpretation most (53.6%). Scotland had evaluated feedback from interpreters most (28.6%) and Northern Ireland had evaluated feedback from health professionals most (66.7%). Service planning based on languages needed and feedback loops into assessing the quality of the services commissioned need strengthening, and contracts of sufficient length for service continuity and planning are required.

2.5 With regards to identification of asylum seeker/refugee status and provision of interpretation through routine NHS records, there were issues with data completeness and quality. There was no standard method for identifying patients who requested or received interpretation services, and search strategies had to be tailored to individual sites. Electronic notes were kept at 3/4 sites but relevant data was not always recorded or coded. Specialist services for asylum seekers had better coding of data on asylum status, language needs, and interpretation provision. It was possible to identify people with interpretation needs or use at each of the four sites, but reliable identification of asylum seekers/refugees was only possible at one specialist primary care service site. Full identifying information was available for data linkage to other datasets.

2.6 Based on the high percentages of complete responses for the EQ-5D-5L questionnaire, a full **health economic evaluation** using a cost-utility analysis framework appears feasible in a future trial. The calculation of the cost per quality-adjusted life year (QALY) gained could be used to inform decision making and priority setting in this important area of healthcare provision. Furthermore, a cost-consequences analysis may be recommended to illustrate the costs and potential multitude of effects of the intervention. However, some additional considerations may include:

- Access to interpreters to discuss interpretation service provision, e.g. average duration, travel time, pay bands etc., to allow intervention implementation cost calculation

- Availability of EQ-5D-5L translations from EuroQol for the most common languages required (including considering time required for translations where languages are not yet available)
- Participants must be able to receive questionnaires in their language of choice instead of having them verbally translated or using online translation applications that will invalidate the questionnaire
- Validity of the UK value sets for asylum seekers and refugees from different countries completing the questionnaire in their native language will need to be explored in more detail.

Strengths and limitations of the study

Patient and public involvement helped in the study design and drafting of recruitment materials and data collection tools was a strength. It also led to the development of an ethically robust research protocol and successful data collection from groups who may otherwise not have been reached, especially at a time when Covid-19 restrictions were in place. Face to face training of peer-researchers rather than online training on conducting interviews may have yielded a richer response from interview participants.

Survey constraints include Covid-19 restrictions affecting data collection, meaning most questionnaires (89.6%) were completed online. There was high in-questionnaire drop out on sequential questions ('if x then y'). Future questionnaires should be shorter and digital versions should hide sequential options when not appropriate. The lack of electronic copies of multi-lingual questionnaires may have introduced bias towards inclusion of those with better English language abilities, although peer-researchers and third sector organisations supported completion. It was noted that using an online link resulted in a small number of respondents (n=14) giving postcodes in England to receive their voucher. In comparing peer researcher and community links methods of recruitment to the survey we could not assess response rates, since a denominator was not quantifiable. The postal survey from NHS sites approach required a clinical researcher and greater time investment which are likely to make this approach more costly although we did not conduct health economic comparisons.

A constraint of using peer researchers for interviews was that conversations were more structured than semi-structured resulting in shorter interviews for analysis.

The Quality Assessment Matrix was completed by a single respondent, the Principal Investigator for each site, although they consulted others.

Constraints for the survey with commissioners included the re-organisation of NHS England over the course of the study, with differences in commissioning infrastructure in transition. Across the UK, organisations were not always aware where responsibility sat for interpretation services, and who placed contracts, monitored and evaluated this function.

With regard to data sources, it is probable that we did not capture all patients who accessed interpretation through sites, due to problems with recording/coding and we also probably did not identify all patients who were asylum seekers due to these factors. There were significant IT and information governance issues that would indicate replication on a large scale would be challenging, although this could be mitigated by asking site Principal Investigators to access data locally. These issues were less problematic at the Specialist service, where 101/147 NHS identified patients were sourced.

Comparison with previous literature: Our research reflects previous findings which found challenges to interpretation included a lack of availability, use of family, friends (leading to problems of accuracy and lack of confidentiality) [14], differences in dialect between patients and interpreters [11,15], and interpreters who were of an unsuitable gender [11]. Problems in access include lack of knowledge about what is available (among patients and practitioners); confidence and trust; and time-consuming processes which conflict with the delivery of routine care [1].

Recent policy developments: The Equality Act 2010 stipulates that people seeking asylum should not be discriminated against due to a lack of knowledge of English. The Welsh Government Health and Wellbeing provision for refugees and asylum seekers [31] has emphasised the responsibility of the Health Boards to ensure adequate interpretation resources that are suitable for the case and can communicate complex issues in an empathic and accurate manner. The 2018 Auditor General for Wales' report 'Speak my language: Overcoming language and communication barriers in public service' [32] also emphasised continuity of interpreters may be beneficial for patients with chronic long-term conditions or mental illness, and specialized interpreters with knowledge and training in mental health issues or trauma may be more appropriate. Recent policy development in Scotland [33] has highlighted the importance of communication, specifically language and access to interpretation, when accessing health and social care services.

Future research: A UK wide evaluation of interpretation services for asylum seekers and refugees, including the health economic component is feasible and recommended. Further insights by surveying third sector representatives to explore their views and experiences of supporting people needing interpretation could be considered. Assessing the accuracy/fidelity of interpretation is challenging but merits further research.

Conclusion:

We have carried out a mixed methods study which provides new evidence about:

Current interpretation service use in primary and emergency healthcare in Wales and assessment of the quality of interpretation provision, including views from those with lived experience of the asylum system and health care providers

The feasibility of full UK evaluation, in which we:

a. met progression criteria

b. tested methods for surveying asylum seekers and refugees

c. gained knowledge of current commissioning across the UK

d. described the availability of routine NHS data around interpretation need and provision and potential for data linkage

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 health care through interpretation services.

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Glossary

Asylum Seeker:
A person who has left their country of origin and formally applied for asylum in another country but whose application has not yet been concluded. An asylum seeker becomes a refugee on receiving leave to remain. There are various stages to the process of claiming asylum, which affect legal rights and entitlements.

Section 95 support:
Asylum seekers are excluded from claiming mainstream welfare benefits and in most cases from working. Section 95 of the Immigration and Asylum Act 1999 gives the Home Office power to grant support to asylum seekers, and their dependents, whose claims are ongoing, or who are destitute or about to become destitute. Support is usually provided in the form of furnished accommodation (free rent and utilities), plus a weekly cash allowance of £45.00 to enable the persons to meet other "essential living needs".

Section 4 support:
Section 4 of the Immigration and Asylum Act 1999 gives the Home Office power to grant support to some destitute asylum seekers whose asylum application and appeals have been rejected. To qualify for Section 4 support, refused asylum seekers must be destitute, or be likely to become destitute within the next 14 days (or 56 days if they are already receiving support); and satisfy one of the following five conditions:

- They are taking all reasonable steps to leave the UK or place themselves in a position in which they are able to leave the UK
- They are unable to leave the UK because of a physical impediment to travel or for some other medical reason
- They are unable to leave the UK because in the opinion of the Secretary of State there is no viable route of return
- They have applied for judicial review of the decision on their asylum claim and has been granted permission to proceed
- The provision of accommodation is necessary to avoid breaching their human rights

Those who receive the support are generally provided with accommodation and £45.00 loaded weekly onto a cashless payment card that can be used to buy food and other essential items where card payments are accepted.

Refused asylum seeker:
A person whose asylum application has been unsuccessful and who has no other claim for protection awaiting a decision. A refused asylum seeker may have the right to appeal the decision, or, if all appeal avenues have been followed unsuccessfully, may be 'appeal-rights exhausted'. At this stage, refused asylum seekers may have all financial support withdrawn and may have to leave their asylum accommodation.

People Seeking Sanctuary:
The term 'people seeking sanctuary' has sometimes been used in this report to describe all asylum seekers, people refused asylum and refugees where there is no significant difference between the different legal categorisations: some issues affect all people seeking sanctuary regardless of where they are on the asylum 'journey'. This term aims to re-centre the discussion surrounding asylum seekers and refugees on the individuals and communities who are affected by these issues.

Refugee:
Internationally the term 'refugee' is used to describe a person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is living outside the country of his nationality. In the United Kingdom, a person is officially considered a refugee when they have their claim for asylum accepted by the UK Government.

Appendices

Appendix 1: Recommendations arising from this research

For Policy Makers - Welsh Government

Develop commissioning guidance and standards for interpretation in health and care (already exist in England and Scotland)

Establish regular reviews of Interpretation Commissioning and Provision

For Interpretation Service Planners and Commissioners

Strengthen planning by auditing of population **language needs** and strengthening links with Home Office and strategic migration partnerships who will be aware of upcoming influx of people from countries with UK resettlement schemes

Promote health and care interpretation services to the local population

Work with the Home Office to make new asylum seekers and re-settlement programme arrivals to the UK aware that they are entitled to interpretation services when accessing the NHS

Ensure consistent interpreter skills and aptitude for health interpretation, through funded accredited training for interpreters

Place contracts of sufficient length for service continuity, quality evaluation and planning for next cycle

For NHS Services

Design processes to allow non-English speakers to request interpretation (for example with a standard sample language text sheet or picture cards for language needed)

Design processes to enable patients to book primary care appointments in their language of choice to enable access

Improve the use of language need coding and alert systems on patient notes and electronic records of interpretation needed

Train health care providers on interpretation entitlements and processes, how to work with interpreters and check on understanding with interpreters following consultations

Ensure longer appointment times where interpretation is required to reduce pressure on clinicians

Develop processes for if a patient refuses an interpreter

For NHS jointly with Interpretation Services Providers

Simplify processes to access an interpreter especially for unplanned/urgent care

For planned care, develop process to share the name, gender and language/ dialect of the interpreter with the patient prior to appointment, (in case the individual knows the interpreter or has a gender-sensitive issue)

For planned care, offer patients the opportunity to choose the gender of their interpreter for sensitive appointments

For planned care, assess the need for and offer where possible, continuity of interpreter throughout the patient journey, (especially important for a course of treatment eg cancer care or pregnancy)

Establish feedback loops between the NHS and interpretation service provider organisations on the quality of service

Home Office and Local Authorities

Make Health and Social Services Group Welsh Government and NHS Wales aware of new Resettlement schemes and periods of predicted increased arrivals

Make new asylum seekers and re-settlement programme arrivals to the UK aware that they are entitled to interpretation when accessing health, social care and other services

Assess likely English language needs for groups of new asylum seeker or re-settlement programme arrivals to the UK and communicate to NHS Planners and Commissioners

Encourage early integration into 'English lessons for Speakers of other Languages' (ESOL)

Researchers

A UK wide evaluation of interpretation services for asylum seekers and refugees, including the health economic component is feasible and recommended

Recruitment methods selected should reflect the research questions and the population sought

Explore methods to assess the accuracy/fidelity of interpretation in health consultations

Raise awareness that EQ-5D-5L translations from EuroQol may not be readily available for all languages, which is necessary to have valid quality of life measures

If peer-researchers are used to carry out qualitative interviews, in-depth training should be provided

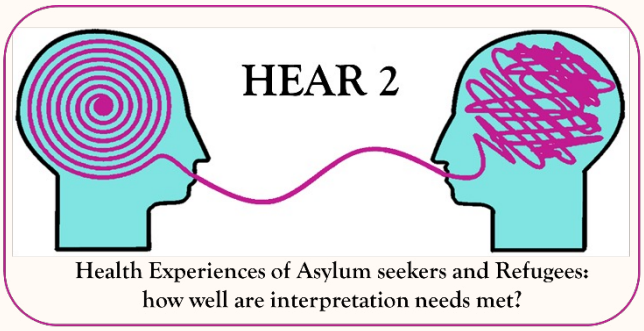
Research and information governance permissions can delay research across NHS sites. Time needs to be allowed to navigate these required processes and strong partnership working with NHS based Principal Investigators is necessary to avoid or reduce delays

Questionnaires should be short and hide sequential options until needed in digital versions and should be multi-lingual to reduce bias towards inclusion of those with better English language abilities

Appendix 2: Matrix of HEAR2 study areas mapped to programme objectives

	Logic model (a)	ASR survey (b)	ASR survey method comparisons (c)	Provider interviews (d)	ASR interviews (e)	UK Commissioner's survey (f)	Routine NHS data (availability quality, linkage) (g)	Quality Assessment Matrix (h)	Health Economics (i)	Progression Criteria (j)
AIM: 1.0 Description & Evaluation: To provide information about demand and patient experience; and evaluate the quality of interpretation services delivered in primary and emergency care in Wales	**Objective:** 1.1 To describe the scale, nature of the needs of asylum seekers and refugees for interpretation services in primary and emergency care in Wales (including demographics, health conditions and interpretation service delivery)									
		X		X	X		**X**			
	Objective: 1.2. To describe quality of service provision									
	(X co-production of indicators of quality)	X		X	X	X		**X**		
	Objective: 1.3. To describe challenges in accessing and using services for asylum seekers, refugees and providers of health care and interpretation									
		X		**X**	**X**	X				
AIM: 2.0 Feasibility: To assess the feasibility of a comprehensive evaluation of interpretation services in primary and emergency care across the UK, including a description of currently commissioned interpretation services	**Objective:** 2.1 Engagement of services in research, whether predetermined progression criteria are met									
										X
	Objective: 2.2 Availability, reliability and quality of data sources about language needs (e.g. NHS records and other)									
							X			
	Objective: 2.3 Comparison of utility of survey collection methods including traditional postal survey of general practice and emergency care attenders; and peer researcher- administered questionnaire survey in community settings									
		X	X							
	Objective: 2.4 Existing models of service provision in these settings in Wales and across the UK									
				X	X	X				
	Objective: 2.5 Potential to link of study participants to retrieve outcomes and resource use from routine datasets, e.g. Patient Episode Database Wales (PEDW) interpretation services in primary and emergency healthcare across the UK									
							X			
	Objective: 2.6 To assess feasibility of undertaking a full health economic evaluation as part of definitive future trial: collecting the cost of providing interpretation, the quality of life data (using EQ-5D—5L in different languages) and healthcare resource use.									
		(X)							X	

Appendix 3: Asylum Seeker and Refugee questionnaire



Study ID:

Survey with people seeking asylum and refugees about using interpretation services

Public Health Wales, Swansea University, and Wales based charities are asking you to complete this questionnaire to help us understand your interpretation needs and any experience of using interpretation services; or any difficulty you may have had finding an interpreter when you visited or contacted your family doctor, the 999 emergency ambulance service, the hospital Accident and Emergency (A&E) or NHS 111/NHS Direct telephone helplines.

Your experience and views will help NHS Wales to provide better care to people who need interpretation support. The information you provide will not be shared and will be safely stored at Swansea University. Please answer as many questions as you can. It will take about 30 minutes to complete the questionnaire.

If you complete the questionnaire online (https://swansea.onlinesurveys.ac.uk/hear2-asylum-seeker-and-refugee-survey-final-version), your answers will still be private and safely stored. If you are completing the questionnaire with a researcher or support worker, please leave it with them and they will return it securely in a sealed envelope to the research team at Swansea University.

If you have any questions about the study or the survey, please contact:

Josie Nicholas, Senior Research Officer, Public Health Wales

Email: Josephine.Nicholas@wales.nhs.uk

Section A: About you

1. What is your country of nationality?

2. What is your country of birth?

3. How long have you been living in the UK?

4. Gender: Are you?

- ☐ Male
- ☐ Female
- ☐ Other
- ☐ Prefer not to say

5. How old are you?

- ☐ 18-30
- ☐ 31-50
- ☐ 51-65
- ☐ 66+

6. Marital situation: Are you?

- ☐ Single
- ☐ Living with a partner (not married)
- ☐ Married
- ☐ Separated or divorced
- ☐ Widowed

7. Which of these describes your current situation?

- ☐ Refugee
- ☐ Asylum seeker Section 95
- ☐ Asylum seeker Section 4
- ☐ Asylum seeker whose application has been refused
- ☐ Don't know
- ☐ Other (please describe below)

8. Do you consider yourself to have a long-term illness or disability (a physical or mental health problem that prevents you from doing activities)?

- ☐ Yes (If Yes please describe this/these conditions)
- ☐ No

9. Work or educational situation: Are you?

Please tick all that apply

- ☐ Employed full-time
- ☐ Employed part-time
- ☐ Unemployed
- ☐ Volunteering
- ☐ In education or training part-time
- ☐ In education or training full-time
- ☐ None of the above

Section B: Languages

10. What is your level of English?

Please tick all that apply

- ☐ I can read English well
- ☐ I can read a little English
- ☐ I cannot read English

- ☐ I can speak English well
- ☐ I can speak a little English
- ☐ I cannot speak English

- ☐ I can hold a conversation in English with a health professional
- ☐ I cannot hold a conversation in English with a health professional

11. Which language do you feel most comfortable speaking in everyday life?

12. What language or languages do you speak?

Section C: Your interpretation needs

13. Did you know that the NHS should provide you with an interpreter if you need help with talking to a doctor, nurse, or receptionist?

☐ Yes ☐ No

14. Have you ever used any type of interpretation for a healthcare contact or visit?

☐ Yes ☐ No *(If **No**, please say why, e.g. not needed, did not know who to ask, embarrassed did not know could ask for one)*

If no would you ask next time?

☐ Yes ☐ No ☐ Don't know

15. In the last year, have you ever contacted your GP (family doctor)?

☐ Yes ☐ No *(Go to question 16)*

A. During your most recent contact or visit with your GP, how easy was it for you to talk to the GP yourself? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 16)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before your contact or visit to the GP?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in your care or treatment?

☐ Yes *(If **Yes**, please say why)* ☐ No ☐ Don't know

16. In the last year, have you ever contacted other people at your GP surgery? e.g. receptionist, nurse, midwife

☐ Yes ☐ No *(Go to question 17)*

A. During your most recent telephone contact or visit with other people at your GP surgery, how easy was it for you to talk to them yourself? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 17)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before your telephone contact or visit to see other people at your GP surgery?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in your care or treatment?

☐ Yes (*If **Yes**, please say why*) ☐ No ☐ Don't know

17. In the last year, have you ever contacted Out of Hours GP (after 6pm or at the weekend)?

☐ Yes ☐ No *(Go to question 18)*

A. During your most recent contact or visit with the Out of Hours GP, how easy was it for you to talk to the GP yourself? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 18)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before your contact or visit with the Out of Hours GP?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in talking to the Out of Hours GP?

☐ Yes (*If **Yes**, please say why*) ☐ No ☐ Don't know

18. In the last year, have you ever called the 999 emergency ambulance service?

☐ Yes ☐ No *(Go to question 19)*

A. During your most recent 999 emergency call, how easy was it for you to talk to the 999 advisor on the telephone? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 19)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before you spoke to the 999 advisor?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in talking to the 999 advisor on the telephone?

☐ Yes (*If **Yes**, please say why*) ☐ No ☐ Don't know

19. In the last year, have you ever been treated by a 999 emergency ambulance paramedic?

☐ Yes ☐ No *(Go to question 18)*

A. During your most recent 999 contact, how easy was it for you to talk to the paramedic yourself? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 20)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before your contact or visit by the paramedic?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in your care or treatment?

☐ Yes (*If **Yes**, please say why*) ☐ No ☐ Don't know

20. In the last year, have you attended the hospital Accident and Emergency department (A&E)?

☐ Yes ☐ No *(Go to question 21)*

A. During your most recent A&E contact, how easy was it for you to talk to the A&E doctor, nurse or receptionist yourself? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 21)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before you spoke to A&E doctor, nurse or receptionist?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in your care or treatment?

☐ Yes (*If **Yes**, please say why*) ☐ No ☐ Don't know

21. In the last year, have you ever contacted the telephone NHS 111 (formerly NHS Direct)?

☐ Yes ☐ No *(Go to question 22)*

A. During your most recent A&E contact, how easy was it for you to talk to the A&E doctor, nurse or receptionist yourself? *Please tick one option*

☐ Very easy
☐ Easy
☐ Neutral
☐ Somewhat difficult
☐ Very difficult

B. Did you use an interpreter?

☐ Yes ☐ No *(Go to question 22)*

*If **Yes**, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker*

C. If you used an interpreter, who arranged the interpreter for you?

D. Did the interpreter have to be arranged before you spoke to the NHS 111 or NHS Direct advisor?

☐ Yes ☐ No ☐ Don't know

E. Did using an interpreter cause any delay in talking to the NHS 111 or NHS Direct advisor?

☐ Yes (*If **Yes**, please say why*) ☐ No ☐ Don't know

Section D: Your experience of using an interpreter

22. Have you ever used or needed an interpreter? If no, *please go to Section E.*

☐ Yes ☐ No

23. Have you used a professional telephone or face to face interpreter **provided by the NHS** during a healthcare contact or visit?

☐ Yes ☐ No *(please go to question 33)*

24. Did you have any choice in choosing your interpreter? e.g. man or woman, or preferred language?

☐ Yes ☐ No ☐ Sometimes

25. Did the interpreter explain their role to you?

☐ Yes ☐ No ☐ Sometimes

26. Did the interpreter explain that they would not be judging you in anyway?

☐ Yes ☐ No ☐ Sometimes

27. Did the interpreter explain that they will interpret exactly what is said and that all information will be kept private?

☐ Yes ☐ No ☐ Sometimes

28. Did the interpreter speak the language you were most comfortable in using?

☐ Yes ☐ No ☐ Sometimes

29. Did the interpreter correctly explain your health problem?

☐ Yes ☐ No ☐ Sometimes

30. Did the interpreter make it easier for you to talk about your health problem?

☐ Yes ☐ No ☐ Sometimes

31. What did you think about the overall interpretation experience?

☐ Excellent ☐ Very good ☐ Good ☐ Poor ☐ Very poor

32. Have you been offered the same interpreter for each health visit or contact?

☐ Yes ☐ No ☐ Sometimes

33. Can you tell us in your own words about your thoughts on using interpretation services or interpreters? What was good or bad and how it could be improved to make it better?

34. Have you used a **support worker from a local charity or voluntary group** to interpret for you during a healthcare visit or contact?

☐ Yes ☐ No *(please go to question 42)*

35. Did the interpreter explain their role to you?

☐ Yes ☐ No ☐ Sometimes

36. Did the interpreter explain that they will interpret exactly what is said and that all information will be kept safe?

☐ Yes ☐ No ☐ Sometimes

37. Did the interpreter speak the language you were most comfortable in using?

☐ Yes ☐ No ☐ Sometimes

38. Did the interpreter correctly explain your health problem?

☐ Yes ☐ No ☐ Sometimes

39. Did the interpreter make it easier for you to talk about your health problem?

☐ Yes ☐ No ☐ Sometimes

40. What did you think about the quality of the interpretation?

☐ Excellent ☐ Very good ☐ Good ☐ Poor ☐ Very poor

41. Have you been offered the same interpreter for each health visit or contact?

☐ Yes ☐ No ☐ Sometimes

42. Can you tell us in your own words about your thoughts on using interpretation services or interpreters? What was good or bad and how it could be improved to make it better?

E: Your general health and quality of life

Under each heading, please tick the **ONE** box that best describes your health **TODAY**

43. MOBILITY

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

44. SELF-CARE

- ☐ I have no problems washing or dressing myself
- ☐ I have slight problems washing or dressing myself
- ☐ I have moderate problems washing or dressing myself
- ☐ I have severe problems washing or dressing myself
- ☐ I am unable to wash or dress myself

45. USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems doing my usual activities
- ☐ I have slight problems doing my usual activities
- ☐ I have moderate problems doing my usual activities
- ☐ I have severe problems doing my usual activities
- ☐ I am unable to do my usual activities

46. PAIN / DISCOMFORT

- ☐ I have no pain or discomfort
- ☐ I have slight pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort
- ☐ I have extreme pain or discomfort

47. ANXIETY / DEPRESSION

- ☐ I am not anxious or depressed
- ☐ I am slightly anxious or depressed
- ☐ I am moderately anxious or depressed
- ☐ I am severely anxious or depressed
- ☐ I am extremely anxious or depressed

48. We would like to know how good or bad your health is TODAY.

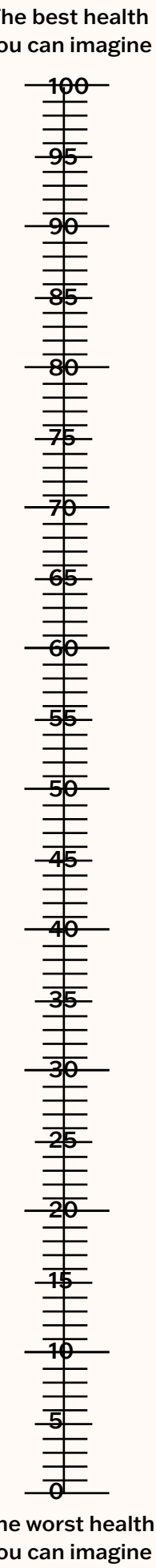
This scale is numbered from 0 to 100.

100 is the best health you can imagine.

0 means the worst health you can imagine.

Please mark an **X** on the **ruler shown on this page** to indicate how your health is TODAY.

Now, write the number you marked on the scale in the box



SECTION F: Final questions & thank you

49. Please enter today's date.

50. Did you complete this questionnaire with the help of a researcher/support worker/ family/friend?

☐ Yes ☐ No

*If you answered **Yes** to the above question, please provide their name and who it was below.*

If you were in a different study in the future we would like to know if you would have any objection to us linking your questionnaire to your NHS health information. Your name, date of birth and address will be turned into a code so that no one will know that it is you.

51. Would you agree for us to link your questionnaire answers to your health information?

☐ Yes ☐ No

*If **Yes**, please provide your information*

Name:

Date of birth:

Address and post code:

We may like to talk to you about your experience of needing or using an interpreter. This is optional and anything you say will be kept confidential. If you choose to provide your contact details they will be kept separately from your survey responses.

52. Would you be interested in taking part in an interview?

☐ Yes ☐ No

*If **Yes**, please provide your contact details*

Name:

Address:

Email:

Telephone number:

If you would like to receive a £10 voucher as a gift for completing this survey please provide your full name and email address below, and if you have one a postal address.

Name:

Address and post code:

Email:

Appendix 4 – Interview Guides

Interview Schedule for Asylum Seekers and Refugees

1. Have you used interpretation services when accessing healthcare? By interpretation services, I mean someone who is paid or who volunteers to interpret – not a member of your family or friend.
   - How many times?
   - Primary care?
   - Emergency care?
   - On the phone or face to face?

2. Thinking about the most recent times you used an interpretation service, can you tell me more about how that was arranged?
   - How did you request an interpreter/how did the provider find out you needed one?
   - Who arranged them?
   - Did you have to wait for an interpreter to be found?
   - Was the interpreter available when you needed them?

3. What did you think about the quality of the interpretation service?
   - Were you confident that the interpreter was accurate in repeating what you said?
   - Did you think that the information they interpreted back to you was complete and clear?
   - Did you think that they treated you with respect?

4. Did you feel confident about sharing personal information with the interpreter?
   - If not, in what way did you not feel confident?
   - Did you trust them to keep your information private outside the consultation?

5. Is there any way in which you think interpretation services for health care could be better?

6. Tell me about yourself…
   - What is your home country?
   - How long have you been in the UK?
   - Who do you live with?
   - Children at home?

7. Is there anything else you would like to tell me?

Interview or Focus group topic guide for health care providers

1. Have you used interpretation services when providing healthcare? By interpretation services, I mean someone who is paid or who volunteers to interpret – not a family or family member or friend of the patient.
   - How often?
   - Setting - primary care/ambulance service/emergency department?
   - On the phone or face to face?

2. Thinking about the most recent times you used an interpretation service, can you tell me more about how that was arranged?
   - At what point did you find out that the patient needed an interpreter?
   - How did you access an interpreter? Who arranged this?
   - Did you have to wait for an interpreter to be found?
   - Was the interpreter available when you needed them?
   - Did the need for an interpreter have any impact on when and how patient care was delivered?

3. What did you think about the quality of the interpretation service?
   - Were you confident that the interpreter was accurate in repeating what you said?
   - Did you think that the information they interpreted back to you was complete and clear?

4. Did you think that the interpreter treated the patient with respect?
   - Do you think that they respected the confidence and privacy of the patient?

5. When you use an interpretation service, who pays the cost?
   - If charged locally, how are payments made?
   - If charged locally, what implications does this have?

6. Is there any way in which you think interpretation services for health care could be better?

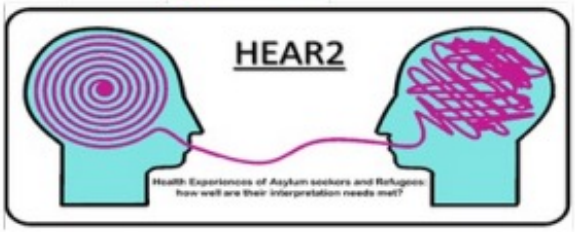
7. Is there anything else you would like to tell me?

Interview or Focus group topic guide for Interpreters

1. Do you provide interpretation as your main role/employment or as an additional role to work/study/home commitments?
2. Do you provide interpretation in a paid capacity or a voluntary capacity or both? (if none apply – exclude unless can answer as a HC professional – in which case use that tool)
3. In terms of your interpretation, which organisation would you be working for?
   For each organisation;
   - Would you be working for them in a permanent post or as a self-employed interpreter that they can call on?
   - How many hours on average per week would you be working?
   - Would this cover day, evening and night time hours?
   - Would you cover planned appointments/consultations, emergencies or both?
   - Have you provided interpretation for primary care/ambulance service/emergency department?
4. Have you provided on the phone, by video call or face to face?
   - If more than one, what do you feel about each method – which works best for you, and for the patient?
5. What languages do you provide interpretation for?
6. Time allocation and how alerted
   - How are you alerted to the need for your services?
   - How much notice do you receive usually that you will be needed to help with interpretation?
   - Are you assigned any time to meet the client to talk with them before the health appointment that interpretation is required for?
   - Are you assigned any time following the appointment to explain the health appointment outcome more fully?
7. Cross checking understanding
   - Has a health care professional ever asked you to tell them what your understanding is about what they have said?
   - Is what the health professional means always clear to you?
8. Thinking about the role and the valuable service you provide…
   - What is the best thing about your role as an interpreter?
   - What is the worst (most difficult/stressful) thing?
   - How could your role be made easier/less stressful for you?
   - How could the service be improved for the patient do you think?
   - How could the service be improved for the health care professional do you think?
9. Training
   - Did you need to have any special training to act as an interpreter?
   - If so what was this? Where did you train?
   - What additional training do you think interpreters would benefit from?
   - What additional training do you think health care professionals would benefit from regarding use of interpreters in health care consultations?
10. If you do not mind me asking - Do you have any lived experience of the UK asylum process personally in your family?
11. Is there anything else you would like to tell me?

Appendix 5: Commissioner's questionnaire and data handling rules

Commissioner's questionnaire



Interpretation services in primary care, emergency care, and urgent care ((link)

Page 1: Welcome

Thank you again for agreeing to take part in our survey

1. We are interested in interpretation services for primary care, emergency care, and urgent care for all users, especially for asylum seekers and refugees.

2. Completing the survey will probably take about **15 minutes.**

3. We will use the answers from the survey to inform our analysis and to produce research papers for publication in peer-reviewed journals. A lay summary will be produced for public dissemination. Any publications or reports generated from this survey will not be able to identify you and will not be able to find out your name, organisation's name, or contact details.

4. If you would prefer to complete the **questionnaire over the phone**, please let us know and the Study Manager will contact you to arrange a time to call.

Study Manager: Dr. Rabeea'h W Aslam; Email: r.w.aslam@swansea.ac.uk; Telephone: 07900857741

5. Public Health Wales is the sponsor for this study. They will be using your information to undertake this study and will act as the data controller. This means that they are responsible for looking after your information and using it properly. Individuals from Swansea University who are part of the research team and regulatory organisations will have access to your responses for research purposes. **Any publications or reports generated from this**

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survey will not be able to identify you and will not be able to find out your name, organisation's name, or contact details. You can find out more about how we use your information by contacting the Study Manager Dr. Rabeea'h W Aslam.

This study has been reviewed and given a favourable opinion by the Research Ethics Committee, REC ref: 21/PR/0743

Page 2: About you and your organisation

1. Where are you based?

- ○ England
- ○ Scotland
- ○ Wales
- ○ Northern Ireland

2. What is your job title?

3. What is the name of your organisation? (for example Devon Clinical Commissioning Group, Swansea Bay University Health Board, NHS Borders)

4. What size population is your organisation responsible for?

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Page 3: Interpretation service(s)

5. For interpretation service(s) in primary care, emergency care, and urgent care, which of the following functions are you or your organisation involved in? Please select all that apply.

	Applies to me	Applies to my organisation	Don't know
Assessing needs and planning	☐	☐	☐
Designing services and deciding priorities	☐	☐	☐
Seeking public and patient views on service provision/design	☐	☐	☐
Setting data on use (quantitative/qualitative)	☐	☐	☐
Setting and/or monitoring quality standards	☐	☐	☐
Funding, contracting and procurement	☐	☐	☐
Oversight of delivery	☐	☐	☐
Coordination of delivery	☐	☐	☐

6. Who provides interpretation service(s) in your area for primary care, emergency care, and urgent care? Please list providers' names.

6.a. Are services available 24 hours a day 7 days a week?

- ☐ Yes
- ☐ No
- ☐ Don't know

6.a.i. If Yes, please specify which ones:

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7. Does your organisation commission interpretation service(s) for use by the following care providers in your area? Please tick all that apply.

	Yes - face to face	Yes - telephone	Yes - video call	None	Don't know	Other
GP practices	☐	☐	☐	☐	☐	
GP out of hours	☐	☐	☐	☐	☐	
Hospital emergency departments (incl. medical admissions unit)	☐	☐	☐	☐	☐	
Urgent care centres (e.g. walk-in centres)	☐	☐	☐	☐	☐	
Ambulance service	☐	☐	☐	☐	☐	
NHS111/NHS24	☐	☐	☐	☐	☐	

8. In your area, are any third sector organisations involved in the delivery or coordination of interpretation service(s) in primary care, emergency care, and urgent care?

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- ○ Yes
- ○ No
- ○ Don't know

8.a. If yes, do they receive NHS funding to provide this service?

- ☐ Yes
- ☐ No
- ☐ Don't know

8.b. If applies, please list the names of these organisations.

9. Do you gather information on the use of interpretation service(s) by those who are **asylum seekers or refugees** for primary care, emergency care, and urgent care in your area?

- ☐ Yes
- ☐ No

10. Are there any specialist interpretation service(s) available for **asylum seekers and refugees** accessing primary care, emergency care, and urgent care in your area?

- ○ Yes
- ○ No
- ○ Don't know

10.a. If Yes, please specify the name(s) of the organisation(s).

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Page 4: Evaluation of interpretation services

11. In the last 3 years, has your organisation undertaken any of the following:

	Yes	No	Don't know
Audited language needs for your population	☐	☐	☐
Provided training for health practitioners in primary care, emergency care, and urgent care on the use of interpretation service(s)	☐	☐	☐
Promoted interpretation services to the local population	☐	☐	☐
Evaluated feedback by patients on interpretation service(s)	☐	☐	☐
Evaluated feedback by interpreters on interpretation service(s)	☐	☐	☐
Evaluated feedback by health and social care professionals on interpretation service(s)	☐	☐	☐

12. Please provide feedback on any challenges with the delivery of interpretation service(s) in primary care, emergency care, and urgent care in your area.

13. Please provide feedback on any specific challenges with the delivery of interpretation service(s) to asylum seekers and refugees in primary care, emergency care, and urgent care in your area.

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Page 5: Planning for interpretation service(s)

14. Does your organisation know how many people using primary care, emergency care, and urgent care in your area have made use of interpretation service(s) in the financial year April 2020 - 2021?

- ○ Yes
- ○ No
- ○ Don't know

15. Do you anticipate the need for interpretation service(s) in primary care, emergency care, and urgent care in your area to increase, decrease, or stay the same in the next financial year April 2022 - 2023?

	Increase	Decrease	Stay the same
GP practices	☐	☐	☐
GP out of hours	☐	☐	☐
Hospital emergency departments (incl. medical admissions unit)	☐	☐	☐
Urgent care centres (e.g. walk-in centres)	☐	☐	☐
Ambulance service	☐	☐	☐
NHS111/NHS24	☐	☐	☐

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Page 6: Procurement/Contracting of interpretation services

16. Is there a specification for the interpretation service(s)?

- (•) Yes
- ( ) No
- ( ) Don't know

16.a. If Yes, please link here

17. How does your organisation commission interpretation service(s)?

- ( ) Directly
- ( ) Indirectly (e.g. consortium)
- ( ) Mixed (directly and indirectly)
- ( ) Don't know
- ( ) Other

17.a. If Other, please specify.

18. What is the length of contracts for your interpretation service(s) providers in primary care, emergency care, and urgent care?

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19. Would your contracts normally be

- ☐ Block contracts
- ☐ Fee per service
- ☐ Mixed
- ☐ Other
- ☐ Don't know

20. If information is available, what is the approximate annual cost for interpretation service(s) for primary care, emergency care, and urgent care in your area for the financial year ending in April 2021?

Page 7: And finally...

21. Do you wish to receive a summary of findings from this survey?

- ○ Yes
- ○ No

22. Would you be willing to be contacted regarding further research into interpretation services?

- ○ Yes
- ○ No

23. If yes to either Q21 or Q22, please provide an email address here

24. Do you have any other comments?

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Page 8: Thank you for taking the time to complete this survey

If you have any questions about the survey or the study please contact:

Dr Rabeea'h W Aslam (Study Manager & Researcher), Swansea University

Email: R.W.Aslam@swansea.ac.uk

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Data handling rules

Rule 1. If there is missing data for > 90% of the questions, disregard this set of responses. Three responses were excluded on this basis.

Rule 2. If there is a response from the older CCGs which correspond to a part of the ICB, we will include all the data (from the CCGs and ICB).

Rule 3. If there is a response from a person representing a region in England, and some ICBs in that region, we will include all of the responses (region and ICB).

Rule 4. If there are two similar responses from the same ICB or CCG or HB, include the response that is more complete. However, if the organisation adds in that a certain response is their official response, choose that response.

Three responses were excluded on this basis.

Rule 5. In England, only include responses from Regions, ICBs and CCGs. However, if there is a response from a trust, only include those trusts which commission primary care including out of hours primary care. This includes ambulance services Trusts, NHS 111, NHS 24.

Five responses were excluded on this basis.

Appendix 6: PPI advisors, PAG members and Peer Researchers by area

Individual	PPI member	PAG member	Peer-researcher member	Location (South-West or North Wales)
a	/	PAG	/	SW
b	PPI	PAG	/	SW
c	PPI	PAG	PR	SW
d	/	PAG	PR	SW
e	/	PAG	PR	SW
f	/	PAG	PR	SW
g	/	PAG	PR	SW
h	/	/	PR	SW
i	/	/	PR	SW
j	/	/	PR	SW
k	/	/	PR	SW
l	/	/	PR	SW
m	/	/	PR	N
n	/	/	PR	N

Appendix 7: Further results for Objective 1.1

Table 1: Gender

		Female	Male	Total
Site	Site A	53	48	101
	Site C	1	2	3
	Site D	6	5	11
	Site E	22	10	32
	Total	82	65	147

Table 2: Age (years)

		Mean	Median	Minimum	Maximum
Site	Site A	34.4	31	18	74
	Site C	42.7	28	27	73
	Site D	51.4	48	36	82
	Site E	45.2	44.5	23	86
	Total	38.2	36	18	86

Table 4: Number of contacts recorded per service

		Number of patients	Number of contacts per patient				Total patient contacts (exceeds number of patients)
			1	2	3	4	
Site	Site A	101	83	14	4	0	123
	Site C	3	3	0	0	0	3
	Site D	11	9	1	1	0	14
	Site E	32	5	5	21	1	82

Table 5: Recorded reason for contact

Site	Advice	Mental	Physical	Missing/NR/NK	Total
Site A	2	7	16	98	123
Site C	0	0	2	1	3
Site D	0	0	2	12	14
Site E	2	5	18	57	82
Total	4	12	38	168	222

Appendix 8: Further results for Objective 1.2b

Table 7: Number of criteria met/partially met/not met/no evidence for each site

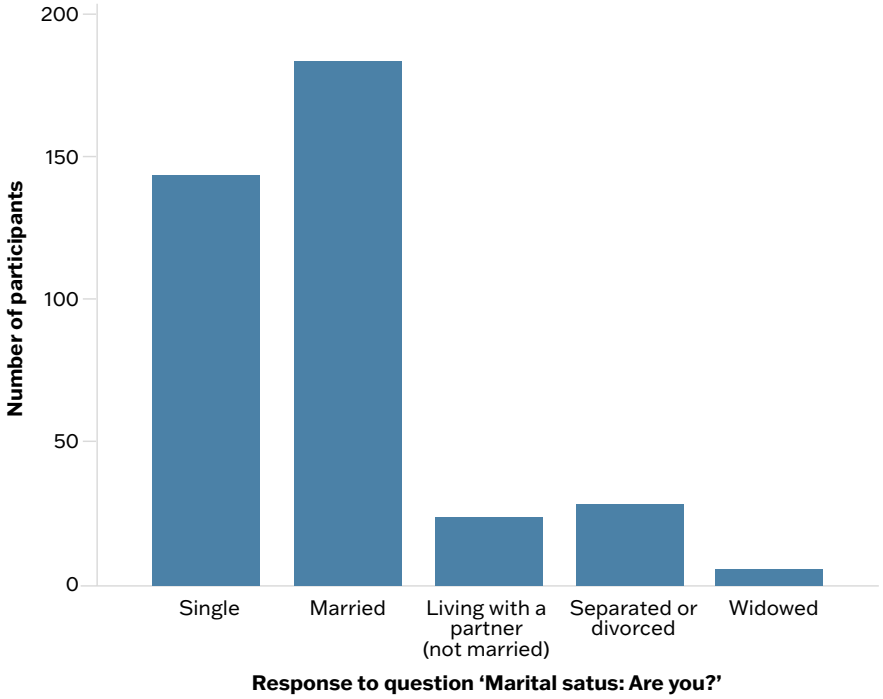
	Met	Partially Met	Not Met	No Evidence
Site A	26	8	6	1
Site B	5	14	17	5
Site C	26	9	6	0
Site D	15	11	14	1
Site E	11	5	25	0

Table 8: NHS staff and processes

Criteria	Met	Partially Met	Not Met	No Evidence
Understand legal requirement and rationale	2	2	1	0
Committed to equality of access	5	0	0	0
Supported to be aware of obligations	1	2	1	1
Aware of resource allocation	1	3	1	0
Supported to book and work with interpreters	1	2	2	0
Understand role of interpreter	1	2	2	0
Requirement for interpreter not based on assumptions but processes	2	0	3	0
Processes followed when patient refuses an interpreter	0	0	4	1
Feedback loop with interpretation service provider	0	3	2	0
Information about assignment provided to interpreter beforehand	2	3	0	0
Engage with competent interpreters only	2	0	3	0
Recognise interpreting as three-way process (interpreter, practitioner, patient)	3	1	1	0
Respect interpreters as professional colleagues	3	1	1	0
Continuity of interpreter throughout patient journey assessed	1	0	4	0
Debrief with interpreter following assignment	1	0	4	0
Access to training on how to work with interpreters	0	0	5	0
Patients do not pay for interpretation	4	1	0	0
Communication needs highly visible and shared when patient referred on	1	4	0	0
Carers of patients have access to interpretation	3	1	1	0
Healthcare provider books interpreter	4	1	0	0
Name and gender of interpreter shared with patient prior to appointment	0	0	4	1
Raise awareness of availability of interpreters	2	3	0	0
Interpreter need does not delay access to services	1	1	3	0
Patients aware of the different formats available for language support	3	0	1	1
Appropriate communication formats used to call patients to appointments	3	0	0	2
Patient record indicates communication needs	1	3	1	0
Consent gained for family/friend to act as interpreter	1	2	2	0
Individuals under the age of 16 not used for interpretation unless an emergency	3	1	1	0
Role of interpreter not taken on by staff other than 'language brokering'	4	0	1	0
Interpreter is only present to facilitate communication	5	0	0	0
Confidential and accessible feedback procedure in place for staff and patients	1	1	3	0

Appendix 9: Further results for Objective 1.3a

Graph 1: Marital status of participants



Bar graph excludes 'Missing' responses, n=1

Table 10:

3. How long have you been living in the UK? * 7. Which of these describes your current situation? Crosstabulation

Count

		7. Which of these describes your current situation?								Total
			Asylum seeker Section 4	Asylum seeker Section 95	Asylum seeker Section not known	Asylum seeker whose application has been refused	Don't know	Other	Refugee	
3. How long have you been living in the UK?	1 to less than 2 years	0	1	19	0	0	0	1	8	29
	10 or more years	0	0	8	0	1	6	7	37	59
	2 to less than 5 years	0	2	67	2	3	4	4	78	160
	5 to less than 10 years	1	7	18	0	3	8	0	57	94
	Less than 1 year	0	0	25	0	0	0	0	8	33
	Missing	1	1	2	0	0	0	0	5	9
Total		2	11	139	2	7	18	12	193	384

Table 11: Top 12 responses to 'Which language do you feel most comfortable speaking in everyday life?'

	Number (%)
Arabic	102 (26.6)
English	92 (24.0)
Kurdish	37 (9.6)
Russian	19 (4.9)
Spanish	13 (3.4)
Albanian	12 (3.1)
Turkish	10 (2.6)
Persian/Farsi	9 (2.3)
Bangla	7 (1.8)
French	5 (1.3)
Lingala	5 (1.3)
Otjiherero	5 (1.3)
Other*	50 (13.0)
Missing	18 (4.7)
Total	384 (100.0)

**'Other' included languages such as Chichewa, Sinhalese, Tamil, Igbo, Kurdish Sorani, Urdu and Yoruba.*

Table 12:

7. Which of these describes your current situation? * 10. Level of reading Crosstabulation

		Count				
		10. Level of reading				Total
		I can read a little English	I can read English well	I cannot read English	Missing	
7. Which of these describes your current situation?		0	2	0	0	2
	Asylum seeker Section 4	3	4	2	2	11
	Asylum seeker Section 95	41	55	11	32	139
	Asylum seeker Section not known	0	1	0	1	2
	Asylum seeker whose application has been refused	2	4	1	0	7
	Don't know	3	12	0	3	18
	Other	5	5	0	2	12
	Refugee	51	93	22	27	193
Total		105	176	36	67	384

Table 13:

7. Which of these describes your current situation? * 10. Level of speaking Crosstabulation

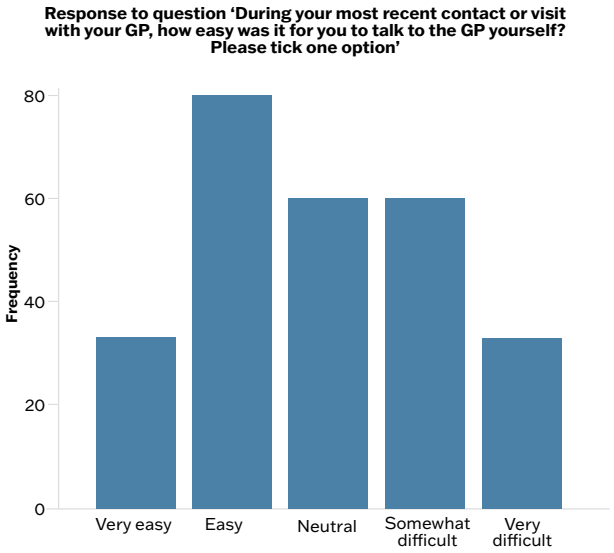
		Count				
		10. Level of speaking				Total
		I can speak a little English	I can speak English well	I cannot speak English	Missing	
7. Which of these describes your current situation?		1	1	0	0	2
	Asylum seeker Section 4	4	2	2	3	11
	Asylum seeker Section 95	52	29	15	43	139
	Asylum seeker Section not known	1	1	0	0	2
	Asylum seeker whose application has been refused	1	2	1	3	7
	Don't know	5	8	1	4	18
	Other	5	2	0	5	12
	Refugee	69	46	14	64	193
Total		138	91	33	122	384

Table 14:

13. Did you know that the NHS should provide you with an interpreter if you need help with talking to a doctor, nurse, or receptionist? * 7. Which of these describes your current situation? Crosstabulation

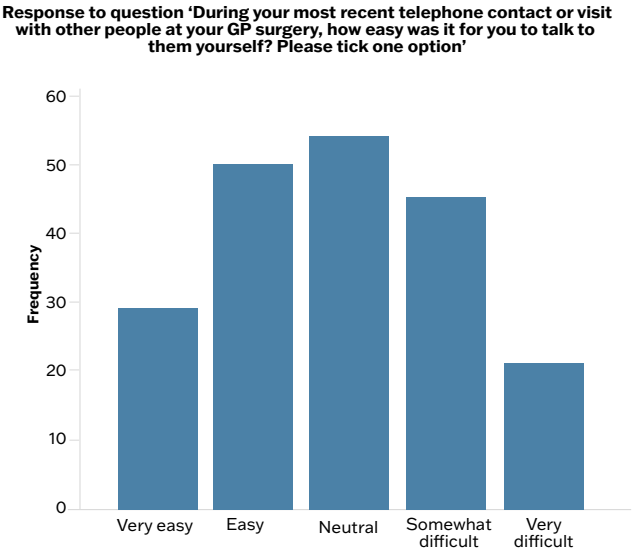
		Count								
		7. Which of these describes your current situation?								
			Asylum seeker Section 4	Asylum seeker Section 95	Asylum seeker Section not known	Asylum seeker whose application has been refused	Don't know	Other	Refugee	Total
13. Did you know that the NHS should provide you with an interpreter if you need help with talking to a doctor, nurse, or receptionist?	Missing	0	0	1	0	0	0	0	0	1
	No	0	6	43	0	4	8	5	39	105
	Yes	2	5	95	2	3	10	7	154	278
Total		2	11	139	2	7	18	12	193	384

Graph 3: How easy was it for you to talk to the GP yourself?



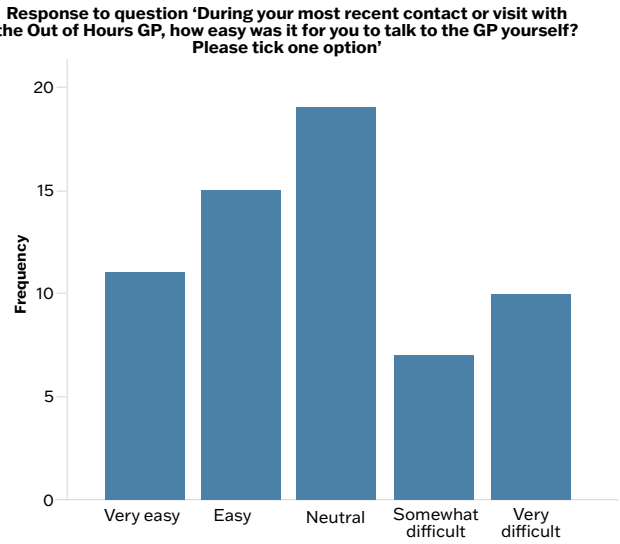
Bar graph excludes 'Missing' responses, n=2

Graph 4: How easy was it for you to talk to other people at your GP surgery yourself?



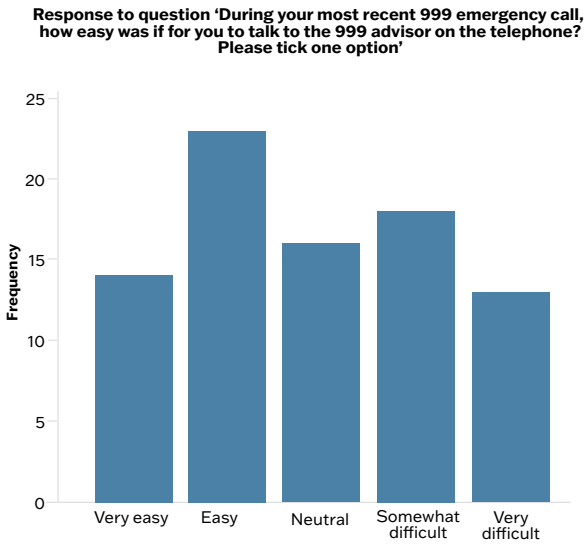
Bar graph excludes 'Missing' responses, n=3

Graph 5: How easy was it for you to talk to the Out of Hours GP yourself?



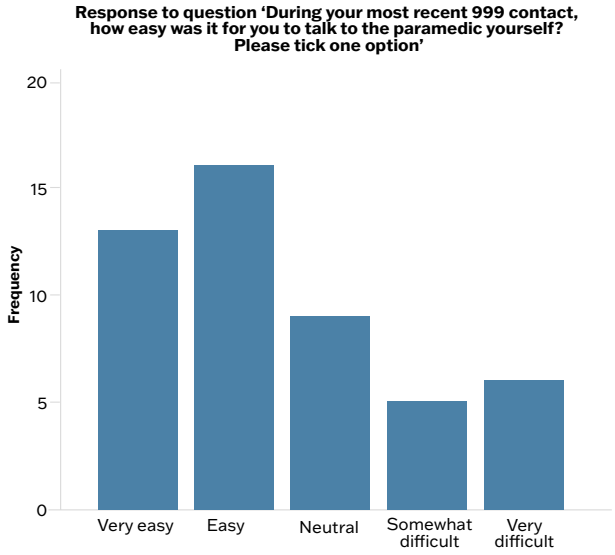
Bar graph excludes 'Missing' responses, n=4

Graph 6: How easy was it for you to talk to the 999 advisor on the telephone?



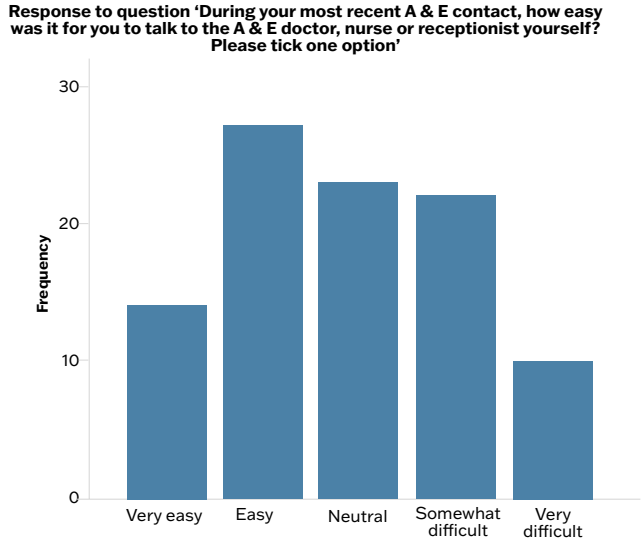
Bar graph excludes 'Missing' responses, n=1

Graph 7: How easy was it for you to talk to the paramedic yourself?



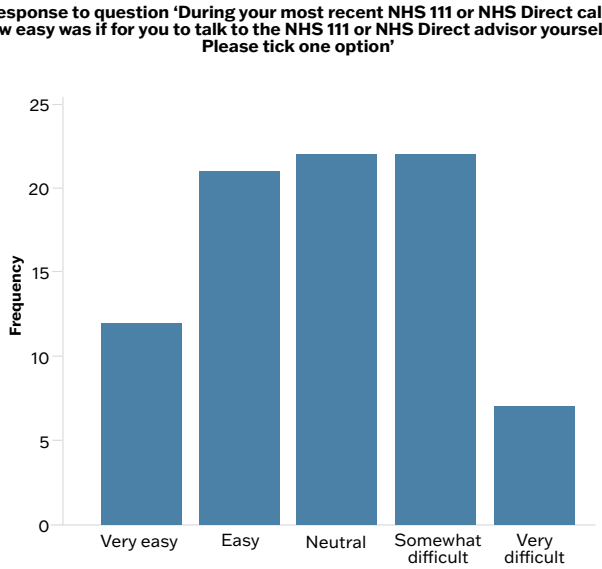
Bar graph excludes 'Missing' responses, n=3

Graph 8: How easy was it for you to talk to A&E staff yourself?

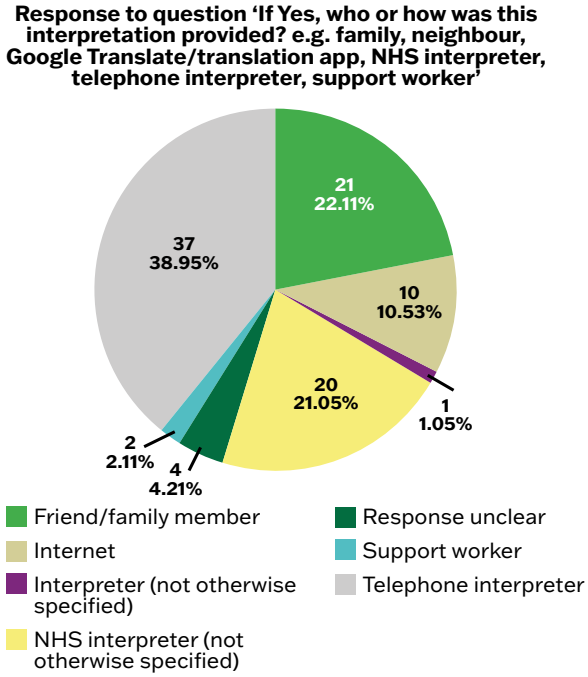


Bar graph excludes 'Missing' responses, n=4

Graph 9: How easy was it for you to talk to the NHS 111 advisor?

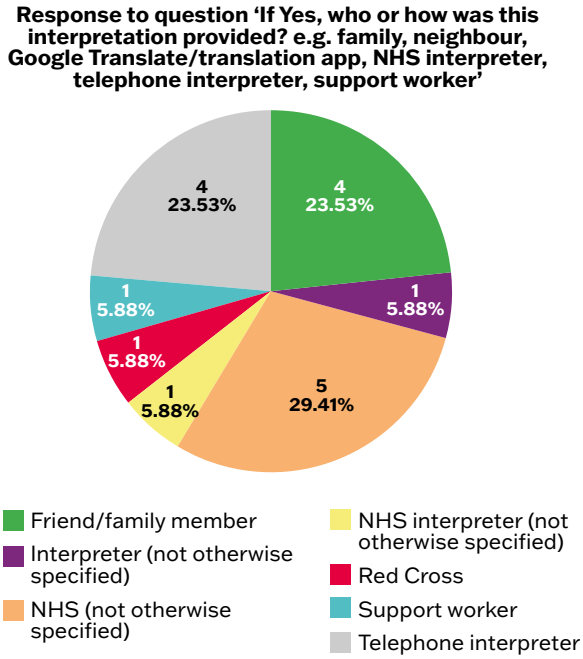


Graph 10: For visits to GP



Pie chart excludes 'Missing' responses, n-169 and responses that were not applicable, n=4

Graph 11: For visits to GP



Pie chart excludes 'Missing' responses, n=173 and responses that were not applicable, n=7

Table 15: For visits to GP

Did the interpreter have to be arranged before your contact or visit to the GP?

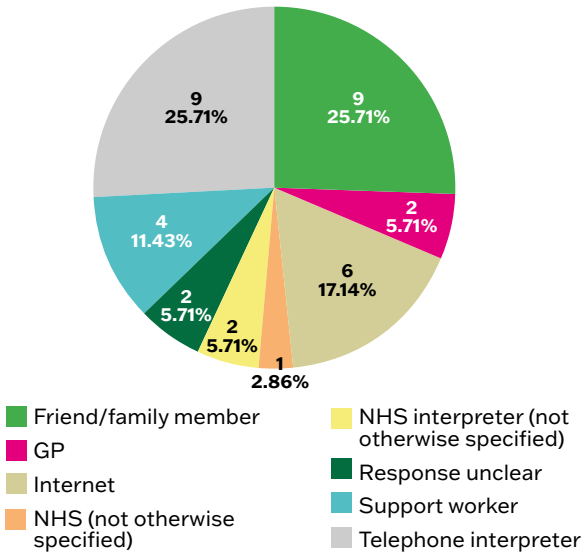
Of those who responded to this question these were their responses:

	Number (%)
Yes	49 (35.0)
No	47 (33.6)
Don't know	44 (31.4)
Total	140 (100.0)

Appendix 10: Asylum seeker and refugee questionnaire results – further details related to contact with other people at GP surgery

Of those respondents who had contacted other people at their GP surgery in the last year, 40 (19.8%) reported that they used an interpreter. 36 participants provided further information about how the interpretation was provided. The most common responses were 'Friend/family member' (9, 25.7%) and 'Telephone interpreter' (9, 25.7%) as shown in the graph below:

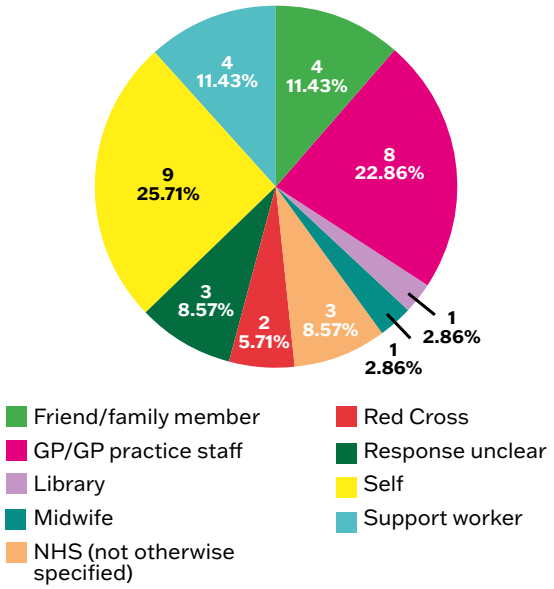
Response to question 'If Yes, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker'



Pie chart excludes 'Missing' responses, n=166 and responses that were not applicable, n=1

35 participants provided information about who arranged the interpreter for them. Nearly half of respondents (48.6%) stated that interpretation had been arranged by either 'Self' or 'GP/GP practice staff.' Other responses included 'Friend/family member' (4, 11.4%), and 'Support worker' (4, 11.4%) as seen in the graph below:

Response to question 'If you used an interpreter, who arranged the interpreter for you?'



Pie chart excludes 'Missing' responses, n=165 and responses that were not applicable, n=2

Of 71 valid responses, 29 (40.8%) respondents stated that the interpreter had to be arranged before their contact or visit to see other people at their GP surgery. 68 valid responses were provided in answer to the question 'Did using an interpreter cause any delay in your care or treatment? 44 (64.7%) participants did not think that using an interpreter caused any delay in their care or treatment:

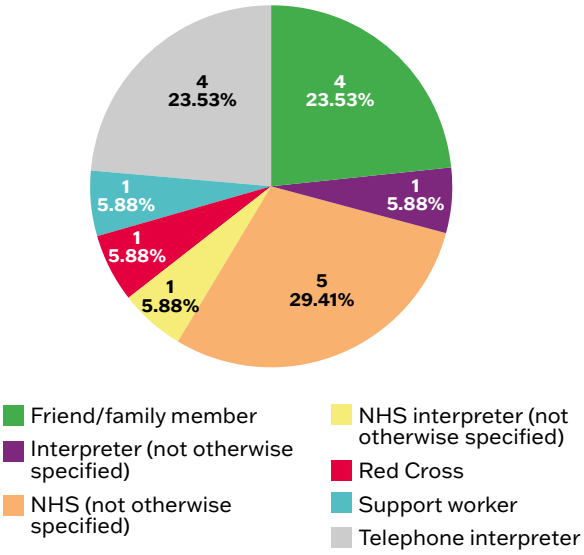
	Number (%)
Yes	8 (11.8)
No	44 (64.7)
Don't know	16 (23.5)
Total	68 (100.0)

Those respondents who believed there had been a delay in their care or treatment reported that this was because of the time taken to obtain interpreter (n=4) and poor quality of interpretation (n=1).

Appendix 11: Asylum seeker and refugee questionnaire results – further details related to contact with Out of Hours GP

Of those respondents who had contacted an Out of Hours GP in the last year, 17 (25.8%) reported that they had used an interpreter. 18 participants provided further information about how the interpretation was provided. The most common responses were 'NHS (not otherwise specified)' (5, 29.4%), 'Friend/ family member' (4, 23.5%) and 'Telephone interpreter' (4, 23.5%) as seen in the graph below:

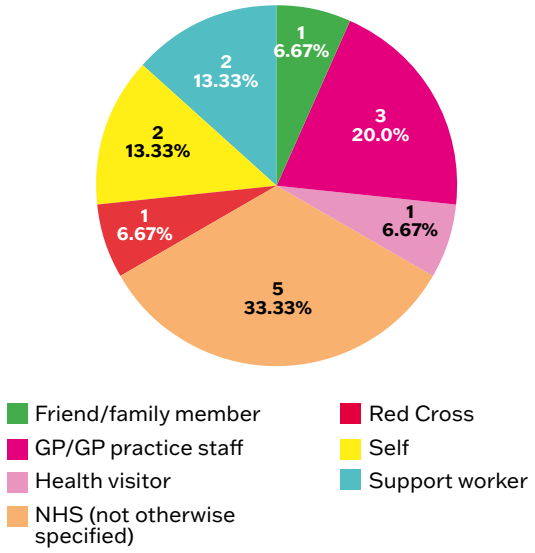
Response to question 'If Yes, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker'



Pie chart excludes 'Missing' responses, n=48 and responses that were not applicable, n=1

15 participants provided information about who arranged the interpreter for them. 5 (33.3%) respondents reported that interpretation had been arranged by 'NHS (not otherwise specified)' with other answers including 'GP/GP practice staff' (3, 20.0%), 'Support worker' (2, 13.3%), and 'Self' (2, 13.3%) as seen in the graph below:

Response to question 'If you used an interpreter, who arranged the interpreter for you?'



Pie chart excludes 'Missing' responses, n=50 and responses that were not applicable, n=1

Of 28 valid responses, 11 (39.3%) respondents stated that the interpreter had to be arranged before their contact or visit with the Out of Hours GP, with an equal number of respondents stating that the interpreter did not have to be arranged beforehand. When asked if using an interpreter caused any delay in talking to the Out of Hours GP, out of 29 valid answers 20 participants (69.0%) answered 'No':

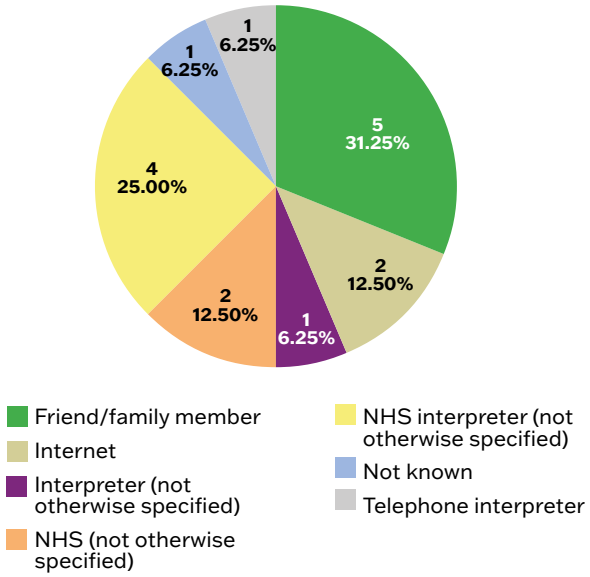
	Number (%)
Yes	4 (13.8)
No	20 (69.0)
Don't know	5 (17.2)
Total	29 (100.0)

Only one reason for a delay was provided which was 'Time taken to obtain interpreter.'

Appendix 12: Asylum seeker and refugee questionnaire results – further details related to contact with 999 emergency ambulance service

Of those respondents who had called the 999 emergency ambulance service in the last year, 16 (18.8%) reported that they used an interpreter. 16 participants provided further detail about how the interpretation was provided as shown below:

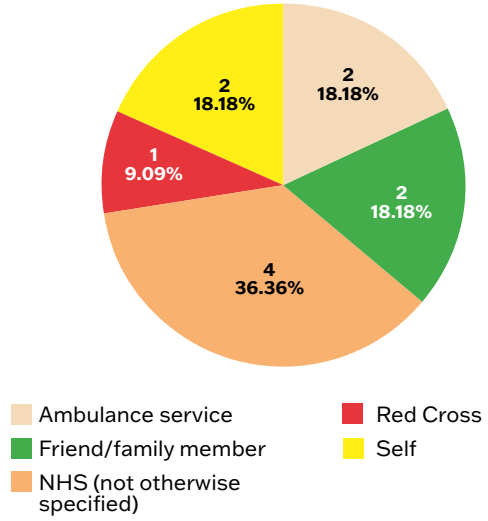
Response to question 'If Yes, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker'



Pie chart excludes 'Missing' responses, n=67 and responses that were not applicable, n=2

11 participants provided information about who arranged the interpreter for them. 'NHS (not otherwise specified)' was the most common response (4, 36.4%), followed by 'Ambulance service' (2, 18.2%), 'Friend/family member' (2, 18.2%), 'Self' (2, 18.2%) and 'Red Cross' (1, 9.1%) as shown below:

Response to question 'If you used an interpreter, who arranged the interpreter for you?'



Pie chart excludes 'Missing' responses, n=72 and responses that were not applicable, n=2

Of 25 valid responses, 9 (36.0%) respondents stated that the interpreter had to be arranged before they spoke to the 999 advisor while 13 (52.0%) respondents reported that the interpreter did not have to be arranged beforehand. When asked if using an interpreter caused any delay in talking to the 999 advisor on the telephone, of 26 valid answers 20 (77.0%) participants answered 'No':

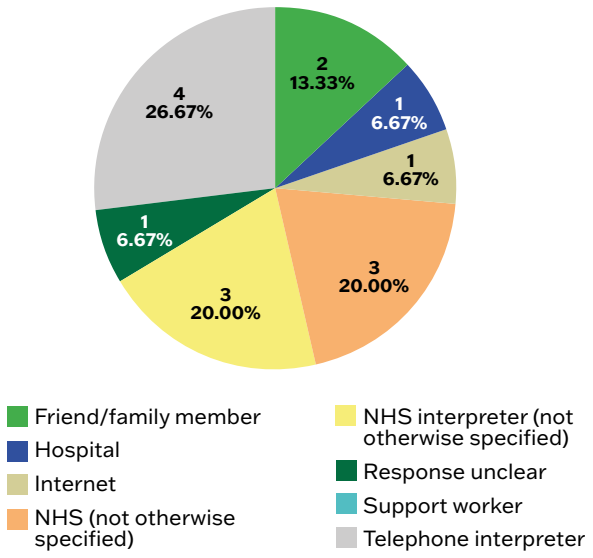
	Number (%)
Yes	3 (11.5)
No	20 (76.9)
Don't know	3 (11.5)
Total	26 (100.0)

Only one reason for a delay was provided which was 'Poor quality of interpretation.'

Appendix 13: Asylum seeker and refugee questionnaire results – further details related to contact with 999 emergency ambulance paramedic

Of those respondents who had been treated by a 999 emergency ambulance paramedic in the last year, 15 (28.8%) reported that they used an interpreter. 15 participants provided further detail about how the interpretation was provided with the most common answers being 'Telephone interpreter' (4, 26.7%), 'NHS interpreter (not otherwise specified)' (3, 20.0%), and 'NHS intepreter (not otherwise specified)' (3, 20.0%) as shown in the graph below:

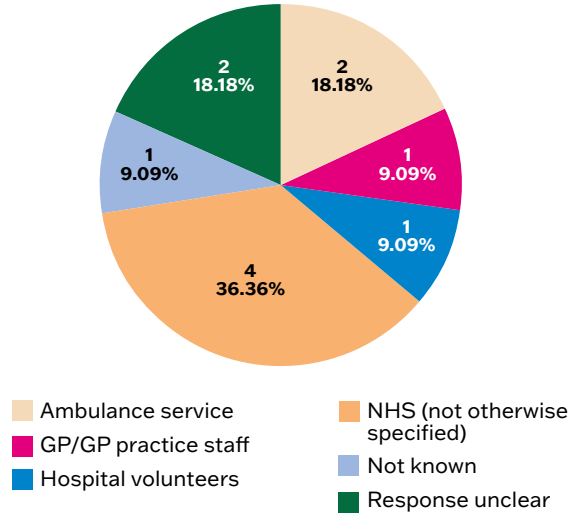
Response to question 'If Yes, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker'



Pie chart excludes 'Missing' responses, n=36 and responses that were not applicable, n=1

When we asked 'If you used an interpreter, who arranged the interpreter for you?' there were many 'Missing' responses but 11 participants provided this information. The most common response was 'NHS (not otherwise specified)' (4, 36.7%). Other answers included 'Ambulance service' (2, 18.2%), 'GP/GP practice' (1, 9.1%) and 'Hospital volunteers' (1, 9.1%) as shown below:

Response to question 'If you used an interpreter, who arranged the interpreter for you?'

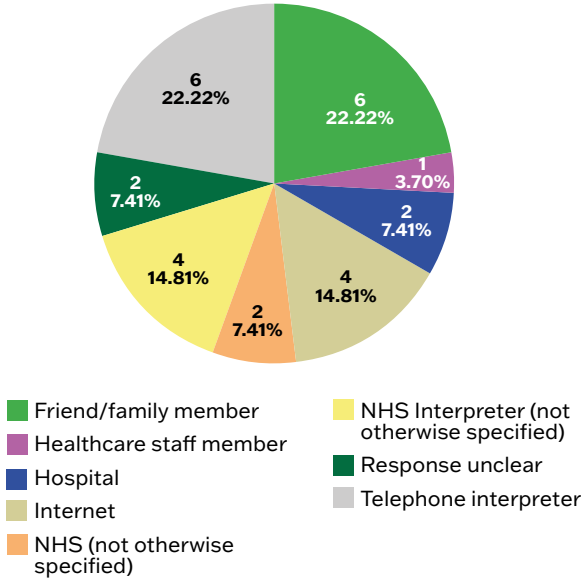


Pie chart excludes 'Missing' responses, n=39 and responses that were not applicable, n=2

Of 21 valid responses, 9 (42.9%) respondents stated that the interpreter had to be arranged before their contact or visit by the paramedic. Similarly, 10 (47.6%) respondents reported that the interpreter did not have to be arranged beforehand. When asked if using an interpreter caused any delay in their care or treatment, 20 participants provided a valid answer, of which 16 (80.0%) responded 'No' and 4 (20.0%) responded 'Don't know.'

Appendix 14: Asylum seeker and refugee questionnaire results – further details related to contact with A&E

Response to question 'If Yes, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker'

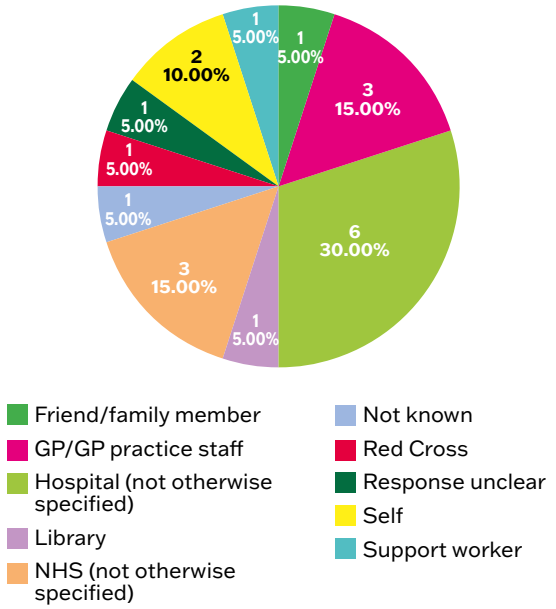


Pie chart excludes 'Missing' responses, n=72 and responses that were not applicable, n=1

Did using an interpreter cause any delay in your care or treatment?

	Number (%)
Yes	5 (12.5)
No	25 (62.5)
Don't know	10 (25.0)
Total	40 (100.0)

Response to question 'If you used an interpreter, who arranged the interpreter for you?'

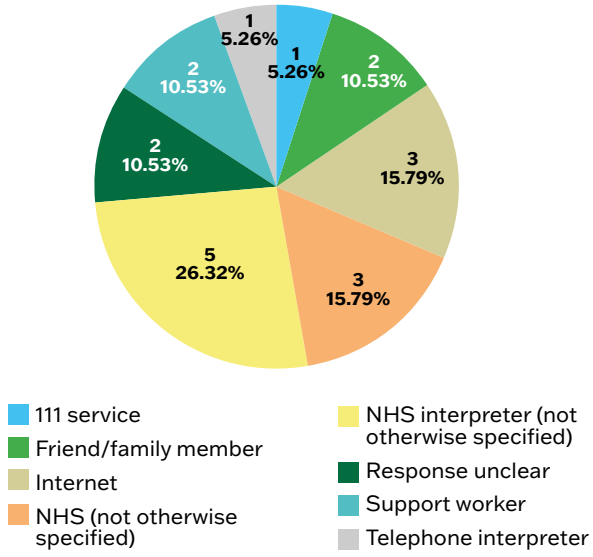


Pie chart excludes 'Missing' responses, n=78 and responses that were not applicable, n=2

Appendix 15: Asylum seeker and refugee questionnaire results – further details related to contact with NHS 111

84 (21.9%) respondents had contacted NHS 111 in the last year. 33 participants reported that it was either 'Very easy' or 'Easy' to talk to the NHS 111 or NHS Direct advisor themselves, while 29 participants reported that it was either 'Very difficult' or 'Somewhat difficult.' (Graph in Appendix G). Of those respondents who had contacted NHS 111 in the last year, 25 (29.8%) reported that they had used an interpreter. 19 participants provided information about who or how the interpretation was provided with the most common responses being 'NHS interpreter (not otherwise specified)' (5, 26.3%), 'Internet' (3, 15.8%), and 'NHS (not otherwise specified)' (3, 15.8%) as shown below:

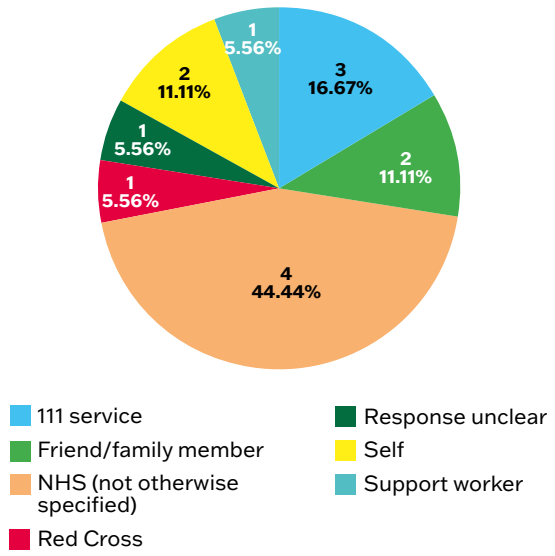
Response to question 'If Yes, who or how was this interpretation provided? e.g. family, neighbour, Google Translate/translation app, NHS interpreter, telephone interpreter, support worker'



Pie chart excludes 'Missing' responses, n=65

When we asked 'If you used an interpreter, who arranged the interpreter for you?' there were many 'Missing' responses but 18 participants provided this information. 'NHS (not otherwise specified)' was the most common answer (8, 44.4%), with others including '111 service' (3, 16.7%), 'Friend/family member' (2, 11.1%) and 'Self' (2, 11.1%).

Response to question 'If you used an interpreter, who arranged the interpreter for you?'



Pie chart excludes 'Missing' responses, n=66

Of 33 valid responses, nearly half of the respondents (16, 48.5%) stated that the interpreter had to be arranged before they spoke to the NHS 111 or NHS Direct advisor. 5 (15.2%) did not know and 12 (36.4%) reported that the interpreter did not have to be arranged beforehand. When asked if using an interpreter caused any delay in talking to the NHS 111 or NHS Direct advisor, 35 participants provided a valid answer with the majority of participants (24, 68.6%) stating 'No' as shown below:

	Number (%)
Yes	6 (17.1)
No	24 (68.6)
Don't know	5 (14.3)
Total	35 (100.0)

For those participants who had experienced a delay in their care or treatment the reason given was 'Time taken to obtain interpreter.'

Appendix 16: Asylum seeker and refugee questionnaire results – responses to final questions

Did you complete this questionnaire with the help of a researcher/support worker/family/ friend?

	Number (%)
Yes	207 (53.9)
No	169 (44.0)
Missing	8 (2.1)
Total	384 (100.0)

Would you agree for us to link your questionnaire answers to your health information?

	Number (%)
Yes	161 (41.9)
No	208 (54.2)
Missing	15 (3.9)
Total	384 (100.0)

Would you be interested in taking part in an interview?

	Number (%)
Yes	110 (28.6)
No	258 (67.2)
Missing	16 (4.2)
Total	384 (100.0)

Appendix 17: Free text responses to asylum seeker and refugee questionnaire

Respondents were asked the following question, inviting free text responses, firstly in relation to professional interpreters arranged by healthcare providers (Q33) and secondly in relation to interpretation provided by support workers from local charities or voluntary groups (Q42).

Can you tell us in your own words about your thoughts on using interpretation services or interpreters? What was good or bad and how it could be improved to make it better?

We coded the text, using a coding frame developed inductively from the data.

x respondents (out of a total of y respondents) provided free text. [112] people responded to Q33, and [102] people responded to Q42. [95] responded to both questions.

We coded each discrete idea as a statement, meaning one person's response may contain multiple coded statements. So, for example, in the following sentence:

> *'The good thing is that they're helping me sometimes to explain my problem // but the not good thing is that sometimes they don't understand you right.'*

The first part is coded to 1.1. Generally positive/positive opinion, and the second part is coded to 2.2 Negative experiences or concerns/problems with quality.

Professional interpretation facilitated by health care providers

Respondents provided a total of 313 statements reporting their views on professional interpretation services. Much the biggest group of statements (178) were generally positive. Most of these provided praise of some sort, talking about the interpretation services being, for example, 'helpful', 'non-judgemental', 'understanding' or 'lovely'.

39 of these positive statements specifically identified the benefits of using interpretation services. In addition to help with communication, interpreters were seen as having a supportive role:

> *'It's good and it doesn't make you feel alone.'*

88 statements described some kind of problem associated with interpretation services. The biggest group of these (51) were concerns about the quality of services, such as a perceived lack of empathy from interpreters or the interpreter's English not being of a high enough standard. 32 statements were about problems with accessing interpretation services, such as a lack of knowledge about entitlement or problems making needs known to a receptionist.

18 respondents described alternatives to using formal interpretation, such as family or friends.

26 statements were suggestions for improvement, including providing easier routes to give feedback if the interpreter was felt to be poor quality, and improving awareness of entitlement:

> *'First tell to everybody that this is a right. I didn't know before.'*

Interpretation provided by support workers from charities or voluntary groups

Respondents provided a total of 271 statements reporting their views on interpretation provided by support workers. Again, the biggest proportion of these (156) were positive:

> *'Gives the chance for the voiceless to have a voice.'*

60 statements reported problems of some sort. As well as specific concerns about quality (26) and access (27) issues, there were general concerns about the impact of interpretation:

> *'You feel less privacy.'*

Respondents also raised specific concerns relating the gender of interpreters:

> *'People might be uncomfortable depending on the gender of the interpreter due to religion or other matters.'*

And about the need to be specific about dialects:

> *'I speak Iraqi Arabic but I had an interpreter who is Egyptian Arabic which was a difficulty understanding.'*

18 respondents described alternatives to using formal interpretation.

23 statements were suggestions for improvement, including making more use of third sector provision in health care settings:

> *'I think NHS should use volunteering services more often.'*

Appendix 18: Further results for Objective 2.3

Table 17: comparison of the number of completed questionnaires, by methodological approach, with percentage completed online and response rate, where applicable*

	Number of individuals sent a questionnaire	Number of completed questionnaires (% of total completed on-line)	Response rate (%)*
Peer-researcher supported	N/A	170 (78.2%)	N/A
Community links	N/A	214 (98.6%)	N/A
Postal survey from NHS sites	118	45 (0.0%)*[1]	38.1%

N/A = not available; n = number

*[1] 50 questionnaires were returned but 5 were duplicates and were therefore not analysed further.

Table 19: comparison of language and interpretation needs of respondents by methodological approach

Topic of question		Methodological approach: Peer-researcher supported n (%) of total	Community links n (%) of total	Postal survey from NHS sites n (%) of total
Level of reading English	I can read English well	79 (46.5%)	97 (45.3%)	0 (0.0%)
	I can read a little English	58 (34.1%)	47 (22.0%)	20 (44.4%)
	I cannot read English	13 (7.6%)	23 (10.7%)	23 (51.1%)
	Missing	20 (11.8%)	47 (22.0%)	2 (4.4%)
Level of speaking English	I can speak English well	45 (26.5%)	46 (21.5%)	1 (2.2%)
	I can speak a little English	78 (45.9%)	60 (28.0%)	19 (42.2%)
	I cannot speak English	16 (9.4%)	17 (7.9%)	21 (46.7%)
	Missing	31 (18.2%)	91 (42.5%)	4 (8.9%)
Level of conversational English	I can hold a conversation in English with a health professional	46 (27.1%)	38 (17.8%)	0 (0.0%)
	I cannot hold a conversation in English with a health professional	57 (33.5%)	16 (7.5%)	38 (84.4%)
	Missing	67 (39.4%)	160 (74.8%)	7 (15.6%)
Language most comfortable speaking, first response given (most frequent five languages and response missing) **Kurdish and Kurdish Badini and Kurdish Sorani combined* **[2] Farsi and Persian/Farsi combined*	*Language 1*	Kurdish*: 31 (18.2%)	Arabic: 80 (37.4%)	Dari: 16 (35.6%)
	Language 2	English: 30 (17.6%)	English: 62 (29.0%)	Arabic: 5 (11.1%)
	Language 3	Arabic: 22 (12.9%)	Kurdish*: 10 (4.7%)	Kurdish* 5 (11.1%)
	Language 4	Russian: 18 (10.6%)	Turkish: 8 (3.7%)	Pashto: 4 (8.9%) Spanish: 4 (8.9%) Farsi*[2]: 4 (8.9%)
	Language 5	Albanian: 10 (5.9%)	Farsi*[2]: 7 (3.3%)	
	Missing	4 (2.4%)	14 (6.5%)	1 (2.2%)
Total number of questionnaires		**170**	**214**	**45**

Table 20: Comparison of respondents' overall self-reported experience of using interpretation services

		Methodological approach		
		Peer-researcher supported	Community links	Postal survey from NHS sites
Topic of question		**n (%) of total**	**n (%) of total**	**n (%) of total**
Knowledge that the NHS should provide an interpreter	**Yes**	123 (72.4%)	155 (72.4%)	42 (93.3%)
	No	47 (27.6%)	58 (27.1%)	2 (4.4%)
	Missing	0 (0.0%)	1 (0.5%)	1 (2.2%)
Ever used interpretation for healthcare visit	**Yes**	96 (56.5%)	126 (58.9%)	37 (82.2%)
	No	73 (42.9%)	87 (40.7%)	7 (15.6%)
	Missing	1 (0.6%)	1 (0.5%)	1 (2.2%)
Use of professional telephone/ face to face interpreter provided by the NHS during a healthcare contact or visit	**Yes**	69 (40.6%)	73 (34.1%)	31 (68.9%)
	No	67 (39.4%)	85 (39.7%)	9 (20.0%)
	Missing	34 (20.0%)	56 (26.2%)	5 (11.1%)
Of those who answered yes (see question above for total), overall interpretation experience	**Excellent**	9 (13.0%)	13 (17.8%)	8 (25.8%)
	Very good	27 (39.1%)	26 (35.6%)	10 (32.3%)
	Good	28 (40.6%)	31 (42.5%)	9 (29.0%)
	Poor	4 (5.8%)	2 (2.7%)	0 (0.0%)
	Very poor	0 (0.0%)	0 (0.0%)	2 (6.5%)
	Missing	1 (1.4%)	1 (1.4%)	2 (6.5%))
Total number of questionnaires		**170**	**214**	**45**

Table 21: Percentage of complete responses and missing data and mean health-related quality of life/utility scores based on immigration status (SD=standard deviation)

	Refugees	Asylum seekers	Other	Don't know
EQ-5D-5L				
Complete responses	209 (94.6%)	167 (96.5%)	12 (100.0%)	20 (100.0%)
Missing	12 (5.4%)	6 (3.5%)	0 (0.0%)	0 (0.0%)
Mean score (SD)	0.728 (0.350)	0.744 (0.254)	0.821 (0.197)	0.803 (0.284)
Visual Analogue Scale (VAS)				
Complete responses	201 (91.0%)	160 (92.5%)	12 (100.0%)	19 (95.0%)
Missing	20 (9.0%)	13 (7.5%)	0 (0.0%)	1 (5.0%)
Mean score (SD)	67.11 (25.79)	69.28 (25.09)	68.75 (11.70)	69.11 (21.81)

Table 23: Comparison of differences of health-related quality of life/utility scores based on immigration status (SD=standard)

EQ-5D-5L		Mean difference	p-value	95% Confidence interval	
				Lower	Upper
Refugee	Asylum seeker	-0.015	0.964	-0.097	0.067
	Other	-0.092	0.739	-0.328	0.142
	Don't know	-0.075	0.725	-0.260	0.110
Asylum seeker	Refugee	0.0152	0.964	-0.067	0.097
	Other	-0.078	0.833	-0.314	0.159
	Don't know	-0.060	0.844	-0.247	0.128
Other	Refugee	0.093	0.739	-0.142	0.328
	Asylum seeker	0.078	0.833	-0.159	0.314
	Don't know	0.018	0.999	-0.271	0.307
Don't know	Refugee	0.075	0.725	-0.110	0.260
	Asylum seeker	0.060	0.844	-0.128	0.247
	Other	-0.018	0.999	-0.307	0.271
Visual Analogue Scale (VAS)					
Refugee	Asylum seeker	-2.166	0.847	-9.01	4.68
	Other	-1.641	0.996	-20.84	17.56
	Don't know	-1.996	0.987	-17.50	13.51
Asylum seeker	Refugee	2.166	0.847	-4.68	9.01
	Other	0.525	1.000	-18.81	19.86
	Don't know	0.170	1.000	-15.50	15.84
Other	Refugee	1.641	0.996	-17.56	20.84
	Asylum seeker	-0.525	1.000	-19.86	18.81
	Don't know	-0.355	1.000	-24.17	23.46
Don't know	Refugee	1.996	0.987	-13.51	17.50
	Asylum seeker	-0.170	1.000	-15.84	15.50
	Other	0.355	1.000	-23.46	24.17

Appendix 19: Further results for Objective 2.4

Table 24: Availability of interpretation services

		Total	England	Scotland	Wales	Northern Ireland
Respondents		44	28	7	6	3
Population of area respondents stated responsible for		42	100,000 – 60,000,000	1800000	8000 – 3,000,000	148500 – 800,000
Services available 24 hours a day 7 days a week in primary care	**Yes**	32	16 (57.1%)	7 (100.0%)	6 (100.0%)	3 (100.0%)
	Don't know	5	5 (17.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
No.of people using primary care, emergency care, and urgent care in your area have made use of interpretation service(s) in the financial year April 2020 - 2021?	**Yes**	31	18 (64.3%)	6 (85.7%)	4 (66.7%)	3 (100.0%)
	No	5	5 (17.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Don't know	8	5 (17.9%)	1 (14.3%)	2 (33.3%)	0 (0.0%)
Do you gather information on the use of interpretation service(s) by those who are asylum seekers or refugees for primary care, emergency care, and urgent care in your area?	**Yes**	12	8 (28.6%)	2 (28.6%)	2 (33.3%)	0 (0.0%)
	No	32	18 (64.3%)	5 (71.4%)	4 (66.7%)	3 (100.0%)
Are there any specialist interpretation service(s) available for asylum seekers and refugees accessing primary care, emergency care, and urgent care in your area?	**Yes**	9	6 (21.4%)	2 (28.6%)	0 (0.0%)	1 (33.3%)
	No	23	13 (46.4%)	4 (57.1%)	5 (83.3%)	1 (33.3%)
	Don't know	11	8 (28.6%)	1 (14.3%)	1 (16.7%)	1 (33.3%)

Table 25: Aspects of service commissioning

		England	Scotland	Wales	Northern Ireland
Audited language needs for your population	**Yes**	14 (50.0%)	2 (28.6%)	1 (16.7%)	1 (33.3%)
	No	8 (28.6%)	4 (57.1%)	4 (66.7%)	1 (33.3%)
	Don't know	6 (21.4%)	1 (14.3%)	0 (0.0%)	0 (0.0%)
Provided training for health practitioners in primary care, emergency care, and urgent care on the use of interpretation service(s)	**Yes**	12 (42.9%)	6 (85.7%)	5 (83.3%)	3 (100.0%)
	No	10 (35.7%)	0 (0.0%)	1 (16.7%)	0 (0.0%)
	Don't know	6 (21.4%)	1 (14.3%)	0 (0.0%)	0 (0.0%)
Promoted interpretation services to the local population	**Yes**	14 (50.0%)	6 (85.7%)	5 (83.3%)	2 (66.7%)
	No	9 (32.1%)	0 (0.0%)	0 (0.0%)	1 (33.3%)
	Don't know	5 (17.9%)	1 (14.3%)	1 (16.7%)	0 (0.0%)
Evaluated feedback by patients on interpretation service(s)	**Yes**	15 (53.6%)	1 (14.3%)	2 (33.3%)	0 (0.0%)
	No	8 (28.6%)	4 (57.1%)	2 (33.3%)	2 (66.7%)
	Don't know	5 (17.9%)	2 (28.6%)	2 (33.3%)	0 (0.0%)
Evaluated feedback by interpreters on interpretation service(s)	**Yes**	6 (21.4%)	2 (28.6%)	1 (16.7%)	0 (0.0%)
	No	15 (53.6%)	5 (71.4%)	2 (33.3%)	2 (66.7%)
	Don't know	7 (25.0%)	0 (0.0%)	3 (50.0%)	0 (0.0%)
Evaluated feedback by health and social care professionals on interpretation service(s)	**Yes**	14 (50.0%)	4 (57.1%)	3 (50.0%)	2 (66.7%)
	No	11 (39.3%)	3 (42.9%)	1 (16.7%)	1 (33.3%)
	Don't know	3 (10.7%)	0 (0.0%)	2 (33.3%)	0 (0.0%)

Table 26: Commissioners views regarding interpretation service need in next financial year

		England	Scotland	Wales	Northern Ireland
GP practices	**Increase**	21 (75.0%)	5 (71.4%)	5 (83.3%)	2 (66.7%)
	Decrease	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Stay the same	4 (14.3%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
GP out of hours	**Increase**	15 (53.6%)	3 (42.9%)	5 (83.3%)	3 (100.0%)
	Decrease	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Stay the same	6 (21.4%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Hospital emergency departments (incl. medical admissions unit	**Increase**	13 (46.4%)	4 (57.1%)	5 (83.3%)	3 (100.0%)
	Decrease	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Stay the same	2 (7.1%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Urgent care centres (e.g., walk-in centres)	**Increase**	12 (42.9%)	4 (57.1%)	4 (66.7%)	3 (100.0%)
	Decrease	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Stay the same	3 (10.7%)	1 (14.3%)	0 (0.0%)	0 (0.0%)
Ambulance service	**Increase**	10 (35.7%)	2 (28.6%)	3 (50.0%)	2 (66.7%)
	Decrease	1 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Stay the same	3 (10.7%)	0 (0.0%)	0 (0.0%)	1 (33.3%)
NHS 111/NHS24	**Increase**	10 (35.7%)	2 (28.6%)	3 (50.0%)	2 (66.7%)
	Decrease	1 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Stay the same	3 (10.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Is there a specification for the interpretation service(s)?	**Yes**	20 (71.4%)	4 (57.1%)	4 (66.7%)	3 (100.0%)
	No	5 (17.9%)	0 (0.0%)	1 (16.7%)	0 (0.0%)
	Don't know	3 (10.7%)	3 (42.9%)	1 (16.7%)	0 (0.0%)
How does your organisation commission interpretation service(s)?	**Directly**	15 (53.6%)	4 (57.1%)	3 (50.0%)	0 (0.0%)
	Indirectly (e.g. consortium)	2 (7.1%)	0 (0.0%)	1 (16.7%)	2 (66.7%)
	Mixed (directly and indirectly)	5 (17.9%)	1 (14.3%)	2 (33.3%)	1 (33.3%)
	Don't know	1 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Other	4 (14.3%)	2 (28.6%)	0 (0.0%)	0 (0.0%)
Would your contracts normally be	**Block contracts**	2 (7.1%)	2 (28.6%)	0 (0.0%)	1 (33.3%)
	Fee per service	16 (57.1%)	2 (28.6%)	3 (50.0%)	1 (33.3%)
	Mixed	6 (21.4%)	2 (28.6%)	2 (33.3%)	0 (0.0%)
	Other	1 (3.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Don't know	4 (14.3%)	1 (3.6%)	1 (16.7%)	1 (33.3%)

Table 27: Length of contract with interpretation service providers in primary, emergency and urgent

		England	Scotland	Wales	Northern Ireland
What is the length of contracts for your interpretation service(s) providers in primary care, emergency care, and urgent care?	Missing	4 (14.3%)	2 (28.6%)	2 (33.3%)	0 (0.0%)
	1y	3 (10.7%)	2 (28.6%)	3 (50.0%)	1 (33.3%)
	2 – 3 yr	13 (46.4%)	2 (28.6%)	0 (0.0%)	1 (33.3%)
	5y	3 (10.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
	Ongoing	5 (17.9%)	1 (14.3%)	1 (16.7%)	1 (33.3%)

Table 28: Interpretation services commissioned

		England	Scotland	Wales	Northern Ireland
GP practices	Yes - face to face	20	5	5	1
	Yes - telephone	21	5	5	0
Hospital emergency departments (incl. medical admissions unit)	Yes - face to face	3	5	4	2
	Yes - telephone	4	5	4	1
Urgent care centres (e.g. walk-in centres)	Yes - face to face	8	4	4	2
	Yes - telephone	9	5	4	1
Ambulance service	Yes - face to face	1	0	1	2
	Yes - telephone	2	1	1	1

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HEAR 2
Health Experiences of Asylum seekers and Refugees: how well are interpretation needs met?

GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales

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