“EVERYWHERE, IT IS NEEDED”

A summary report on the experiences of accessing professional interpreting services in Tower Hamlets.

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PEOPLE ST

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This report summarises the findings from three community focus groups with Somali and Sylheti speakers in Tower Hamlets. Participants fed back their experiences and perceptions of professional interpreters at GP surgeries and hospital appointments. The aim was to gather insights from Bangladeshi and Somali communities who have not taken part in the wider INTERPRET-X project to check local experiences against the wider research findings.

Photo: Focus group with Bengali women in Tower Hamlets 29th april 2024

People Street is a not for profit, agile community development agency. We exist to unite the bottom up, real world experiences of grassroots communities with the top-down perspectives of service designers and researchers. We believe great pathways and services are created when researchers hear directly from the communities most at risk of being excluded by the service in creation, because all too often we test our assumptions with the easy to reach.

As part of INTERPRET-X project, People Street were commissioned by Surrey University to convene and deliver 3 community based focus groups with participants who have used professional interpreting services within their GP practices. INTERPRET-X is a collaborative study investigating the uptake and experiences of interpreting services in GP practices amongst South Asian communities.

Methodology

We kick-off every project by hosting a briefing session with Community Researchers who are themselves representative of the communities we seek to reach. They speak community languages, are respected leaders in their local areas, have lived and living experiences that they openly share to build trust. They are experts by experience and this expertise is utilised to build a picture of the participants we may want to engage and the places we may want to reach into to recruit participation. The scoping is collaborative, iterative and community led: this means that communities have the right to choose whether a piece of research takes place or not, where the research happens, they are a part of the research process including influencing and shaping interview questions.

The **Scoping** exercise can last between 2-3 weeks depending on the complexity of the research. For this project, we ran a 3-week scoping sprint identifying all the potential partnerships, venues and public spaces. This involves physical walk-abouts, telephone calls and meetings.

Once the scoping was agreed, we began several cycles of **Outreach**, using the feedback to iterate our plan. We visited mosques, markets, libraries, community organisations and GP practices. In these sessions we introduced ourselves, our approach, and the research. We explained that we were working collaboratively with the researchers at Surrey University, but that we were independent.

We spent a lot of time assuring people that we would not collect or share identifiable information. Most importantly, we listened. These early conversations were about listening to the issues people were facing in their lives, listened without it being a formal research conversation. In community development practice, you start with the people, and so, that's what we did. Start where people are at, listen with respectful curiosity to the issues emerging, giving people time to share what they feel is important to them, what's worrying them right now. Through these outreach conversations, potential participants are testing out whether they can trust us, whether we are people "to do business with" before they commit to taking part in the research. For this project, we spoke to over 60 people over three weeks during the outreach phase lasting 128 hours.

The **Recruitment** process involves taking people through the details of the research, including sharing an easy-to-read information sheet. Due to language barriers and digital exclusion, we conducted outreach and screening in mother-tongue.

The **Research** took place in community settings that are frequented by the communities we were reaching. We used the Interview Questions codesigned by the People Street community researchers and Surrey University researchers (Appendix A). We hired the hall ahead of time and shared the timing and location 4 weeks before the session to give people as much notice as possible. Everyone received 3 calls/text:

1. To check participants had travel arrangements in place, had the correct time and location. Answer any questions. We do the travelling so we mitigate barriers to accessing the sessions and have no out of pocket expenses as a result of taking part. We also let them know we will be providing food and refreshments.
2. Reminder call one week before the session to check it was still convenient and they still wanted to take part. Check if they have any questions.
3. Bangladeshi group: Text on the morning of the session to remind of time and address of session. Somali Group: Audio message on WhatsApp night before to remind participants of the time.

We always provide lunch/refreshments, tea/coffee. This is an important detail as it makes people feel looked after and respected. We share leftovers amongst the group members at the end of the session and they help us pack up. This language of caring builds trust, it deepens the narrative between researchers and local people. Each participant also received a voucher to repay them for their time.

Three focus groups were conducted in mother-tongue and back translated into English. Discussions were facilitated by a community translator and an experienced facilitator using a semi-structured format, allowing participants to share their thoughts and experiences freely.

Once all three focus groups were completed, the team met again to review the raw data. We hold sense making sessions to share what we 'heard' and discuss the findings as a team. We explore differences in our hearing and highlight these differences ready for the **check in** session. We also collate the themes where we agree and start to draw out the quotes and stories that back our assumptions. We then agree which participants we need to speak to for the check-in sessions and begin booking these as telephone calls at times that are convenient to participants. The purpose of these informal discussions was to check our assumptions. We hold ourselves to account and always embed feedback or check-in loops to mitigate against unconscious bias and errors in our sense making.

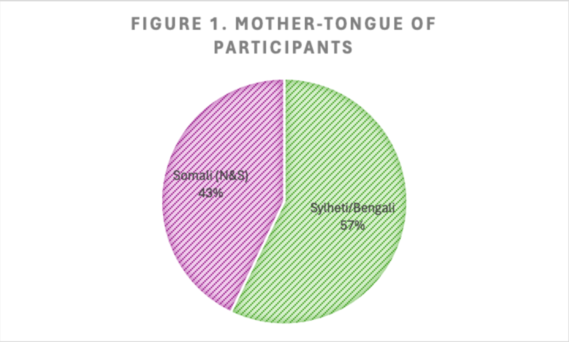

FIGURE 1. MOTHER-TONGUE OF PARTICIPANTS

In total, twenty-eight participants attended one of the three focus groups. Three of the participants took part in check-in sessions which lasted 30-35 minutes each. We delivered two Bengali speaking sessions, one male and one female with eight participants in each group. We also delivered a focus group with twelve Somali women. Twenty of the participants were female, eight were male.

The youngest participant was 34 years and the oldest 80 years old. There was good distribution across the age ranges. The age distribution was imperative as it helps us to challenge assumptions that language exclusion only applies to our elderly communities. All the participants had experience of using professional interpreting services in primary care and in hospital settings in Tower Hamlets.

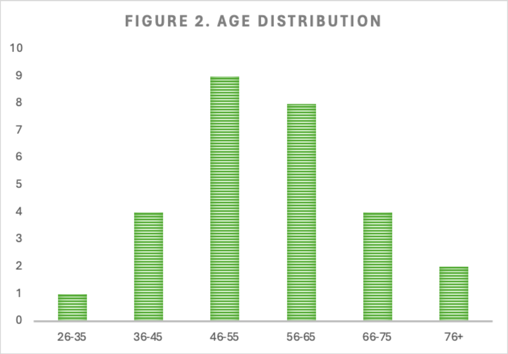

FIGURE 2. AGE DISTRIBUTION

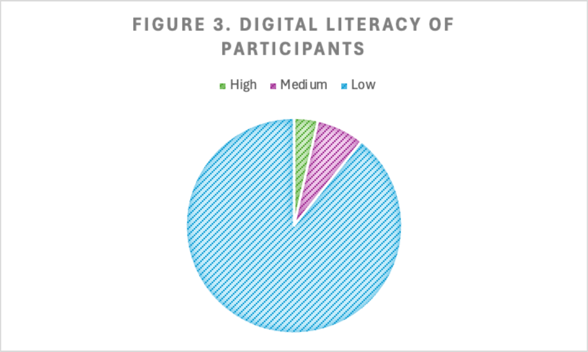

FIGURE 3. DIGITAL LITERACY OF PARTICIPANTS

Although all participants had a smartphone, and many had apps such as banking apps, NHS app, email and WhatsApp, they have support to download, register and use these services. During the screening process, we go through a self reported digital literacy scale and only 1 person scored high, twenty-five scored low and two people scored medium on the digital literacy scale.

During the screening process we also capture whether people are living with a long term health condition. We use this information to identify the people most at risk of the poorest outcomes, and invite them to take part in the focus groups. Our approach is founded on the principles of proportionate universalism[1]. We take an intersectional approach to ensure we are reaching the people who are most at risk of

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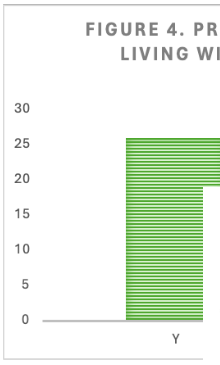
[1] https://www.instituteofhealthequity.org/resources-reports/towards-health-equity-a-framework-for-the-application-of-proportionate-universalism

the poorest outcomes, are most likely to be excluded or experience the greatest barriers to accessing healthcare. For this research, the Surrey team wanted to speak to South Asian communities. We went further and included a Somali speaking group to show that the issues of securing effective interpreting are cross-cultural. We included health outcomes, digital literacy and postcode as additional indicators to create participant profiles.



What participants told us:

We started each session asking participants what they understood by the term *Professional Interpreting/Interpreters*. It's important to note that there was no direct translation in Sylheti or Somali for *professional* so the translators needed to explain the term using examples of other types of professions. In summary, participants understood the term as a person who has been appointed by the GP surgery or hospital to translate the conversation. The image on the right captures the words they used to describe their understanding.

Photo: Focus group at Granby Hall with Somali women 3rd May 2024

Two researchers from Surrey University, Professor Katriina Whitaker and Dr Graham Hieke were invited to sit in the community-led focus groups. The reason is two-pronged. Firstly, to build trust in the research process amongst communities traditionally excluded from academic and health research. We wanted to show our communities that there are researchers who value their experiences and will make the time to come out to them and include their living and lived experiences in research. Secondly, we are committed to sharing our practice with colleagues from a range of disciplines and organisations. We want to build the inclusive research muscles of as many teams as possible! In light of this, we have not written this summary report in a traditional format with data analysis and results, since Katriina and Graham also took notes and these focus groups offered them an opportunity to sense-check. Instead, we have taken the raw feedback as well as our knowledge of the communities to surface the themes emerging for the participants who took part in the research conversations.

We have identified 4 key themes with example quotes from the focus groups.

1. Awareness and signposting
    - Participants emphasised the critical role of reception staff in identifying people who need an interpreter at the booking stage. Some participants highlighted that the receptionists know straight away that they need language support and sort out interpreting.
    - Most people reported that they were told at booking to bring someone to interpret because it would result in securing an appointment quickly.
    - Others were not given any information about professional interpreting and tried to communicate their needs to the doctor in broken English.
    - Lack of interpreting leads to cancelled appointments, delays in accessing treatment, referrals and support.

“They know me, I’m on the record that I need an interpreter.” Bengali woman

“Doctor says when you come, you bring an interpreter with you.” Bengali woman

“Receptionist says if you bring someone it will make it quicker.” Bengali woman

“I couldn’t understand the GP. I told him, I no understand, need interpreter.” Bengali woman

“Really hard to find a Somali interpreter and we have to cancel appointment” *Somali woman*

“...Because when he's (GP) talking over the phone I don’t understand… when you are face to face, you can explain something. You just point. Yeah.” Bengali man

“...Don’t always understand every time I go to GP. Kids are big now so we can’t use them so we need interpreters whenever we need to see the GP.” Bengali man

“If we have interpreters available then it’s better for us as we can get appointment quickly.” Bengali man

“I ask for interpreters during making appointment”. Bengali man

2. Quality, accessibility and availability of professional interpreters
    - Concerns were raised regarding the accessibility and availability of professional interpreting services
    - There were many concerns about the quality of interpreting especially for community languages with multiple dialects such as northern and southern

Somali and Bangla versus Sylheti. Issues with incorrect dialect makes it difficult to communicate with the interpreter and therefore the doctor well.

- Participants suggested the need for improved booking systems and accessible technology as online systems difficult to access
- To ensure timely access to interpreters for all patients.
- Participants highlighted the need for more interpreters in facilitating clear and accurate communication between healthcare providers and patients with limited English.
- Lack of interpreting leads to people not seeking medical treatment.

"Sometimes it is better speaking your broken English than having an interpreter you don't understand (wrong dialect)" Somali woman

"Sit and wait all day for interpreter" Bengali man

"...dial everyday to ask if interpreter available…it takes 7 days to get an appointment this way."

Bengali woman

"...delayed appointment, I waiting as there is shortage of interpreters" Bengali woman

"And particularly during the telephone appointment, it's very, very difficult and important to have a interpreter." Bengali man

"...GP doesn't have any Somali workers"

"Sometimes the GP tries to get interpreters over the phone and if they can't get hold them then they reschedules our appointments, So this delays in getting help with our conditions, by then we recover as we sometimes have to wait long time." Bengali man

"Before my children helped me to book appointment but now they go to uni and college so they can't help as we need to call early in the morning, because of these issues, its been 3 yrs now the I have not seen my GP."

"It's really hard to find a professional Somali interpreter and we have to cancel appointments."

"My wife tries to request interpreter for me still they don't provide interpreters. If they were available it would have been better." Bengali man

"Wrong dialect, I didn't understand them (interpreter) properly" Bengali man

"I don't feel they are translating properly" Bengali woman

"They don't have a good attitude (towards us) and they think they are the boss." Bengali man

"I had a Somali interpreter, his English was perfect but his Somali was no good." Somali woman

"Good interpreters are when I say my problem, they have to say exactly as I say, they need to understand what I'm saying in order to explain to doctors everything.

I'm struggling to email the doctors I don't have language." Bengali woman

"I had a face to face benefits appointment with Somali interpreter on the phone. In middle of appointment, the interpreter told me in Somali that it is their lunch break and the just hang up!" Somali woman

3. Need for privacy and agency:

- All three groups raised the need for an interpreter for health issues they consider as private health matters.
- The lack of interpreters for private concerns leads people to NOT raise issues if a family member is interpreting or if they cannot communicate the issue themselves.
- Female participants also recounted that when given a male interpreter at an appointment, they were left unable to share private health matters in the appointment.
- There was a discussion in the Bengali women and Somali women's session where participants had received a letter or been verbally told they could NOT bring their own interpreter, The discussion suggests that this was because the appointment was for sexual health but at the time of booking, the reason for not bringing a family member was not clearly communicated. (Appendix B)
- While some participants expressed satisfaction with interpreters who demonstrated linguistic proficiency and cultural understanding, many participants felt that the interpreters were not conveying the issues adequately.
- People raised the desire to speak for themselves and were frustrated that they were dependent and reliant on someone else to communicate on their behalf. This shows up in the lack of trust at times that interpreters are "painting" the full picture.

"Also I can't take my daughters for all the health issues due to privacy, I'm unable to see GP because of not having interpreters available." Bengali man

"The doctor booked my smear but I missed it. I didn't want to tell my son."

"I had no choice, felt like I was disturbing my daughter in law" Bengali woman

"Its embarrassing telling you're children, no privacy" Bengali woman

“Sometimes, we don’t say the main problem (if child interpreting)” Bengali woman

“We play down the issue in front of the children. Tell them ‘Its nothing, It’s okay’” Bengali woman

“Children stress and worry about us.” Bengali woman

“I don't want to tell children private things” Somali woman

“Children don't know the medical terms to explain” Somali woman

“Embarrassing situations using family” Somali woman

“Told not to bring interpreter (child) with me but not told why” Somali woman

4. Importance of family interpreting

- Whilst the participants raised issues and concerns with having children and family members translate, there was also appreciation for having someone who knows you communicating on your behalf.
- Participants felt taken care of, heard and advocated for when a family member acted as an interpreter. This highlights the vital role family interpreting plays in supporting communication between doctors and their patients.
- People rely on family members to fill the gaps in professional translators and many working children interpret on the phone for a parent who is at a face to face appointment with their doctor. This mixed approach means the patient can use non-verbal communication with the GP as well as having someone who can communicate effectively about the nature of the symptoms verbally on their behalf.

“Family explain better” Bengali woman

“It is good when family interpret because they can take care of you at home, remind you of things.”

Bengali woman

“My daughter explains to me the medicine when I go home” Bengali woman

“Family understand what you are going through and they tell that to the doctor.” Bengali woman

“I trust my family member because they know me.” Somali woman

“They (children) know our condition so can explain to doctor in depth.” Somali woman

“They (children) give you extra care and explaining everything. What they see, how you’ve been…”

Somali woman

Photo: Focus group with Bengali men in Tower Hamlets 29th April 2024

Sense making

At People Street, we complete each research cycle with a sense making session. We look at the themes emerging and we discuss what this means to our communities. We bring in our rich experience and knowledge of the community to make sense of the themes, how different barriers play out in the community and we look for ways communities build resilience and solutions. This process, led us to identify the following:

1. There is no continuity in interpreting in Tower Hamlets so it's hard for patients to build trust, understanding and rapport with professional interpreters.
2. Both Bangladeshi and Somali women are concerned about their children worrying about them and their health, so they may play down symptoms in front of their family interpreters.
3. Bengali men on the other hand are worried about taking children's time away from work or study for interpreting so they will try to get by on their own.
4. Digital exclusion further exacerbates barriers to accessing primary care when you already present with a language barrier.
5. GP booking systems exclude people with poor literacy skills, language barriers and low digital skills/confidence.
6. Communities facing language barriers, want to be able to use family interpreters for routing appointments but want professional interpreters for private health issues and serious health concerns.
7. Intra-community sensitivities may lead to patients and interpreters not letting medical practitioners know that they are not understanding each other because of differences in dialect.

Conclusion

The feedback from these community focus groups underscores the importance of high-quality interpreter services in GP surgeries. It is clear that there is a shortage of quality and diverse interpreters available at Primary Care and that patients themselves have to resolve the language gaps they face navigating the health system. What these focus groups illustrate is that language barriers persist across a range of communities and are not age or culturally specific. It also highlights that digital exclusion is exacerbating health inequalities alongside language and literacy barriers and these need to be tackled together if we are to create accessible health systems that are fit for the future.

Acknowledgments

We would like to thank everyone who took part in the focus groups, your courage and generosity shines a light forward so that others can benefit. We would also like to thank the Surrey University team who have encouraged and supported this work and were terrific guests. Thank you for championing and believing in our approach. And finally, our Community Researchers Farida, Mostafa, Nimo and Khadra, you are the beacons who make this work possible, your insights, diligence and commitment is why your communities love and respect you, thank you.

Appendix A

Codesigned questions for the focus groups facilitated by People Street.

INTERPRET-X Understanding uptake and experiences of interpreting services in GP practices

1. What do you understand by "professional interpreting service"?
2. Do you know about interpreting services at your doctor's office? If yes, how do you find out about them? How can we make this information better?
3. How can we make more people aware of the need for interpreters, especially among doctors and nurses?
4. When do you think it's really important to have a professional interpreter (like in a medical emergency)? When do you think it's not as important?
5. Let's talk about getting medical help from start to finish. What do you need to know about interpreters, and when do you need this information?
6. What are the good and bad things about using friends or family as interpreters?
7. How do you feel about using technology to get language help? Do you prefer phone calls, video calls, or translation machines?
8. Do you have any other ideas on how we can make it easier to get professional interpreting help?

Appendix B

In the session the Somali group raised the concern that they were told they weren't allowed to bring a family member to interpreter but were not told why or did not understand why. We therefore spent some time in the session working out potential wording that was clear to understand but also easy to interpret.

How to let patients know why you are booking professional interpreting:
Suggested wording from Somali women's group: **"We want to protect your privacy and make sure you understand…"**