BME Health Forum

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INFORMAL CONSULTATION ON GRIP INTERPRETING SERVICES

This report and recommendations are based on feedback from the following:

- A meeting held with representatives from 4 organisations – voluntary and statutory
- 3 one-to-one interviews with the GRIP interpreters
- 3 one-to-one interviews with representatives from community groups

Outline of Task Group

This Task Group aimed at providing a community perspective on interpreting services in health in KCW. *Silkap* Consultants are currently undertaking a review of GRIP services looking at management systems and ways in which the services could be improved. The BME Health Forum has been formally interviewed by *Silkap* as part of their evaluation.

This informal consultation initiative by the BME Health Forum is a separate initiative aimed at providing a community perspective on interpreting services provided by GRIP. The BME Health Forum has sought feedback as part of an informal consultation with its members - community groups, GRIP Interpreters and Commissioners. Issues arose over bookings policies, use of full-and part-time interpreters and other aspects. All feedback is anonymous.

FINDINGS AND ISSUES FROM CONSULTATION

Staff Recruitment and Employment Practices

1. The **rates of pay** offered by GRIP are low, which inhibited job applications and led to fairly rapid turnover of staff.

2. **Sessional workers** are paid £11 for the first hour, then £9 per hour, and shorter periods were paid pro rata. They are not paid for time spent on paperwork and some staff had had no pay increase for 3 years. They are not paid for travel time. They have no minimum guaranteed hours of work; fares are not paid at pre- 9-30am rates for sessional workers (limited to a £4-30 per day travel card) and travel expenses are sometimes taxed. Staff therefore do not like doing sessions before 9.30am as they have to cover the additional travel costs themselves.

3. **Sessional staff** might do 15-16 sessions per week, with forms to complete for each job. Wages, in particular for sessional workers are very often not accurate and it takes a long time to chase GRIP to rectify this. Taking into account travel time, sessional staff cannot do more than 4 jobs per day = 16 jobs per week – and hence being paid for 16-20 hours for the whole week.

4. As sessional staff are **not guaranteed a certain number of hours** (as happens with Home Office and other public service bodies who guarantee a minimum number of hours – i.e. 16 per week), they cannot reply on this as a regular job and source of income. This has implications for receiving benefits and a viable source of employment and income for people.

5. **Full-time interpreters** receive one-year contracts, with a review and an evaluation of the number of jobs done, at the end of the year. They are generally paid at grade 5, starting at £16 per hour (£17,095 p.a.).

6. There is some competition among interpreters and they needed to **market** themselves. The general understanding – although this is not in the contract – is that the more business you bring in the more likely your contract will be renewed. Interpreters we spoke to said that they enjoyed their jobs, however, due to the low pay (especially when one has a degree and post-graduate qualification in interpreting), they spend time looking for other jobs.

7. In general GRIP has a **reputation for low pay** by interpreting providers and amongst interpreters.

8. **Training** is offered as working time for full-time and part time interpreters though not for sessional interpreters. The training is very comprehensive covering medication, customer services, HIV, mental health, etc. A foreign language degree and DPSI (Diploma in Public Service Interpreting) is supposedly required, but **not actually obligatory**. The lower-level Bilingual Skills certificate is easier to achieve.

9. All interviewees stated that the interview process was undertaken in English and their **knowledge of native/foreign languages was not tested**; nor was the applicant's knowledge of medical terms in English tested.

10. **Staff meetings**, linguistics meetings and marketing meetings are held by and for interpreters. They are a good way of getting information about current training opportunities, employment issues etc. Support and supervision are available – only if it is requested.

11. The interpreters we spoke to felt that feedback from professional medical staff indicates that they feel the **quality of interpreters from GRIP was not that high.** Also, PCGs who have no choice in using GRIP services, it was felt they too do not have a good reputation for quality services.

12. When interpreting at **St Mary's Hospital**, if interpreters have to wait for over 2 hours, they have to get permission from customer services to continue waiting. This happens quite a lot due to delayed appointments. If this is not given, they have to leave and the appointment is missed.

13. With better wages and conditions, interpreting could be a **good way to get into the field of health work**; which raised the question of whether there might be opportunities for bilingual advocates or link workers.

14. Interpreters felt that the **receptionists** expect them to pacify patients, especially when there is a long waiting time.

Client Feedback and Partnership Working

15. **Appointments with GPs** are usually 10 minutes long; and good practice suggests that with an interpreter present, the appointment should be 20 minutes long. Interpreters felt that this does not usually happen, and GPs often get impatient with interpreters if the appointment goes over 10 minutes. This sometimes puts interpreters under pressure to summarise what has been said rather than translate what is actually being said.

16. Sometimes **Health Professionals** also try to push interpreters into convincing patients to take a particular decision. This puts them in a very difficult position as they have to explain time and again that their role to only to interpret and not to advocate or advise the client.

17. There is **no formal process for comments** on the service by clients. Currently GPs and other health professionals can comment on the work of the interpreters by filling in the space provided for comments in the forms signed by these professionals.

18. No one has the task of **interpreting medication** or contents of tablet boxes/bottles: interpreters feel that this should be part of the interpreting process as clients do not understand English and they end up accompanying – if they can - the client the chemist and interpreting medication for them on a voluntary basis.

19. Those present agreed that **interpreters for Mental Health** Services should be given extra training for Care Programme Assessment meetings and/or ward rounds, since bad interpreting could lead to misdiagnosis, even sectioning. Words, e.g. “anxiety” are often misinterpreted. Also, when visiting social workers with clients, there could be multiple issues. GRIP had no special Mental Health interpreters. There should also be more training to cover specialist areas to enable more accurate and professional interpreting service. Particularly when interpreting on mental health issues, for care programmes, ward rounds or the Mental Health Act, interpreters should have had special training.

20. Interpreters suggested that GRIP does a **skills/language audit** of its current interpreters so that appointments can be allocated according to this, when possible.

21. They also suggested having a **long-term personal development plan** for each interpreter – this could be done on collaboration with Human Resources dept.

22. GRIP could not always supply interpreters and sometimes **cancelled** jobs arranged. Demand from GPs had increased and could not always be met: there are problems with particular languages, eg. Polish and Czech. Booking was by fax: computerisation made it easier from that point.

23. It was felt that GRIP has a **very good computer system** which can track the whereabouts of interpreters and their schedules.

24. There is currently no alternative service to GRIP in K&C; but in Hammersmith **CITAS** had just begun work for Riverside and overlapping areas. It provided better and quicker provision of interpreters – especially at short notice - but there was no liaison with GRIP.

25. Neither GRIP nor CITAS covered **emergencies**: In this case Language Line is used. As the PCGs policy is not to cancel patient appointments, if GRIP is not able to provide an interpreter, K&C PCG sometimes used community groups, paying the hourly rate of £11: there was training and support for them in this regard but the training is generic rather than focusing on specific communities or areas such as Mental Health.

26. It was felt that it will be important to develop the **capacity for voluntary and community groups** to provide high-quality interpreting services. The issue of confidentiality was vital, as was the importance of the need to develop a mechanism to pay community groups for this service (i.e. service level agreements).

27. **Bookings** with GRIP cannot be made **by community groups**; only by GPs receptionists. This makes it very difficult for clients or for community organisations advocating on behalf of their clients. It makes the whole process of booking an interpreter very time consuming. A process should be introduced whereby community organisations should be able to book interpreters on behalf of their clients by contacting GRIP directly.

28. On the issue of **translation of written materials**, jobs are not currently allocated according to those with specialist knowledge on a specific service or area, or quality of translator's skills in medical translation. This sometimes results in some medical terms not been properly translated and issues not specifically highlighted. Sometimes you find leaflets with literal translations that have totally missed the whole concept and rendered the leaflet or information useless.

29. It was suggested that GRIP obtains **feedback from users** by, for example, running sessions in community groups, and getting feedback from users and professionals directly.

30. It was also suggested that the issue of **support to family members** who provide interpreting services needs to be looked at, as at the preset time there is nothing available.

31. Also, long-term, it would be good if GP surgeries and hospitals can look into the possibility of **recruiting bi-lingual receptionists**.

32. There is currently no interpreting service covering **opticians nor dentists**, and feedback from clients to interpreters indicates that this is a lack in service provision.

RECOMMENDATIONS:

EMPLOYMENT & TRAINING ISSUES

(i) We would recommend that a system for a **long-term training and development plan** be drawn up for interpreters to facilitate a strategic approach to staff development and training.

(ii) Given that GRIP has a reputation for low rates of pay, this leads to high staff turnover. We recommend that the **rates of pay and conditions are reviewed** in line with other public service interpreting service providers.

(iii) Concerns were raised about **conditions for sessional interpreters** – in terms of travel times, minimum guaranteed hours of work and rates of pay.

(iv) Feedback indicates that **support and supervision** are available, but are only provided if requested. It was suggested that this should be reviewed and should be an on-going internal procedure.

(v) It was suggested that current **staff meetings**, as well as linguistic and marketing meetings continue – interpreters felt that these were a good way of getting information across.

(vi) It was recommended that the current system whereby **training** is offered as paid work time for full-time and part time interpreters be continued – although this is not available for sessional interpreters. The training is very comprehensive covering medication, customer services, HIV, mental health, etc.

QUALITY SERVICE

(vii) Concerns were raised that at interview and in terms of required qualifications, GRIP does not test nor make it obligatory to have a **qualification in interpreting**. A foreign language degree and DPSI (Diploma in Public Service Interpreting) is supposedly required, but **not actually obligatory** (the lower-level Bilingual Skills certificate is easier to achieve). We would recommend that in order to maintain high standards and quality, that interpreters be tested during the recruitment process on their language skills and their qualifications should be checked.

(viii) It was also recommended that applicant's **knowledge of medical terms** in English should be tested during the selection process.

(ix) Feedback suggests that the PCGs had no option but to use GRIP's services. It was suggested that if **GRIP's monopoly** on interpreting service provision was ended and they were faced with competition – including possibly from voluntary/community sector providers.

FEEDBACK FROM CLIENTS

(x) There is **no formal process for comments** on the service by clients. Currently GPs and other health professionals can comment on the work of the interpreters by filling in the space provided for comments in the forms signed by these professionals.

(xi) It was suggested that GRIP obtains **feedback from users** by, for example, running sessions in community groups, and getting feedback from users and professionals directly.

MECHANISMS FOR BOOKINGS AND IT DEVELOPMENTS

(xii) It was felt that GRIP has a **very good and sophisticated computer system** that could be developed to improve and simplify the bookings system for booking interpreters. It was recommended that the whole bookings system be reviewed to include issues like developing a system for registered community groups to make bookings directly with GRIP.

REMIT OF INTERPRETERS

(xiii) Interpreters felt that at times, **Health Professionals** also try to push interpreters into convincing patients to take a particular decision. This puts them in a very difficult position as they have to explain time and again that their role to only to interpret and not to advocate or advise the client.

(xiv) No one has the task of **interpreting medication** or contents of tablet boxes/bottles: interpreters feel that this should be part of the interpreting process as clients do not understand English and they end up accompanying – if they can - the client the chemist and interpreting medication for them on a voluntary basis.

(xv) There is currently no interpreting service covering **opticians nor dentists**, and feedback from clients to interpreters indicates that this is a lack in service provision.

SPECIALISED INTERPRETING

(ii) We would recommend that GRIP does a **skills/language audit** of its staff to ensure that when possible, interpreters can be matched up to specific requirements (e.g. interpreting in mental health and HIV/AIDS cases) or specific languages (e.g. including various dialects and specialised knowledge in translation services).

(iii) Those present agreed that **interpreters for Mental Health** Services should be given extra training for Care Programme Assessment meetings and/or ward rounds, since bad interpreting could lead to misdiagnosis, even sectioning. Words, e.g. "anxiety" are often misinterpreted. Also, when visiting social workers with clients, there could be multiple issues. GRIP had no special Mental Health interpreters. There should also be more training to cover specialist areas to enable more accurate and professional interpreting service. Particularly when interpreting on mental health issues, for care programmes, ward rounds or the Mental Health Act, interpreters should have had special training.

(iv) On the issue of **translation of written materials**, jobs are not currently allocated according to those with specialist knowledge on a specific service or area, or quality of translator's skills in medical translation. This sometimes results in some medical terms not been properly translated and issues not specifically highlighted. Sometimes you find leaflets with literal translations that have totally missed the whole concept and rendered the leaflet or information useless.

PARTNERSHIP WITH COMMUNITY AND VOLUNTARY GROUPS

(v) As many patients bring reply on **family members or friends** to interpret for them, GRIP should look into offering support to them – i.e. developing simple guidelines for interpreting for family members or friends, and other resources, telephone help-line, etc.

(vi) **Bookings** with GRIP cannot be made **by community groups**; only by GPs receptionists. This makes it very difficult for clients or for community organisations advocating on behalf of their clients. It makes the whole process of booking an interpreter very time consuming. A process should be introduced whereby community organisations should be able to book interpreters on behalf of their clients by contacting GRIP directly.

(vii) It was felt that it will be important to develop the **capacity for voluntary and community groups** to provide high-quality interpreting services. The issue of confidentiality was vital, as was the importance of the need to develop a mechanism to pay community groups for this service (i.e. service level agreements).

(viii) With better wages and conditions, interpreting could be a good way to **get into the field of health wor**k. Community groups recommended that GRIP or NHS Trusts work with community groups or forums to put together funding applications to regeneration funding sources, etc., for funding to support advocates and others from local BME communities to train as interpreters and health advocates.

ISSUES FOR SERVICE PROVIDERS – PCTs, NHS Trusts, etc.

(ix) Also, long-term, it would be good if GP surgeries and hospitals can look into the possibility of **recruiting bi-lingual receptionists**. Given new developments concerning patient and user involvement structures (PALs, Patient Forums, etc.), it was felt that this is a good opportunity to employ advocates and members of staff from various local communities. Links could be made here, for example, with local health advocate training courses run by, for example, the Migrant & Refugee Communities Forum and the Somali Welfare Association (both accredited courses funded by the *King's Fund*).

(x) When interpreting at **St Mary's Hospital**, if interpreters have to wait for over 2 hours, they have to get permission from customer services to continue waiting. This happens quite a lot due to delayed appointments. If this is not given, they have to leave and the appointment is missed.

(xi) It was suggested that the **role of interpreters be clarified** with receptionists as interpreters felt that they are expected to pacify patients when there is a long waiting time.

(xii) **Appointments with GPs** are usually 10 minutes long; and good practice suggests that with an interpreter present, the appointment should be 20 minutes long. Interpreters felt that this does not usually happen, and GPs often get impatient with interpreters if the appointment goes over 10 minutes. This sometimes puts interpreters under pressure to summarise what has been said rather than translate what is actually being said.

(xiii) Neither GRIP nor CITAS covered **emergencies**: In this case Language Line is used. As the PCGs policy is not to cancel patient appointments, if GRIP is not able to provide an interpreter, K&C PCG sometimes used community groups, paying the hourly rate of £11: there was training and support for them in this regard but the training is generic rather than focusing on specific communities or areas such as Mental Health.

(xiv) Given the move to PCTs and the expected **closer liaison between health and social care service providers**, it was felt that many of the issues related to interpreting for health services also apply to social services and other social care providers, and that there needs to be co-ordination on this amongst service providers.