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Provision of interpreting support for cross-cultural communication in UK maternity services: A Freedom of Information request

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ABSTRACT

Background: Language, communication and understanding of information are central to safe, ethical and efficient maternity care. The National Health Service (NHS) commissioning board, NHS England, describes how healthcare providers should obtain language support through professionally trained interpreters. Providers of interpreters are commissioned to deliver remote/face to face interpretation across the NHS. Services can be booked in advance or calls can be made in real time. However, women report infrequent use of professionally trained interpreters during their maternity care, often relying on friends and family as interpreters which can compromise confidentiality, disclosure and accuracy.

Methods: To determine the demand for, and provision of, professionally trained interpreters in practice, we sent a Freedom of Information (FOI) request to 119 NHS Trusts delivering maternity services in England in November 2022. For the financial years 2020/2021 and 2021/2022, we asked how many women in the maternity service were identified as needing an interpreter, the number and mode of interpreter sessions, and the annual spend on interpreting services. Data were analysed using descriptive statistics.

Results: One hundred maternity Trusts responded by 21st April 2023 (response rate 100/119–84 %). Of these, 56 (56 %) recorded a woman's need for an interpreter. Nineteen Trusts relied on documentation in paper notes and 37 Trusts recorded the information on a digital system. From the 37 Trusts where this information could be digitally retrieved, women requiring interpreter support reflected between 1 and 25 % of the annual birth rate of the Trust (average 9 %) and received an average of three interpreter sessions across their pregnancy, birth and postnatal journey. Telephone was the dominant mode used for interpreting sessions, though 11 Trusts favoured face to face interpreting. Financial spend on interpreting services varied across Trusts; some funded their own in-house interpreting services, or worked with local community groups in addition to their contracted interpreting provider.

Conclusion: Information obtained from this FOI request suggests that documentation of a woman's interpreting need is not complete or consistent across NHS maternity services. As a result, it is not clear how many women require an interpreter, the mode of provision or how frequently it is provided, and the cost involved. However, the limited information available suggests a failure to provide interpreter support to women at each scheduled care encounter. This raises questions

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about, the risk of women not understanding the care being offered, and the increased risk of uninformed, unconsented care as women traverse pregnancy and birth.
Tweetable: There appears to be failure to provide interpreter support to women at each scheduled maternity care encounter increasing the risk of uninformed, unconsented care.

What is already known:

- The use of professionally trained interpreters ensures understanding of care options available and allows women to ask questions, increasing the quality of care.
- Women and healthcare professionals report inconsistent or absent provision of quality interpreting support in UK maternity services.
- Within maternity care in the UK, women with cross-cultural communication needs are at risk of inadequate, unconsented care with significant physical and psychological consequences.

What this paper adds:

- An FOI request suggests that the majority of UK maternity services do not robustly record a woman's need for interpreting support to facilitate provision for appointments.
- Where maternity services digitally record a need for interpreter support, women received an average of three interpreter supported sessions despite a recommended 14–17 healthcare professional contacts if a standard, uncomplicated maternity care pathway is experienced, reflecting significant unmet need.
- Disparity between interpreter requests by healthcare professionals and fulfilment of these requests by contracted interpreting providers reflects significant issues in service supply.

1. Background

Language, communication and understanding of information are central to safe, ethical and efficient maternity care (Cramer 2017). There is a significant body of international literature showing how cross-cultural communication needs negatively impact people's health – from their ability to navigate and access care to the quality, safety and outcomes of the care received (Flores 2005; Floyd and Sakellariou 2017; Hadziabdic and Hjelm 2019; Markin and Coleman 2021; Whitaker et al., 2022). This is especially applicable to maternity services due to the unscheduled nature of serious complications and the onset of labour. In the UK, an estimated 1041,000 people are unable to speak English well or at all, with women disproportionately affected (ONS 2021). The top four languages in the UK after English are Polish, Romanian, Punjabi and Urdu, reflecting historical and contemporary patterns of economic migration (ONS 2021). This context is augmented by the unpredictable global migration flows of crises caused by war and political instability, UK refugee dispersal practices and migration patterns that mean geographical areas can support multiple language profiles. Health services need to be prepared for cross-cultural consultations across multiple and changing linguistic and cultural communities.

The National Health Service (NHS) commissioning board, NHS England, have pledged to improve the health outcomes of mothers and babies by focusing on the populations with greatest experience of ill health who reside in the 20 % most deprived areas of the UK (NHSE 2022). The most recent annual MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) report, covering the time period 2018–2020, describes a 2.5 times increased risk of maternal death amongst women from deprived areas compared to women living in more affluent areas. Furthermore, ethnic disparities in maternal mortality in the UK continue to be a challenge as women from Black ethnic backgrounds are 3.7 times more likely to die, and women from Asian ethnic backgrounds 1.8 times more likely to die, than white women during pregnancy, birth and up to 90 days postnatally (Knight et al., 2022). While ethnicity is not synonymous with deprivation, and does not reflect English language ability, women with cross-cultural communication needs are overrepresented within these groups, experiencing intersecting disadvantage, and poor maternal and infant outcomes (MBRRACE Collaboration 2022, Birthrights 2020). While it is not possible to directly measure the impact of English language proficiency on maternity outcomes, communication failures can result in sub-optimal awareness of the need to seek medical help (Birthrights 2020) and where to seek help (Alshawish et al., 2013), and the assessment of serious medical symptoms (Johnsen et al., 2020). Therefore, supporting cross-cultural consultations, where provider and patient do not have a shared linguistic and cultural background, is essential to meet the NHS England pledge (van den Muijsenbergh et al. 2014).

Women with cross-cultural communication needs are at increased risk of inadequate, unconsented care, that could leave them feeling isolated, unsupported, and unable to communicate (Johnsen et al., 2020; MacKenzie 2021;Nicholls et al., 2021; Bridle et al., 2020). For birthing people to be equal partners in their maternity care, they need access to information about their pregnancy and birth, to be able to ask questions, understand the answers and know where to seek help (NHSE 2016). The NHS Race and Health Observatory (RHO) review section on maternity recommends: "Renewed and serious efforts are needed to ensure ready access to high quality interpreting services" (p7, Robertson et al., 2021). The positive impact of interpreter use on medical encounters is well documented (Flores 2005). NHS England describes how Trusts should obtain language support through professionally trained

interpreters (PTIs) (NICE 2012). Providers of PTIs are commissioned to deliver remote/face to face interpretation across the health service delivery portfolio. Services can be booked in advance or calls can be made in real time.

However, women report infrequent use of PTIs during their maternity care, often relying on friends and family as interpreters which can compromise confidentiality, disclosure and accuracy (Johnsen et al., 2020; Rimmer 2020). The RHO rapid evidence review mirrors findings from research in Denmark (Johnsen et al., 2020) and Sweden (Esscher et al., 2014), describing a lack of consistent and high quality interpreting services to be a common issue for women without host country language skills in maternity services, impacting access to, receipt and quality of care (Robertson et al., 2021). Within the UK, there is a translational gap between policy and practice, and undermining the NHS's commitment to woman centred, safe, equitable care (van den Muisenbergh et al. 2014; MacKenzie 2021). Our study aims to inform this context by quantifying the demand for, and provision of, professional interpreters within maternity services in England.

2. Method

To measure the demand for, and provision of, PTIs in practice in response to the documented experiences of women and midwives, we sent a Freedom of Information (FOI) request to NHS Trusts delivering maternity services in England in November 2022. Since the public have a right to see information held by a public authority, no ethical approval was required. A total of 148 NHS Trusts are listed on the NHS maternity services dashboard. Two of these have disbanded, one was an oncology hospital, two were mental health trusts, three did not have a FOI contact on their website and 21 were governed by a central corporate Trust. This resulted in 119 FOI email contacts for Trusts delivering maternity services in England. We asked:

1 How many women in the maternity service were identified as needing an interpreter in financial years 2020/2021 and 2021/2022?
2 How many face to face or telephone or video interpreter sessions were conducted in the maternity services (antenatal, labour, postnatal) in financial years 2020/2021 and 2021/2022?
3 What was the annual spend on interpreter sessions in maternity services in financial years 2020/2021 and 2021/2022?

On receipt of their response, their data was entered into an excel spreadsheet for analysis. The standard timescale for FOI response is 20 days. However, due to the extreme pressures on the NHS and workload constraints, some Trusts warned in advance that there may be a delay in responding to the request. Non-responders were contacted after an additional 4 weeks and again at 12 weeks. Data were

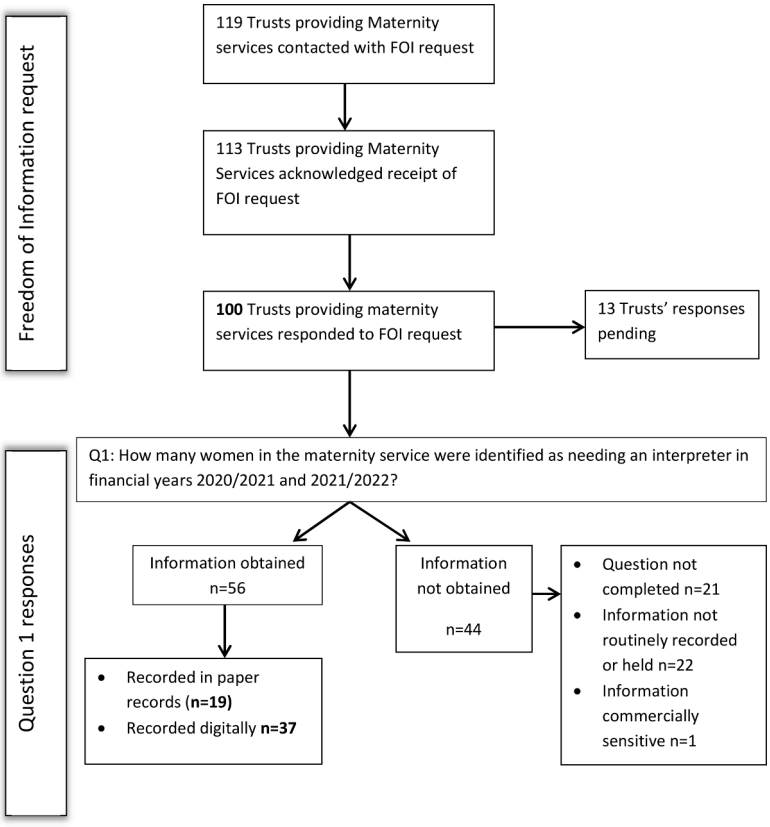

Fig. 1. Freedom of Information request Question 1 responses.

analysed using descriptive statistics (Yellapu 2018).

3. Results

A total of 119 NHS Trusts offering maternity services were contacted either by email, online form or post as per their website FOI guidance. 113 acknowledged receipt of the request and 100 responded at five months (by 21st April 2023), with 13 pending. Those who had **not** responded in this timeframe were inner city tertiary referral centres with 8000–17,000 births per year ($n = 5$) and smaller district generals with an average of 4500 births per year ($n = 8$). Data availability was variable, with more than one category missing from most Trusts.

Question 1: How many women in the maternity service were identified as needing an interpreter in financial years 2020/2021 and 2021/2022?

Of the 100 Trusts who responded to our FOI request, 56 (56 %) provided information on how many women in the maternity service were identified as needing an interpreter. Nineteen (19 %) Trusts described this information as recorded in paper records and 37 (37 %) recorded it digitally in the local maternity information system (e.g. Badgernet). Information relating to this question was not obtained from 44 Trusts (44 %) as the question was not completed by 21, the information was described as not routinely recorded or held by an additional 23, and was deemed commercially sensitive information by one (Fig. 1).

Only the 37 Trusts who recorded a woman's need for an interpreter digitally were able to supply numbers of women who required an interpreter. The 19 Trusts who recorded a woman's need in paper notes were unable to extract this information. Recorded need for an interpreter varied widely, from 3 to 1848 women with an average of 377 in 2020/21 and 422 in 2021/22. When mapped against the Trust birth rate, these women represented an average of 9 % of total births in each Trust. This ranged from 1 to 25 % but reflected potentially one woman with interpreting needs birthing every day across these Trusts.

Question 2: How many face to face or telephone or video interpreter sessions were conducted in the maternity services (antenatal, labour, postnatal) in financial years 2020/2021 and 2021/2022?

In response to the question about the number and mode of interpreting sessions conducted, an increased number of Trusts 43 % (43/100) could digitally access the mode of interpreting support (face to face, telephone, video call), though two of these were only

	NHS Trust	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
Interpreter sessions 2020/2021		1	7.3	1.3	1.7	0	2.2	5.46	0.1	18.2	1.8	24.6	6.57	0.45	2.1	0.5	0.9	5	1.6	1.9	0.7	8
Interpreter sessions 2021/2022		1	9.1	3.2	0.8	9.2	3.43	8.7	0.1	33.2	3.46	6.1	8.59	0.36	6.8	0.5	1	4.2	1.4	2.2	1.2	8

(Editable source data)

Figure 2 created in Excel below:

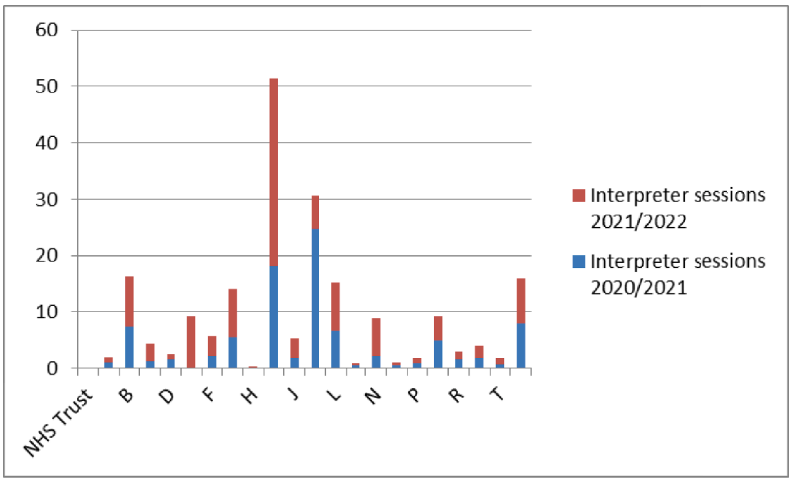

Fig. 2. Average number of interpreter sessions per woman digitally recorded as needing interpreter support.

Table 1
Response to all three Freedom of Information questions from seven Trusts.

No. women 20/21	No. women 21/22	F2F 20/21	F2F 21/22	Telephone 20/21	Telephone 21/22	Video 20/21	Video 21/22	Total contacts 20/21	Average	Total contacts 21/22	Average	Spend 20/21	Spend 21/22
17	16	36	45	3	10	0	0	39	2.2	55	3.43	£4193.41	£6161.04
1043	1256	1145	2654	4558	8112	0	0	5703	5.46	10,766	8.57	£89,287.80	£164,576.10
240	184	59	98	387	540	0	0	446	1.8	638	3.46	£12,212	£27,304
135	143	64	219	823	1010	in F2F numbers	887	6.57	1229	8.59	£10,979.87	£15,699.99	
515	595	2245	2011	353	489	0	0	2598	5.04	2500	4.2	£83,913	£83,037
482	403	1056	866	2474	2818	3	3	3533	7.3	3687	9.1	£95,593	£99,447
1018	1176	112	89	39	49	N/A	N/A	151	0.14	138	0.1	£68,250.11	£66,719

able to provide data for antenatal services. More Trusts were able to provide a total number of interpreting sessions (59 %, $n = 59/100$), with nine reporting the information to be held by the interpreting provider. These figures ranged from 19 to 13,500 episodes with an average number of sessions across reporting Trusts of 1971 in 2020/21 and 2464 in 2021/22. Trusts were unable to attribute interpreting sessions to particular women, stating that some women may have had more than one interpreting session, thus the number of sessions is not representative of the number of women who need an interpreter. An additional caveat given was the presence of family or friends to interpret in some sessions for some women, thus interpreters would not have been booked through the Trust/Trust provider.

Information on the number of interpreter sessions was not available from 29 % (29/100) of Trusts as they declared the data to be collected at the divisional level ('women's services' that include gynaecology or 'family services' that include paediatrics) or at the hospital level. Thus retrieval of data for maternity sessions would require hand searching of invoices. This would exceed an appropriate limit of 18 hours as laid down in the Freedom of Information (Fees and Appropriate Limit) Regulations 2004, and as such were exempt under S12 of the Freedom of Information Act. Two Trusts chose not to disclose, considering the information commercially sensitive, with one further Trust missing data.

Across the 43 Trusts reporting the mode of interpreting sessions, telephone interpreting dominated during 2020/21 as the NHS moved to a remote consulting model during the pre-vaccination stage of the Covid-19 pandemic of 2020/21. Video interpreting was recorded as being used in 21 Trusts but, in six of these, numbers of video interpreting sessions are either included in the telephone or face to face interpreting figures or not recorded, as the mobile device was shared between clinical areas and thus sessions could not be attributed to maternity services. During this year, there were tight restrictions impacting healthcare consultations in UK maternity services that excluded partners from appointments and attendance in labour until 'established labour' was confirmed. While face to face interpreting increased in many of these 43 sites in the following year of 2021/22, telephone interpreting remained the dominant mode of interpreter support. However in 11/42 Trusts across England, face to face interpreting was the most frequent mode of interpreting in both 2020/21 and 2021/22. amongst the 37 Trusts (37 %) who digitally recorded a woman's interpreter need, 20 of these recorded the total number of interpreter sessions delivered during the maternity pathway. For 18 of these Trusts, women received an average of three interpreter sessions each during their maternity care journey. The two remaining Trusts reported significantly higher interpreter use. For example, one reported an average of 24 interpreter sessions per woman in 2020/2021, reducing to six sessions the following year; this first figure is suggestive of a high number of interpreter sessions for a small cohort of women who perhaps experienced additional care needs within their pathway. The other high use Trust reported an average of 18 interpreter sessions per woman identified as needing support in 2020/21, rising to 33 in 2021/22 (Fig. 2).

Question 3: What was the annual spend on interpreter sessions in maternity services in financial years 2020/2021 and 2021/2022?

In response to the question about financial spend on interpreting services in the preceding two years, 51 % (51/100) shared their spending figures showing significant variation in both per session and total costs between Trusts. Spending in 2021/22 ranged from £624 to £296,405 in each Trust, with an average of £43,317. Thirty-five Trusts reported maternity spending on interpreting services to be unavailable as it is amalgamated into the hospital budget and not reported by care division. Two Trusts declared this financial data to be held by the contracted interpreting company, with five Trusts declaring this information as commercially sensitive and choosing not to disclose their spending on interpreter services in maternity. Seven Trusts did not provide an answer to question three.

A detailed breakdown of the amount spent was only returned from seven Trusts, as summarised in Table 1 to illustrate the variety in reported interpreter need, mode, total use and spend.

Information from only four Trusts reported the fulfilment rate for face to face interpreter requests within their spending breakdown. This reflects where a maternity professional has requested a face to face interpreter booking from the contracted interpreting provider in advance of an appointment with a woman who requires interpreter support. Those appointments or interactions where an interpreter did not attend or the interpreting provider was unable to offer an interpreter for the appointment are classified as unfulfilled. In two of these Trusts, 75 % and 35 % of known needs for an interpreter went unfulfilled in the year 2020/2021. This rate fell in the following year (2021/2022) to 47 % of interpreter requests being unfulfilled and 5 % respectively. In the third Trust, 18 % of requests for interpreter support were unfulfilled in 2020/21, rising to 34 % in 2021/22. The fourth Trust reported 8 % of face to face and telephone interpreter requests to be unfulfilled. In all four sites, these figures highlight a significant unmet need for interpreter support. This data is not available for the remaining 96 Trusts.

The amount each Trust spent on their interpreting services in maternity was not complete enough to draw meaningful comparisons or conclusions. However, it is clear that different Trusts are paying varying amounts for interpreter services, with some funding their own in-house interpreting services, or working with local community groups in addition to the contracted interpreting provider (such as BigWord, AA Global or Language Line).

4. Discussion

4.1. Summary

Only 56 % (56/100) of Trusts who responded to the FOI request recorded a woman's need for an interpreter. Nineteen Trusts relied on documentation in paper notes and 37 Trusts recorded the information on a digital system. From the 37 Trusts where this information could be digitally retrieved, women requiring interpreter support reflected between 1 and 25 % of the annual birth rate of the Trust (average 9 %) and received an average of three interpreter sessions across their pregnancy, birth and postnatal journey. Telephone was the most common mode used for interpreting sessions, though 11 Trusts favoured face to face interpreting. Data regarding fulfilment of interpreter request was only provided by a small number of Trusts and may not reflect practice. While the data was not

complete, it is clear Trusts are paying varying amounts for interpreting services.

4.2. Discussion

Documentation of a woman's interpreting need is not systematic or consistent across NHS maternity services, sometimes relying on hand held notes that do not support practitioners to book interpreter services in advance of the woman's appointment. If paper notes were not available, there would be no system of warning that interpreter support was required. A standard maternity care pathway as recommended by NICE Antenatal Care Guidance (NICE, 2021a) for a nulliparous woman experiencing an uncomplicated pregnancy, birth and postnatal care would entail a minimum of ten midwife antenatal appointments, two ultrasound scans, birth, discharge home and then three postnatal community visits (NICE 2021b). This adds up to a minimum of 17 contacts between the woman and a midwife/health care provider. A standard maternity care pathway for a parous woman would comprise seven antenatal appointments, two ultrasound scans, birth, discharge home and a minimum of three postnatal visits, totalling 14 contacts. For women whose interpreting need was recorded digitally, there appears to be a failure to ensure interpreter support at each scheduled care encounter. This has implications for care pathway planning and navigation of scheduled care encounters, including those where ascertaining consent is essential.

The rate of interpreter request fulfilment in our data was only available for four trusts, but revealed a significant gap between demand and provision, raising concerns over service supply. This information suggests a supply side gap and implies interpreter provision to be complex and multi-factorial. The year 2020/2021 covers the Covid pandemic in England where people from ethnic minority backgrounds were disproportionately affected by Covid. This may have impacted availability of PTIs, many of whom are employed in 'zero hour' contracts around other work and family commitments. However, if Trusts are not accessing interpreter support for the scheduled appointments across the pregnancy and postnatal care journey, structural and institutional barriers must also be analysed.

The positive impact of professional interpreter use on medical encounters is well documented, raising the quality of clinical care for patients to approach or equal that for patients without language barriers (Karliner et al., 2007). Awareness amongst maternity professionals of the impact of professional interpreters on the accuracy and quality of maternity care is essential. Absent or irregular PTIs undermine midwifery care (Cramer 2017), and act as an independent risk factor for poor outcomes (Karliner et al., 2007; Chitongo et al., 2022; Divi et al., 2007), unconsented procedures (such as episiotomy in labour) (MacLellan et al., 2023) and birth trauma (Markin and Coleman 2021; Birthrights 2020), and contribute to disparities in maternal mortality (Cosstick et al., 2022). Evidence suggests higher satisfaction with medically trained interpreters amongst service users, with no particular mode of interpreting (face to face, telephone, video) found to be superior (Joseph et al., 2018). However, women and midwives have expressed concerns about accuracy of translation and confidentiality (MacLellan et al., 2022; Mengesha et al., 2018; Rayment-Jones et al., 2021). Midwives report inefficient care and professional dissatisfaction when they cannot access timely, accurate, trusted PTIs to support women with cross-cultural communication needs (Bridle et al., 2020; Oscarsson 2020). Inaccurate cross-cultural communication compounds the vulnerability women experience during pregnancy and childbirth (Bridle et al., 2020). The RHO rapid review calls for research that engages with under-served women and families to co-produce interventions that make services appropriate to their needs and priorities (Robertson et al., 2021). This FOI request shows that PTI services are available in each Trust but the data raises more questions about the quality and consistency of the interpreting service structures and administration methods, their monitoring and accountability. It also raises questions about structural barriers to accessing interpreter support for maternity staff and the high risk of uninformed, unconsented care as women traverse pregnancy and birth. Institutional and structural analysis needs to accompany and inform the co-produced interventions recommended by the RHO, in order to deliver on NHS England aspirations of improving maternal and neonatal outcomes.

4.3. Limitations

The principal limitation of this enquiry is the methodology inherent in an FOI request. While public institutions are obliged to respond, it is challenging to follow up as often contact details are a generic email or postal address. The quality of information is dependant on the accessibility of the information at Trust level, the responsiveness of the targeted department and the interpretation of the FOI questions. The authors were unaware that fulfilment of interpreter request would be recorded and so did not specifically ask each Trust. Consequently this data is only available for four Trusts who volunteered this in their interpretation of our question. The level of missing data from Trusts constrained the depth of analysis possible. The lack of information to illustrate where in the maternity pathway interpreters are less likely to be used, or most prevalent days/times interpreter requests are most likely to be unfulfilled, or which language needs are least likely to be met raise more questions than this enquiry is able to answer. However, recording what information is available and where the gaps appear to be should inform the next line of questioning and action in meeting the cross-cultural communication needs of women birthing in the NHS maternity service.

4.4. Conclusions

Information obtained from this FOI request suggests that documentation of a woman's interpreting need is not complete or consistent across NHS maternity services. As a result, it is not clear how many women require an interpreter, the mode of provision or how frequently it is provided and the cost involved. However, the limited information available suggests a failure to provide interpreter support to women at each scheduled care encounter. This raises questions about, the risk of women not understanding the care

being offered, and the increased risk of uninformed, unconsented care as women traverse pregnancy and birth.

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Credit author statement

The project was conceived by SK and JM. Data collection was undertaken by JM. JM and AM analysed the data. JM wrote the first draft. All authors edited and approved the final manuscript. JM is the guarantor of the manuscript.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Supplementary materials

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