GPs at the Deep End

Deep End Report 43

Language and Cultural Health Inequalities at the Deep End: Understanding the Context, and What Can Be Done

On Wednesday 4th December 2024, the Deep End GP group hosted an in-person roundtable discussion on language and cultural health inequalities at the Deep End. The discussion explored the challenges faced by staff in delivering and patients in accessing equitable and high-quality services within areas of higher ethnic diversity.

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EXECUTIVE SUMMARY

Context/challenges

Language and cultural differences can present challenges for individuals when accessing healthcare in the UK where English is the dominant language used. The use of skilled interpreters for patients with little or no English is vital to enable people to be fully involved in discussions and decisions about their care. Appointments requiring an interpreter for communication take significantly more time to ensure safety and quality. The interplay between ethnically diverse populations and poorer health outcomes is seen most intensely within socio-economically deprived communities where 'Deep End' practices are located, and where ethnically diverse populations are registered. Workloads are known to be higher (and workforces smaller) in these areas, creating additional challenges in healthcare provision.

Specific challenges

The additional work and skills required to deliver healthcare to ethnically diverse populations are not well understood or recognised in professional training, or in current funding allocations to general practice. Absence of standardised practice processes to capture language requirements within patient records, or to have reliable access to their interpreting-service usage data impacts on practices' ability to plan and accommodate the needs of patients. Quality, availability, reliability and continuity of interpreting services is highly variable, with quality assurance and commissioning processes for services poorly understood. Wider systemic barriers for people, such as challenges in registering with a general practice or communicating effectively across the primary-secondary care interface, compound these challenges.

Recommendations for addressing cultural and language health inequalities in general practice

1. **Equitable funding to drive equitable care.** More effectively match resource (including human resource) to need, through:

- **Creation of an Enhanced Service for Cultural and Language Health Inequalities** – to support the significant additional workload that is entailed, facilitate improvements in coding, data collection and reporting, practice processes, design and delivery of care and workforce training. Recognised as an interim measure until workload more effectively resourced through core General Medical Services (GMS) funding.
- **Sustainable core funding for community link workers, financial inclusion workers and the third sector** – to enable holistic care and support with navigation of services.

2. **Enable high-quality data recording and collection.** High-quality data will drive understanding and quality improvement by:

- **Improving data collection within practices to include:**
    - Routine coding of language needs using agreed Read code
    - Routine coding of ethnicity
    - Routine coding when an appointment includes an interpreter

- **Improving and standardising mechanisms within Health Boards and Health and Social Care Partnerships (HSCPs) – for practices to routinely, accurately and easily obtain their own translated appointment data (frequency, volume and languages used).**

3. **Training for Health and Social Care Workforces.** Improved training in cultural competency/humility and in interpreter use will improve patient experience and quality of care, facilitated by:

- **Inclusion in undergraduate and postgraduate training curricula.**
- **Incorporation into planned national work around improving health equity training for health and social care workforces.**

4. **Improve Governance and Quality Assurance of Interpreting Services**

- **Greater clarity around current procurement processes for commissioned interpreter services.**
- **Greater clarity around current governance frameworks and quality assurance mechanisms for commissioned interpreter services.**
- **Ensure mechanisms in place to allow feedback from NHS end-users to drive improvement.**
- **Expectation of high-quality training for interpreters working in healthcare settings (including trauma-informed practice) plus ongoing supervision and support for all interpreters working within commissioned services.**

5. **Improve System Support for patients**

- **Improve the GP registration process** which could include the provision of a private area, the use of an interpreter, and awareness-raising (with practices and with patients) that ID and proof of address are not a pre-requisite to registration. **A separate piece of work should be funded by Scottish Government to improve the registration process for *all* patients struggling to register in general practice.**
- **Improve accessibility of health information for patients -** Provision of high-quality, nationally developed health information in a language and format most appropriate for the patient's cultural and language needs. This should include an explanation of how the NHS works and how to make the best use of it.
- **Improve information sharing between professionals -** Inclusion of language and cultural requirements when communicating between healthcare teams and across interfaces of care. **This could be part of anti-racism plans that are currently being developed in Health Boards.**
- **Improve healthcare appointment systems -** Specific consideration and accommodation of interpreter requirements when allocating appointments and communicating appointment details.
- **Care Navigation support -** Specific consideration of need for navigation support to support patients to be able to make use of the healthcare resources available.
- **Increase accessibility and availability of 'English for Speakers of Other Languages' ESOL (or equivalent) for patients.**

INTRODUCTION

Scotland has experienced **significant demographic change** over the past decade, including an increase of individuals from minority ethnic backgrounds. In 2022, 12.9% of the population were from minority ethnic backgrounds, an increase from 8.2% in 2011 [1].

Language and cultural differences can present challenges for people when accessing healthcare. The use of skilled interpreters for patients with little or no English is vital to enable full involvement in discussions and decisions about their care. The General Medical Council states that "steps to meet patients' language and communication needs" should be taken to support patients "to engage in meaningful dialogue and make informed decisions about their care" [2]. Appointments with an interpreter take significantly more time to ensure safety and quality. The interplay between ethnically diverse populations and poorer health outcomes is seen most intensely in socio-economically deprived communities where 'Deep End' practices are located. Workloads are higher (and workforces smaller) in these areas, creating challenges in healthcare provision [3].

The **additional work and skills required** to deliver healthcare to ethnically diverse populations are **not well understood or recognised** in professional training or in current funding allocations to general practice. The context is one of increases in new GP registrations for patients requiring interpreters, with many of these patients being among the most vulnerable in our society, including refugees and asylum seekers, people who have been trafficked or have a torture history, and those with complex physical and mental health needs. A mistrust of authority and Government institutions [4] can hinder people's ability to feel confident in engaging with healthcare [5], compounded by challenges in understanding how a complex organisation such as the NHS 'works' [6]. It is also recognised that there can be a lack of confidence amongst clinicians about how ethnicity can impact on disease incidence and prevalence.

The **roundtable discussion bought together** Deep End GPs, representatives from the Scottish Government Health Equity and Racialised Health Inequalities team, Public Health Scotland (PHS) and NHS Education for Scotland (NES). Valuable input was also gained from attendees representing organisations working with people in the asylum system and people with refugee status, ethnic minorities, community and patient groups.

Discussions identified challenges faced by both patients and those delivering healthcare services. Several important themes are presented related to language and cultural health inequalities. Recognition and resourcing of the additional workload generated, constraints around workforce capacity, and unmet needs around training (with subsequent negative impacts on staff and patient experience) were all highlighted. Absence of standardised practice processes to capture language requirements within patient records, or to have reliable access to their interpreting-service usage data impacts on practices' ability to plan and accommodate the needs of these patients. Quality, availability and reliability of interpreting services was also felt to be highly variable, with quality assurance and commissioning processes poorly understood. These themes are explored in more detail in the rest of the report, and **a series of recommendations are made**, both at a practice and national level, which the group felt would assist in provision of equitable healthcare for this patient group.

SPECIFIC CHALLENGES

Participants discussed specific challenges related to language and cultural inequalities facing patients and practices in Deep End communities. These include concerns about workload, workforce capacity, interpreting services, data, system barriers for patients, and issues related to training. Examples of good practice were also discussed.

Workload

Participants were concerned about impacts on workload including the additional time required to use interpreting services, the intersection with socioeconomic disadvantage, and the impact of psychological trauma.

Additional time

Providing care to ethnically diverse populations was recognised to be highly rewarding work, both emotionally and intellectually, but this was affected by a lack of training, support and resources. Most practices **aim to offer double appointments (usually 20 minutes instead of 10 minutes)** to patients who require Interpreting services, with these patients often requiring multiple follow-up appointments. The impact on the workload of an already-stretched system is felt not only by clinical staff, but also by Community Link Workers and administrative staff. For instance, admin staff use interpreters to facilitate registrations, make appointments, and communicate information from the practice, requiring additional time to explain how the NHS works and signposting, when appropriate, to other resources such as Pharmacy First. A lack of training in how to effectively work with an interpreter can also place extra pressures on those delivering and aiding access to care.

Estimates of the scale of the additional workload involved were variable. One participant reported that **thirty per cent of new registrations** at their practice over a one-month period were from patients requiring interpreter work; another participant estimated that twenty-five per cent of their practice population had this requirement; a third participant estimated that at least twelve per cent of their patients were coded as needing an interpreter when accessing healthcare.

Different health beliefs and intersectional disadvantage

In addition to the need for longer appointments to ensure adequate time for safe and quality interpretation, it was recognised by participants that presenting issues are often complex and require **sensitive and culturally informed approaches**. For instance, minority ethnic groups in the UK are recognised to be at risk of poor medication management because of factors such as health beliefs, language barriers, and difficulties navigating the healthcare system [7]. All these factors also translate to significant additional workload for practices caring for ethnically diverse populations.

Deep End practices tend to have a higher proportion of patients requiring interpreters and are also dealing with other **consequences of socio-economic disadvantage**. Resources in these practices are already stretched, with higher workloads and smaller workforces [3]. Patients often have earlier-onset multiple long-term conditions, higher levels of social complexity, and there is a recognised difficulty in recruitment and retention of staff due to the intensity of the work.

Impact of psychological trauma

It was recognised by participants that it is common (and best) practice to offer double appointments to account for the additional time for interpreting needs. However, this does not include the additional time that is also needed to deal with often complex physical and mental health problems, impacting the ability to take a trauma-informed care approach. **Patients often require multiple follow-up (double) appointments to address complex issues and build trust**. This can then cause difficulties in ensuring other patients are not disadvantaged when there are a finite number of appointments available. The balance of ensuring equitable provision and avoiding 'splits' between different patient demographics was recognised as being difficult to achieve.

One participant reported that at their previous practice in Glasgow, over the period of just one year, the number of people in the asylum system who had registered had **increased from 15 to 123**, with associated long and complex consultations due to background health conditions and trauma histories, as well as the additional time taken to support registration for these patients due to language difficulties and cultural expectations. Of the 123 patients, 44 were identified as needing an interpreter (although the figure was thought to be possibly higher). These 44 patients attended the practice for appointments 451 times since registering in the previous year. This was in 2015 [8]. A decade later, the challenges were felt to be unchanged.

Such consultations were recognised by participants to **involve considerable "emotional labour"**, with a significant impact on the clinician's capacity and ability to function, with no time to 'reset' or process before they see their next patient. One practitioner highlighted how one day they had led interpreted consultations involving six languages, leaving them feeling exhausted.

Workforce Capacity

Workforce capacity concerns related to GP numbers, GP funding, and funding for Community Link Workers and third sector supports.

GP Workforce Capacity

The number of GP wholetime equivalent (WTE) in Scotland has **decreased by 6%** since 2013 [9] despite a 7% rise in patients registered with a GP over the past decade [10]. In 2023, a single full-time GP was responsible for 1,715 patients, an increase of 13% compared to a decade ago [11]. Participants recognised that many of the patients experiencing language and cultural health inequalities had significant and complex healthcare needs, requiring the specific input of a GP. The declining workforce has made this more difficult to achieve. There are also known to be smaller clinical and administrative workforces in practices in more socio-economically deprived areas [3].

General Practice funding

Current funding formulas for general practice **do not factor in the extra workload** required to provide care to patients who require interpreting services. This was felt to disproportionately impact practices at the Deep End, which tend to have a higher proportion of patients with interpreting needs and health and social care complexity. This issue was highlighted at the annual Scottish Local Medical Committee Conference the week prior to our roundtable, with a motion passed recognising the *"significant impact on*

GP workload in looking after patients who require interpreters" adding to "*health inequalities, particularly on practices serving deprived populations*." The motion demanded the additional workload be resourced contractually, with the Scottish General Practice Committee to negotiate an enhanced service for practices supporting the growing number of patients with additional language needs, and for this to be developed with new additional General Medical Services funding [12].

Third Sector and Community Link Worker Funding

The third sector provides **invaluable support** to many ethnically diverse communities. Working in collaboration with general practice, often through community link workers, it plays a significant role in improving healthcare access and literacy.

The city of Glasgow – having been the sole asylum dispersal centre in Scotland up until 2022 – has a wealth of experience in supporting such communities. However, with dispersal now taking place across Scotland, **funding is also required** to support the creation of appropriate infrastructures **to facilitate collaboration** between third sector organisations and healthcare in other areas of Scotland.

The need to ensure **sustainable core funding for community link workers**, practice-based financial inclusion workers, and third sector services was identified by participants as key to addressing health inequalities and the inverse care law for patients in socio-economically disadvantaged areas, including those with additional language needs. Their key role in enabling more holistic care, embedded within communities, is threatened by recent budgetary cuts and lack of long-term funding commitments.

Interpreting Services

Participants described variable quality of interpreting services, concerns about using family members, the decline of in-person interpreters and relational continuity, and scope for better training and quality assurance.

Variable quality of Interpreting Services

Challenges related to telephone interpreting services included: time spent waiting on the phone for interpreters, being cut off mid-consultation, and requests for a specific gender of interpreter not always being available, which could prevent patients fully expressing themselves.[i] Participants described **routinely waiting at least five minutes** to obtain an interpreter, which – if a double appointment is offered – is a quarter of the consultation. Reports of waiting on hold for an interpreter, however, sometimes exceeded 15 minutes. Calls were frequently cut off halfway through the consultation, requiring clinicians to call back, only to be connected to another interpreter with loss of continuity and time.

The **variable quality of interpreting services** available was raised, with concerns expressed that not all the information being discussed in consultations was being relayed. For example, patients may spend some time talking about their concerns but only one sentence is then interpreted back. Interpreters were often reported to appear distracted, with sounds in the background related to travelling, cooking or undertaking childcare duties. This impacted on the confidence of the clinician (and likely the patient) to fully engage in complex and sensitive conversations.

[i] This is not the case in all Health Boards.

Use of family members due to unreliable access to formal interpreters

There was a recognised **tension between NHS guidance** (which states that family members should not be used) and the real-life implications of this, when access to formal interpreters was not always reliable, or of high quality. The use of official interpreters is intended to ensure accuracy and impartiality of Interpreting. However, feedback from participants was that the Interpreting service quality can be so poor that having a family member interpret created what felt like a "better consultation".

Patient preference about who they would prefer to interpret for them was **felt to be important**. It was also felt that, if appropriate, having a family member in the room alongside the use of a telephone interpreter could support the patient and pick up on body language and non-verbal cues. Support from family members was also highlighted as potentially important in accompanying patients to appointments. Professional guidance does not recommend using online translating systems or services such as 'Google Translate' in healthcare settings as there is no assurance of the quality of their translations; however, some participants said they had had to resort to this at times because an interpreter was not available, and this was the 'least bad' option.

Decline of in-person interpreters and relational continuity

Following the Covid pandemic, there has been a decline of in-person interpreter availability. In-person interpreters are often harder to organise, and limited funding has impacted the availability of this service. As such, **telephone Interpreting services tend to be used by default**. The interpreter on the telephone is consequently unable to pick up on body language and non-verbal cues. Participants reflected that rapport-building can be adversely affected due to the tendency to focus on the speakerphone as opposed to the clinician and patient looking directly at each other.

Positive feedback was given by participants about their experience of using interpreters via video-link. This enabled wider access to available interpreters, compared to in-person interpreters from the area. It was felt that a video interpreter was a good compromise between having an in-person interpreter and a telephone interpreter, as this enables the individual and interpreter to at least see each other. It was also felt that for some patients, video interpreting may be less intimidating than having an interpreter present in the room. Again, the **importance of being able to offer choice** was highlighted.

The nature of interpreter allocation within NHS services (random allocation at the time of appointment) **erodes the ability to provide continuity of care** – both relational and informational – for those needing to consult over several appointments, with different interpreters attending follow-up appointments. It is known that relational continuity of care is especially important for inclusion health groups because of the importance of trust-building to support disclosure, improve adherence to treatment, and support navigation of services [13]. The impact of relational discontinuity was also noted when patients had to move practice due to a change of accommodation, not uncommon for newly arrived communities and those seeking asylum. As one participant noted:

"Communities already have that trusted relationship with our [community] groups. They don't have the fear about how sharing information will affect their immigration status."

Training and quality assurance of Interpreting services

The variable quality of telephone interpreters raised questions as to the training provided, specifically with regards to interpreting in a healthcare setting. Questions surrounding how confidentiality could be assured were also raised. It was also recognised that some **interpreters may have experienced psychological trauma** themselves, and that they may find interpreting healthcare consultations re-triggering for past experiences. A lack of time for appointments also meant that there was not time for either a briefing or debriefing with the interpreter at the beginning or end of appointments. It is unclear how much support, mentorship or supervision interpreters receive in their role, but this was recognised to be important by all participants.

It was reported that some interpreters appear to feel uncomfortable talking about certain issues, such as sexual health, and instead appear to talk around the subject. Glossaries, covering healthcare terms, were suggested as potentially beneficial for interpreters by one of the participants with personal experience of working as an interpreter.

There was also felt to be a lack of understanding among healthcare professionals about the Health Board procurement process for interpreting services and whether there was a **recognised quality assurance framework**, a 'gold standard' framework, and a reporting or governance framework. Questions were also raised about whether the Fairer Scotland Duty and the Public Sector Equality Duty were being applied in decision-making.

Data

Coding of Interpreting needs and Ethnicity

There is **variation in the reliability and accuracy of coding** which patients need an interpreter. Some, but not all, practices code interpreting requirement at the point of registration. Some, but not all, practices code at the point of appointment allocation. Some practices do not routinely code at all. There is no unified approach in the coding of consultations where interpreting services are used, making it difficult to measure the workload involved. Some participants reported accessing interpreter-use activity data either from their Health Board or directly from the interpreting service. This had provided them with insights regarding the time spent on such consultations and the range of languages used. However, difficulties were reported in gaining this data, in addition to a lack of knowledge about how to access it. It was unclear whether such data would also provide more nuanced information about how the time is spent, for example, time spent on hold waiting for a call, or time spent consulting once connected to an interpreter.

Practice-level data on the use of telephone Interpreting services is captured through a unique identifying code for different practices. General practice teams therefore need to be consistent about using the correct code for their practice if they are to capture reliable practice-level data. It was recognised that this may not always happen, for example when locum GPs were working across different practices, unaware of the unique code for each. Data collection was recognised to be a crucial element of **understanding the scale of additional language needs in local communities**, to allow meaningful workforce and service delivery planning. The usefulness of data extends beyond the general practice and can highlight the need for adequate capacity and sustainability of third and voluntary sector services for populations experiencing language and cultural health inequalities.

High-quality recording of ethnicity data was also recognised to be an important way of understanding the disparities in disease prevalence and outcomes for people from different ethnic backgrounds, which in turn allows a more proactive and inclusive approach to planning, delivering and resourcing care.

System Barriers for Patients

Several system-level barriers for patients were described, including difficulties registering with GP practices, challenges navigating services, and fragmentation of care across the primary/secondary care interface.

Difficulty registering with a GP practice

There are additional barriers to registering with a general practice for patients with additional language needs. Examples were shared of **practices continuing to ask for photographic ID and proof of address** – and declining registration if these couldn't be shared. This is despite guidance that, while proof of identity and address are recommended to help access existing NHS records, inability to provide this is not a reason to delay or refuse registration at a GP practice [14]. This was a source of great frustration:
"The most common reason for not being able to register was not having a fixed address, or not knowing their CHI number…I mean, who knows their CHI number?"

Participants also highlighted a **lack of private space availability in practices** to facilitate in-person registration for patients with additional language needs who will often present at reception. Concerns were raised about confidentiality during the registration process if a private space could not be found, with the potential for re-traumatising patients, impacting on future trust-building and ability to accept and engage with care.

Examples were shared of ensuring access to a private space, and a member of the **administration staff assisting with registration forms**, using an interpreter. It was found that this not only aided the patient registering to access healthcare, it also assisted in creating a positive relationship with the practice and building trust.

Navigating services

The use of on-the day booking systems, with the subsequent '8am rush', was recognised to be **particularly problematic for those with additional language needs**. This included difficulty in articulating healthcare needs, particularly over the telephone, with patients often relying on friends or family members to book appointments for them thereby affecting confidentiality. Patients with additional language needs were recognised as more likely to book appointments in-person, due to difficulties with phone-based communication. Patients were often reported as confused as to why a receptionist was asking the reason for the appointment (an issue not confined to this group of patients). This also presented challenges with confidentiality, with patients having difficulty communicating their healthcare needs while others in the waiting room looked on and listened.

It was recognised that patients may not understand or take on board the signposting and care navigation provided by reception staff. The option of bypassing this point in the patient journey, allowing people to directly book into appointments with named clinicians was discussed, but it was felt that this might widen health inequalities for the rest of the

English-speaking practice population, and potentially create or widen divisions and perceptions of unfairness. It was also recognised that other inclusion health groups, without additional language needs, would also potentially benefit from this approach.

Participants spoke of the challenges patients faced in not being able to directly contact and arrange an interpreter to articulate their healthcare needs:

"We were called to see a woman who had just delivered a stillborn baby on the street outside our practice. She had no English and hadn't been able to contact an interpreter. The whole event was deeply traumatising for her, and for the staff attending. There are no mechanisms for support when this kind of thing happens."

Communication between primary and secondary care

Specifically communicating language (and cultural) requirements for patients across the primary-secondary care interface was recognised as important for **informational continuity and streamlining care**. Some specialities routinely ask for this information in their referral proforma, some do not. It was also recognised that sharing an interpreter requirement was only part of the process in supporting patients to be able to make use of specialist appointments. Participants also reflected how consideration also needs to be given to how the appointment information is shared, and how attendance could be supported and enabled. Health literacy was also raised as a challenge.

Training

Lack of training in trauma-informed care and cultural humility

For patients with additional language needs, accessing healthcare can be a stressful and even traumatic experience. It was recognised that there are unmet training needs for both the administrative and clinical staff in general practice teams. **Reception staff are often the first point of contact** for patients with additional language needs and this initial experience can have lasting impact on patients (and on staff). The unmet training needs were felt to include cultural competence and humility in healthcare delivery, and trauma-informed care. A lack of such training was recognised by participants as contributing to negative healthcare experiences for the patient, recognised as a key driver for 'missingness'. Missingness research has shown that every contact with the healthcare system impacts on the person's future likelihood of becoming missing and their ability to make use of the healthcare offered [15]. Missingness is associated with significantly poorer health outcomes and high levels of unmet need [16,17].

Examples of Good Practice

Participants shared examples of good practice in caring for patients with language and cultural barriers to healthcare. Some of these are captured below.

Freedom From Torture: continuity, interpreter briefings, and training

Freedom from Torture, a charitable organisation, provides therapeutic care for survivors of torture. Relational continuity is prioritised with the same interpreter for the client

attending both healthcare appointments and appointments to assist with medico-legal reports. The doctor or therapist also builds up a professional relationship with the interpreter due to the continuity approach, with time built into appointments to enable a briefing and debriefing for the interpreter. Video interpreters and local interpreters are used. Video interpreters facilitate a wider pool of interpreters, increasing availability, with the screen angled so that clients and interpreters can see each other. E-learning resources provided in training include a module on working across languages and cultures.

Community and healthcare orientation course for people in the asylum system and with refugee status

A specialist community link worker in Glasgow is involved in providing a community orientation course to people in the asylum and people with refugee status in Glasgow. The course runs over three sessions to avoid providing too much information at one time. Session one relates to accessing healthcare, including Pharmacy First and self-referrals. Session two covers education, such as English for Speakers of Other Languages (ESOL) courses, and volunteering opportunities to tackle isolation and support community integration. The third session focusses on resilience building and peer support.

Providing group healthcare information sessions for different languages

The Minority Ethnic and Health Inclusion Services (MEHIS), based in NHS Lothian, has run “Let’s Prevent Diabetes” educational sessions for Indian, Pakistani, Chinese, Arabic and African communities, known to be at higher risk of developing diabetes. This has included group sessions in particular languages. These sessions also explored cultural differences in diet, and more tailored steps that could be made to reduce the risk of diabetes. The service also shared health videos in different languages, for example relating to the Covid vaccine. They can also provide relational continuity as they can support families over time, helping attend appointments, and proactively making links with financial advice, family support, and the local ESOL service.

Welcoming general practice environments

One participant described how they had made changes within their practice to ensure that it felt like a more welcoming environment. This included a poster in their reception welcoming patients in different languages. In the absence of dedicated funding to make improvements, or pre-existing translated resources, the practice has also innovated by providing a link to ‘Google Translate’ on its website so that patients of different nationalities who do not speak English can access translated information on their web pages. The practice website also signposts to information in different languages on NHS inform, and the Scottish Government “Welcome Pack to New Scots” [18].

Providing on-site interpreter for high-prevalence languages

One participant spoke about how he was aware of a practice in England with a large number of patients from the Roma Community. To facilitate provision of healthcare and overcome language barriers and recognised mistrust from this community, the practice offered in-person interpreters to attend on a specific morning a week to facilitate patients registering with the practice, help with form-filling and assistance with booking appointments.

Conclusion

Access to equitable healthcare is a human right [19], however as the Inverse Care Law shows there are often fewer resources for those who need them the most. This includes patients with additional language needs, when the most vulnerable are often living in socio-economically deprived areas with higher baseline levels of need. This is compounded by language barriers driving further access and communication difficulties and consequently affecting the ability to build trust between this group of patients and healthcare providers. In turn this can impact on patients' ability to effectively make use of the healthcare system, potentially leading to increased "missingness", known to adversely affect health outcomes.

The Roundtable discussion **highlighted multiple challenges** faced by those experiencing language and cultural health inequities in general practice and makes a series of recommendations. These include ensuring appropriate funding to support the additional associated clinical workload in general practice to enable equity of access for all patients; support to improve data collection to provide an 'evidence-base' to capture the scale and need; training for healthcare staff in both trauma-informed care and in cultural competency/humility; improved clarity around governance and quality assurance structures for interpreting services; improved practical and system supports for patients with additional language needs in accessing healthcare services.

To overcome these challenges, it is imperative that organisations including the Scottish Government, Public Health Scotland, Health and Social Care Partnerships, Health Boards and training institutions – such as Medical Schools and NHS Education for Scotland, third and voluntary sector organisations, general practice and hospital-based services all work together effectively and innovatively. In **identifying tangible actions**, we hope to mitigate language and cultural health inequalities, supporting patients with additional language needs to have equitable access to high quality healthcare.

RECOMMENDATIONS

Equitable funding to drive equitable care

Many of the recommendations below would be enabled by more equitable resourcing of general practices according to the needs of the local populations. This 'proportionate universalism' approach would help to address the existing inverse care law, which states that access to health care is poorest for those who need it the most. Resource includes both direct funding and human resource, i.e. distribution of workforces.

- **Creation of an Enhanced Service for Cultural and Language Health Inequalities** – An enhanced service, although recognised to have limitations, would allow additional funding to be directed to practices to support the significant additional workload that is entailed, facilitate improvements in coding, data collection and reporting, practice processes, design and delivery of care and workforce training. Recognised as an interim measure until workload more effectively resourced through core General Medical Services (GMS) funding.

We would anticipate a key role for Scottish Government and the Scottish General Practice Committee (SGPC) to progress this.

- **Sustainable core funding for community link workers, financial inclusion workers and the third sector** – to enable holistic care and support with navigation of services.

We would anticipate a key role for Scottish Government, local authorities and Integration Joint Boards (IJBs) to progress this.

Enable high-quality data recording and collection

High quality data will drive understanding and quality improvement.

- **Improving data collection within practices to include:**
  - Routine coding of language needs using agreed Read code
  - Routine coding of ethnicity
  - Routine coding when an appointment includes an interpreter

- **Improving and standardising mechanisms within Health Boards and Health and Social Care Partnerships (HSCPs) – for practices to routinely, accurately and easily obtain their own translated appointment data (frequency, volume and languages used).**

We would anticipate a key role for Health Boards to progress these recommendations. This activity could also be part of any Enhanced Service.

Training for health and social care workforces

Training in cultural competency/humility and in interpreter use will improve patient experience and quality of care.

- **Inclusion in undergraduate and postgraduate training curricula.**
- **Incorporation into planned national work around improving health equity training for health and social care workforces.**

We would anticipate a key role for NHS National Education for Scotland (NES), Professional Bodies and Scottish Government (Workforce Directorate) to progress this recommendation.

Improve governance and quality assurance of Interpreting services

- **Greater clarity around current procurement processes for commissioned interpreter services.**
- **Greater clarity around current governance frameworks and quality assurance mechanisms for commissioned interpreter services.**
- **Ensure mechanisms in place to allow feedback from NHS end-users to drive improvement.**
- **Expectation of high-quality training for interpreters working in healthcare settings (including trauma-informed practice) plus ongoing supervision and support for all interpreters working within commissioned services.**

We would anticipate a key role for Health Boards and Healthcare Improvement Scotland (HIS) to progress this recommendation.

Improve system supports for patients

- **Improve the GP registration process** which could include the provision of a private area, the use of an interpreter, and awareness-raising (with practices and with patients) that ID and proof of address are not a pre-requisite to registration. **A separate piece of work should be funded by Scottish Government to improve the registration process for *all* patients struggling to register in general practice.**
- **Improve accessibility of health information for patients -** Provision of high-quality, nationally developed health information in a language and format most appropriate for the patient's cultural and language needs. This should include an explanation of how the NHS works and how to make the best use of it.
- **Improve information sharing between professionals -** Inclusion of language and cultural requirements when communicating between healthcare teams and across interfaces of care. **This could be part of anti-racism plans that are currently being developed in Health Boards.**
- **Improve healthcare appointment systems -** Specific consideration and accommodation of interpreter requirements when allocating appointments and communicating appointment details.
- **Care Navigation support -** Specific consideration of need for navigation support to support patients to be able to make use of the healthcare resources available.

- **Increase accessibility and availability of 'English for Speakers of Other Languages' ESOL (or equivalent) for patients.**

We would anticipate a key role for Scottish Government (Primary Care Division), NHS24 (through the NHS Inform website), Health Board interface groups, local authorities, and general practices to progress this.

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APPENDIX 1 ATTENDEES

Deep End GPs

- **Carey Lunan**, GP and Chair of Scottish Deep End Group
- **David Blane**, GP, Senior Clinical Lecturer and Academic lead for Deep End
- **Lynsay Crawford**, GP and Director of Vocational Studies for COMET scheme
- **Gillian Dames**, GP, Glasgow
- **Anthony McMahon**, GP, Glasgow
- **Laura Montgomery**, GP, Edinburgh
- **Helen Richardson**, GP, Edinburgh
- **Petra Sambale**, GP, Glasgow
- **Andrea Williamson**, GP, Professor of General Practice and Inclusion Health
- **Tara Womersley**, GP, Edinburgh and NES Health Inequality Fellow

Invited others

- **Jamie Dale**, Community link worker for asylum support, the ALLIANCE
- **Felician Francis**, Lived experience of the asylum system and interpreting work
- **Smita Grant**, Minority Ethnic Health Inclusion Service (MEHIS), NHS Lothian
- **Dan Jary**, Lead doctor, Freedom from Torture
- **Rahima Kashim**, Scottish Government Racialised Health Inequalities team
- **Traci Kirkland**, VoiceOver, Govan Community Project
- **Rishma Maina**, Consultant in Public Health, Public Health Scotland
- **Elaine Taylor**, GP Associate Advisor, NHS Education for Scotland
- **Melanie Weldon**, Scottish Government Racialised Health Inequalities team