Royal College of Obstetricians & Gynaecologists

Cross-Cultural Communication and Language Support: Standards for Maternity Care and Women's Health

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Maternity Services Standards Framework: Section 12

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Chapters

Foreword

Professor Ranee Thakar

RCOG President

As President of the Royal College of Obstetricians and Gynaecologists, and as a clinician who has spent many years on the frontline, I am acutely aware that the heart of safe and compassionate care lies in our ability to communicate—clearly, respectfully, and without barriers. Every day, I have witnessed how language can be a bridge to understanding, trust, and healing, or, when absent, a source of confusion, distress, and inequity.

This document, Cross Cultural Communication, is the result of a collective commitment to ensuring that no woman or birthing person is left behind because of the language they speak. It is grounded in the lived experiences of patients and clinicians, in robust evidence, and in the legal and ethical duties that underpin our profession.

Too often, I have seen the consequences when communication fails—when vital information is misunderstood, when consent is not truly informed, or when a woman's voice is lost in translation. These moments are not just clinical risks; they are failures of dignity and justice. Conversely, I have also seen the profound difference that skilled interpreters, culturally sensitive staff, and inclusive systems can make. They transform care, empower families, and restore trust.

The standards set out practical, actionable steps for NHS commissioners, providers, agencies, and interpreters. They call for free access to professional interpreters, robust documentation of language needs, gender-appropriate and culturally safe communication, and clear processes for feedback and informed refusal. They also recognise the opportunities and risks of digital innovation, insisting that technology must always serve,

not supplant, the human connection at the core of care. The true danger of digital technology lies in its potential to amplify the divides we are striving to close.

Above all, this work is a call to action. It is a roadmap for closing equity gaps, reducing harm, and ensuring that every woman and birthing person can be heard, understood, and respected—no matter what language they speak.

I thank Professor Hassan Shehata, RCOG Senior and Global Health Vice President, for his vision and passion and for collaborating with experts to produce this document. My thanks and gratitude extend to all the contributors and the RCOG Centre for Women's Global Health who helped produce these standards which I am proud to present. I urge all who read them—clinicians, commissioners, policymakers, and community members—to join us in making this vision a reality. Together, we can and need to ensure that communication is never a barrier to safe, high-quality care, but a foundation for trust, partnership, and better outcomes for all.

Ranee Thakar
President, RCOG

Professor Hassan Shehata

RCOG Senior and Global Health Vice President

As the lead author of this document, I am pleased to present these standards, which reflect my long-standing commitment to ensuring that language is never a barrier to safe, respectful and equitable care. Throughout my clinical career, I have seen how communication failures can undermine trust, compromise safety and leave women and birthing people feeling unheard. These standards aim to change that by embedding clear, practical expectations across the system—so that communication support is treated as a core clinical need, not an optional extra.

Developed through evidence, expert collaboration and the real experiences of families and clinicians, this framework provides a roadmap for commissioners, providers and interpreters to work together in delivering culturally sensitive, rights-based care. I am grateful to all contributors who helped shape this important work. My hope is that these standards strengthen our collective ability to ensure every woman and birthing person is understood, informed and supported at every stage of their care.

Professor Hassan Shehata
Senior and Global Health Vice President, RCOG

Executive summary

Grounded in human rights (ECHR Articles 8 and 14), the Equality Act 2010, the NHS Constitution and a strong research base, this document reframes cross-cultural communication support as an essential clinical safety function. It sets out system-wide standards to ensure that no woman or birthing person is less safe, less informed or less respected because they do not speak English fluently. It responds to clear evidence that migrant, refugee and ethnically minoritised women and birthing people face higher risks of poor outcomes, and that inadequate communication contributes to delayed diagnosis, obstetric and gynaecological complications, trauma, mistrust and avoidable harm.

The standards are structured across the key parts of the system:

- **Women and birthing people:** rights to free professional interpreters, documentation of language and interpreter preferences, gender-appropriate interpreters in non-emergencies, culturally safe communication, explicitly discourages routine use of family members as interpreters except in life-threatening emergencies and clear processes for informed refusal.
- **NHS commissioners:** Commissioners should embed these standards within existing national levers – including Guidance for Commissioners: Interpreting and Translation Services in Primary Care, the Improvement Framework for community language services, the NHS Standard Contract, the Medium Term Planning Framework and the Strategic Commissioning Framework – so that language support is treated as a core safety, equity and performance issue rather than a peripheral add-on.
- **NHS providers:** duties to deliver 24/7 access to telephone, video and face-to-face interpreting; embed language needs in EPRs and booking systems; allow extended appointment times; train all staff in "working with interpreters"; and link language support directly to risk management, safeguarding and inequality-reduction work.
- **Interpreting agencies:** obligations around vetting, qualifications, safeguarding, information governance, quality assurance, continuity systems and emergency access.
- **Interpreters:** professional standards covering training and registration, confidentiality, impartiality, cultural competence and safety, clear boundaries, safeguarding duties and ongoing professional development and wellbeing.
- **Innovation and digital integration:** cautious, safety-first use of AI and digital tools, restricted to low-risk administrative roles, with explicit prohibition for breaking bad news, safeguarding, consent and other high-risk situations. All tools should operate within strong governance, data-protection and human-in-the-loop accuracy frameworks.

Taken together, these standards provide a practical roadmap for commissioners, providers, agencies and interpreters to reduce harm, close equity gaps and ensure that every word in maternity and neonatal care can be heard, understood and trusted.

Introduction and rationale

Effective communication is a core clinical skill, not an optional extra. For women and birthing people who are migrants, refugees or from ethnically minoritised communities, language barriers sit on top of existing structural racism, social exclusion and poverty, amplifying risk across the perinatal pathway (Kapadia et al., 2022; Draper et al., 2023). These groups already experience higher rates of maternal and perinatal morbidity and mortality, poorer experiences of care and reduced trust in services (Felker et al. 2025, Awe et al.2025, Birthrights 2022). When services fail to provide safe, timely and culturally competent interpreting, inequalities are not only maintained – they are actively deepened.

In England and Wales, almost one in three births are now to women born outside the UK, rising to nearly three in five in London (ONS, 2023). Census data show that of 5.1 million people who do not speak English as a main language, around 20% report that they do not speak English well or at all; applied to the birthing population this equates to approximately 37,000 live births per year where the mother may struggle to communicate without support (ONS, 2022). Yet MacLellan et al. (2024) found that only around 9% of births in responding Trusts were recorded as requiring an interpreter, with women receiving an average of just three interpreted contacts across pregnancy, birth and postnatal care. This gap between need and documented provision is a patient-safety problem and an equity failure.

Improving the completeness and quality of ethnicity and language data is therefore foundational. NHS England's Ethnicity Recording Improvement Plan sets out specific expectations for more accurate and consistent recording of ethnicity, while the Patient Safety Healthcare Inequalities Reduction Framework frames safety-related inequalities as a core focus for systems and providers (NHS England, 2025a; NHS England, 2025b). Embedding language and interpreting indicators alongside ethnicity in these datasets allows commissioners and providers to see where communication failures are contributing to avoidable harm and to act accordingly.

Reports from safety investigators, regulators and third-sector organisations show the consequences of inadequate interpreting for migrant, refugee and ethnically minoritised women and birthing people. HSIB's national maternity programme identified language barriers as a contributing factor in intrapartum stillbirths, with almost half of the women in one review not having English as a first language and variable adherence to guidance on interpreter use (HSIB, 2020). MBRRACE-UK highlighted cases where lack of independent interpreting undermined women's ability to make informed choices and may have contributed to maternal death (Draper et al., 2023). The Sands Listening Project and Birthrights' inquiry into racism in maternity care described women being denied interpreters, asked to rely on partners or children, or told professional interpreting was "too

expensive", with lasting distress when they later realised that what was done to them did not match what they thought they had consented to (Sands, 2023; Birthrights, 2022).

Qualitative and realist evidence has unpacked how poor or absent interpreting leads to delayed diagnosis, obstetric complications, trauma and mistrust. Project20 (Rayment-Jones et al., 2021), co-authored by Sandall and Silverio, showed that when interpreters are unavailable, under-used or of poor quality, women are less likely to disclose risk factors such as domestic abuse, mental health concerns or previous obstetric complications; they may miss appointments, delay seeking help for reduced fetal movements or present late in labour. Bridle et al. (2021) documented midwives' accounts of "navigating women's care without language", describing clinical situations in which the team "couldn't talk to her", struggled to assess pain or labour progress, and worried that consent was not truly informed.

These breakdowns have concrete safety repercussions. Without accurate interpretation, women may not understand the significance of symptoms such as bleeding, ruptured membranes or reduced fetal movements, delaying attendance and diagnosis. In labour, misunderstanding explanations about induction, caesarean section or instrumental birth can lead to refusal of clinically indicated interventions, or conversely, to apparent acquiescence where consent is coerced or poorly informed. Cramer 2017, Karliner et al. 2007, tory of Rana Abdelkarim 2025) A case cited in national investigations describes a woman with "conversational English" who was not offered an interpreter, did not understand written information about "contractions" and "established labour", and presented with obstructed labour, resulting in neonatal brain injury (HSIB, 2020).

Beyond clinical outcomes, inconsistent interpreting damages relationships and trust. Women report feeling "voiceless", dependent on partners, or concern about the accuracy of the interpreted consultation (Crowther et al. 2019, Higgingbottom et al. 2020, Healthwatch England, 2022; Rayment-Jones et al., 2021) MacLellan et al. 2022, Sellevold et al. 2022). Midwives describe moral distress when they cannot be sure that a woman's wishes have been heard or respected (Bridle et al., 2021). Over time, these experiences reinforce community narratives of unsafe, culturally unsafe or discriminatory gynaecology and maternity services, deterring future help-seeking and widening inequities.

Despite clear national guidance – for example from NICE and OHID – evidence shows that services continue to rely on partners, other relatives or untrained bilingual staff as ad-hoc interpreters, particularly in busy clinics and triage settings (OHID, 2021). Women themselves may request family involvement, often due to concerns about confidentiality or lack of choice of interpreter gender or modality (Rayment-Jones et al., 2021; Hadziabdic et al., 2011). However, routine use of family members is associated with omissions, filtering of sensitive information, safeguarding risks and blurred boundaries. Hadziabdic et al. (2011) describe missed diagnoses and mistreatment in primary care linked to misinterpretation, while other qualitative work reports children feeling over-burdened by responsibility for relatives' health decisions (Yick & Daines, 2017). Case analyses from other health systems starkly illustrate how a single mistranslated term can change the entire clinical trajectory:

misinterpretation of one word in a Spanish/English encounter led to a catastrophic misdiagnosis and long-term disability in the widely cited Willie Ramirez case, underlining "the value of a single word" in healthcare communication (Kelly, 2010). The same principle applies in maternity, neonatal and women's health settings, were errors around symptoms, consent or safeguarding can have life-changing consequences.

The ethical and legal case for robust interpreting standards is compelling. Under Article 8 of the European Convention on Human Rights (ECHR), women and birthing people have a right to respect for their private and family life, which includes bodily autonomy, reproductive decision-making and confidentiality. Article 14 prohibits discrimination in the enjoyment of these rights, including discrimination linked to language, ethnicity or migration status (Council of Europe, 1950). Informed consent, as required by common law and professional regulators, depends on being able to understand information about proposed interventions, risks, benefits and alternatives in a language and format that is meaningful to the individual. Failure to provide appropriate interpreting can therefore render consent invalid, breach duties of candour, and in the most serious cases amount to inhuman or degrading treatment when women experience procedures as coerced or incomprehensible.

NHS organisations also have explicit statutory and contractual duties. Under the Equality Act 2010 and the Public Sector Equality Duty, NHS bodies should have due regard to eliminating discrimination and advancing equality of opportunity; this includes taking active steps to remove language-related barriers that disproportionately affect migrant and ethnically minoritised communities (HM Government, 2010). The NHS Constitution, GMC and NMC all emphasise the duty to communicate effectively, support involvement in decisions and respect patients' preferences, values and cultural needs (NHS England, 2021). Existing NHS England guidance on commissioning and the Improvement Framework for community language translation and interpreting services require commissioners and providers to ensure reliable, high-quality interpreting, adequate appointment length, and clear recording of interpreting need (NHS England, 2018; NHS England, 2025).

These standards also sit within a wider national policy context in which communication equity is recognised as integral to quality, safety and inequality reduction. NHS England has issued specific guidance for commissioners on interpreting and translation in primary care and an Improvement Framework for community language, translation and interpreting services, both of which position safe language support as a core responsibility rather than a discretionary add-on (NHS England, 2018; NHS England, 2025c). Alongside the Equality Act 2010 and the NHS Constitution, duties under the NHS Act 2006 and the Health and Social Care Act 2012 require the NHS to make reasonable efforts to involve people in the planning and delivery of services they use. Ensuring that women and birthing people can understand and contribute to those discussions is therefore not only good practice but a legal expectation.

However, current guidance is fragmented and often generic. It does not fully address the specific complexities of gynaecology, maternity and neonatal care – including rapid escalation in emergencies, safeguarding, bereavement, mental health, or the use of

emerging AI-enabled tools. Furthermore, there is currently no existing standard of care across the nation regarding women's health. The Independent Technical Review of qualifications for spoken-language interpreting in the justice sector illustrates the value of a system-level approach, defining qualification levels, competencies, and quality-assurance mechanisms across commissioning, providers and individual interpreters (HM Courts & Tribunals Service & Ministry of Justice, 2025). These standards adapt that logic to gynaecology, maternity and neonatal services: setting out clear, evidence-based standards for women and birthing people's expectations (Chapter 1), NHS commissioners (Chapter 2), providers (Chapter 3), interpreting agencies (Chapter 4), interpreters' professional standards (Chapter 5) and digital innovation (Chapter 6).

Here is an integrated, polished paragraph that incorporates your original evidence-grounding sentence and clearly signals that overarching standards follow at the end of the Introduction:

These standards are grounded in the evidence synthesised by Sands & Tommy's Joint Policy Unit, MBRRACE-UK, HSIB, the NHS Race & Health Observatory and a growing body of qualitative and realist research (Kapadia et al., 2022; HSIB, 2020; Draper et al., 2023; Rayment-Jones et al., 2021; Sands & Tommy's Joint Policy Unit, 2025). They are explicitly rights-based and safety-focused: the aim is that no woman or birthing person's outcome is worsened, and no clinician's practice is compromised, because language support was absent, inadequate or unsafe. The document therefore concludes with a set of overarching standards which apply across all maternity, women's health and neonatal services. These system-wide expectations—covering safety, equity, human rights, governance and the prohibition of unsafe interpreting practices—form the foundation for all subsequent role-specific standards in this document and should be read as universal requirements that underpin commissioning, provider responsibilities, interpreter practice and digital innovation.

1. Women and birthing people

Expectations

Women and birthing people who need language support should not experience a different standard of care from those who are fluent in English. Building on the Sands & Tommy's Joint Policy Unit briefing and national guidance, this section sets out what women and birthing people are entitled to expect from gynaecology, maternity and neonatal services in relation to translation and interpreting (Sands & Tommy's Joint Policy Unit, 2025; NHS England, 2025; MacLellan et al., 2024).

These expectations are grounded in both human rights and domestic law. ECHR Articles 8 and 14 protect private and family life and prohibit discrimination in the enjoyment of other rights; in practice, this means that women and birthing people should be able to understand

and participate in decisions about their care regardless of the language they speak. Duties under the NHS Act 2006 and Health and Social Care Act 2012 require the NHS to make reasonable efforts to involve people in the planning and delivery of services they receive, which cannot be achieved if they are unable to communicate effectively. National guidance for commissioners on interpreting and translation in primary care reinforces that safe language support is a core commissioning responsibility rather than a peripheral service (NHS England, 2018).

At the core is the expectation of free access to professional interpreters and translated information wherever language barriers could affect safety, understanding, consent or experience. This applies across the whole pathway: first contact, antenatal care, scans and screening, intrapartum care, theatre, postnatal and neonatal care, bereavement and general gynaecology. Women and birthing people should not have to "choose" between understanding their care and avoiding financial or social costs. However, FOI data show that this right is often not realised in practice, with MacLellan et al. (2024) finding that interpreter use is recorded for only a small fraction of births despite much higher likely need.

To make rights real, expectations should be translated into clear processes: systematic recording of language needs, proactive offers of interpreters, translated materials, culturally safe communication and timely, extended consultations when interpreting is required. Women and birthing people should be informed, from their earliest contact, not only that they are entitled to interpreters free of charge, but also how to request them, how to give feedback, and what safeguards exist when new technologies such as AI-enabled tools are used (NHS England, 2018; NHS England, 2025).

1.1 Rights and expectations for interpreting services

Ensuring equitable, safe and high-quality maternity and women's healthcare requires that standards of care are comparable for all women and birthing people, regardless of clinical complexity, background or protected characteristics. Central to this is the provision of high-quality translation and interpreting support. National recommendations, including the Sands & Tommy's Joint Policy Unit briefing and NHS England guidance (NHS England, 2025; MacLellan et al., 2024), emphasise that communication support is not an optional addition but an essential component of safe care. Under the NHS Act 2006 and the Health and Social Care Act 2012, services should make reasonable efforts to involve individuals in their care, while human rights legislation—specifically Articles 8 and 14 of the European Convention on Human Rights—confirms the right to personal, informed choice, irrespective of the language a person speaks (Birthrights).

From a rights perspective, access to professional interpreting is therefore not merely supportive but fundamental—it is a precondition for informed consent, shared decision-making and non-discriminatory practice (ECHR Articles 8 and 14; NHS England, 2025).

Language barriers can compromise every dimension of care: patient safety, accurate consent, understanding of risks and benefits, continuity of care, and overall experience.

Clear, consistent and proactive processes should underpin these rights. At first contact—and always by booking—interpreting requirements should be documented comprehensively in the woman's clinical record, including preferred spoken language, dialect, interpreter gender and any literacy considerations. This information should be visible across all maternity and gynaecology services, triggering automatic interpreter booking for planned encounters and ensuring interpreting is offered at every interaction.

Persistent inequalities reinforce the need for robust interpreting provision. Women from global majority backgrounds experience disproportionate risks of maternal and neonatal death (MBRRACE, 2025), and MNSI (2025) highlights that these heightened risks are compounded by communication barriers and lack of accessible information. The MNSI report (2023) identified variable adherence to interpreting guidance, noting that 22% of intrapartum stillbirth cases involved families whose first language was not English. Compliance with the Accessible Information Standard (AIS) and the Patient Safety Healthcare Inequalities Reduction Framework (NHS England, 2025) is therefore critical.

High-quality communication is greatly enhanced when using professionally trained interpreters, with evidence indicating that in-person interpreting often offers the most accurate and effective communication (Hadziabdic et al., 2009, Karliner LS et al. 2007). Women and birthing people should expect that interpreters—whether provided by the NHS or external agencies—are professionally qualified, confidential, and bound to interpret impartially and accurately in alignment with NRPSI, CIOL and NRCPD codes of conduct. Where a woman declines a professional interpreter—commonly due to confidentiality concerns in small communities, prior negative experiences, or a preference for a familiar support person—staff should sensitively explore these reasons and offer alternatives such as telephone interpreting, female interpreters, or interpreters from outside the local area (Hadziabdic et al., 2011; NHS England, 2018). Any decision to decline professional interpreting should be clearly documented, including capacity assessment, risks discussed, who will interpret and when the decision will be reviewed.

Poor communication is not merely inconvenient—it can be traumatic. Birth trauma is often exacerbated when women feel unheard, unable to communicate or excluded from decision-making. Feelings of distress, dismissal and powerlessness can undermine trust and contribute to long-term negative experiences of care (Birthrights, 2024). To provide culturally safe communication, services should schedule extended consultation times when using interpreters, recognising that interpreted encounters may require more time—particularly where complex results, screening decisions or risk-benefit discussions are involved.

Finally, transparency is essential regarding the use of AI-enabled or automated translation tools. Women and birthing people should be informed when such tools are used for low-risk administrative tasks, made aware of their limitations, and reassured that they can request a

trained human interpreter at any time. AI should never be used for consent, safeguarding, breaking bad news or any complex clinical discussion (NHS England, 2025).

Standards – 1.1 Rights and expectations

- **1.1.1** Women and birthing people should be offered professional interpreting and translated information, free at the point of use, for all encounters where language barriers could affect safety, consent, understanding or experience.
- **1.1.2** Interpreting services should be available across all stages of perinatal and women's health care, including antenatal, intrapartum, postnatal, neonatal, bereavement and general gynaecology.
- **1.1.3** Preferred language (including dialect and literacy needs) and interpreter requirements should be recorded at first contact and made visible across all services and settings.
- **1.1.4** Women and birthing people should be informed at first contact and booking of their right to a professional interpreter and how to request one, including for emergency attendances and community or virtual contacts.
- **1.1.5** Women and birthing people should be informed of how to provide feedback or raise concerns about interpreting, including in their own language.
- **1.1.6** Routine use of family members, friends or children as interpreters is discouraged, except in extreme life-threatening emergencies where no professional or approved digital option is immediately available.
- **1.1.7** When a woman or birthing person declines a formal interpreter and prefers family interpreting in non-emergency situations, staff should discuss risks of miscommunication, explore alternatives, and clearly document the decision and review plan.
- **1.1.8** Women and birthing people should be given clear information about any use and limitation of AI-enabled tools in interpreting and translation, and a straightforward route to request a human interpreter instead

1.2 Cultural sensitivity

Expectations around interpreting relate not only to access, but also to how interpreting is delivered. Women and birthing people should be able to expect that both interpreters and staff demonstrate cultural sensitivity, respect for diverse beliefs and family structures, and an awareness of how culture shapes communication. This includes recognising differing ways of expressing pain, distress, fear, sexuality, reproductive health needs and consent—especially for refugee and migrant women who may have experienced war, displacement, trafficking or gender-based violence (Hadziabdic et al., 2011; Mengesha et al., 2018).

Cultural sensitivity is essential for safe communication. Qualitative evidence shows that when cultural norms are dismissed, minimised or pathologized, women may withdraw, provide only minimal answers or defer to partners or relatives, undermining both safety and

autonomy (Hadziabdic et al., 2011; Rayment-Jones et al., 2021). Women and birthing people should therefore expect interpreters to treat their cultural and religious beliefs with respect while still operating within UK safeguarding and legal frameworks. They should feel safe to discuss sensitive topics—including contraception, pregnancy choices, sexuality, FGM, domestic abuse, infertility, miscarriage and loss—without fear of judgement or breach of confidentiality (Mengesha et al., 2018).

Gender of the interpreter

Autonomy regarding interpreter gender is a critical component of culturally safe care. Many women, especially those affected by sexual violence, domestic abuse, FGM, trafficking, honour-based violence or other trauma, may require a **female interpreter** for intimate examinations—such as vaginal examination, abdominal palpation or breastfeeding support—or for conversations relating to sexual and reproductive health. In all non-emergency settings, gender-specific requests should be treated as a reasonable expectation rather than an optional preference. In emergencies, when delay would compromise safety, women and birthing people should receive a clear explanation, and efforts should be made to provide a female interpreter as soon as feasible.

Use of family members and declining professional interpreting

Some women may decline a professional interpreter and prefer to rely on family members, often due to fear of community-level breaches of confidentiality or negative past experiences with services. Others may speak some English yet struggle to understand complex medical terminology (Higginbottom et al 2020). Women and birthing people should be informed that routine use of family members, friends or children is strongly discouraged due to the risks of miscommunication, coercion, omissions and safeguarding failures (OHID, 2021; Migrant and Refugee Health Partnership, 2019). National guidance is explicit: professional interpreters should always be offered, and relatives or children should only be used in exceptional, time-critical emergencies where no professional or approved digital option is immediately available.

In non-emergency settings, staff should explore reasons for declining a professional interpreter, explain specific risks, and offer alternatives such as telephone interpreting, female interpreters or interpreters from outside the local community. Any decision to decline professional interpreting should be clearly documented, including who will interpret, what risks were discussed, assessment of capacity and consent, and plans for review (NHS England, 2018; Hadziabdic et al., 2011).

Quality, safety and feedback

Poor-quality interpreting is itself a patient safety issue. Service-user experience—including concerns about interpreting—is a core part of quality monitoring (Migrant and Refugee Health Partnership, 2019; NHS England, 2018). Approaches to informing, engaging and obtaining feedback from women and birthing people should follow principles set out in

CQC's Health Inequalities Engagement Framework, which emphasises co-design, co-ownership and long-term partnership with communities facing the greatest inequalities (CQC, 2025). Providing translated information about the right to an interpreter, routes for raising concerns and ways to contribute to service improvement is therefore both an equity measure and an integral component of clinical governance.

Use of AI-enabled translation tools

Finally, cultural sensitivity includes transparency about the use and limitations of AI-enabled tools. Women and birthing people should be informed when automated translation or AI-supported tools are used for low-risk tasks such as appointment reminders or signposting and be made aware that these tools may make errors. They should always be reassured that they can request a human interpreter. AI should never be used for breaking unexpected news, consent processes, safeguarding discussions or any complex clinical communication (NHS England, 2025).

Standards – 1.2 Cultural sensitivity

- **1.2.1** Women and birthing people should be able to expect interpreters and staff to be culturally sensitive and respectful of their beliefs, practices and family structures.
- **1.2.2** Interpreting should support open discussion of sexual and reproductive health, FGM, trauma and mental health in a way that is non-judgemental and confidential.
- **1.2.3** In non-emergency settings, women's and birthing people's gender-specific interpreter requirements (e.g. female interpreter) should be respected and treated as a reasonable expectation.
- **1.2.4** Where gender preferences cannot be met because of emergency time pressures, staff should explain the situation, minimise distress and arrange a gender-appropriate interpreter as soon as practicable.

1.3 Timely service

Timeliness is a core component of quality. Women and birthing people should expect interpreting services to be available promptly, minimising delays in assessment and treatment. Long waits for an interpreter, or inadequate time allocated for interpreted consultations, can lead to rushed explanations, unanswered questions and incomplete consent discussions, with direct consequences for both safety and experience (Sands & Tommy's Joint Policy Unit, 2025; Rayment-Jones et al., 2021).

Women and birthing people who do not speak English are also more likely to have complex psychosocial needs, including mental health concerns, experiences of trauma, housing instability and social isolation (NHS England 2025 Improvement framework). These needs can only be identified and supported through holistic assessment and personalised care planning, which reinforces the importance of allowing adequate time for interpreted consultations, such as double-length appointments.

The Supporting Effective Interpretation in Maternity digital toolkit further recommends extended appointments for consultations involving significant information exchange such as anomaly scan follow-ups, diabetes clinics or discussions about birth options after caesarean (Supporting Effective Interpretation within Maternity Digital Toolkit; Sands & Tommy's Joint Policy Unit, 2025).

In urgent and emergency contexts, timely access to interpreters – often via 24/7 telephone or video services – is essential to avoid delays in triage, pain relief, emergency procedures or neonatal resuscitation. Women and birthing people should not experience slower or more fragmented care because of language barriers.

Standards – 1.3 Timely service

- **1.3.1** Women and birthing people should be able to expect interpreting services to be available promptly, minimising delays in assessment, decision-making and treatment.
- **1.3.2** Services should build in additional time for consultations where interpreting is required, for example by offering double-length appointments for complex or high-risk discussions.
- **1.3.3** Urgent and emergency maternity and neonatal services should have rapid access pathways (e.g. 24/7 telephone/video) to interpreters so that language barriers do not delay critical care.

Case examples

Safe, rights-based practice

A 32-year-old woman recently arrived as a refugee attends a booking with limited spoken English and no literacy in English. The community midwife uses a telephone interpreter in her preferred language and dialect, confirms that she prefers a female interpreter and records this in the electronic record, along with "requires interpreters for all contacts". The midwife books slightly extended appointments and ensures that scan, diabetes and safeguarding referrals all flag the interpreting need.

When the woman later attends triage with reduced fetal movements, the midwife immediately contacts the 24/7 telephone interpreting service. The interpreter explains their role, interprets verbatim, and the woman can describe her symptoms clearly and ask questions about CTG and induction. She later reports feeling "safe" and "listened to" and provides positive feedback through a translated survey form. This scenario shows how early documentation, gender-appropriate interpreting, extended consultation time and continuity across services operationalise women's rights and reduce risk, consistent with Sands & Tommy's JPU and national guidance (Sands & Tommy's Joint Policy Unit, 2025; NHS England, 2018).

Unsafe practice

A 25-year-old woman with limited English presents in labour with her partner. No interpreter is booked; staff rely on the partner to interpret. There is no documentation of language needs, capacity assessment or discussion of alternatives. During labour, staff suggest continuous CTG and later an emergency caesarean section; the partner "interprets", and the woman nods but appears distressed and does not ask questions.

Postnatally, she discloses to a health visitor – via a professional interpreter – that she did not understand why she had surgery, thought she was consenting only to "stronger pain relief", and felt pressured by her partner, who had previously opposed a caesarean for cultural reasons. Important information about domestic abuse was never disclosed because the partner was always in the room. This scenario reflects the risks identified in Hadziabdic et al. (2011), Mengesha et al. (2018) and Project20 (Rayment-Jones et al., 2021): filtered information, coerced decisions and significant ethical and safety breaches when family members replace professional interpreters.

Key steps – Women and birthing people expectations

- **Make rights explicit:** Develop standard translated wording and scripts that inform women and birthing people at first contact and booking of their right to free professional interpreting, how to request it, and why family interpreting is discouraged.
- **Fix recording and visibility:** Embed mandatory fields for preferred language, dialect, literacy and interpreter gender preference in booking and triage templates, with EPR alerts to ensure visibility across services.
- **Operationalise gender and culture:** Build gender-specific interpreter options and cultural considerations into booking systems and clinic templates, and ensure staff know how to request female interpreters and extended appointments.
- **Create feedback routes:** Co-produce simple, translated feedback tools (paper and digital) so women and birthing people can comment on interpreting quality, safety and respect in their own language.
- **Support safe refusal conversations:** Train staff to hold structured, non-judgemental conversations when women decline professional interpreting, including how to explore concerns, discuss risks, document informed refusal and plan review.

2. NHS commissioning

Commissioners sit at the apex of the system that either enables or undermines safe, equitable interpreting and translation. They do this through allocating resource and funding and specifying service level commitments from providers. While individual Trusts deliver care, it is integrated care boards (ICBs) and other commissioning bodies that determine whether sufficient, high-quality language support is available, sustainable and governed as a core patient-safety function rather than a discretionary add-on. NHS England's Guidance for Commissioners: Interpreting and Translation Services in Primary Care and the Improvement Framework for community language services both highlight that safe language support is a commissioning responsibility, not a matter for individual clinicians to solve alone (NHS England, 2018; NHS England, 2025c). In maternity, neonatal and women's health care, commissioning decisions directly shape who can access interpreters, at which points in the pathway, and to what standard.

Commissioning that focuses only on headline cost or call volume, without attention to qualification levels, continuity, modality mix, safeguarding and cultural competence, creates a false economy: apparent savings offset by preventable adverse events, complaints, litigation and the human cost of trauma and mistrust. Conversely, robust commissioning frameworks can explicitly align language services with the NHS 10 Year Health Plan for England 2025, the Core20PLUS5 maternity ambitions and local inequality-reduction strategies, ensuring that translation and interpreting are resourced proportionately to population need and clinical risk (NHS England, 2025; Kapadia et al., 2022).

Central to this is a requirement for continuous audit and transparent data flows between providers, agencies and commissioners. Commissioners should not be reliant on ad-hoc FOI requests or one-off reviews to understand the scale and quality of interpreting provision. Building on approaches described in the Sands & Tommy's briefing and by MacLellan et al. (2024), appropriately resourced contracts should require standardised coding of language need and interpreting use in electronic patient records, and regular submission of aggregate data by language, ethnicity, deprivation, service setting and clinical stage (antenatal, intrapartum, postnatal, neonatal). This enables commissioners to identify gaps (for example, high-need languages with low recorded interpreter use), track trends over time, and target quality-improvement support where risk is greatest (Sands & Tommy's Joint Policy Unit, 2025; MacLellan et al., 2024).

To justify funding allocation, commissioners also need to set clear expectations for timeliness, continuity and safety, using key performance indicators (KPIs) that go beyond crude utilisation counts. These might include median time from request to interpreter connection in triage; the percentage of high-risk contacts (such as safeguarding discussions, complex consent, bereavement) supported by professional interpreters; and the proportion of contacts for women with recorded language need where interpreter ID and modality are

documented. Qualitative feedback from women and birthing people should form part of the performance framework, recognising that experiences of dignity, respect and cultural safety are integral to quality (Healthwatch England, 2022; Birthrights, 2022; Sands, 2023).

Commissioners should align their metrics with wider NHS work on healthcare inequalities, including the Ethnicity Recording Improvement Plan and the Patient Safety Healthcare Inequalities Reduction Framework, which both stress the importance of complete, high-quality ethnicity data and targeted action on safety gaps (NHS England, 2025a; NHS England, 2025b). The National Healthcare Inequalities Improvement Programme further frames patient-safety inequalities as a core commissioning concern, not a niche specialty issue (NHS England, 2025b). Including language need, interpreter use and communication-related incidents within these existing frameworks will help ensure that interpreting is treated as part of mainstream safety and inequality-reduction work.

Multi-year planning frameworks also provide a natural home for these standards. The Medium-Term Planning Framework – Delivering change together 2026/27 to 2028/29, the Strategic Commissioning Framework and the NHS Standard Contract all offer levers for embedding communication equity and language support into strategic commissioning and financial plans, rather than relying on short-term, fragmented arrangements (NHS England, 2025c; NHS England, 2025d; NHS England, 2025e). Language support requirements, data flows and KPIs should be explicitly written into contract schedules and planning templates for maternity, neonatal and women's health services.

Finally, commissioning standards should embed meaningful user involvement, governance and accountability. Migrant, refugee and ethnically minoritised communities should be involved in setting priorities, co-designing specifications and reviewing provider performance, not just consulted at the margins. ICBs and other commissioning bodies should designate executive leadership for communication equity, embed language support in board assurance frameworks and risk registers, and ensure that serious incidents, complaints and near-misses involving interpreting are reviewed and acted upon (NHS England, 2018; NHS England, 2025).

2.1 Availability and accessibility

From a commissioning perspective, availability and accessibility mean more than having a contract in place. Commissioners should ensure that women and birthing people can access interpreters when they need them, in a suitable modality, with appropriate gender choices, regardless of where they enter the maternity or neonatal system.

Service specifications should require 24/7 availability of interpreting for maternity and neonatal services, with rapid access for urgent and emergency cases. This typically includes round-the-clock telephone interpreting and the ability to connect to video interpreting for situations where non-verbal cues or visual aids are important (NHS England, 2018; NHS

England, 2025). Contracts should also mandate gender preference options for interpreters in non-emergency contexts, recognising the importance of female interpreters for intimate examinations, safeguarding and trauma-related care.

Commissioners should also plan for rare languages and dialects, not only the most common languages. This may involve establishing contingency arrangements through regional or national interpreter pools, collaboration across ICBs, or access to specialist agencies that can mobilise rare-language interpreters at short notice (Local Government East of England, 2011).

Specifications should require all commissioned providers to record and share preferred language and interpreter requirements in clinical records, so that language needs identified in primary care, community settings or emergency departments are visible to maternity and neonatal teams, and vice versa. The Improvement Framework for community language services emphasises the importance of commissioning end-to-end pathways rather than isolated contracts (NHS England, 2025).

Standards – 2.1 Availability and accessibility

- **2.1.1** Commissioners should ensure contracts provide 24/7 access to interpreting for maternity and neonatal services, with rapid response for urgent and emergency cases.
- **2.1.2** Service specifications should require gender preference options for interpreters in non-emergency contexts and set out how these preferences will be met.
- **2.1.3** Commissioning arrangements should include contingency provision for rare languages and dialects, including access to regional or national interpreter pools.
- **2.1.4** All commissioned providers should be required to record and share women and birthing people's preferred language of communication, dialect and interpreter requirements in clinical records, enabling continuity across services and sectors.

2.2 Training and certification

Commissioners play a pivotal role in shaping the professional landscape for interpreters. While day-to-day training delivery sits with providers and agencies, contracts and frameworks can either incentivise a low-cost, low-skill market or support a qualified, accountable workforce.

Building on the justice sector's Independent Technical Review, commissioners should specify that providers use interpreters who meet minimum qualification and registration standards (e.g. DPSI or equivalent, NRPSI/CIOL/NRCPD registration), and that agencies offer ongoing CPD, maternity-specific training and safeguarding updates (HM Courts & Tribunals Service & Ministry of Justice, 2025). In addition, commissioners are well-placed to support the creation and maintenance of a 'National Register of Community Interpreters' at Levels

3–6, covering frequently used community languages beyond the small number currently represented in national registers.

Commissioning policies should also reference provider obligations around AI-related training: ensuring that staff understand the limits of AI tools and that interpreters are familiar with local governance arrangements and prohibited uses (NHS England, 2025).

Standards – 2.2 Training and certification

- **2.2.1** Commissioning specifications should refer to provider responsibilities for training and certification (as set out in NHS provider standards), including minimum interpreter qualification and registration requirements.
- **2.2.2** Commissioners should support the development and use of a Level 3–6 National Register of Community Interpreters, particularly for high-need maternity languages.

2.3 Service quality monitoring

Quality monitoring is the primary lever by which commissioners can move beyond "having a contract" to assuring performance. Contracts should include explicit obligations for providers and agencies to supply data and participate in audits, and for commissioners to use those data in structured reviews.

Service specifications should mandate regular auditing of interpreter use, timeliness and quality, including spot checks for both human and AI-mediated provision. Commissioners should expect providers to report on coverage (for example, the proportion of bookings with preferred language recorded), access (response times, modality use), and continuity (use of the same interpreter for high-risk or complex cases) (NHS England, 2018; NHS England, 2025).

EPR integration is critical. Commissioners should require systems that allow interpreter ID, language and session data to be captured and shared, so that continuity and gaps can be monitored across providers. Feedback mechanisms should be commissioned that gather and analyse perspectives from both women and birthing people and providers, disaggregated by ethnicity, deprivation and language spoken where possible, in line with inequality-reduction aims (Kapadia et al., 2022; Healthwatch England, 2022).

KPI frameworks should extend beyond activity counts to include impact on safety, outcomes and experience, such as reduced serious incidents where language is a contributory factor, improved understanding of care plans, and satisfaction with privacy and respect. Escalation processes for quality or safeguarding breaches – including contractual levers, remedial action plans and, where necessary, re-commissioning – should be clearly defined in contracts (Local Government East of England, 2011; NHS England, 2025).

Standards – 2.3 Service quality monitoring

- **2.3.1** All interpreting and translation contracts should include clear requirements for regular audit of interpreter use, timeliness, continuity and quality, including spot checks of both human and AI-assisted provision.
- **2.3.2** Commissioners should require EPR-enabled recording and reporting of interpreter ID, language, modality and session data, enabling continuity monitoring.
- **2.3.3** Commissioners should commission mechanisms to gather and analyse feedback from women, birthing people and providers, with results disaggregated by ethnicity, deprivation and language spoken where possible.
- **2.3.4** Providers should be required to measure and report the impact of interpreting and translation on safety, health outcomes and satisfaction, using agreed KPIs.
- **2.3.5** Contracts should include escalation processes for addressing quality, performance or safeguarding breaches relating to interpreting and translation.

2.4 Awareness and promotion

Commissioning is not only about infrastructure; it is also about signal and visibility. Commissioners can use their influence, funding and partnerships to raise awareness that interpreters are a right, not a privilege, and to ensure that women and birthing people know how to access them.

Specifications should require providers to participate in ongoing public awareness campaigns that inform women and birthing people of their right to an interpreter, how to request one and why professional interpreting is safer than relying on family or friends. Commissioners can support this by funding multi-lingual materials, working with local authority and voluntary sector partners, and aligning messaging with other public-health and maternity safety campaigns (NHS England, 2018; OHID, 2021; Sands & Tommy's Joint Policy Unit, 2025).

Standards - 2.4 Awareness and promotion

- **2.4.1** Commissioning arrangements should include requirements for ongoing public awareness activities that inform women and birthing people of their right to free professional interpreting and how to access it.

2.5 Governance and accountability

Robust governance is essential if language support is to be treated as a core safety function rather than a peripheral service. NHS England's Improvement Framework for community language services provides a baseline for what good governance should look like, including strategic alignment, risk management, data flows and user involvement (NHS England, 2025).

Commissioners should adopt this framework as a minimum and ensure that all contracts are explicitly aligned with it. Contracts involving AI-enabled interpreting or translation should require providers and vendors to comply with NHS governance standards for digital clinical safety and data protection, including regular model updating, monitoring for bias, and completion of data protection impact assessments (NHS England, 2025).

At organisational level, there should be director-level leadership and board-level accountability for commissioning and contracting of translation and interpreting services across the ICB's geographic area. This includes ensuring that risks and performance related to language support are visible in board assurance frameworks, quality reports and maternity/neonatal safety dashboards.

Standards - 2.5 Governance and accountability

- **2.5.1** Commissioners should use NHS England's Improvement Framework for Community Language Translation and Interpreting Services as the baseline for commissioning governance.
- **2.5.2** Contracts involving AI-enabled interpreting or translation should require compliance with NHS digital governance, data protection and continuous updating protocols.
- **2.5.3** Commissioning bodies should ensure director-level leadership and board-level accountability for translation and interpreting services across their geographic area.

2.6 Woman and birthing person safety and risk management

From a commissioning standpoint, language support is fundamentally a patient-safety intervention. Specifications should therefore require providers to integrate interpreting into their safeguarding, risk and escalation frameworks, rather than treating it as a parallel system.

Commissioning requirements should state that providers should have clear safeguarding and escalation protocols for situations in which interpreters identify risk of harm – such as FGM, domestic violence, trafficking, forced marriage, self-harm or child protection concerns. Providers should demonstrate that interpreters are trained in safeguarding escalation and statutory referral duties, and that they know how to raise concerns safely (Migrant and Refugee Health Partnership, 2019; Rayment-Jones et al., 2021).

Commissioners should ensure that contracts include robust mechanisms for handling complaints, informal concerns and near-miss incidents involving interpreting errors or omissions. These mechanisms should be accessible to women, birthing people, staff and interpreters themselves, and should feed into both provider-level governance and commissioner oversight (HSIB, 2020; Healthwatch England, 2022).

Evidence suggests that clear communication about interpreter bookings can reduce missed appointments and improve engagement (NHS England, 2018, Supporting Effective

Interpretation within Maternity – Digital Toolkit). Commissioners can therefore require providers to implement systems such as SMS or digital notifications to women and birthing people confirming interpreter booking details, particularly for high-risk or complex appointments.

Standards – 2.6 Woman and birthing person safety and risk management

- **2.6.1** Commissioning specifications should require providers to have clear safeguarding and escalation protocols for situations where interpreters identify risk of harm.
- **2.6.2** Commissioners should ensure that providers have robust mechanisms for handling complaints, informal concerns and near-miss incidents involving interpreting or translation errors.
- **2.6.3** Providers should evidence that staff and interpreters receive training in safeguarding escalation and compliance with statutory referral duties.
- **2.6.4** Providers should be required to implement systems (e.g. SMS notifications) to confirm interpreter bookings to women and birthing people, especially for high-risk or complex appointments.

2.7 Continuous improvement and co-production

Finally, commissioning should be understood as a continuous improvement process, not a one-off procurement exercise. Contracts should embed mechanisms for learning, adaptation and co-production with those most affected by language barriers.

Commissioners should require providers to involve women and birthing people from diverse communities in the design, evaluation and improvement of interpreting services. This may include co-design of materials and pathways, user representation on steering groups and procurement panels, and involvement in incident reviews (Sands & Tommy's Joint Policy Unit, 2025; Kapadia et al., 2022).

ICBs and other commissioners should also fund regular focus groups or advisory panels with women, families and community representatives to shape culturally appropriate approaches and to sense-check whether commissioned services are meeting real-world needs. Commissioning contracts should include mechanisms for annual review and joint learning between providers, commissioners and service users, using audit findings, user feedback and new evidence to refine specifications over time.

This level of co-production is not only good practice but also reflects the legal duty on the NHS to make reasonable efforts to involve people in the design and commissioning of services that affect them, as set out in the NHS Act 2006 and Health and Social Care Act 2012. CQC's Health inequalities engagement framework for ICSs similarly emphasises that tackling inequalities requires structured, sustained engagement with those most affected

(CQC, 2025). Commissioners should therefore resource and formalise involvement of migrant, refugee and ethnically minoritised women and birthing people in specification design, procurement panels and contract review, including via accessible interpreting and reimbursement for participation.

Standards – 2.7 Continuous improvement and co-production

- **2.7.1** Commissioning specifications should require providers to involve women and birthing people from diverse communities in the design, evaluation and improvement of interpreting and translation services.
- **2.7.2** Commissioners should fund regular focus groups or advisory panels with women, families and community representatives to inform culturally appropriate approaches and monitor impact.
- **2.7.3** Contracts should include mechanisms for annual review and joint learning between providers, commissioners and women and birthing people, with clear processes for updating service models and specifications.

Key steps – NHS commissioning

- **Review and realign contracts:** Review existing interpreting and translation contracts against these standards; update specifications to embed maternity-specific requirements, qualification thresholds, safeguarding clauses and AI-governance requirements.
- **Mandate standardised data:** Require standardised EPR coding of language need and interpreter use across all commissioned maternity and neonatal providers and use these data in routine quality reports.
- **Co-produce KPIs and dashboards:** Co-produce KPI dashboards with clinicians, risk teams, community representatives and interpreters; include them in regular ICB board and quality committee reports.
- **Create user panels and advisory groups:** Establish maternity interpreting user panels and community advisory groups, resourcing participation from migrant, refugee and ethnically minoritised communities.
- **Embed governance and escalation:** Ensure director-level leadership and board-level accountability for language support; incorporate interpreting-related risk into board assurance frameworks and inequality-reduction plans.
- **Require annual audit and learning:** Require providers and agencies to submit annual audit reports on safety incidents, complaints, near-misses and user feedback relating to interpreting, with agreed improvement plans and follow-up review.

3. NHS provider requirements

While commissioners set the framework, it is NHS provider organisations – Trusts and Health Boards – that determine whether safe, equitable interpreting is reliably available at the point of care. Providers control the day-to-day systems, staffing, culture and governance that make the difference between "best endeavours" and a consistently safe service. This section outlines the minimum expectations for maternity and neonatal providers around availability and accessibility, workforce training, quality monitoring, cultural competence and awareness, and should be read alongside the digital and AI governance standards in section 12.6 (Sands & Tommy's Joint Policy Unit, 2025; MacLellan et al., 2024; HM Courts & Tribunals Service & Ministry of Justice, 2025).

3.1 Availability and accessibility

Maternity and neonatal care are 24/7 services, and language support should be organised on the same basis. At the point of booking, every woman and birthing person should have a clearly documented preferred language of communication, including dialect, literacy needs and any preference regarding interpreter gender. This information should not sit passively in a single booking entry; it should be visible and actively used across the pathway, appearing on clinic lists, triage screens, ward boards, theatre lists and neonatal handovers so that interpreters can be arranged as a matter of routine rather than at the last minute (NHS England, 2018; MacLellan et al., 2024).

Interpreting support should be reliably available at all times of day and night. Trusts should ensure that telephone interpreting can be accessed 24/7 for urgent and emergency contacts, that video interpreting is available when visual cues or lip-reading are important, and that face-to-face interpreting is routinely offered for high-risk or sensitive encounters such as FGM consultations, safeguarding case conferences, complex consent or bereavement. British Sign Language and other non-spoken language support should be provided on an equal footing with spoken languages, in line with existing best-practice guidance (Association of Sign Language Interpreters, 2018).

Where local language needs are high and predictable, providers should consider employing interpreters directly for the main demographic languages, while maintaining contracts with external agencies for rare languages and surge capacity (Baz et al., 2025; Li, 2025). Experience from Project20 and other qualitative work illustrates that gaps in capacity and continuity at provider level underpin much of the "vicious circle" of delayed help-seeking and poor experience for migrant women (Rayment-Jones et al., 2021; Bridle et al., 2021; Li, 2025). At the same time, bilingual clinical staff should not be treated as an informal substitute for professional interpreters. Their ad-hoc use should be restricted to genuine emergencies in which no other option is immediately available, and they should be

supported to hand back to professional interpreting as soon as possible (Migrant and Refugee Health Partnership, 2019).

When women or birthing people decline the use of a professional interpreter, this should trigger a careful conversation rather than simply being accepted and recorded. Staff should explore underlying concerns – for example fear about confidentiality in small communities, prior negative experiences or a strong wish to involve a partner – and explain the potential clinical and safeguarding risks of relying on untrained family members or friends, which have been repeatedly highlighted in qualitative research and safety reviews (Hadziabdic et al., 2011; Rayment-Jones et al., 2021; Healthwatch England, 2022). Risks and options should be set out in a way that supports genuine choice, and the discussion, decision and review plan should be clearly documented.

Use of AI-enabled tools for interpreting or translation should only occur within a clearly defined Trust policy and risk assessment. Providers should specify where digital tools may be used (for example, low-risk administrative messaging), where they are prohibited (such as consent, safeguarding, breaking bad news), and how human-in-the-loop verification will operate for each language (NHS England, 2025). AI systems should support, not replace, professional interpreters, and women should always be able to opt for a human interpreter without disadvantage, consistent with the cautionary approach recommended in the Supporting Effective Interpretation within Maternity digital toolkit and national digital safety standards (NHS England, 2025).

Standards – 3.1 Availability and accessibility

- **3.1.1** All women and birthing people should have their preferred language of communication (including dialect and literacy needs) documented at booking.
- **3.1.2** Where interpreters are required, this need – including any interpreter gender preference – should be clearly highlighted in documentation and electronic records for all subsequent visits.
- **3.1.3** Interpreter gender preference should be respected in non-emergency contexts; in emergencies, the priority is timely, life-saving care while minimising distress.
- **3.1.4** Women and birthing people who decline use of a formal interpreter should have their reasons explored and be counselled on the risks, including potential negative and life-threatening consequences.
- **3.1.5** Interpreting services should be readily available 24/7, particularly for urgent and emergency situations.
- **3.1.6** Providers should offer a range of interpreting and translation options, including in-person, written, telephone and video; BSL and other non-spoken languages should be provided in parity with spoken languages.
- **3.1.7** Women, birthing people and communities should be actively involved in co-producing and improving interpreting services.

- **3.1.8** Any use of AI tools for interpreting or translation should operate only within clearly defined Trust policy and risk assessment, supported by AI governance SOPs, human-in-the-loop verification and documented use for each language.
- **3.1.9** Providers should explore employing interpreters directly for the main demographic languages, alongside commissioned services.
- **3.1.10** Routine use of bilingual staff as interpreters is discouraged and should be limited to emergency situations; where used, they should be trained in interpretation and familiar with clinical terminology, and hand back to professional interpreters as soon as practicable.
- **3.1.11** Women and birthing people should be informed of the risks of using non-professional interpreters (including family and friends).

3.2 Training and certification

understand the risks involved. Providers are therefore expected to treat training on communication through interpreters as a core element of clinical competence. All staff who interact with women and birthing people – midwives, nurses, obstetricians, neonatologists, anaesthetists, maternity support workers, sonographers, triage and reception staff – should receive structured induction and regular refreshers on when and how to book interpreters, how to conduct an interpreted consultation, and how to respond if language needs are not being met (Migrant and Refugee Health Partnership, 2019; British Psychological Society, 2018).

This training should cover practical skills such as preparing for an interpreted consultation, agreeing ground rules, speaking in the first person, using short segments of speech, checking understanding and allowing time for questions. It should also address how to manage situations where family members insist on interpreting, how to re-establish professional interpreting, and how to escalate concerns about poor-quality or unsafe interpretation, reflecting findings from Project20 and midwives' experience of "not being able to talk to her" when language support is inadequate (Rayment-Jones et al., 2021; Bridle et al., 2021). Legal and ethical principles – including confidentiality, consent, safeguarding duties and documentation standards – should be made explicit, drawing on lessons from HSIB investigations and professional codes (HSIB, 2020; Jidong, 2020; Yick & Daines, 2017).

NHS-employed interpreters, where they exist, should be treated as a defined professional group with clear expectations around qualifications and ongoing development. They should hold appropriate interpreting credentials and receive annual updates in adult and child safeguarding, as well as regular revalidation in line with Trust policy and the minimum standards described in the Independent Technical Review (HM Courts & Tribunals Service & Ministry of Justice, 2025). Maternity- and neonatal-specific training on terminology, local pathways and sensitive areas such as loss, FGM, mental health and domestic abuse is essential, echoing recommendations from Sands, Tommy's and the Race & Health Observatory on tackling intersectional risk (Sands, 2023; Kapadia et al., 2022; Sands & Tommy's Joint Policy Unit, 2025).

Staff and interpreters should also be supported to understand the role and limitations of AI systems. Training should make clear that AI tools may help with some low-risk tasks but cannot be relied upon for safety-critical communication, and that any AI-mediated content used clinically should be subject to human review and local governance as required under NHS digital clinical safety standards (NHS England, 2025).

Standards – 3.2 Training and certification

- **3.2.1** AI systems used for language support should be regularly updated and validated for accuracy and reliability in medical terminology for each language in which they are deployed.
- **3.2.2** Centrally/NHS-employed interpreters should receive yearly safeguarding training (adult and child) and periodic revalidation in line with Trust policy.

3.3 Service quality monitoring

Translation and interpreting should be monitored with the same seriousness as other safety-critical functions such as medicines management or infection control. Providers should ensure that electronic systems can capture the information needed for meaningful oversight. This includes recording language, dialect, literacy needs, interpreter gender preference and whether an interpreter was used at each relevant contact, along with the interpreter's ID, modality and date/time. Standard "interpreter status" fields in triage, clinic, labour, theatre and postnatal documentation will allow teams to see briefly whether professional interpreting was used, declined, or not required (NHS England, 2018; MacLellan et al., 2024).

These data should feed into regular audits across the maternity and neonatal pathway. Providers should be able to see, for example, whether women with identified language needs are being consistently offered interpreters; whether particular services (such as triage, community clinics or neonatal units) have lower rates of documented interpreter use; how long it takes to connect to interpreters in urgent situations; and whether translated information resources are reaching and being used by those who need them. Work by Rayment-Jones et al. (2021), Li (2025) and Baz et al. (2025) suggest that without such systematic monitoring, gaps in offer, uptake and quality remain invisible and inequities persist.

Quality monitoring should not rely on quantitative data alone. Trusts should establish mechanisms for women, birthing people and staff to give feedback about interpreting services, including translated surveys, patient stories and community engagement, as highlighted by Healthwatch, Birthrights and Sands (Healthwatch England, 2022; Birthrights, 2022; Sands, 2023). Concerns about accuracy, impartiality, confidentiality or cultural safety should be easy to raise and should trigger timely review. Sampled reviews or "spot checks" of interpreted encounters, with consent, can help to identify training needs and systemic issues in both human and AI-mediated communication (Yick & Daines, 2017; Jidong, 2020).

Oversight should be anchored in governance. Responsibility for interpreting and translation should sit clearly within existing structures, such as the Chief Nurse portfolio and Quality Committee. Risks and themes should be visible on maternity and neonatal dashboards and risk registers, and serious incidents or complaints should explicitly consider whether language barriers or interpreting practice contributed to what happened (HSIB, 2020; Care Quality Commission, 2023). Where possible, provider-level dashboards and quality reports should mirror indicators used in national programmes such as the Patient Safety Healthcare Inequalities Reduction Framework, so that language-related safety risks and interpreter-use patterns are visible alongside other Core20PLUS5 maternity and women's health priorities (NHS England, 2025b), feeding into the wider Perinatal Quality and Safety Model and local inequality-reduction work (Kapadia et al., 2022; NHS England, 2025).

Standards – 3.3 Service quality monitoring

- **3.3.1** Providers should implement mechanisms to regularly monitor and evaluate the quality of both human and AI interpreting services, including spot checks and case reviews.
- **3.3.2** EPR systems should record interpreter ID, language, modality and session data for all interpreted contacts.
- **3.3.3** Feedback from women, birthing people and health professionals on interpreting services should be routinely collected and used to inform quality improvement.
- **3.3.4** Use of interpreters and dissemination/use of translated educational tools should be regularly audited to confirm that all who need support are being offered appropriate interpreting and translation.
- **3.3.5** Board-level accountability should be established (e.g. Chief Nurse and Quality Committee oversight), with interpreting-related risks and findings feeding into the Perinatal Quality and Safety Model and other escalation pathways.

3.4 Cultural competence and patient safety

Communication through interpreters is inseparable from questions of culture, racism and trauma. Providers should therefore go beyond technical accuracy to create environments in which women and birthing people feel safe, respected and able to speak freely. This means embedding cultural competence, anti-racism and trauma-informed care in local maternity and neonatal strategies, training, supervision and reflective practice, reflecting findings from the NHS Race & Health Observatory and Birthrights' inquiry into systemic racism in maternity care (Kapadia et al., 2022; Birthrights, 2022).

Clinicians should be supported to understand how beliefs about pregnancy, birth, loss, sexuality and family roles differ across cultures, and how this shapes the way women express symptoms, distress and consent. Services should aim, wherever possible, to offer

continuity of interpreter for women with complex psychosocial needs, histories of violence or torture, or safeguarding involvement, so that they do not have to re-tell distressing stories to a new interpreter at each visit. Evidence from Project20 and midwives' accounts suggests that continuity of interpreter improves trust, disclosure and women's sense of safety (Rayment-Jones et al., 2021; Bridle et al., 2021; Mengesha et al., 2018). Private, quiet spaces for interpreted consultations are crucial, particularly when discussing sensitive topics that women may not wish family or community members to overhear.

Alongside these broader commitments, providers should give clear practical guidance on how to run safe interpreted consultations. Longer appointment times should be routinely built into clinic templates for complex or high-risk discussions conducted through an interpreter, in line with the Sands & Tommy's JPU briefing and the Supporting Effective Interpretation within Maternity digital toolkit (Sands & Tommy's Joint Policy Unit, 2025). Clinicians should be encouraged to meet briefly with the interpreter beforehand to clarify aims, identify any particularly sensitive areas and confirm the woman's name, dialect and preferred form of address. During the consultation, they should speak directly to the woman or birthing person, maintain eye contact, use short, jargon-free sentences and pause regularly to allow interpretation and clarification (Migrant and Refugee Health Partnership, 2019; Mengesha et al., 2018).

After challenging encounters – for example, those involving stillbirth, emergency procedures, safeguarding disclosures or significant conflict – both clinicians and interpreters may benefit from a brief debrief. Providers should recognise the emotional impact of this work and ensure that mechanisms exist to identify and respond to vicarious trauma among staff and interpreters, including access to supervision, psychological support and peer discussion (Yick & Daines, 2017; Jidong, 2020; Sands, 2023).

Standards – 3.4 Cultural competence and patient safety

- **3.4.1** Healthcare providers should be trained and supported in cultural competence, anti-racism and trauma-informed care so they can work effectively with interpreters and understand the cultural contexts of the women and birthing people they care for.
- **3.4.2** Guidelines for culturally appropriate care in perinatal and women's health services should be developed, implemented and regularly reviewed.
- **3.4.3** Practical clinical guidance should be in place to support safe interpreted consultations, including: offering double-length appointments; pre-briefing interpreters and checking name, dialect and gender; speaking directly to the woman or birthing person and maintaining eye contact; using short sentences .and allowing clarification pauses; debriefing interpreters after complex or traumatic sessions; and recording interpreter details in the notes at every relevant contact.
- **3.4.4** Providers should monitor for vicarious trauma among interpreters and staff working frequently with interpreted, trauma-related content, and ensure access to appropriate wellbeing and psychological support.

3.5 Awareness and promotion

Interpreting and translation services can only improve safety and experience if women, birthing people and staff know that they exist and understand how to use them. Providers therefore have a responsibility to make language support visible, normalised and easy to access.

Information about the availability of free professional interpreters should be woven through all communication channels: posters and leaflets in key local languages in waiting areas and wards; statements in appointment letters and text reminders; information on Trust websites and patient portals; and verbal explanations at booking and early contacts (NHS England, 2018; OHID, 2021; Healthwatch England, 2022). These messages should make clear that interpreters are free of charge, bound by confidentiality and there to support the woman or birthing person, and that using professional interpreters is safer than relying on family members or friends, echoing themes reported by bereaved and migrant parents in Sands' and Birthrights' work (Sands, 2023; Birthrights, 2022).

Staff-facing information is equally important. Trusts should ensure that clear, concise guidance on how to book interpreters in different settings and at different times of day is readily available – for example, via quick-reference guides in triage and labour ward, intranet pages, and inclusion in induction packs (Migrant and Refugee Health Partnership, 2019; British Psychological Society, 2018). Staff should know which digital tools are approved, what they may and may not be used for, and how to escalate if systems fail or interpreting is not available when clinically required (NHS England, 2025).

Finally, providers should signpost staff to established best-practice resources on working with interpreters, including guidance from the British Psychological Society, the Migrant and Refugee Health Partnership, the Association of Sign Language Interpreters, and the Sands & Tommy's Joint Policy Unit briefing (Association of Sign Language Interpreters, 2018; Migrant and Refugee Health Partnership, 2019; Sands & Tommy's Joint Policy Unit, 2025). Incorporating these into local training and policy will help to ensure a consistent, evidence-informed approach across services.

Standards – 3.5 Awareness and promotion

- **3.5.1** The availability of free interpreting and translation services should be actively promoted to women and birthing people through multiple channels, including leaflets, posters and digital platforms in relevant languages.
- **3.5.2** All staff should be aware of how to access and use interpreting and translation services effectively, including any approved AI-powered tools and other digital communication technologies.
- **3.5.3** Providers should signpost staff to established best-practice resources on working with interpreters (e.g. British Psychological Society, Migrant and Refugee

Health Partnership, ASLI, Sands & Tommy's JPU) and embed these within local guidance, training and induction programmes.

Key steps – NHS provider requirements

- **Map need and capacity:** Review local population language data and current interpreter usage to identify gaps in availability, continuity and modality (telephone, video, face-to-face, BSL).
- **Fix the basics in systems:** Update booking and EPR templates so language, dialect, literacy and interpreter gender preference are mandatory fields, and interpreter status/ID is recorded at every relevant contact.
- **Strengthen access routes:** Produce clear SOPs and quick-reference guides for booking interpreters 24/7 across all maternity and neonatal settings, including rare-language and emergency pathways.
- **Train staff and interpreters:** Implement regular "working with interpreters" training for all staff and annual safeguarding/CPD for any NHS-employed interpreters, including clear messaging on AI limitations.
- **Embed governance and audit:** Add interpreting and translation to risk registers and dashboards; audit offer and use of interpreters and translated materials; act on findings through improvement plans.
- **Make services visible:** Promote free professional interpreting to women and birthing people in key languages, and ensure staff know how – and why – to use it as a core safety intervention, ensure adequate appointment time slots (extra time) when interpreters are required.

4. Language Service Providers (LSPs)

Responsibilities

Language Service Providers, also known as interpreting and translation agencies, who serve as intermediaries between clients and interpreters or translators (Baños, 2025), sit at the operational heart of language support. Even with strong commissioning and clear provider policies (Cambridge, 2001; NHS England, 2018, 2025), safety and equity will be compromised if agencies do not reliably supply appropriately qualified interpreters, robust safeguarding and responsive services tailored to maternity, neonatal and gynaecology care (Li, 2025). The Independent Technical Review for spoken-language interpreting in the justice system makes clear that LSPs are not simply booking offices but quality-critical organisations with explicit responsibilities for vetting, training, governance and assurance (HM Courts & Tribunals Service & Ministry of Justice, 2025). Similarly, NHS England's Improvement Framework for community language services emphasises that providers should be able to evidence qualification standards, governance, performance and user feedback across complex multi-provider markets (NHS England, 2025).

In maternity and neonatal settings, LSPs therefore have a direct role in upholding women's and birthing people's rights under the ECHR (Articles 8 and 14) by ensuring that communication is safe, confidential, non-discriminatory and available when needed. This section describes the minimum expectations of LSPs that supply services to NHS maternity and neonatal providers.

4.1 LSPs – professionalism and safeguarding

LSPs should set and enforce high ethical and safeguarding standards. Interpreters working in maternity and neonatal services are frequently exposed to sensitive information about sexual and reproductive health, pregnancy loss, domestic abuse, FGM, trafficking and mental health (Le Neveu, Berger and Gross, 2020; Rayment-Jones, Harris, et al., 2021; Cull et al., 2022; MacLellan, McNiven and Kenyon, 2024; Li, 2025). Agencies therefore have a duty to ensure that every interpreter they deploy is safe, competent and supported.

At a minimum, LSPs should operate clear codes of conduct requiring confidentiality, impartiality, non-discrimination and professional boundaries, aligned with NRPSI (NRPSI, 2016), ITI (Institute of Translation and Interpreting, 2020), CIOL (Chartered Institute of Linguists, 2022) and NRCPD codes (NRCPD, no date) and with NHS safeguarding expectations (NHS England, 2023). LSPs are responsible for ensuring access to NHS-equivalent mandatory safeguarding training and development at no cost to the interpreter (NHS England, 2018). Safeguarding training (adult and child) should be completed and evidenced before any contact with women, birthing people or babies in maternity and neonatal settings, and refreshed regularly (NHS England, 2018).

Given the complexity of healthcare communication, LSPs should ensure that interpreters providing maternity and neonatal services hold at least a Level 3 Certificate in Community Interpreting (CCI) in healthcare settings, or an equivalent healthcare-specific interpreting qualification (NHS England, 2018; ISO 21998, 2020). This ensures that interpreters possess the specialised knowledge and terminology required for safe communication, while allowing some flexibility across different qualification routes (ISO 21998, 2020). In addition, LSPs should ensure that interpreters receive specific training in **"interpreting in UK healthcare"**, covering NHS structures, maternity/neonatal pathways, consent, capacity, safeguarding and documentation (ISO 21998, 2020)(NHS England, 2018; Baz et al., 2025; Li, 2025).

Women and birthing people should be able to assume that any interpreter provided by an LSP has been properly trained, vetted and briefed, and that the LSP will act promptly if concerns about conduct or competence are raised (NHS England, 2018).

Standards – 4.1 Professionalism and safeguarding

- **4.1.1** LSPs supplying interpreters to maternity, neonatal and gynaecology services should set and enforce high ethical standards, including confidentiality, impartiality, non-discrimination and professional boundaries (NRPSI, 2016; NHS England, 2018; ISO 21998, 2020; NRCPD, no date).

- **4.1.2** LSPs should ensure that all interpreters have access to NHS-equivalent mandatory safeguarding training (adult and child) free of charge, and that such training is completed and evidenced before any contact with women, birthing people or babies.
- **4.1.3** Spoken language interpreters working in maternity and neonatal settings should hold at least a Level 3 Certificate in Community Interpreting (CCI) in healthcare or an equivalent healthcare-specific interpreting qualification; sign language interpreters should have British Sign Language Level 6 or an honours degree in their second language (NHS England, 2018; ISO 21998, 2020).
- **4.1.4** LSPs should provide training in "interpreting in UK healthcare", including maternity and neonatal care, to all interpreters working in these settings. (NHS England, 2018; Baz et al., 2025; Li, 2025).

4.2 Information governance and confidentiality

LSPs handle highly sensitive personal information, whether directly (through interpreters' work) or indirectly (through booking data and call logs). LSPs should therefore meet NHS-equivalent information governance (IG) and confidentiality standards (NHS England, 2018) .

Interpreters should comply with IG requirements and maintain confidentiality in accordance with NHS standards, UK GDPR and the Data Protection Act (NHS England, 2018). LSPs should have clear written policies covering secure storage and transmission of data, restrictions on recording or sharing information, and prohibition of unapproved apps or devices for clinical communication. Where LSPs supply or support digital or AI-enabled tools, they should also comply with relevant digital clinical safety standards (e.g. DCB0129 and DCB0160), ensuring hazards are identified, mitigated and monitored (NHS England, 2025).

NHS England's Improvement Framework recommends that when procuring new translation and interpreting services, commissioners and Trusts explicitly specify qualification and training standards and require that interpreters are registered with recognised professional bodies (e.g. NRPSI, ITI, CIOL, NRCPD) wherever possible (NHS England, 2025). LSPs are responsible for making sure these requirements are met and can be evidenced on request.

Standards – 4.2 Information governance and confidentiality

- **4.2.1** LSPs should ensure that interpreters comply with NHS information-governance requirements and maintain confidentiality in line with UK GDPR and NHS standards (NHS England, 2018).
- **4.2.2** LSPs should have clear IG policies covering secure handling of personal data, restrictions on recording or sharing information, and use of approved systems only.
- **4.2.3** Where LSPs provide or support digital or AI-enabled interpreting tools, they should comply with relevant NHS digital clinical safety and data-protection standards, including DCB0129/DCB0160.

- **4.2.4** LSPs should be able to evidence interpreter registration with recognised professional bodies (e.g. NRPSI, ITI, CIOL, NRCPD) where applicable, and to demonstrate that qualification and training standards specified by commissioners are met.

4.3 LSP responsibilities – qualifications, quality and continuity

Beyond basic professionalism and IG, LSPs have wider responsibilities for ensuring quality, continuity and reliability of interpreting provision (ISO 21998, 2020). Research in maternity services highlights how systemic weaknesses in LSP practices, such as variable qualification standards, lack of continuity, support, and poor communication with providers, contribute to safety risks and structural inequality (Dong et al. 2016, Baz et al., 2025; Li, 2025).

LSPs are responsible for ensuring that all staff and contractors deployed to maternity and neonatal work have obtained at least a Level 3 CCI in healthcare interpreting (or equivalent) and are matched to appropriate roles based on their competence and experience (ISO 21998, 2020). For example, interpreters with more advanced qualifications and experience should be prioritised for high-risk encounters (e.g. safeguarding, complex consent, FGM, bereavement), while less experienced interpreters may be restricted to lower-risk settings under supervision.

Quality assurance should be active and ongoing, not a one-off check at recruitment. LSPs should:

- Monitor accuracy, completeness and professionalism through random or targeted audits of interpreted sessions (with consent), using bilingual supervisors or clinicians.
- Collect structured feedback from women, birthing people and clinicians on clarity, respect, neutrality and perceived safety.
- Track performance metrics such as missed or late assignments, connection times and patterns of concern by language or setting (NHS England, 2025).

Continuity of interpreter is particularly important for women with complex psychosocial needs, trauma histories or safeguarding concerns (Rayment-Jones, Dalrymple, et al., 2021). LSPs should maintain systems that support continuity wherever feasible, for example by flagging women whose care would benefit from continuity and allocating a small, consistent pool of interpreters to them (Rayment-Jones et al., 2021; Mengesha et al., 2018; Baz et al., 2025). This should always be balanced with women's right to request a different interpreter if trust or rapport is lacking.

4.4 Accessibility

Women and birthing people have a right to effective communication at any time of day or night, regardless of where they access care. To uphold this, interpreting providers should be able to supply interpreters 24 hours a day, 7 days a week, with response times that match the urgency of maternity and neonatal care (ECHR Article 8; NHS England, 2018).

This means LSPs should maintain sufficient capacity and operational resilience to meet demand across telephone, video and, where required, in person modalities, including for languages of lesser diffusion and at short notice. Failure to provide timely access to interpreters risks delay in triage and emergency treatment, undermining women's safety and autonomy (Rayment-Jones, Harris, et al., 2021; Cull et al., 2022; Kwan et al., 2023; Li, 2025).

Standards – 4.4 Accessibility

- **4.4.1** Interpreting providers should be able to provide access to interpreters 24 hours a day, 7 days a week, for maternity, neonatal and gynaecology services.
- **4.4.2** LSPs should maintain sufficient capacity across telephone, video and face-to-face modalities to meet agreed response times, including for urgent and emergency contacts.

4.5 Recruitment and hiring

Recruitment is a critical control point for safety and quality. LSPs should evidence **robust vetting and hiring processes**, ensuring that only suitably qualified, safe and competent interpreters are admitted to maternity and neonatal rosters (NHS England, 2018; ISO 21998, 2020).

At a minimum, this includes verification of identity, right to work, enhanced DBS checks, qualification certificates, professional registration (where applicable), safeguarding training and references. Where these processes are not currently in place, commissioners and providers should mandate them in contracts and retain audit rights to inspect vetting records (HM Courts & Tribunals Service & Ministry of Justice, 2025; Baz et al., 2025; NHS England, 2025).

LSPs should keep up-to-date rosters that clearly indicate each interpreter's languages, dialects, qualification level, healthcare experience and any restrictions on work (e.g. not to be deployed for safeguarding or FGM consultations). This allows providers to book safely and ensures that high-risk work is allocated only to those with appropriate competence.

Standards – 4.5 Recruitment and hiring

- **4.5.1** LSPs should operate robust recruitment and vetting processes, including verification of identity, right to work, enhanced DBS checks, qualifications, safeguarding training and references for all interpreters.
- **4.5.2** LSPs should maintain up-to-date rosters showing each interpreter's languages, dialects, qualification level, healthcare experience and any work restrictions.
- **4.5.3** LSPs should accept commissioner and provider audit of recruitment and vetting records and address any deficiencies through agreed action plans.

Key steps – LSPs

- **Tighten vetting and qualifications:** Review recruitment and vetting policies to ensure all maternity/neonatal interpreters hold at least Level 3 CCI (or equivalent), have current safeguarding training, and have undergone full DBS and right-to-work checks.
- **Strengthen safeguarding and IG:** Update codes of conduct, safeguarding policies and IG procedures so they explicitly reflect NHS safeguarding guidance, UK GDPR and digital clinical safety standards, and ensure all interpreters are trained and signed up to them.
- **Build a visible quality-assurance system:** Establish routine audits of interpreted sessions (with consent), collect structured user and staff feedback, and create performance dashboards tracking timeliness, reliability, complaints and compliments.
- **Implement continuity flags and rostering:** Introduce systems to flag women and birthing people who would benefit from continuity of interpreter and adjust rostering to offer consistent interpreters where possible.
- **Guarantee 24/7 access:** Stress-test 24/7 coverage through joint exercises with maternity and neonatal units, ensuring agreed response times can be met, including for rare languages and sudden surges in demand.
- **Support external scrutiny and learning:** Engage constructively with commissioner and provider audits, share de-identified learning from incidents and complaints, and use findings to drive continuous improvement in interpreter recruitment, training and deployment.

5. Interpreters

Professional standards

Interpreters are central to whether women and birthing people understand their choices. Professional bodies such as the spoken language register and voluntary regulator NRPSI, the British Sign Language (BSL) regulator and registers NRCPD, and the institutes (CIOL and ITI) set out core principles of accuracy, confidentiality, impartiality and competence for professional qualified public service interpreters.

Evidence shows that professional interpreting is clearly superior to lay interpreting in terms of safety and accuracy, with calls for professional remote interpreting rather than ad-hoc arrangements (Gerger et al., 2025). Qualitative studies underline the risks when professional standards are not upheld women feeling “voiceless”, misrepresented or silenced; family

members filtering information; and interpreters themselves struggling with vicarious trauma (Mengesha et al., 2018; Jidong et al., 2020; Yick & Daines, 2017).

This section translates high-level professional codes into concrete expectations for interpreters in maternity and neonatal care.

5.1 Registration, training and safeguarding

Interpreters in maternity and neonatal services should be fully trained and qualified. The minimum qualification is a Level 3 Certificate in Community Interpreting. Until a regulator is established for Level 3 interpreters, commissioners are encouraged to carry out a physical check of qualifications with interpreting agencies contracted to deliver service languages.

The preferred qualification is a Level 6 Diploma in Public Service Interpreting (DPSI) or a Level 6 Diploma in Community Interpreting.

Standards – 5.1 Registration, training and safeguarding

- **5.1.1** Interpreters should be registered with and regulated by the National Register of Public Service Interpreters (NRPSI) and/or be suitably qualified in at least Level 3 Certificate of Community Interpreting (CCI).
- **5.1.2** Where interpreters have not already had their security clearances checked by NRPSI, they should undergo appropriate checks and clearance in line with Disclosure and Barring Service (DBS) guidelines. Commissioners are encouraged to carry out a physical check of those documents with interpreting agencies if the interpreter has not already been vetted by NRPSI.
- **5.1.3** If not registered with NRPSI and not holding a Level 3 Certificate of Community Interpreting (CCI), then interpreters can be found in the membership of recognised professional institutes such as CIOL or ITI, but their public service interpreting experience should be checked and validated.

As a minimum, spoken-language interpreters should:

- **5.1.4** Have completed mandatory safeguarding training for both children and adults, in line with NHS organisational standards, with evidence of regular refreshers (NHS England, 2023).
- **5.1.5** Understand the Mental Capacity Act and be able to interpret accurately and neutrally in capacity assessments while maintaining boundaries – supporting the person to make their own decision rather than steering it.
- **5.1.6** Domain-specific knowledge is also essential. Interpreters should understand basic obstetric and neonatal concepts (e.g. induction, pre-eclampsia, fetal movements, caesarean section, FGM, stillbirth, neonatal intensive care), the structure of UK maternity services, and the legal framework around consent and safeguarding. Without adequate training, lay interpreters may use everyday expressions that distort meaning (for example, describing induction as ‘forcing the

baby out') with predictable impact on fear, refusal and mistrust (Mengesha et al., 2018).

For British Sign Language (BSL), interpreters should have achieved BSL Level 6 or an honours degree in their sign language and be registered with the National Registers of Communication Professionals working with Deaf and Deafblind people (NRCPD).

5.2 Confidentiality

Confidentiality is a cornerstone of professional interpreting, explicitly set out in the Code of Professional Conduct guiding professional interpreting practitioners.

"Trust is paramount - the clinician's trust of the interpreter with the language, the interpreter's trust of the clinician's understanding of the cultural issues and taking the right clinical direction and the client's trust in both by simply opening up" (Annmarie Fox 'An interpreter's perspective' 2001). This is achieved when interpreters adhere to the Code of Professional Conduct's principal tenets.

Interpreters should protect the woman's, birthing person's and healthcare provider's privacy, guaranteeing that no information obtained through interpreting work will be disclosed, except when legally required. Information obtained during or in connection with interpreting work should not be disclosed to family, community members or others, except where there is a legal or safeguarding requirement.

Confidentiality includes the interpreter's handling of data and ensuring that all interactions, from face to face, to over the telephone or video, are conducted in a secure environment and cannot be overheard or interrupted.

Standards – 5.2 Confidentiality

- **5.2.1** Interpreters should maintain strict confidentiality about all information gained during assignments, sharing it only with the clinical team as necessary for care and safeguarding.
- **5.2.2** Interpreters should not disclose information to family members, community contacts or on social media, even if they believe "everyone already knows".
- **5.2.3** At the start of consultations, interpreters should explain to women and birthing people that anything said in their role as interpreter will be shared with the healthcare provider and clarify the limits of confidentiality.

5.3 Impartiality

In maternity care, impartiality is frequently tested: interpreters may share language, culture or religion with the woman and her family, and may hold strong personal views on contraception, termination, FGM, caesarean section or gender roles (Santamaria Ciordia, 2017).

Interpreters should make it clear that anything shared with them in their capacity as an interpreter during the consultation will be relayed to the healthcare professional and to the woman as part of the clinical conversation. The role is not that of a private confidant; it is to facilitate impartial communication between the woman and the clinical team.

Interpreters are permitted, and expected, to intervene briefly if they believe a miscommunication has occurred or require clarification, signalling this clearly to both parties (BACP, 2016; Santamaria Ciordia, 2017).

Research with refugee and migrant women has shown that fears about interpreters 'talking in the community' are a major barrier to using professional interpreting services; explicitly explaining confidentiality obligations can reassure women and improve uptake (Jidong et al., 2020; Yick & Daines, 2017).

Interpreters shall not align themselves with partners or elders, thus minimising a woman's expressed preferences, or discouraging disclosure of domestic abuse because "this is a family matter" (Mengesha et al., 2018; Rayment-Jones et al., 2021).

Standards – 5.3 Impartiality

- **5.3.1** Interpreters should remain neutral and unbiased, interpreting accurately without adding, omitting or altering content according to personal beliefs or loyalties.
- **5.3.2** Interpreters should not provide personal opinions, advice or counselling about clinical decisions; they should encourage women and birthing people to direct questions to the healthcare professional.
- **5.3.3** If miscommunication is suspected, interpreters may briefly intervene to seek clarification, making their intervention explicit to both parties and then resuming neutral interpreting.
- **5.3.4** Where a woman appears not to understand what has been interpreted, clinicians retain responsibility for checking and supporting understanding.

5.4 Respect

Interpreters should consistently use respectful forms of address, avoid derogatory or stigmatising terms, and be sensitive to how women and birthing people wish to be described. This includes respect for partners, families and clinicians. Interpreters should not make disparaging comments/ asides, as these are often picked up, be it tone or body language.

Respect also means recognising the power imbalance inherent in clinical settings. Many migrant and refugee women associate hospitals with previous trauma or persecution.

Standards – 5.4 Respect

- **5.4.1** Interpreters should treat all parties with respect, recognising the inherent dignity of women and birthing people, their families and healthcare providers.
- **5.4.2** Interpreters should use respectful language and avoid derogatory, stigmatising or mocking comments or behaviour.
- **5.4.3** Interpreters should be sensitive to preferred forms of address and identity and adapt their language accordingly.

5.5 Cultural awareness and cultural safety

Where interpreters perceive a cultural barrier or misunderstanding that risks harm, they have a responsibility to alert the appropriate parties. Interpreters should not become gatekeepers, filtering what women say or colluding in harmful norms (e.g. minimising FGM as 'just tradition').

Studies of maternity interpreting highlight that interpreters often recognise subtle expressions of distress that clinicians might miss; when interpreters are supported to raise concerns appropriately, opportunities for support are increased (Jidong et al., 2020; Rayment-Jones et al., 2021).

Standards – 5.5 Cultural awareness and cultural safety

- **5.5.1** Interpreters should be aware of cultural nuances and their own biases, ensuring these do not interfere with the interpreting process.
- **5.5.2** Interpreters may, when necessary, briefly explain cultural nuances or potential misunderstandings, clearly signalling when they are adding cultural context rather than interpreting verbatim.
- **5.5.3** Interpreters should alert the healthcare team if they believe a cultural barrier, misunderstanding or prejudice – including their own – poses a risk to the woman or birthing person.
- **5.5.4** Interpreters should not reinforce harmful cultural norms or minimise practices that breach human rights or UK law (e.g. FGM, domestic abuse).

5.6 Role boundaries, responsibilities and professional development

Interpreters should avoid stepping outside their specific role by providing personal opinions, advice or counselling to women, birthing people or providers. All interpreting, including face to face, telephone and video, should be conducted in a secure environment where conversations cannot be overheard or interrupted, in line with professional and IG guidance (ITI Code section 2.4; Rayment-Jones et al., 2021).

Interpreters may be the first to hear disclosures about domestic abuse, exploitation, trafficking, FGM or self-harm. They should know how to respond; listening without judgement, explaining that they cannot keep such information secret if someone is at risk, and promptly sharing concerns with the appropriate professional or safeguarding lead (Migrant and Refugee Health Partnership, 2019; NHS England, 2023).

Standards – 5.6 Role boundaries, safeguarding and professional development

- **5.6.1** Interpreters should maintain clear professional role boundaries, introducing themselves and explaining their role at the start of each assignment.
- **5.6.2** Interpreters should not provide personal opinions or counselling, accept inappropriate gifts or develop dual relationships that compromise impartiality.
- **5.6.3** All telephone and video interpreting should be conducted in a secure environment where conversations cannot be overheard or interrupted.
- **5.6.4** Interpreters should understand and fulfil safeguarding responsibilities, promptly escalating concerns about abuse, exploitation or risk of harm via agreed pathways.
- **5.6.5** Interpreters should engage in ongoing professional development related to maternity, neonatal care, mental health and safeguarding, and should have access to supervision or debriefing to manage the emotional impact of their work.

Key steps – Interpreters' professional standards

- **Align roles with standards:** Agencies and providers should update interpreter role descriptions, contracts and handbooks to reflect these standards, including qualification, registration, confidentiality, impartiality, cultural safety and safeguarding expectations.
- **Joint training with clinicians:** Develop joint training modules for interpreters and maternity/neonatal teams on terminology, consent, capacity, safeguarding, cultural safety and trauma-informed practice, using case examples from local incidents and research.
- **Embed codes and guidance:** Ensure NRPSI, CIOL/ITI and NRCPD codes, along with local safeguarding and IG policies, are shared with all interpreters and regularly revisited in supervision and CPD.
- **Create safe feedback and support structures:** Establish accessible pathways for interpreters to seek supervision or debriefing after distressing sessions, and to raise concerns about unsafe practice without fear of reprisal.
- **Use user feedback for learning:** Incorporate feedback from women, birthing people and staff about interpreting (including respect, clarity and cultural safety) into interpreters' appraisals and CPD planning, and into service-level quality improvement.

6. Innovation and digital integration

Digital and AI-enabled tools are transforming how health services communicate. Automated text messaging, patient portals, machine translation and, increasingly, large language models all offer apparent solutions to longstanding capacity and access problems. For gynaecology, maternity and neonatal services, these tools can help reach women and birthing people in multiple languages, provide reminders and signposting, and support staff in preparing translated information. However, they also bring risks: inaccurate translations, hidden bias, opaque decision-making and threats to privacy. In the context of pregnancy, birth and early parenthood – where communication is often complex, emotionally charged and safety-critical – those risks are magnified.

Digital and health literacy are essential when translating health information for diverse communities as is cultural awareness. Many people face barriers in understanding written and spoken health information, and an increasing amount of care now relies on digital access—booking appointments, navigating online forms, or judging whether information found on the internet is trustworthy. The Health Literacy Toolkit highlights how low literacy, limited digital confidence, language barriers, and lack of access to devices or the internet can exclude individuals from care. Ensuring information is written in plain language, culturally appropriate, accessible across platforms, and supported by "universal precautions" such as Teach-Back helps us reach all communities fairly and effectively.

The Sands & Tommy's JPU and independent technical reviews emphasise that digital tools should augment, not replace human communication and professional interpreting (Sands & Tommy's Joint Policy Unit, 2025). Automated systems cannot reliably handle the nuance of safeguarding conversations, mental health disclosure, consent for invasive procedures or bereavement care. Errors in these contexts can lead not only to distress and mistrust but also to serious harm. At the same time, there is legitimate scope to use digital tools for low-risk, standardised communication when embedded in robust governance frameworks and overseen by humans with appropriate language and clinical expertise (NHS England, 2025).

6.1 Digital and AI standards

Digital and AI solutions used for language support in maternity and neonatal care should be treated as **clinical tools**, not just IT products. This means that – like medicines, devices or clinical pathways – they require evidence of effectiveness, ongoing evaluation and clear indications and contraindications.

Before deployment, all digital and AI solutions used for translation or interpreting support should be **medically validated for accuracy.** Validation should include testing across target languages and dialects in use locally, in realistic gynaecology/maternity/neonatal scenarios,

and should involve bilingual clinicians and/or professional interpreters. A single "demo" or general benchmark is not sufficient.

Once in use, these tools should be regularly evaluated for:

- **Clinical accuracy and safety** – Are key terms, risks and instructions correctly conveyed?
- **Equity of access** – Are tools available across devices, languages and formats for different groups, or are some women systematically excluded?
- **Alignment with women's and birthing people's preferences** – Are digital modes offered as options, not imposed, and can women easily choose a human interpreter instead?
- **Regulatory conformance** – does the tool comply with data protection and GDPR requirements, information security standards and any relevant NHS compliance standards?
- **User experience** – is the tool intuitive (easy to use), responsive (speed of use), and reliable (up time)?

Crucially, AI-enabled tools should only be used in **low-risk, non-clinical or pre-clinical contexts**, such as:

- Appointment reminders and practical information (time, location, transport, how to change or cancel).
- Standard signposting to trusted, human-validated translated resources (e.g. national leaflets, videos).
- Internal, staff-facing tools to draft translations that are always checked and corrected by a competent bilingual professional before use.
- Collecting routine feedback via simple survey questions, where misunderstanding is unlikely to cause immediate harm and human clarification is available.

Women and birthing people should be informed whenever automated translations are used, and reassured that they can ask for clarification through a professional interpreter.

- Conversely, some uses of AI or general machine translation should be **prohibited** because error or nuance loss is unacceptable. This includes, but is not limited to:
- Breaking bad news or discussing serious diagnoses (e.g. fetal anomaly, stillbirth, neonatal brain injury).
- Consent for procedures or treatments with material risks (e.g. induction, caesarean section, instrumental birth, surgery, blood transfusion).
- Safeguarding assessments, including domestic abuse, FGM, trafficking, honour-based abuse and child protection.
- Mental health, suicide or self-harm assessments.
- Capacity assessments under the Mental Capacity Act.
- Complex complaint handling and formal investigations.

In these contexts, women and birthing people should have access to professional interpreters (telephone, video or face-to-face, as appropriate). AI tools may at most support clinicians behind the scenes (e.g. as drafting aids), but final communication should be mediated by a trained human interpreter.

All AI-powered tools should adhere to NHS standards on clinical safety, equality and confidentiality, including appropriate control of data usage and clear statements to women about how their information will be handled (Translation services & technology in public sector organisations (FOI study) 2023, Full report: Evidence review of use of AI in the public sector 2025, Data of the project TS&TECH@PSO(FOI) - NHS trusts 2025).

Standards – 6.1 Digital and AI standards

- **6.1.1** All digital and AI solutions used for translation or interpreting support in maternity; neonatal and gynaecology services should be medically validated for accuracy before deployment in clinical settings.
- **6.1.2** Digital and AI solutions should be subject to regular evaluation for clinical accuracy, equity of access and alignment with women's and birthing people's preferences.
- **6.1.3** AI-powered tools may only be used in low-risk, non-clinical or administrative contexts (e.g. reminders, signposting, staff drafts) and never as substitutes for professional interpreters in high-risk clinical communication.
- **6.1.4** AI and general machine translation should not be used for breaking bad news, discussing serious diagnoses, obtaining consent, conducting safeguarding or mental health assessments, or undertaking capacity assessments; professional interpreters are required in these contexts.
- **6.1.5** Women and birthing people should be clearly informed whenever digital or AI tools are used to communicate with them and should always have the option to use a human interpreter.
- **6.1.6** AI-powered tools should adhere to NHS standards on confidentiality and data usage and should not use women's data for secondary purposes (e.g. model training, marketing) without explicit approval.

6.2 Governance and data protection

Innovation should sit inside a strong governance and data-protection framework. Trusts and ICBs remain accountable for ensuring that AI and digital tools used for language support meet NHS safety, privacy and equality standards, even when these tools are supplied by external vendors.

Use of AI systems should comply with local and national policies, UK GDPR and the Data Protection Act. This includes completing Data Protection Impact Assessments (DPIAs) for any system that processes personal data, with explicit consideration of:

- Where data are stored and processed (vendor data location, including any transfers outside the UK/EEA).
- Compliance with the NHS Data Security and Protection Toolkit (DSPT).
- Encryption of data in transit and at rest.
- Data retention schedules and deletion processes.
- Audit logs capturing access, changes and system actions.
- Clear opt-in/opt-out options for women and birthing people.
- Explicit prohibition of secondary data use (e.g. training commercial models) without informed consent.

Conversations and text processed by AI should be encrypted and stored securely, and only for as long as necessary. Women and birthing people should have transparent information about what is stored, for what purpose, and how they can access or delete their data.

Digital and AI tools should also be assessed against relevant international standards, for example:

- ISO 27001 for information security.
- ISO 17100:2015 for translation services quality.
- ISO 18587:2017 for post-editing of machine translation.
- ISO 5060:2024 for evaluation of translation quality.

Vendors should be able to demonstrate compliance or alignment with these standards as part of procurement.

AI and digital tools should be regularly audited and monitored for security and functional vulnerabilities, including bias or differential performance across languages and groups. Any issues identified should be addressed promptly through patching, configuration changes or – where necessary – withdrawal of the tool. Digital clinical safety standards such as DCB0129 and DCB0160 provide a framework for identifying hazards and mitigating them (NHS England, 2025).

Standards – 6.2 Governance and data protection

- **6.2.1** All AI and digital tools used for language support should comply with local and national policies, UK GDPR, the Data Protection Act and NHS information-governance requirements.
- **6.2.2** DPIAs should be completed and kept up to date for all AI and digital tools processing personal data, covering data location, DSPT compliance, encryption, retention, audit logs, opt-out mechanisms and secondary data use.
- **6.2.3** Conversations and data processed by AI should be encrypted in transit and at rest, stored securely, and retained only for defined periods consistent with DPIA and clinical-need decisions.
- **6.2.4** Women and birthing people should be offered clear opt-in/opt-out choices for AI processing of their data and should not be disadvantaged for choosing to opt out.

- **6.2.5** Vendors supplying AI and digital translation tools should demonstrate compliance or strong alignment with relevant international standards (e.g. ISO 27001, 17100, 18587, 5060) and NHS digital clinical safety standards (e.g. DCB0129, DCB0160).
- **6.2.6** AI and digital tools should be regularly audited and monitored for security, functional performance and bias, with prompt remediation or withdrawal where risks are identified.

Key steps – Innovation and digital integration

- Map and risk-assess tools: Conduct a baseline inventory of all digital and AI tools used for translation and interpreting support in maternity, neonatal and gynaecology services; ensure validation and effectiveness evidence is provided, identify where they are being used in high-risk contexts and cease inappropriate use.
- Define a clear local policy: Develop or update a Trust-wide policy on AI and digital interpretation and translation, specifying permitted and prohibited uses, validation requirements, human-in-the-loop expectations and how women can opt out.
- Complete and maintain DPIAs: Ensure DPIAs are completed for all relevant tools, explicitly addressing data location, DSPT, encryption, retention, audit logs, opt-out and secondary data-use safeguards; update vendor contracts accordingly.
- Set up clinical accuracy audits: Establish a regular audit programme where bilingual clinicians or professional interpreters review samples of AI-generated or machine-translated content for accuracy, tone and cultural safety across multiple languages.
- Train staff and inform women: Train staff on the strengths and limits of AI tools, how to explain these to women and birthing people, and when they should switch to professional interpreters; develop simple, translated information for women on how AI is used.
- Embed oversight in governance: Integrate AI and digital translation risks into existing digital safety, IG and clinical governance structures, with regular reporting to quality and safety committees and clear lines of accountability.

7. Conclusion and future directions

These standards are built on a straightforward premise: no woman or birthing person should be less safe, less informed or less respected because they do not speak English fluently. Across Sections 1–6, interpreting and translation have been framed not as optional "extras" but as core components of clinical safety, legal and ethical compliance, and respectful, personalised care in maternity, neonatal and women's health services. Where language support is weak or inconsistent, inequalities widen, consent is undermined and trust is eroded; where it is robust, women and birthing people can participate fully in decisions, disclose risk and experience services as safe, dignified and fair (Rayment-Jones et al., 2021; MacLellan et al., 2024; Li, 2025).

Realising this vision requires a whole-system approach. Women and birthing people should know and be able to exercise their rights to professional interpreters, gender-appropriate and culturally safe communication, and clear routes for feedback across maternity, neonatal and wider women's health pathways. Commissioners should design and fund interpreting and translation services that are fit for purpose, with explicit requirements spanning maternity, gynaecology, sexual and reproductive health and early pregnancy care, underpinned by robust data flows, measurable KPIs and co-produced specifications (NHS England, 2018; NHS England, 2025; Sands & Tommy's Joint Policy Unit, 2025). Providers should embed language support into everyday booking, triage, clinic templates, theatre lists, emergency gynaecology and ambulatory care, staffing models and governance, rather than relying on ad-hoc workarounds.

Interpreting and translation agencies should operate to high standards of vetting, safeguarding, quality assurance and continuity for all services they support, including early pregnancy units, colposcopy, fertility, menopause and sexual health clinics. Individual interpreters should uphold rigorous professional standards of training, registration, confidentiality, impartiality, cultural safety, safeguarding and self-care, recognising the emotional and ethical complexity not only of maternity and neonatal work but also of wider women's health contexts such as pregnancy loss, cancer, chronic pelvic pain, FGM and sexual trauma (NRPSI, 2022; ITI, 2022; Jidong et al., 2020).

None of this will be achieved by policy alone. Genuine partnership with communities and frontline staff is essential. Migrant, refugee and ethnically minoritised women and birthing people – and the organisations that represent them – are experts in the barriers they face and in the solutions that feel safe and acceptable across the life course, from adolescence to post-menopause (Kapadia et al., 2022; Sands & Tommy's Joint Policy Unit, 2025). Midwives, obstetricians, gynaecologists, neonatologists, anaesthetists, sexual and reproductive health clinicians, nurses, health visitors, GPs, doulas and interpreters understand where systems currently fail in day-to-day practice and what practical changes are needed. Future steps

and refinement of these standards should therefore be co-designed, tested and evaluated with those most affected, rather than imposed in a top-down manner.

Looking forward, digital innovation and AI will continue to reshape the communication landscape across maternity, neonatal and women's health services. Used well, digital tools can extend reach, standardise access to high-quality translated information, support self-management and reduce some workload pressures. Used poorly, they risk amplifying existing biases, normalising unsafe shortcuts and creating new privacy and safety hazards. The standards in Section 6 are deliberately cautious: they define clear red lines for prohibited uses, require human-in-the-loop verification and mandate strong governance and data protection (NHS England, 2025). As evidence and technology evolve, these boundaries should be revisited through transparent, multidisciplinary processes – but the foundational principles of safety, dignity, equity and transparency should remain non-negotiable.

Ultimately, these standards are not an end point but a shared roadmap. Future iterations of these standards should continue to align with national frameworks on inequalities, data and commissioning, including the Ethnicity Recording Improvement Plan, the Patient Safety Healthcare Inequalities Reduction Framework, the Medium-Term Planning Framework and the Strategic Commissioning Framework (NHS England, 2025a; NHS England, 2025b; NHS England, 2025d; NHS England, 2025e). This will help ensure that communication equity is not treated as a standalone initiative but as an integral part of how systems plan, commission and improve maternity, neonatal and women's health services. They provide a common language and structure for improving practice, reducing harm and closing equity gaps across commissioning, provision, agency practice, interpreting and digital innovation in maternity, neonatal and women's health care. Their impact will depend on sustained leadership, resources, monitoring and, above all, a collective commitment to ensuring that every word spoken in these services can be heard, understood and trusted by every woman and birthing person, in every language.

- **Standard 7.1**

  All organisations involved in maternity, neonatal and women's health care should treat safe, equitable communication – including access to professional interpreters and translated information – as a core quality and safety priority, on a par with other clinical risk domains.

- **Standard 7.2**

  The development, implementation and review of interpreting and translation services should be co-produced with migrant, refugee and ethnically minoritised women and birthing people, frontline staff and interpreters, across maternity, neonatal and wider women's health services.

- **Standard 7.3**

  Digital and AI-enabled tools used for language support in maternity, neonatal and women's health care should be developed, deployed and reviewed in line with the principles of safety, dignity, equity and transparency, with regular reassessment as evidence and technology evolve.

- **Standard 7.4**

  These standards should be incorporated into local policies, training, audit and governance frameworks across maternity, neonatal and women's health services, and reviewed at least every three to five years – or sooner where major new evidence, technologies or regulatory changes emerge.

Key steps – Conclusion and future directions

- **Formally adopt** these standards at commissioner, provider, agency and interpreting-service level, and map current practice across maternity, neonatal and women's health services against them to identify priority gaps.
- **Establish or strengthen multi-agency,** community-informed steering groups – including women and birthing people, interpreters and frontline staff from maternity, neonatal, gynaecology and sexual and reproductive health – to oversee implementation, monitoring and periodic revision.
- **Integrate** communication equity and safe interpreting into existing safety, inequality-reduction and digital-transformation programmes spanning maternity, neonatal and women's health care.
- **Develop shared audit and reporting frameworks** so that data on language need, interpreter use, continuity, safety incidents, complaints and user experience across maternity, neonatal and women's health services routinely inform quality-improvement work.
- **Invest in ongoing evaluation and research** – including qualitative work with women, birthing people, staff and interpreters – to refine standards over time and respond to emerging evidence and technologies, particularly in relation to AI and digital tools, across the full spectrum of women's health.

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