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Language provisions in Manchester Royal Infirmary

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Introduction

We were interested in how the English public services deal with the demands of a growing non-English speaking population in Manchester, specifically within such important sectors as healthcare. The Manchester Royal Infirmary has a policy of enabling everyone to communicate regardless of language barriers. It has therefore set up a number of provisions to this end, which we will investigate in this project. The 2011 population census, which we will use as reference for figures throughout this piece, shows that Manchester, UK's second biggest city, has one of the largest cultural and ethnic minorities, with 8% of the population not listing English as their main language (16.6% in Manchester proper). It is the first time that the ONS (Office for National Statistics) includes detailed questions about main language and English proficiency in their census. As the ONS writes in their report, "The data also helps local authorities to target, deliver and facilitate the provision of public services, for example, to help identify the need for translation and the interpretation for providing English language lessons » (3) However, we will analyse and take into account the possible inaccuracies of the figures put forth by the ONS, as there seems to be a few discrepancies between the official numbers and the reported reality of Manchester's language communities. The biggest language communities in Manchester are Polish, Punjabi, Urdu, Bengali and Gujarati, which reflects the reality of the linguistic situation in England — albeit with a slightly higher percentage of South Asian languages (3.3%) than in the rest of England (2.5%) —.

Our field research at the MRI covers all types of provisions for LEP (Limited English Proficiency) patients, including interpretation services, multilingual signs, advertisements, leaflets, religious literature in the Multi-Faith Centre etc. Our report will focus on qualitative analyses of the interviews we conducted (both on patients and staff members) and quantitative analyses of the figures we have gathered, in connection with the hospital's policy choices about the aforementioned provisions. Do their choices of language catering rely on the ONS' data or on their own statistics about patients and language needs? If the latter, how do they adapt the offer accordingly? What is the perception of LEP patients?

Research Questions

- How does the Manchester Royal Infirmary cater for the language needs of a growing population of non-English speaking (LEP) patients? Does the offer provided by the MRI meet those multilingual communication demands?
- How do the interpretation services compare to official UN (WHO) guidelines and the various situations examined in the literature (1)?

A Brief Introduction to the MRI

The MRI was founded in 1752 and is a leading centre in cardiology and haematology. The Central Manchester and Manchester Children's Hospital Trust (CMMC Trust) was created as a replacement to the Central Manchester Health Care Trust (CMHT) on April 1st, 2001, making it the largest trust in the UK. CMMC consists of the Manchester Royal Infirmary, the Royal Eye Hospital, the Royal Manchester Children's Hospital, St. Mary's Hospital for Women and Children, and the Dental Hospital. CMMC comprises a number of inner city wards with up to 40% of the population being ethnic minorities. The multilingual nature of the city's population is well recognised with more than 40 languages spoken.

In England, the NHS doesn't offer standardised interpretation services, which

leads to situations where ad hoc interpreters are used. According to a study on ad hoc interpreters (mostly bilingual nurses or family members) conducted by Elderkin-Thompson et al. (2001), 66.1% of segments in which translation should have occurred were translated with substantial errors or omissions or were not translated at all, with potential clinical. These results prompted the CMMC Trust to develop the "Linkworkers service" in the mid-1990s, with the aim of providing contact between patients and staff in addition to interpretation services. This service, which then morphed into the current Interpretation and Translation Services (ITS) is advertised on most of the hospital's leaflets (see Annex 1 and 2), in the most used languages according to the Linkworkers audit conducted between 1998 and 2003 (and with one additional language, Hindi).

The ITS is composed of 6 permanent interpreters who work as full-time hospital staff and cover the following language categories: Bengali, Urdu/Punjabi/Hindi, Somali, Polish, Arabic/Kurdish, and Mandarin/Cantonese. Nine "bank interpreters" cover the following languages: two for Bengali, two for Urdu/Punjabi, two for Mandarin/Cantonese, one for Vietnamese, one for Farsi and one for Somali. They are freelance interpreters without a fixed contract with the hospital, and when the in-house can't meet the demand, they outsource to the bank interpreters and, as a last resort (and for languages not covered by the staff), to external agencies.

The complete list of languages provided by the ITS staff is as follows: Arabic, Bengali, Cantonese, Farsi, Hindi, Kurdish, Mandarin, Polish, Punjabi, Somali, Urdu and Vietnamese.

An interpreter training programme has recently been set up by NHS to ensure that all ITS interpreters know clearly about their responsibilities and attitudes. Two of the important policies taught through the training programme are especially worth noticing. One is that interpreters are supposed to translate every single sentence/phrase uttered in the consulting room, including patients' complaints. Therefore, what the three Chinese-English interpreters would always do is to clearly tell the patients to leave their complaints outside the consulting room, or otherwise everything will be translated. The other is called "safeguarding policy" according to the interpreters: sometimes patients would complain about child/woman abuse with their interpreters but tell them not to inform doctors; in such cases interpreters will have to inform doctors about the abuse even though it is "against" the patients' will. Interpreters, as well as doctors and nurses, are supposed to strive hard to ensure patients' health and safety.

Most interpreters were hired at the time of the Linkworkers service, in the 1980s and 1990s, and were not required to have any academic specialization in hospital interpretation. However, around 1999, the NHS started to organize courses for the interpreters to be formally qualified. These included a twenty-two-month course in medical terminology and occasional "updates", or workshops on new terminology.

Methods

We have been to the MRI to do an in situ observation of the various wings (Manchester Royal Infirmary, the Royal Eye Hospital, the Royal Manchester Children's Hospital, St. Mary's Hospital for Women and Children, and the Dental Hospital) of the Hospital to collect or photograph the various tokens of multilingual information we could find. In addition, we followed several of the interpreters of the Interpretation and Translation Service (ITS) to observe the actual practices and, where possible, to interview the patients to get an idea of the patients' opinions about the services provided. The patient's consent was always asked before the consultation (no patient has denied us observation) and of course, before interviewing them.

Our methods differed from our original fieldwork plan insofar as we didn't have any idea how the ITS worked and therefore had to handle the research on a day-to-day basis as well as adapt our questionnaires to the patients we were seeing. It is the nature of hospital interpretation that didn't allow us to establish any set goals with the interviews or the number of patients we were going to see.

We conducted semi-structured interviews, focusing on patients' satisfaction and on how they came into contact with the ITS, as well as on the general perception of the service. The questions were as follows (with a limited amount of options not to impose on the patients and always in accordance with the hospital's privacy policy):

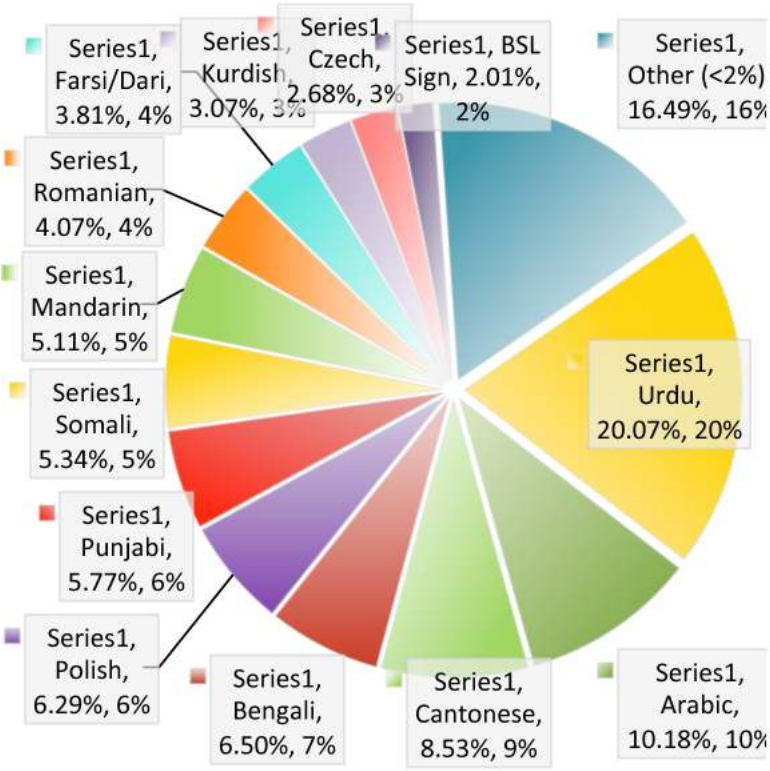
- Are you happy with the interpretation provided?


Like


Indifferent


Dislike

- How did you come in contact with the ITS?
  - > I signed up for it myself
  - > My GP signed me up for it
  - > My family signed me up for interpretation
  - > The nurses/ hospital reception requested automatically



The answers to all these questions will be closely examined at the end of the next section.

A Statistical Overview

We have been given access to the Interpretation and Translation Services' data about all the interpreting jobs carried out in the year 2012 (The graph shows the main languages required and the percentage of interpretation jobs they represented in 2012. We didn't include the languages that made up less than 2% of the jobs, but it is worth noting that they account for 68 of the 81 languages represented).

Field Research Report

We have analyzed this data in detail and in relation to the current speech communities in Manchester (data from the 2011 Census by the Office for National Statistics). We have found that the policy decisions of the ITS department (in terms of language provisions), however, are based solely on the numbers (and the general trends) observed within the MRI, not tailored according the number of speakers of any given language in Manchester.

The IT Services

The IT Services, which are advertised with the same paragraph on the back of all leaflets found in the hospital (picture at the right, Annex 1 and Annex 2), are therefore representative of the percentage of interpreting jobs (graph in the paragraph below): among the

Translation and Interpretation Service

Do you have difficulty speaking or understanding English?

আপনি কি ইংরেজীতে বুঝতে কিংবা বুঝাতে প্রেরেছেন ? (BENGALI)
क्या आपको अंग्रेज़ी बोलने या समझने में कठिनाई है ? (HINDI)
તમે ભાષા કારણે વાતચીત કરવામાં મુશ્કેલી આવે છે ? (GUJARATI)
ਕਿ ਤੁਹਾਨੂੰ ਅੰਗ੍ਰੇਜ਼ੀ ਬੋਲਣ ਜਾਂ ਸਮਝਣ ਵਿਚ ਦਿੱਕਤ ਹੈ ? (PUNJABI)
Miyey ku adagtahay inaad ku hadasho Ingriisida aad sahamto (SOMALI)
هل لديك مشاكل في فهم اوالتكلم باللغة الأنجليزية ؟ (ARABIC)
你有困難講英語或明白英語嗎？ (CANTONESE)
کیا آپکو انگریزی سمجھنے اور سمجھانے میں دقت پیش آتی ہے ؟ (URDU)

☎ 0161 276 6202/6342

most in-demand languages at ITS, they feature (in order of importance): Urdu, Arabic, Cantonese, Bengali, Punjabi, Somali. It is worth noting that the leaflet also includes Gujarati (1.01% of interpreting jobs in 2012) and Hindi (0.33% of jobs), which are minor languages at the ITS. The ad leaves out Polish and Mandarin entirely, even though they represent 6% and 5% of the interpretation jobs respectively. This might be because the ad dates back to the founding of the IT services and the numbers might have been different then. It is still well targeted to the concerned speakers.

Multilingual Advertising

We could find only one occurrence of multilingual advertising (excluding the IT services). It was a triptych of boards in the Audiology department (Annex 3), in English, Hindi and Arabic, about hearing loss. Surprisingly, none of the boards giving directions to the various parts of the hospital were available in another language. Only the "Multi-Faith Center", which included a Christian chapel as well as praying rooms and changing rooms for practicing Muslim patients, had the names of lavatories and changing rooms in Arabic (Arabic alphabet) and Farsi (in transcribed European script) (Annex 4). The Farsi word is actually an Arabic word (Since 1979 and the Islamisation in Iran, the Iranian vocabulary has taken on loads of Arabic words. Farsi also uses: وضو for lavatory). Perhaps surprisingly, the Muslim section displayed no information in Hindi, Urdu or any South- or South-Eastern Asian language at all (The South-East of Asia has the biggest population of Muslims in the world and 90% of the world's Muslims do not speak Arabic as their main language). The Multi-Faith Chapel also provides a few copies of the Quran in Arabic (Annex 5).

In one case, the patient was an elderly lady in her seventies accompanied by her son-in-law who had good English proficiency. During the whole meeting, the son-in-law was trying to replace the interpreter by translating the doctor's words even before the doctor finished speaking, as well as answering questions on behalf of his mother-in-law. Shockingly, when the doctor asked the patient "Do you think you can manage one more pill after each meal", her son-in-law immediately answered "Yes!" on her behalf. In this critical moment, the interpreter managed to make herself heard and told them with a smile "Confusions arise when everyone is trying to speak. Please let the doctor and the patient speak first, and then I'll translate. Thanks so very much" (the utterance was originally in Cantonese and this was our translation), which was the professional attitude to adopt.

Investigating the reality of hospital interpretation

The bulk of our research consisted in following the interpreters' during the various consultations. What emerges from our observations is that there is a certain discrepancy between the official interpretation policy and the reality of day-to-day work. The hospital's policy is to avoid ad hoc interpretation as much as possible (it has been documented in the literature as an ineffective, limited and potentially dangerous practice) and as for the actual interpretation, the guidelines are to strictly interpret word-for-word, without omitting and editing information. The account of Patient 1's consultation goes to show that, as one might expect, the interpreters do have a certain margin within which to operate. However, if they do sometimes edit the doctor's words (when instructed to do so by the doctor), they never omit any information given by the patients. Therefore, they must also interpret any offensive, critical or even aggressive expressions (e.g. the report on Bawan, following page).

Patient: Patient 1 (name not disclosed)

During Patient 1's consultation, it could be perceived that the personnel in the hospital were aware of the importance of health interpretation and how to act when an interpreter was required. The doctor made eye contact with the patient, instead of exclusively with the interpreter, to make the patient feel listened (Baker et al., 1998). An important factor was also the good doctor-interpreter relationship: Patient 1 explained to the doctor that her GP said she should not increase the dose even if she still feels pain. The doctor disagreed and said there was no problem in increasing the dose but Patient 1 insisted on what the GP told her. In that moment, the doctor said to the interpreter "that's rubbish, there's no problem in increasing the dose" and right after "but don't translate that to her". Later on the interpreter made me know that she did not translate that sentence although she always translates word by word, as it is what she learnt in the courses she attended for becoming a Health Care Interpreter. Then we had to go to a different room where a nurse described Patient 1 how to do some exercises to help her recover from her disease. The nurse also looked at Patient 1 while she was talking but as time went by she started to pay more attention to the interpreter. At the end of the consultation, Patient 1 was given a paper explaining the exercises but interestingly it was in English because they do not have papers in more languages.

Thanks to Qianru's proficiency with the languages in question, we manage to find out that the three professional "Chinese/Mandarin to English" interpreters did indeed "act as messengers and provide line-by-line interpretation". Haynes (2011) outlines in her interviews that not all words had a direct one-to-one translation in meaning and

connotation, and that interpreters often struggled to translate a certain word. This is true and our interpreters did have a few moments when they struggled to find a correct word/phrase or to correctly construct the sentence. However, both patients and doctors understood the importance of correct translation and were patient enough to wait for only a few more seconds. Haynes also noted in her report that some interpreters would often participate in a conversation with patients in Vietnamese for two minutes but translate for health practitioners in two sentences. We also noticed this phenomenon. Nevertheless, it was not because "much was omitted" as Haynes inferred, but that patients were not able to fully understand what the sentences meant probably because of the long professional medical terms or slow response (among the elderly, for example), and thus interpreters would have to either slowly repeat the sentences or provide quick explanations.

The ITS is clearly not able to cover all the interpretation requests, even of Chinese. Some of the requests are for community jobs requiring interpreters to go out of the hospital, which consumes time and energy; therefore, ITS usually leave these requests with private agencies.

When we inquired about why the MRI doesn't recruit more in-house interpreters to meet more of the demand, it was explained to us that providing interpreter services is a

Patient : 10 year old boy (had leukaemia for 3 years)
Interpreter : Kurdish-Arabic

The patient's mother (who doesn't speak English) complained a lot about the MRI services and clearly trusted the interpreter much more than the nurses or the doctors. While waiting for the patient's blood test results, the interpreter was interacting with him more as a social worker or almost as a friend asking him about his school activities, but also if things were going better for him because he had troubles to get along with the other kids at school.
We had to wait at least for one hour and a half to get the boy's blood results but the nurses had to take another blood test because the first one was not conclusive. At that time the boy's mom was very angry at the nurses and clearly expressed her discontent to the interpreter.
The interpreter interpreted exactly what the boy's mom was saying, including all the criticism.
With the doctor, there was no real interaction between him and the boy's mother; basically the interpreter was the link between both of them : when the boy's mom had a question or a remark to make the interpreter would translate it to the doctor and vice versa. The doctor asked about the boy's condition since their last appointment, the boy had several times some fevers and no appetite.
Even with an interpreter, there were still some misunderstandings about the last appointment about the medicine : apparently, the boy's mom was supposed to let the hospital know whenever her son would have a high fever, which she didn't do, but she explained to the interpreter she had called the MRI and they told her something different from what the doctor said. So it was indeed a misunderstanding.

big expense as the hospital is self-sustained, and that recruiting means staff management. The Chinese interpreter answered it with a question: "If you are the head of NHS and you are given a certain amount of money, would you use it to bring in more interpreters or to improve medical condition?"

In the case of a Mandarin-speaking patient who was very late to his appointment, the interpreter explained that interpreters are supposed to wait for at least half an hour according to rules and regulations, and that afterwards they are free to go. In such cases, they note down "DNA" which stands for "Do Not Attend" on the time sheets (for records of the period of time spent on interpretation job, used by bank staff only) and still get paid. However, long waiting time has always been a great concern for interpreters – request time is usually shorter than actual service time, which to a certain extent leads to inefficiency and unnecessary expenditure. They could attend to more requests instead of handing over to agencies if not for the time spent in queue.

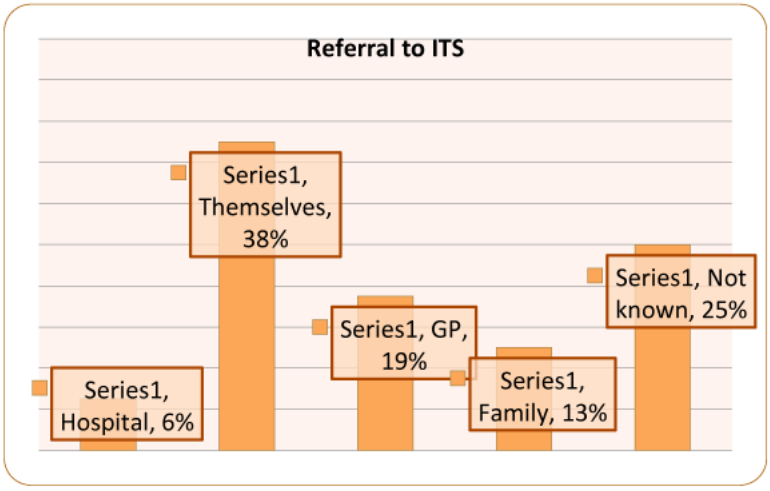
We have also realized that there is a grey area of ad hoc interpretation. In one case, we overheard this interesting conversation between a patient and a nurse which indicated the existence and helpfulness of bilingual doctors: A patient asked in poor English why she wasn't given an interpreter. The nurse went away and came back, saying: "The doctor actually speaks Urdu. So you don't need any interpreter." It appears then that when making his appointment, the reception staff of this particular ward, knowing he would be seeing an Urdu-speaking doctor, didn't require an interpreter. On the other hand some doctors at the MRI prefer to call an interpreter even if they can speak the foreign language. There is no official attitude concerning bilingual doctors, and it would seem practical and economic considerations overrule the need for an official interpreter in those cases.

It also happens that no IT services are provided for post-care. Usually, after a consultation, the interpreter takes the time to translate prescriptions and the "directions for use" leaflets included with medication. In one case, the Mandarin/Cantonese interpreter happened to come across a young man she had previously interpreted for. As he hadn't been provided with interpretation this time, she quickly sent an online request for his next appointment and translated his prescription for him. This particular anecdote led us to believe that interpretation is far from being guaranteed for an LEP patient at any given appointment. Unfortunately, the only way to gather numbers would be to perform an audit directly with the MRI doctors and to monitor exactly how often they see patients who they feel should have interpretation when they don't.

While it was not mentioned in the literature, the interpreters must also be familiar with hospital practices. Interpreters (and us, as we followed them) had to wash their hands with a special product because they go to different areas in the hospital and it is

crucial to disinfect hands in order to avoid nosocomial infections and spreading diseases to different zones.

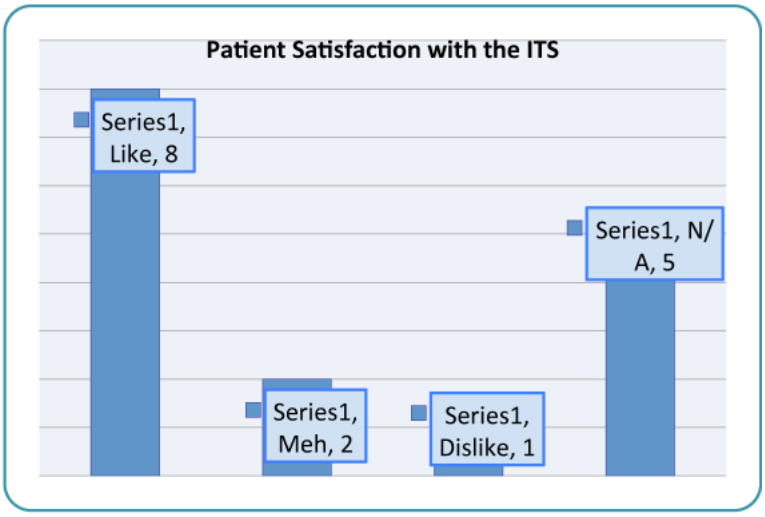
It must be pointed out as well that the Urdu/Hindi/Punjabi interpreters, even if not regarded officially, quite often translate into Mirpuri. The non-official interpretation of this language may be due to the dialect status of this language.



Referral to the IT Services

The most common form of asking for an interpreter was for the patient to ask himself (38%). Usually they do so when they make the appointment online or by phone as they can directly specify that they require an interpreter. The second most recurring case is referral by the patient's GP (19%). Family members asking for interpretation on behalf of the patient account for 13% of ITS referrals (usually when the patient is elderly or has some degree of incapacity). Families sometimes are overprotective and think they can interpret better than any professional as they will watch over their relatives' feelings and wishes (i.e. ad hoc interpretation). On the other hand it may be the case that some families cannot speak English. In any case there has been an increasing awareness of the negative facts of ad hoc interpretation and the usefulness of a Hospital Interpreter.

The least recurrent way is the hospital automatically requiring interpretation (6%). This might be because there are not many patients who arrive to the hospital without any sort of appointment.



Patient Satisfaction

As shown in the graph

(plain numbers, out of 16 respondents), the majority (50%) of the patients said they were very happy with the interpretation provided, saying that they were extremely satisfied with the interpretation services provided. Our Chinese group mate was able to directly ask the patients herself as she had access to Mandarin and Cantonese, which ensured the authenticity of the information. However, because we did not speak or understand the other service languages and we used interpreters to help get answers for the satisfaction survey, we don't deny that the results might be slightly skewed. Nevertheless, we did observe that all those patients who were satisfied with the service seemed genuinely grateful and happy after diagnosis and treatment.

Two out of the sixteen patients graded 5 for evaluation, saying that they were neither satisfied nor dissatisfied. But we were not in the position to ask for further reasons as the interpreters, who obviously did not like the answers, were interpreting for us.

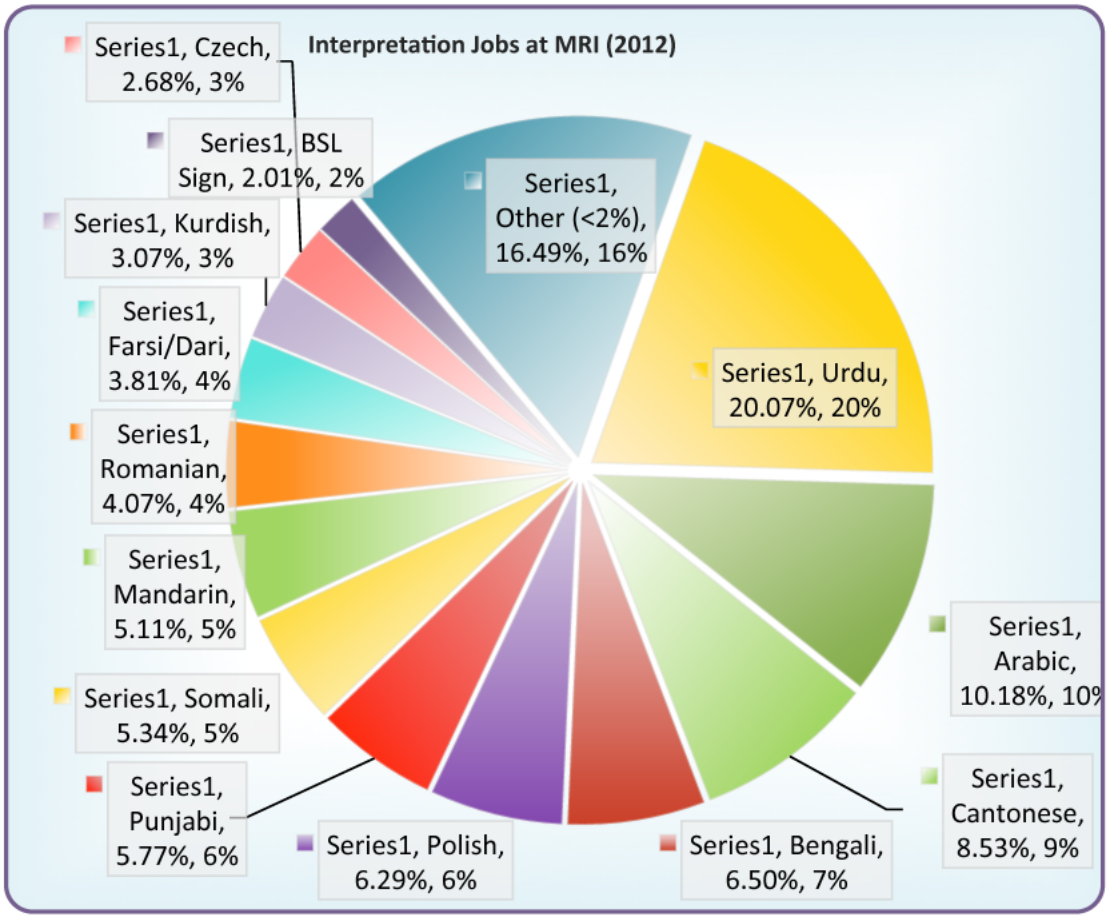
The figure for "dislike" (one out of sixteen) was obtained in an interesting way – we did not see the patient and got the information from the allocated interpreter. She told us that when she arrived at the requested location, the patient told her that he did not want or need an interpreter. She, however, due to regulations, had to accompany him into the consulting room because she had to work according to interpretation service requests. During the whole meeting, the patient was not listening to her although he himself did not speak good English at all, which upset her very much. Therefore, we could safely infer from the narrative that this particular patient did not like the service.

It is not shocking that we did not get the answers from five patients (31%). Three of them left immediately after consultation and thus we did not get the chance to interview them. One of them refused to answer the question possibly due to concerns of privacy.

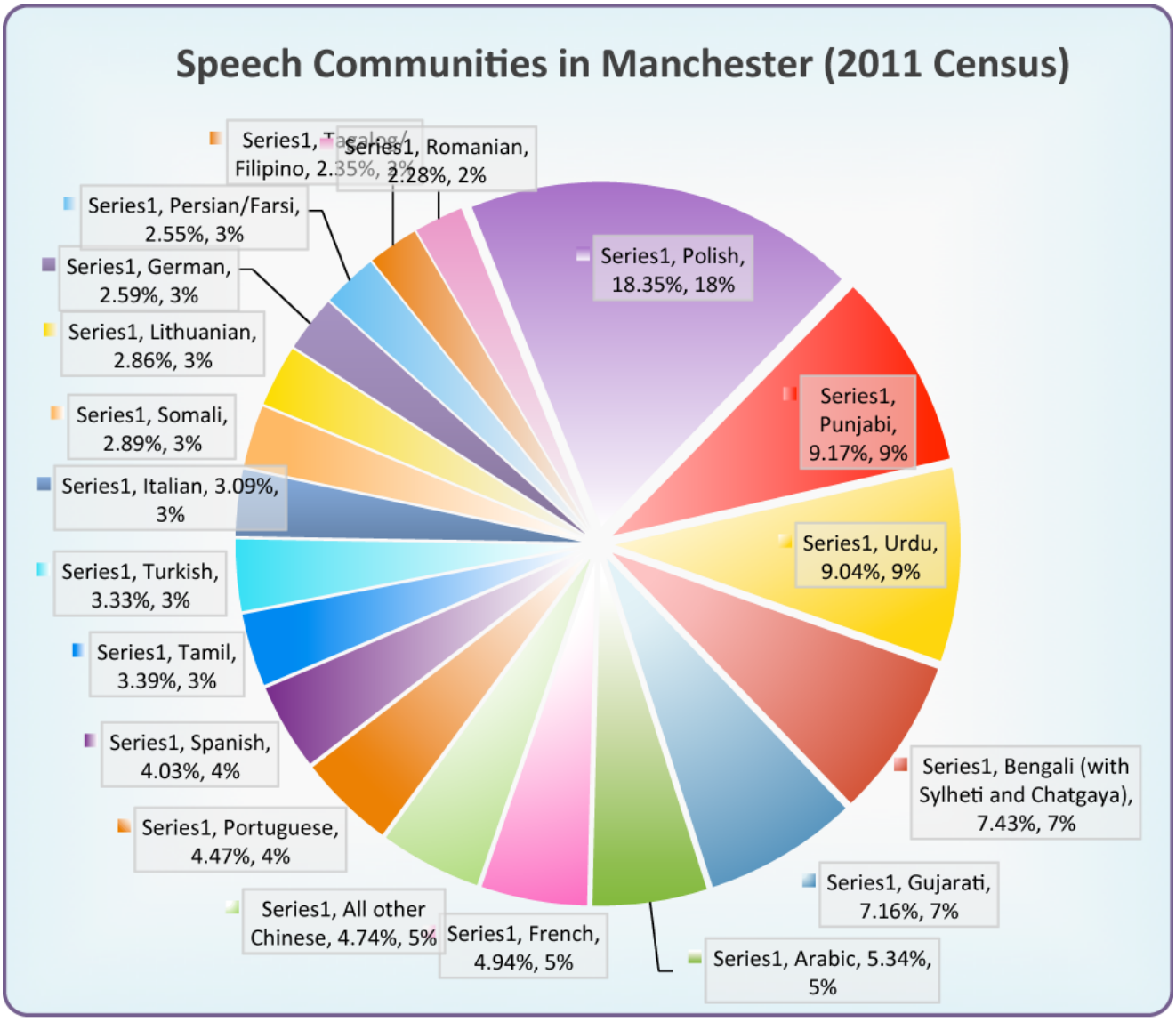
Census Data and MRI Numbers

The language most in demand at the MRI was Urdu (20% of interpretation jobs). According to the Census in Manchester (2011), it is the third biggest non-English speaking community after Punjabi. At the MRI, Urdu is followed by Arabic (10%), a significant discrepancy with the percentage of Arabic among foreign

languages in Manchester (5%). It is quite interesting that the next language in terms of numbers for the MRI is Cantonese (9%) even if the census does not regard Cantonese Chinese as a large foreign language at all —in fact, it only gives importance to all other Chinese (5%) i.e. any variety of Chinese that it is not Cantonese or Mandarin. Therefore the demand of Mandarin Chinese in the ITS (5%) does not correspond with the data census either. At the MRI, Polish only clocks in as the 5th most demanded language, a huge difference with the percentage of Polish speakers in Manchester (18%, the biggest speech community). This can



be easily explained through the fact that Polish immigration started over a century ago and that the Polish community is now well-integrated and largely bilingual. The same explanation goes for Tamil, Gujarati (and to some extent Kurdish), an explanation to which we might add that the shared (colonial) history that India and Sri Lanka have with the United Kingdom and the immigration history (with massive immigration waves 2 to 3 generations ago and a currently very well-established Indian-English identity) plays a huge part in those communities' English proficiency (not to mention that English is actually one of India's official languages).



The percentages for Bengali are exactly the same in both cases (7%) so we can deduct that a significant part of Manchester's Bengali-speaking population has no English proficiency. But something similar happens with Farsi/Dari (MRI terminology) or Persian/Farsi (Census terminology), where the percentages of languages necessitated in the MRI is higher (4%) than its representation in Manchester (3%). The same pattern applies to Romanian, with 4% of the interpreting jobs compared to only 2% of Romanian speakers in the non-English speaking population. The most remarkable language is Somali where the percentage given by the ITS (6%) doubles the one provided by the census (3%), indicating a largely non-English speaking (and therefore non-integrated) Somali population.

The social aspect of interpreters

We've seen through our experiences within the service of interpreters and through all the medical interpretation literature the importance of the cultural aspect of interpretation within healthcare services. As demonstrated by Pöchhacker and Shlesinger (2007) writings, a good interpreter must minimize his presence as much as possible to make doctor-patient communications easier but at the same time he or she also has to bring doctors to a better cultural understanding of the patient. One interesting thing about interpreters in hospitals is that the interpreter can and has the right to defend the patient against the institution by being a protector and negotiator in conflicts; the role of the interpreter is closer to a medico-social worker more than an interpreter. So, as well as being a linguistic agent, who correctly interprets all the medical information, interpreters are almost doing the job of a social mediator, sharing their code of ethics.

The study conducted by Pöchhacker and Shlesinger made it clear that the interpreter's roles differ widely from one context to another. It has shown that doctors need to focus more on the social aspect of interpretation because culturally sensitive care sometimes seems to be left. We have clearly seen with our own observations made of the relationships between patients and interpreters that there is a strong connection between both: not only a professional relationship but also mainly a cultural and social (almost friendly for some case) relationship. The interpretation work has so many multiple facets but the one that people tend to forget about is probably the most important one: the social aspect of it.

The Problem of Statistical Bias

Within the city of Manchester is a large, culturally diverse population of nearly 400,000. The 2011 census showed that about 12% of the population came from an ethnic minority group. These figures are likely to be underestimated as Manchester is one of the top five dispersal areas for asylum seekers and these populations may be unaccounted for in the recent census.

The 2011 Census shows skewed numbers for some communities (Mandarin and Cantonese in particular) which must be taken into account when establishing parallels with the percentages of patients according to language spoken. This has been highlighted by Pr. Y. Matras (4), who outlined: "Manchester is home to the fourth largest Yiddish-speaking community in the world, yet the census only mentions five speakers."

Romani is reported to have only 29 speakers, yet a recent survey by the [university's] Romani Project confirms that there are several hundred Romani speaking households in the city. "Only 1,700 people are reported to speak Cantonese, and only 13 are reported to speak Caribbean Creole, but these figures must surely be wrong. Both communities have many thousands of members." Pr Matras said the difference in numbers could be down to an "under-reporting" of languages, partly through lack of awareness or "fear of stigmatisation".

It could also be the result of people misunderstanding the census question. He added: "For many people, English is [their] main [language] because they use it during most hours of the day at work or place of study, but it is not their home language."

Moreover, the data for the interpretation jobs isn't exactly representative of the number of patients. We have conducted an in-depth analysis of the smaller languages (mostly European, such as German) to establish whether it was a) a specific age population (older patients) and b. the same, recurring patients (through analysis of the successive wards and dates in which the interpretation took place).

It appears indeed that the bulk of the LEP patients come from a certain geographical area; the number of interpretation jobs for the less-represented European languages is not faithful to reality; Dutch, German, are almost exclusively elderly people who visited different wards successively ("Cataract, eye surgery, In-patients, out-patients" is a recurring combination) and take up a relatively high number of "interpretation jobs" in the list. These cases are not statistically significant. In the cases of Sinhalese, Oromo, Ndebele, Malayalam, Madinka, Kutchi, Edo and Ibo, the data allows us to conclude it was between one and three patients for each language, each of them having come back between 2 and 6 times (in the case of a Ndebele-speaking patient). Of course these numbers barely skew the overall statistics, but it is worth noting that the average patients for small languages and European languages are elderly people, either first generation

immigrants of their respective language/country who never learned English, or newly arrived (or perhaps visiting) non-nationals. This is inferred from the data and remains a hypothesis.

According to the Chinese interpreters, most of the middle-aged/old Chinese generation are early immigrants to England and they speak only Cantonese (or in rare cases, plus a little English); because Guangdong Province, the hometown for the language of Cantonese, was along the coast and thus the first area to have contact to foreign influence. Also, data from ITS show that requests for Cantonese do outnumber those for Mandarin: 2668 to 1598 in year 2012, and 3250 to 1989 from April 24th 2012 to April 24th 2013.

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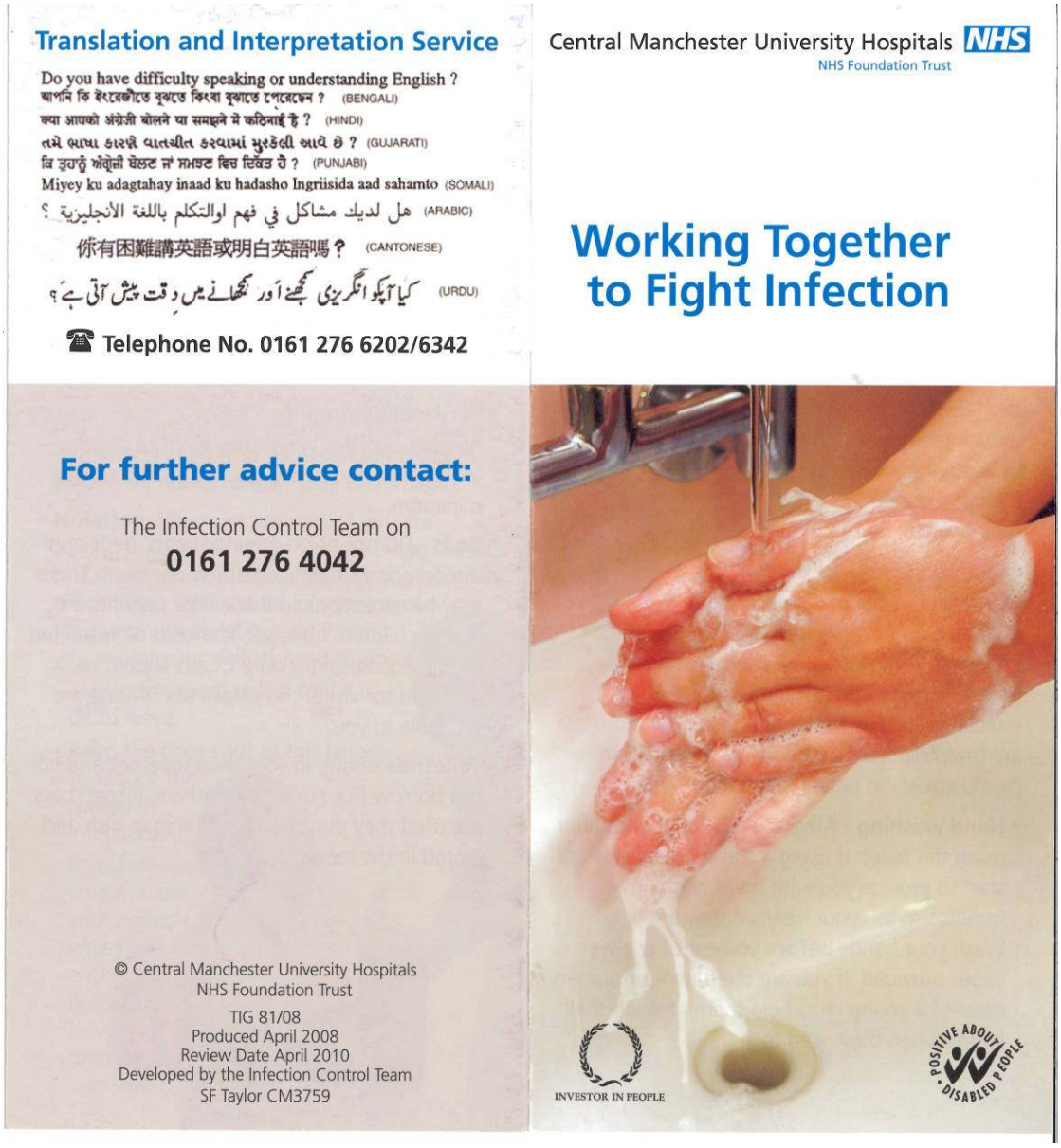
carers/patient-advice-and-support/interpretation-and-translation-service.aspx

on 4th March, 2013

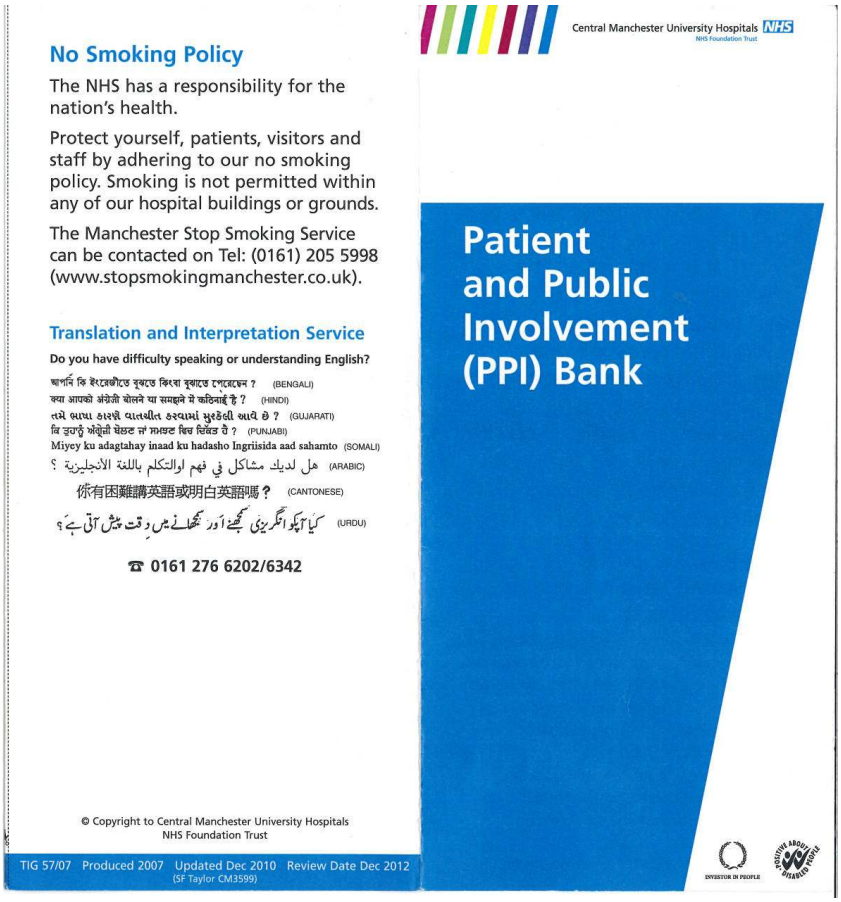
Annexes

Annex 1



Example of a leaflet advertising the ITS

Annex 2



No Smoking Policy

The NHS has a responsibility for the nation's health.

Protect yourself, patients, visitors and staff by adhering to our no smoking policy. Smoking is not permitted within any of our hospital buildings or grounds.

The Manchester Stop Smoking Service can be contacted on Tel: (0161) 205 5998 (www.stopsmokingmanchester.co.uk).

Translation and Interpretation Service

Do you have difficulty speaking or understanding English?

আপনি কি ইংরেজীতে বুঝতে কিংবা বুঝাতে সমস্যায়েছেন ? (BENGALI)
क्या आपको अंग्रेजी बोलने या समझने में कठिनाई है ? (HINDI)
તમે બધા કારણે વાતચીત કરવામાં મુશ્કેલી આવે છે ? (GUJARATI)
ਕਿ ਤੁਹਾਨੂੰ ਅੰਗ੍ਰੇਜ਼ੀ ਬੋਲਣ ਜਾਂ ਸਮਝਣ ਵਿਚ ਦਿੱਕਤ ਹੈ ? (PUNJABI)
Miyey ku adagtahay inaad ku hadasho Ingriisida aad sahamto (SOMALI)
هل لديك مشاكل في فهم اوالتكلم باللغة الأنجليزية ؟ (ARABIC)
你有困難講英語或明白英語嗎？ (CANTONESE)
کیا آپکو انگریزی سمجھنے اور سمجھانے میں دقت پیش آتی ہے ؟ (URDU)

☎ 0161 276 6202/6342

TIG 57/07 Produced 2007 Updated Dec 2010 Review Date Dec 2012
(SF Taylor CM3599)

Central Manchester University Hospitals NHS
NHS Foundation Trust

Patient and Public Involvement (PPI) Bank

Annex 3

An advertisement for the Audiology department (from left to right: Hindi, English and Arabic)

Annex 4

These signs (photographed in the hospital's Multi-Faith Center) were translated by an external agency. The boards include an Arabic translation as well as a Farsi one at the bottom. It can be seen in the use of the special character above the *ū* that this is a technical translation in linguistic script.

As there was no noticeable difference between the translations (in the corresponding language) in each of the boards we queried about it and two native speakers — one per language — elucidated the words "male" and "female" were not translated at all.

Both features lead to our next point: how would an Arabic/Farsi speaker — who obviously is not familiarized with linguistic scripts and in addition cannot speak a word of English — can understand these signs apparently translated into their mother tongues? In view of this, we can conclude that the quality of the translation is poor.

Annex 5

Still in the Multi-Faith Center, a shelf with several copies of the Quran both in Arabic and English.