Report

2011

The University of Manchester

Language within Manchester Health Services: Provisions and Practice

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Introduction

Manchester is a highly diverse community and home to speakers of an array of the world's languages. Ethnicity has proven to be a good indicator of language identity. Using statistics from the 2001 census (appendix 1), Longsight and Moss Side are illustrated as holding the largest non-white population. We would therefore expect more foreign languages to be spoken here and so the majority of our study focuses on these areas. We will visit one GP's surgery in each area in order to acquire data on services available that enable non-native speakers of English to communicate with NHS staff.

The third area of our investigation is focused on the MRI. Although it is not located in the above areas, we have included it in order to obtain data for a health care institution which is not restricted by residential area. People of all languages should be able to access the facilities provided by the hospital. It is integral that communication between patients and NHS staff is maintained in order to establish a universal service which is not obstructed by

language barriers. We would therefore expect provisions to be in place for all languages. We are interested to discover whether this is the case, the types of provisions available (e.g interpretation services, leaflets, online resources) and whether these are equal across languages.

In our plan we stipulated that we would investigate NHS policies concerning access to health care for non-native speakers of English as, as Harold Schiffman suggested, 'certain policies have come about in order to deal with the multilingualism of the citizenry.' (1996: 3) Therefore, we assumed that a policy would be beneficial and therefore, present. However during our preliminary research we tried to gain knowledge of NHS language policies and came across some complications. We began with Manchester City Council, who suggested that we visit their Customer Services centre and directed us to the NHS website. Following this we discovered that there is no language policy implemented across the NHS service, however, there are provisions available upon request; this will now be the focus of our investigation.

We suggest that the NHS does not implement a standard policy, but rather works on a supply and demand basis to avoid supplying unnecessary services and wasting funds. Further to this, if the provisions provided are successful despite not being conditioned by a policy, then why implement one?

Research on the NHS website informed us of some of the provisions available, for example, translators, online information sheets and telephone services. The website suggested that M- Four interpreters were often used in Manchester's health services, and were deployed to the hospitals and doctors surgeries when needed/requested. This directed our investigation towards contacting M-Four and organising an interview with an interpreter.

Research Questions

- Which services are provided to enable effective communication within the domain of health care institutions? Are these services widely available, offered and sufficient?
- Are all language services implemented equally in the chosen linguistically diverse areas?

In addition to the above research questions, originally we also intended to investigate whether any services available had undergone change, if these changes were due to government cuts and potential consequences of such changes. However, after preliminary

research we found people unwilling to talk about the impact cuts may have on the NHS. Furthermore we realised that such information is not readily available and so we would not be able to assess their true impact. Consequently this would result in us making predictions, rather then presenting facts and evidence, which would not be beneficial to our study. Similarly, we do not feel that this investigation would allow enough scope to adequately assess what other services could be provided. Therefore, we will not continue with this as a research question, but may hint towards some possibilities where our research allows.

Methodology

We received permission to conduct research in three health care institutions (New Bank, MRI, Moss Side Family Medical Practice) and divided the group into three pairs, with each pair being allocated a different health care institution. It is worth noting that both Moss Side Health Centre and Longsight Health Centre refused our request to conduct our research.

We specifically targeted our data collection methods according to the type of information we wanted to obtain from whom. For example, we interviewed admin staff at the surgeries in order to gain statistics on the number of non-English speakers registered at both.

We used two primary methods of data collection- interviews and questionnaires. We conducted semi-structured interviews with:

- Admin staff: 2 from MRI (appendix 2), 2 from Longsight, 1 from Moss Side (appendix 3).
- Doctors at both GP surgeries (appendix 4).
- Interpreters at M-Four and 1 from Moss Side (appendix 5).

Questionnaires were distributed to patients at two GP surgeries (appendix 6):

- 20 responses from Longsight
- 10 responses from Moss Side.

Our data collection methods were designed to yield both qualitative and quantitative data. Moyer and Li Wei stressed the importance of qualitative data as it attempts to ‘understand experience from the point of view of the members of the group’ (2008:27), whilst quantitative data also allows a statistical approach.

Results

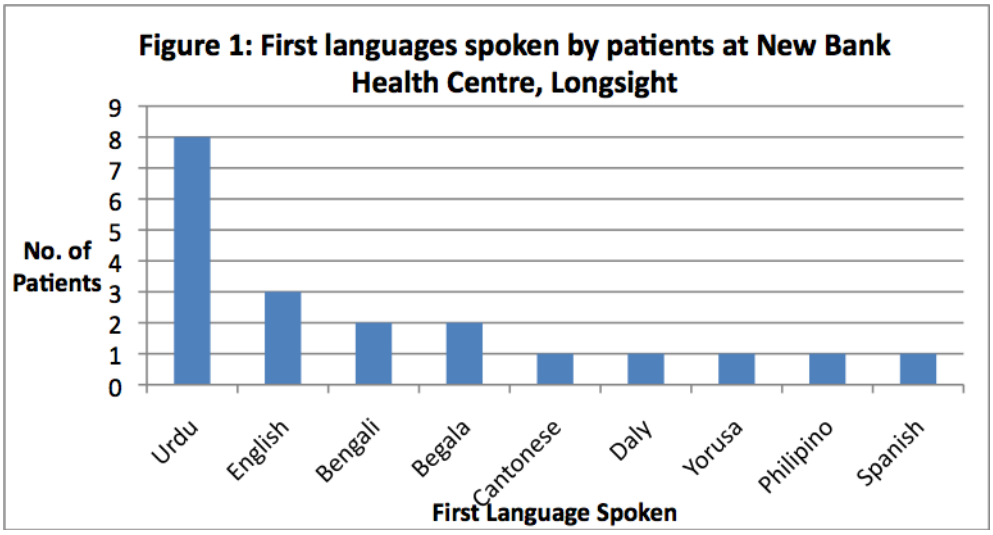
Longsight Surgery

Reception staff identified a total of ten languages (other than English) spoken by patients registered at the surgery- Arabic, Turkish, Kurdish, Spanish, Polish, Chinese, Gujarati, Somali, Punjabi and Urdu. Admin questionnaires provided us with statistics from July 2010:

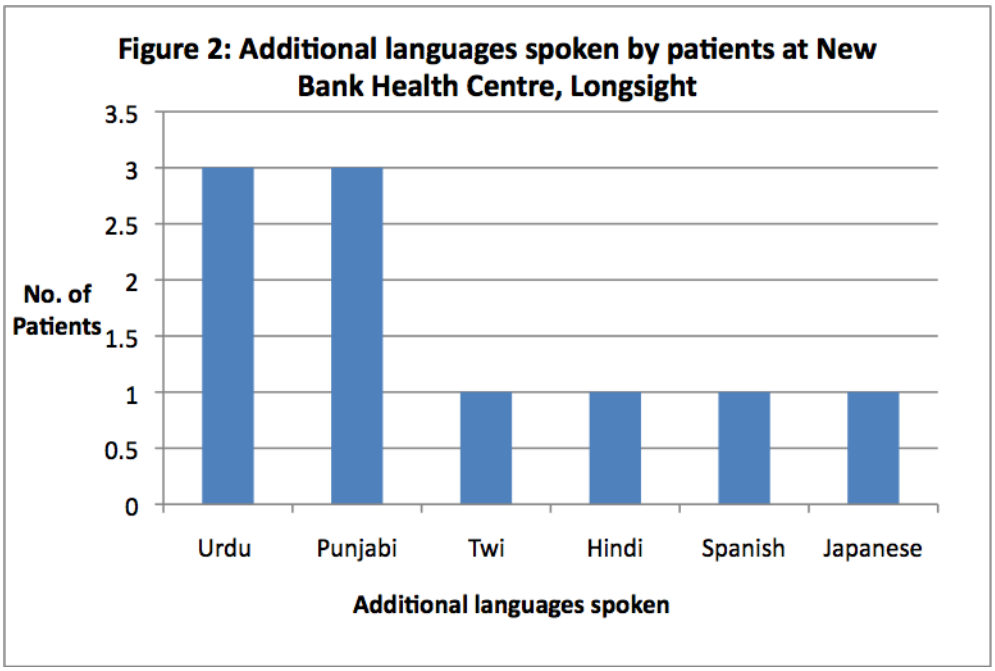
- Number of registered patients: 2553
- 700 patients are students (both native and non-native, but all fluent English speakers, excluding this subsection there are very few fluent English speaking patients)
- 27% native/fluent speakers of English
- 70% non-native speakers can speak at least some English
- 3% unable to speak any English at all

Our study aimed to establish which services are available for the 73% of non-native and non-English speaking patients. In order to gain this information we analysed the questionnaires we distributed and the following was concluded:

Figure 1 supports our earlier prediction that ethnicity can indicate language identity, as Urdu appears to be the most prominent language in Longsight, an area with a large Pakistani community.



Fifteen patients who did not identify English as their first language, expressed the ability to speak it in addition to their mother tongue. Other languages spoken usually corresponded with the language of their birth place and are displayed below (Figure 2):



It was indicated that documentation in Urdu would be preferred to documentation in English, even where Urdu was not the patient's first language, once again reflecting Longsight's dominant Pakistani community. For example, the surgery supplied NHS documents in Urdu, such as leaflets on how to quit smoking (appendix 7), diabetes and cancer screening.

We observed a language barrier between patients and the majority of admin staff. For example patients confused their appointment time- arriving at 9.15 rather than 9.50. To mediate these communication problems, a member of the admin staff, who is fluent in English, Urdu and Punjabi, was on hand to translate. Paralinguistic features, such as gestures to the heart were also used.

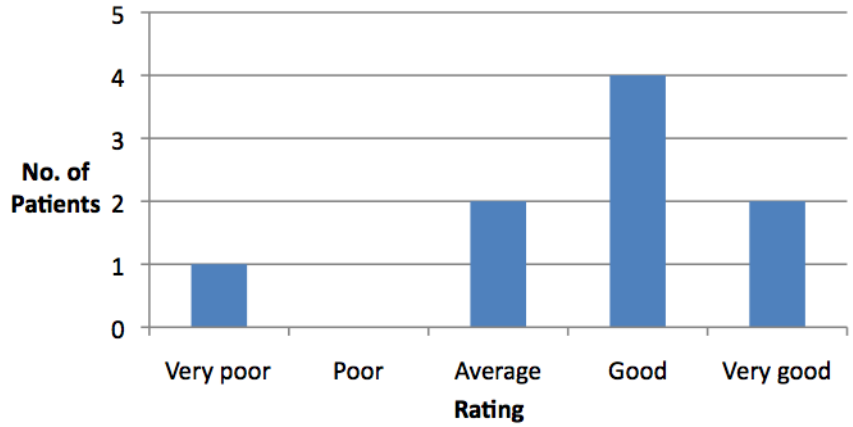
Overall, responses suggested most patients are happy to speak English when consulting with their doctor and therefore do not require interpretation services. However, two patients

indicated they preferred to communicate with their doctor in Urdu, with one patient claiming to already do so. Questionnaires with two other patients (who knew some English) demonstrated that consultations sometimes take place in both English and Urdu. This is possible as at least one of the doctors working at the surgery is fluent in both languages. After consulting with admin and medical staff, we have also found that consultation in any language may be facilitated through a service known as 'Language Line'. This service was also acknowledged by a similar report conducted by Faxon et al, regarding the services available in another Manchester health centre, (2010:5).

On four occasions, patients were unable to participate due to an inadequate understanding of English. On one occasion another patient offered to translate and complete the questions. The data this elicited is therefore particularly beneficial to our investigation, as it is the people with the least knowledge of English who will require more language facilities. It also realised our concerns that eliciting information from patients through the questionnaire method would exclude those most interesting to the research from taking part. Similarly three patients were only able to participate with the aid of a group member, who expanded on the question verbally.

Despite the Admin staff stating that the surgery offered translation services for all of the world's languages via 'Language Line', the questionnaires illustrated that many of the patients are unaware of help on offer. Fourteen patients had no knowledge whatsoever, with the remaining 6 having only very minimal knowledge, with many believing language services were only offered in English, Urdu and Punjabi. Patients then rated these services (Figure 3):

Figure 3: Ratings of the translations services for the New Bank Health Centre, Longsight

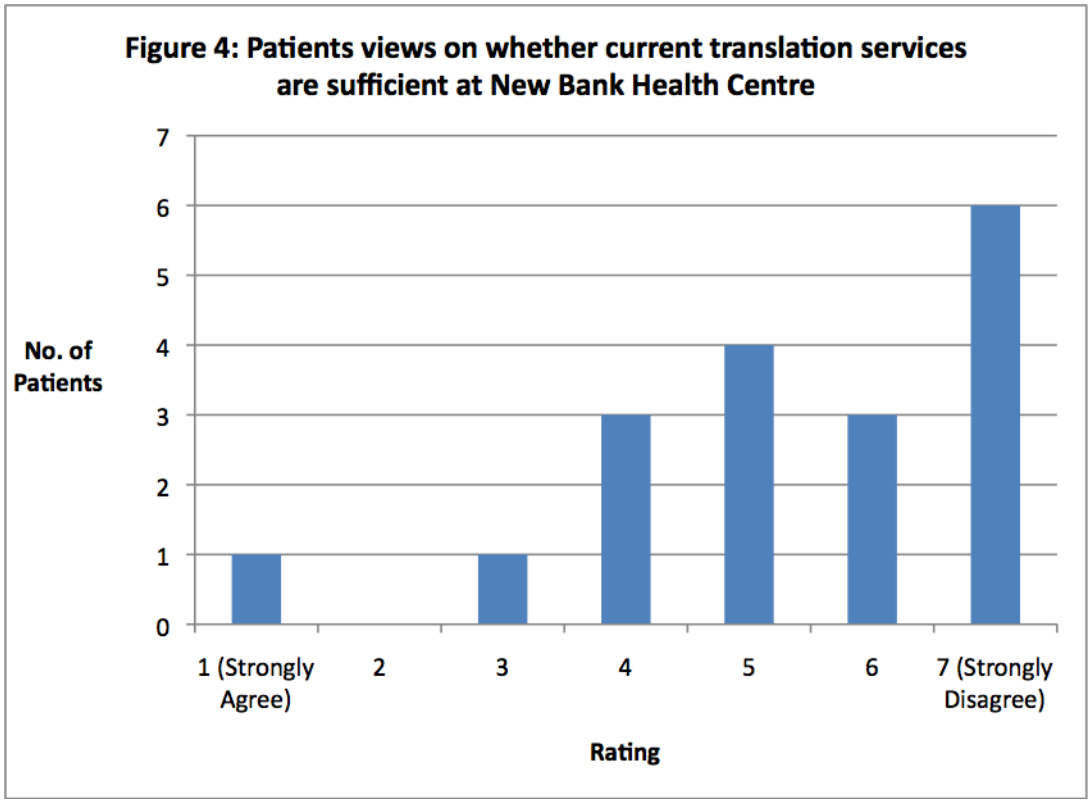


The results here do not correlate with the amount of participants answering to the affirmative in question 6, perhaps indicating a misinterpretation of the question. Participants may have rated the general services New Bank provides, rather than specifically the language services.

Despite a lack of knowledge regarding the services available, 18 participants responded negatively when asked if they encountered problems when communicating with the doctor. These results do not correspond with the extensive communication difficulties expressed by the admin staff, nor with what we observed in the waiting room. This difference suggests that communicative provisions may be focused on patient-doctor correspondence rather than with all NHS workers. Alternatively, it may be that the participants do not understand the terms used as we intended.

Although few participants expressed difficulty communicating with their doctor and made use of the services available, the majority agreed that the NHS needs to provide language services to non-native speakers. Figure 4 shows the responses to question 10:

Figure 4: Patients views on whether current translation services are sufficient at New Bank Health Centre



Where facilities were used to aid communication, the most popular methods were interpreter/translation services and leaflets/documents available in the surgery. Two also expressed having a fluent speaker of English accompany them to their appointment. One participant expressed that although she does not require language services herself, she would appreciate better access to provisions for her mother so that she need not also attend.

In addition, we also interviewed a GP at New Bank Health Centre. She spoke Hindi and English as her first languages, was near fluent in Urdu and could speak some Punjabi. She told us that it is of great help to her profession speaking the languages she does, especially in the Longsight area of Manchester. However, she sometimes encounters problems communicating with patients, which are resolved by using 'Language Line'. Using this service is more time consuming, so it requires booking a 20 minute appointment as opposed to a 10 minute slot. It is surgery policy to employ 'Language Line', as opposed to interpreters, which may differ to other surgery policies. For example, Moss Side Family Medical Practice, does not use Language Line

Moss Side Surgery

The policy at Moss Side Surgery states that when patients register, they must indicate their level of English. This is recorded on their file, and when an appointment is made, the surgery automatically books an interpreter if needed.

During our visit, an interpreter, who was booked for 5 patients, arrived and answered some of our questions. Manar Aldean told us the languages most requiring an interpreter in Manchester are: Arabic, Polish, Urdu, Punjabi and Chinese. She works for an NHS department, which deploys interpreters to GP's surgeries in Manchester. She supported our findings from both surgeries, expressing that services are often neglected in favour of the use of relatives. However, she told us that St Marys Sexual Assault centre uses an onsite interpretation service provided by the Hospital Trust (as discussed in the MRI findings), and it does not allow patients to use relatives. She feels that the service she provides is beneficial to patients, as she visits this surgery often allowing her to build a rapport with patients. It is common for patients to become competent in English and state they no longer require her services.

In Moss Side many patients were unable to complete the questionnaire due to inadequate

knowledge of English. In addition, the reception staff told us not to approach patients directly as a lot of them are illiterate, and would feel uncomfortable being asked to fill out a questionnaire. As a result we only managed to complete 5 questionnaires, and feel that although these responses are valuable, it would be misleading to use graphs to display the findings without more expansive results.

From the questionnaires, we found that many patients used the interpretation services and found them very useful. Of the 5 questionnaires completed all patients rated the services for language provision at the surgery as 'good' or above. They stated no problems communicating with the doctor if there was an interpreter present but nevertheless agreed that provisions need to be in place non-English speaking patients.
The admin staff supplied little information about the distribution of languages within the surgery, but indicated that many are multilingual, which enables them to communicate with patients.

Manchester Royal Infirmary

Although we did not find any leaflets or signs in other languages, we found that most leaflets advertised the Interpretation and Translation Service (ITS) that is provided to the MRI because it is part of Central Manchester University Hospitals NHS Foundation Trust (the Trust). This information was provided in Bengali, Hindi, Gujarati, Punjabi, Somali, Arabic, Cantonese and Urdu (appendix 8)**.** Details of the ITS are also provided on the Trust's website in Arabic, Urdu, Farsi, Chinese, Somali, Polish, Banglan, Romanian and Czech. Unfortunately the leaflets only advertised the ITS on the back and so patients who could not speak English might not be prompted to look at them. Even leaflets targeting South Asian and Black patients failed to provide information in the languages that might be spoken by individuals from these communities (appendix 9).
As the MRI treats patients from across Manchester, it must cater for a range of non-English speaking patients. In order to do so, the Trust provides an ITS, which is located onsite and provides in-house interpreters of the most commonly requested languages: Urdu, Cantonese, Punjabi, Bengali/Sylheti, Farsi/Dari, Hindi, Vietnamese, Arabic, Somali, Mandarin, Polish, Kurdish, Gujarati and Swahili. However, other languages can be catered for (appendix 10).

The Trust's Best Practice Guidance (a copy of which was given to us) states the need to use qualified interpreters as they provide:

- Confidential, impartial and accountable interpretation
- Effective communication of patient's views and feelings
- Information to enable patients to make informed choice in conjunction with health care staff

The Trust also stresses that there are risks involved with not using an interpreter and so guidelines are in place to ensure appropriate interpreters are used (appendix 11). In consideration of its patients, the Trust also attempts to provide the same interpreter, whenever possible, in order to provide the patient with continuity of care.

Although the interpreters are largely employed for face-to-face consultations, they also provide written translation (although the ITS notes that not all non-English speaking patients can read their own language) and give information to patients over the phone. Hospital departments use a Language Identification Card, which is shown to patients to establish their preferred language, however, the ITS note that a language may have several different names and consist of numerous dialects.

In such a sensitive domain, we felt it was inappropriate to approach patients. Therefore, we were unable to ascertain whether these services were sufficient to meet their needs. However, the provision of the onsite ITS, indicates the Trust's willingness to provide language services. The service is often fully booked; therefore external interpreters are sourced to meet demand.

Interpreter Interviews

Three interpreters from M-Four took part in informal interviews. Schleef and Meyerhoff (2010: 7) emphasise the need to inform the participant when recording is to take place, but we found that some seemed reluctant to be recorded and so we decided to take notes instead.

The interpreters indicated that they are needed across the whole of Manchester, but identified Rusholme, Longsight, Cheetham Hill and Levenshulme as areas where they were often required. Two out of the three participants named our selected area, Longsight, but none selected Moss Side, possibly because the interpreters in question were speakers of South Asian languages and the census data shows that much of the population of Moss Side is Black African and Black Carribean. We were unable to interview an interpreter of African/Afro-Carribean languages due to their busy schedules.

The interpreters told us that they are required to interpret everything that patients and doctors say, even if they deem it to be irrelevant. They said that patients often give irrelevant information and can result in the doctor becoming frustrated, as it makes the consultation more time consuming. One interpreter also suggested some doctors dislike using interpreters, as it takes longer to diagnose patients.

One of the interpreters said that although using an interpreter is best (and sometimes the only) way of enabling some patients to communicate with doctors, it is not ideal because patients are often reluctant to disclose some information, despite the fact that interpreters are bound by confidentiality agreements.

None of our interpreters could recall a time at which they had encountered a problem interpreting in a healthcare domain. One interpreter said that she had been trained to understand medical terminology in order to make it easier to interpret in a healthcare domain, where specialised terminology is often used.

All three participants expressed that they could be held accountable for any problems that arose from miscommunication if they were deemed to be the fault of the interpreter, which is why some health care institutions favour interpreters over relatives.

The interpreters mentioned that they are being used less and less as GP's surgeries seem to be favouring another service, 'Language Line'.

4.0 Analysis

Which services are provided to enable effective communication within the domain of health care institutions? Are these services widely available, offered and sufficient?

Across the three health care institutions we have looked at leaflets, interpretations and translation are all widely available. However, in Longsight we found that these services did not seem to be widely offered as most of our participants were unaware of them. In Moss Side there did seem to be more awareness of the service as the interpreter was there to help with 5 patients. As we did not speak to patients at the MRI we are unable to state whether patients find the ITS adequate. In regards to the sufficiency of these services, most participants in the GP's surgeries responded positively towards them.

Are all language services implemented equally in the chosen linguistically diverse areas?

Although we found that Moss Side and Longsight adopt different policies regarding 'Language Line' and interpreters, we felt that both provided a good level of service. The results for Longsight reflect the census data as the GP's surgery concentrated on providing services in Urdu, because it is a dominant language in the area. Similarly, in Moss Side, Somali was favoured, once again reflecting the census data for that area. As the MRI deals with patients from across Manchester no one language is in high demand and so they provide services for any language necessary.

5.0 Conclusion

Given more time, we would have been able to conduct a more detailed investigation within each of the surgeries. This would have enabled us to find ways around the language barrier, which consequently reduced our data collection, especially in Moss Side. Furthermore, we would have liked to expand our study to other areas of Manchester, in order to gain a more extensive comparison of the language services available. However, with the time we had we feel that the information we gained is sufficient enough to conclude that the language services within the health care institutions we looked at are good. However, awareness of the services could be raised by individual surgeries.

Our study makes it clear that the interpretation services and facilities are crucial and the main means of communication between English and non-English speakers. Ronald Wardhaugh expressed that 'People who speak different languages who are forced into contact with each other must find some way of communicating, a lingua franca.' (2006: 59) In the institutions featured in this study, a lingua franca is not used. Instead, the interpreter themselves acts as a lingua franca, being someone that each participant of the conversation can understand in order to aide effective communication.

Both GP surgeries adopted different language policies, and they both seemed to be successful, this suggests that a national NHS language policy is unnecessary as individual institutions are capable of providing a tailored service to suit their patients.

References

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Appendices

Appendix 1: 2001 Census Data

erived 2006-Based SNPP for 2011 StatWard - percentages

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l persons	All groups (no.)	White	Mixed	Indian	Pakistani	Bangladeshi	Black Caribbean	Black African	Chinese	Other ethnic groups	A18 All Non-White Ethnic groups	
ncoats and Clayton	15,523	88.3	2.2	0.9	1.1	0.1	0.7	2.0	2.8	1.9	11.7	100.0
dwick	17,101	47.6	4.8	4.3	4.3	2.3	2.9	14.7	11.3	7.8	52.4	100.0
guley	15,672	92.6	2.0	1.0	0.7	0.3	0.6	0.8	1.0	0.9	7.4	100.0
adford	13,924	82.4	2.8	0.9	0.7	0.2	1.0	4.0	5.7	2.3	17.6	100.0
ooklands	13,825	90.7	2.1	1.6	0.4	0.0	0.4	1.0	1.8	1.9	9.3	100.0
rmage	15,893	78.0	3.3	2.8	6.9	1.3	1.0	1.3	1.9	3.6	22.0	100.0
hanlestown	13,813	93.5	1.9	0.4	0.7	0.0	0.4	1.1	1.2	0.9	6.5	100.0
heetham	19,149	44.1	4.9	5.5	23.9	0.4	1.4	5.1	4.1	10.7	55.9	100.0
horlton	14,003	80.0	2.5	3.7	6.0	0.4	1.5	1.6	1.8	2.4	20.0	100.0
horlton Park	13,865	78.3	4.6	2.5	3.6	0.3	1.9	2.6	1.9	4.4	21.7	100.0
ty Centre	11,476	60.1	2.0	8.3	1.4	0.2	0.5	2.4	21.5	3.7	39.9	100.0
rumpsall	16,178	71.7	3.0	3.3	12.1	0.1	0.9	3.2	1.0	4.6	28.3	100.0
dsbury East	14,794	80.5	2.6	4.8	3.8	1.0	0.4	1.6	2.3	3.0	19.5	100.0
dsbury West	13,473	83.4	2.3	4.7	1.8	0.7	0.6	0.9	2.0	3.5	16.6	100.0
illowfield	15,859	66.1	4.5	6.4	7.4	0.9	1.8	4.9	2.8	5.1	33.9	100.0
orton North	15,697	86.2	2.6	0.4	1.7	0.1	0.9	2.5	3.2	2.4	13.8	100.0
orton South	17,336	81.2	3.2	1.3	5.2	0.4	1.5	2.5	1.7	3.1	18.8	100.0
rpurhey	18,066	88.7	2.5	0.4	1.1	0.1	0.6	2.0	3.1	1.7	11.3	100.0
gher Blackley	15,125	92.5	0.9	1.0	1.2	0.1	0.5	0.7	2.1	1.1	7.5	100.0
ulme	13,877	58.4	5.8	3.0	1.4	0.2	5.3	11.9	7.0	7.0	41.6	100.0
rvenshulme	15,468	68.4	2.9	5.7	12.2	1.1	1.4	2.2	2.5	3.7	31.6	100.0
ngsight	15,690	37.5	4.0	6.2	26.8	8.2	2.8	4.7	3.1	6.7	62.5	100.0
les Platting and Newton Heath	17,216	91.2	1.6	1.5	0.9	0.2	0.6	0.8	2.1	1.1	8.8	100.0
oss Side	18,745	41.7	5.9	3.8	3.6	1.2	8.5	20.3	4.7	10.2	58.3	100.0
oston	15,570	88.8	2.5	0.5	0.5	0.0	0.6	1.9	3.2	2.0	11.2	100.0
orthenden	15,729	91.7	2.3	1.0	1.3	0.1	0.5	0.9	1.0	1.3	8.3	100.0
d Moat	15,000	77.9	4.8	3.6	3.2	1.1	1.1	2.2	1.9	4.2	22.1	100.0
usholme	15,029	49.2	3.1	8.2	10.9	7.3	1.6	6.6	6.6	6.4	50.8	100.0
harston	16,673	93.7	2.6	0.4	0.6	0.0	0.4	0.7	0.6	0.9	6.3	100.0
halley Range	15,469	49.7	4.1	7.6	19.9	0.7	3.6	4.1	2.5	7.8	50.3	100.0
thington	12,507	74.4	3.2	6.6	5.5	0.9	0.7	2.0	2.9	3.8	25.6	100.0
oodhouse Park	15,055	93.0	1.9	0.6	0.3	0.2	0.3	1.2	1.5	0.9	7.0	100.0
anchester	**492,800**	**73.1**	**3.2**	**3.2**	**5.7**	**1.0**	**1.6**	**3.9**	**3.6**	**4.0**	**26.2**	**99.3**

Derived by Policy Analysis from the 2001 Census by Output Area and aggregated by best fit to 2004 ward boundaries. Ward distribution using Electoral Register
d Child Health System. Applied to ONS 2007 Mid-Year Estimate for StatWards (experimental statistics); 2006-based Sub National Popualtion Projections; Ethnic
roups from 2001 Census and ONS Table EE1: Estimated resident population by ethnic group, mid-2007, (experimental statistics).

Appendix 2: Admin staff interviews at MRI:

1. Which languages, other than English, do the majority of your patients speak?
2. Which languages, other than English, do you speak?
3. What translation services do you offer to help communicate with non-native and non-English speakers and what languages do you cater for?
4. Are these translation services widely used?

Appendix 3: Admin staff interviews at Longsight and Moss Side:

1. Which languages, other than English, do the majority of your patients speak and where are they from?
2. Are you able to provide us with statistical data on how many speakers of English as a second language you deal with/are registered at the surgery?
3. Do you speak any languages, other than English? If yes do these aid your communication with non-native speakers of English?
4. What translation services do you offer to help communicate with non-native and non-English speakers and what languages do you cater for?
5. Are these translation services widely used?

Appendix 4: Doctor interviews at GP's surgeries:

1. Do you ever encounter problems communicating with your patients? If yes, how do you overcome these problems?
2. Do you speak another language? If yes, is this helpful in communicating with your patients and did it prompt you to apply to work in an area that has a large number of non-native and non-English speakers?
3. Is having a translator present whilst consulting with patients an effective means of enabling communication between yourself and a patient or is it a hindrance to involve a third party?

Appendix 5: Interpreter interviews at M-Four:

1. Are there are areas of Manchester that seem to require interpretation services more than others?
2. When interpreting communication between doctors and patients, do you translate the response of both participants word for word to each interlocutor, or, do you ask the

interlocutor for more information in order to give a more detailed response to the other participant?

3. Is having an interpreter present the most effective means of ensuring that doctors and patients are able to communicate sufficiently?
4. What problems, if any, have you encountered when working as an interpreter between a doctor and a patient?
5. Can you be held accountable for any problems that arise as a result of an error or miscommunication made during the interpretation process?

Appendix 6: Questionnaire for patients at GP's surgeries:

1- I am aged:

Under 18

18 – 30

30 – 50

50 – 65

65+

2- What is your first language?

3- Were you born in UK or did you move from another country? If so, which one?

4- Do you speak any other languages? If so, which ones?

5- In which is language do you communicate with your doctor?

-Would you prefer your consultation in a different language?

6- Do you know which translations and language services are available in the doctor's surgery?

7- If you have used these services, how would you rate them?

1- Very poor
2- Poor
3- Average
4- Good
5- Very good

8- Have you ever encountered any problems communicating with doctors?

9- Which methods might you use to aid communication with a doctor?

Interpreter/translation services ☐

Online help ☐

Leaflets/documents in the surgery ☐

Having a friend or relative present ☐

Other ☐

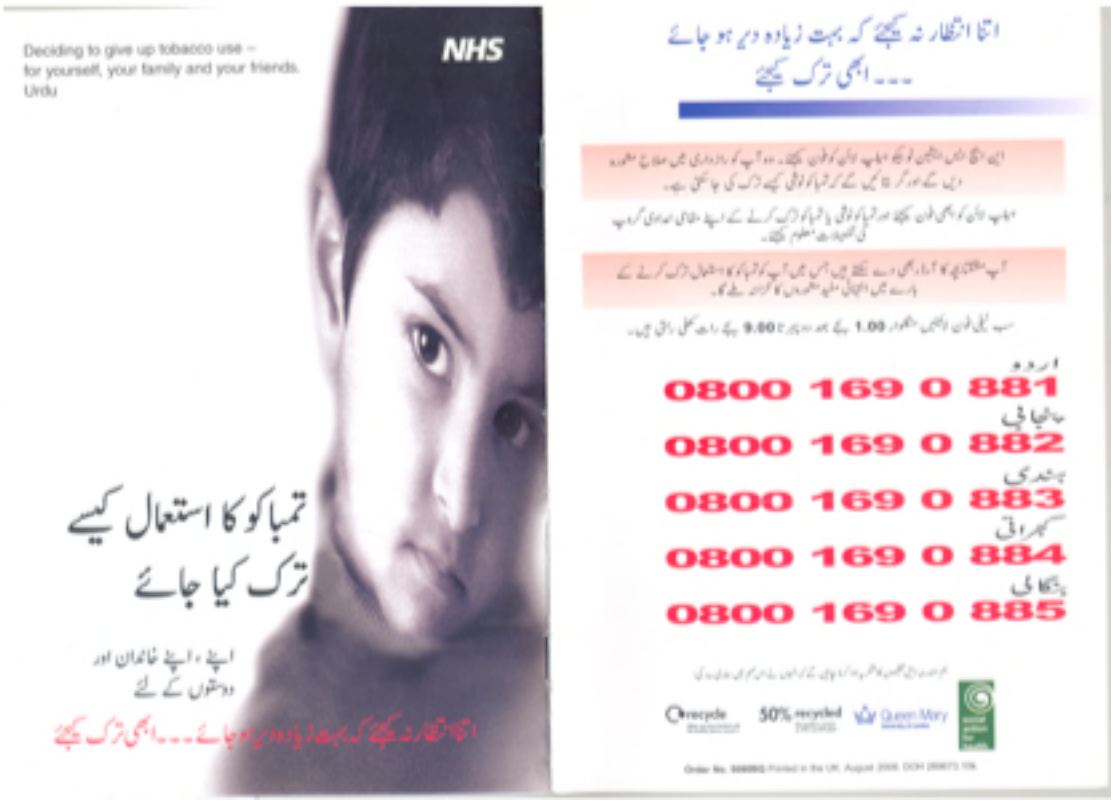
Please specify

10- To what extent do you agree that the NHS does no need to provide services for speakers of English as a second language? Please mark your score on the following scale.

1 2 3 4 5 6 7

(=Strongly agree) (=Strongly disagree)

Appendix 7: NHS leaflets in Urdu:



Appendix 8: Extract from a non-smoking leaflet, which promotes the ITS at MRI

Translation and Interpretation Service

Do you have difficulty speaking or understanding English?

আপনি কি ইংরেজীতে বুঝতে কিংবা বুঝাতে পেরেছেন ? (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 الانجليزية ؟ (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

Appendix 9: Leaflets from MRI targeting South Asian and Black patients:

Appendix 10: Languages catered for by ITS at MRI

Language	Where Spoken	Language	Where Spoken	Language	Where Spoken
Albanian	Albania	Hindi	India	Romanian	Romania
Amharic	Ethiopia	Hungarian	Hungary	Russian	Russia
Arabic	Saudi Arabia	Italian	Italy	Serb-Croat	Serbia
Bengali	Bangladesh	Japanese	Japan	Sinhalese	Sri Lanka
Bosnian	Bosnia	Korean	Korea	Slovak	Slovakia
Brava	Somali	Kurdish	Iraq/Turkey	Somali	Somalia
BSL Sign	UK	Latvian	Latvia	Spanish	Spain
Bulgarian	Bulgaria	Lingala	Congo	Swahili	Kenya
Cantonese	China/Malaysia	Lithuanian	Lithuania	Tamil	Sri Lanka/India
Czech	Czech Republic	Mandarin	China/Malaysia	Thai	Thailand
Dari	Iran/Afghanistan	Mongolian	Mongolia	Tigrini	Eritrea
Farsi	Iran/Afghanistan	Ndebele	Africa	Turkish	Turkey
French	France	Nepali	Nepal	Twi	Ghana
German	Germany	Polish	Poland	Ukrainian	Ukraine
Greek	Greece	Portuguese	Portugal	Urdu	Pakistan/India
Gujarati	India	Punjabi	Pakistan/India	Vietnamese	Vietnam
Hakka	China/Malaysia/Hong Kong	Pashto	Pakistan / Afghanistan	Yoruba	Nigeria

Appendix 11: Preference order table for persons undertaking interpreting:

Best Practice Preference Order Table for Persons Undertaking Interpreting
Preference Order for using Qualified Interpreters

Clinical Consent	1.Professional Interpreters	2.Health Professionals	3.Other NHS Employees	4.Family & Friends	5. Other Patients	6.Children
•Admission • Clinical histories •Treatment plans • Seeking verbal/written consent (procedures, investigations, treatment and research) •Results of investigations/diagnosis •Information about medication •Discharge procedures and referrals •Psychological assessment •Death of a patient	All key phases of care where communication is essential to making decisions, the planning phases of treatment and care.	Only when a **professional Interpreter** is not available and the interpreting needs to go ahead, and is agreed with the patient.	Only when a **professional Interpreter and Health professional** is not available, and the interpreting needs to go ahead, and is agreed with the patient.	Only when a **professional Interpreter Health professional or other NHS employees are** not available, and the interpreting needs to go ahead, and is agreed with the patient.	Not appropriate at anytime	Not appropriate at anytime
Non clinical issues •Menu •Personal care •Complaint •Procedures		Can be used Instead of interpreters	Can be used instead of interpreters	Can be used instead of interpreters		